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EXECUTIVE SUMMARY

BACKGROUND AND PURPOSE

Increasing the uptake of Indigenous Health Training (IHT) is a key strategic goal of General Practice Education and Training (GPET) Ltd. Understanding the attitudes, knowledge and fears amongst registrars and prevocational (junior) doctors regarding IHT is important for informing IHT strategy. Piazza Research, an independent research firm, was commissioned to research this issue during June, July and August 2010.

A two-stage research project was developed. The initial stage involved qualitative focus groups with both registrars and prevocational doctors to explore their attitudes, and to draw out new insights regarding IHT. The results from the qualitative research were then tested statistically during the second stage of the project – an online survey questionnaire.

Results from both the qualitative and quantitative stages of research will inform an IHT-focused marketing and communications strategy to encourage wider participation in IHT posts within the Australian General Practice Training (AGPT) program.

This qualitative research report analyses and summarises the outcomes of the IHT focus groups (stage 1).

METHODODOLOGY

Stage 1 - Focus groups were conducted between mid-June and early August 2010 by Piazza Research focus group moderators.

The focus groups were designed to encourage frank and open discussion about Indigenous Health Training, and to gain feedback from registrars and prevocational doctors (PGY 1+) about ways to encourage them to participate in Indigenous Health Training. The focus groups were recorded using audio equipment with the consent of participants.

Discussion Guide Design - The 2010 Indigenous Health Training Discussion Guide was designed based on consultations with GPET representatives, NACCHO, GPET state affiliates and RTP representatives.

Sample Design - Registrars and prevocational doctors were the target for the focus group component of the research as they represent the market most likely to be deciding about their medical training and career directions. Focus groups ranged in size from 4 to 9 participants. A number of individual in-depth telephone interviews were also conducted with registrars and junior doctors unable to attend focus groups.
A participant verification form was signed by each focus group participant to confirm their attendance and consent for audio recording.

Focus groups were organised with the generous assistance of Regional Training Providers (RTPs), National Aboriginal Community Controlled Health Organisation (NACCHO) state affiliates, General Practice Registrars Australia (GPRA), and hospital based GP Ambassadors.

**Location/venue for focus groups** – Focus groups were held across Australia in RTP offices for registrars and in hospitals for junior doctors. Locations included Canberra, Melbourne, Brisbane, Darwin, Adelaide, and Perth. All South Australian registrars were interviewed by telephone.

**Focus Group Breakdown:**

<table>
<thead>
<tr>
<th>Group</th>
<th>State</th>
<th>City / Town</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>WA</td>
<td>Perth</td>
<td>Urban registrars and junior doctors</td>
</tr>
<tr>
<td>2</td>
<td>NT</td>
<td>Darwin</td>
<td>Urban registrars</td>
</tr>
<tr>
<td>3</td>
<td>NT</td>
<td>Darwin</td>
<td>Junior doctors</td>
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<tr>
<td>4</td>
<td>SA</td>
<td>Various</td>
<td>Urban / rural registrars</td>
</tr>
<tr>
<td>5</td>
<td>SA</td>
<td>Adelaide</td>
<td>Urban junior doctors</td>
</tr>
<tr>
<td>6</td>
<td>VIC</td>
<td>Melbourne</td>
<td>Urban / rural registrars</td>
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<tr>
<td>7</td>
<td>ACT</td>
<td>Canberra</td>
<td>Urban / rural registrars (NSW &amp; ACT)</td>
</tr>
<tr>
<td>8</td>
<td>ACT</td>
<td>Canberra</td>
<td>Urban junior doctors</td>
</tr>
<tr>
<td>9</td>
<td>QLD</td>
<td>Brisbane</td>
<td>Urban / rural registrars</td>
</tr>
<tr>
<td>10</td>
<td>QLD</td>
<td>Redcliffe</td>
<td>Urban junior doctors</td>
</tr>
</tbody>
</table>

**Focus Group Incentive** – In order to encourage the participants to attend the focus groups, GPET offered a ‘lucky door’ prize incentive (Myer gift voucher). Refreshments were also provided.

**Moderation & Data gathering** – The focus group sessions each ran for approximately one hour. All focus groups were moderated by Vanessa Robinson-Conlon. In-depth telephone interviews were conducted by Vanessa Robinson-Conlon and Grant Piazza.

**Recording / Transcribing** - Each session was audio-recorded. These recordings were then transcribed.

**Data Processing & Analysis** - Consultants analysed recordings from each focus group and summarised main themes and ‘consensus answers’. Phone interview transcriptions were incorporated into the relevant focus group summaries (according to state and participant type).

**Note:** Results of qualitative research cannot be projected onto the wider population with statistical reliability. Results in this report should be treated accordingly.
In a small number of focus groups, some comments made by participants were relevant to more than one issue being discussed. In these cases, some comments were included under more than one topic explored.

**Quality Assurance System** - This project complies with ISO 20252 Market, Opinion and Social Research Standard.
**INDIGENOUS HEALTH TRAINING**

**FOCUS GROUP REPORT**

**SUMMARY OF MAIN FINDINGS**

**Interest in IHT** - The consensus from the focus groups was that registrars and junior doctors interested in undertaking an IHT post were generally interested in learning more about Indigenous cultures, as well as contributing to the improvement of Indigenous health outcomes. Some felt that IHT was challenging and exciting. Others suggested offering shorter IHT posts (particularly for rural or remote posts).

Of those not interested, some felt they had either not received enough information about placements or had received negative information. This negative information came from other doctors who had previously undertaken an IHT post, or from university seminars and materials about Indigenous cultures and health. Another detractor was the perception that IHT was based mainly in rural locations, where isolation and domestic issues were a concern. While some perceived rural medicine to be more attractive than urban medicine in a clinical sense, they saw it as less attractive in terms of lifestyle.

**IHT experience/exposure** - **Junior doctors** revealed that most of their exposure to Indigenous people and health had been through their hospital experience or through placement programs such as PGPPP. Junior doctors had received Indigenous cultural education at university, with most finding the delivery of this education to be non-engaging, repetitive and non-memorable. There was a suggestion to introduce some Indigenous cultural and health training into earlier stages of medical training if it were relevant to later training placements.

Some **registrars** had grown up with Indigenous people and some identified as being Indigenous. Most had attended cultural awareness or cultural safety sessions. Of these, half found the experience to be generally positive, while the other half found the experience negative and discouraged them from pursuing IHT. Those who had received cultural awareness training in medical school found it mostly inadequate or negative, only a few received engaging and informative cultural training. The groups suggested Indigenous health and cultural training should be held early in medical training, with some suggestions to include Indigenous health as part of every stage of medical training.

**Major influences** - The major influences when choosing training posts for both registrars and junior doctors were family situations, location, lifestyle and the challenge of treating illnesses rarely seen in mainstream society. People who influenced doctors’ training decisions included supervisors, senior registrars or peers with experience in IHT. Opinion was divided over whether peers and family members would support an IHT placement. Negative influences mentioned were negative preconceptions of Indigenous people and remote communities.
**Major Barriers** - A clear finding from the focus groups was that location and the perceived isolation from partners and children was a major barrier to undertaking an IHT placement. Other barriers included poor pay, lack of information regarding posts, lack of cultural awareness and perceptions of violence and racism in communities. Suggestions to break down these barriers included; greater financial incentives particularly for those with families, enabling junior doctors and registrars to undertake dual Indigenous and non-Indigenous posts and for doctors with experience in IHT to share their personal experiences with junior doctors and registrars.

**Location** - Almost all groups felt location was a major factor to choosing an IHT post. However some registrars commented that they would travel to any location for a ‘really good’ placement. As mentioned above family and lifestyle greatly affected registrar and junior doctor choices of training locations.

**Perceived competence** - Generally registrars indicated they were confident in their clinical skills and cultural awareness and did not feel this would affect their decision to pursue an IHT post. Junior doctors were confident in their clinical skills as long as they had adequate support. The registrars and junior doctors who indicated they were not as confident in their clinical skills wanted more information regarding the different health issues faced in urban and rural IHT posts. A clear indication of the medical resources available was also important. Some wanted more cultural awareness training, including community-specific information, as well as support from community elders and local health workers.

**Support for GP registrars in IHT** - Some groups perceived support for GP registrars as good as, if not better than, other types of placement. One group felt support varied depending on the location of a post while other groups wanted more information regarding availability and types of support. Generally registrars and junior doctors felt support in IHT was a very important factor in their decision to pursue an IHT post.

Suggestions to improve support included having contact with an experienced GP and Aboriginal mentor available as well as someone outside the community (such as an ex-registrar or placement welfare officer) enabling registrars and junior doctors to relay concerns back to someone outside of the local community.

**How to best market IHT** - Registrars and junior doctors were most influenced by personal accounts from others who had completed an IHT post, and suggested this be the focus of marketing campaigns. Hearing real personal experiences from other doctors and registrars was favoured by most over other forms of marketing communication. Although posters and handbooks were not the preference of most participants, it was a general consensus that this marketing material should portray positive images of Indigenous communities and health to encourage interest. Suggested images included healthy, happy people (particularly babies); positive images of people in communities, as well as showing the surrounding landscapes.
It was suggested that messages state the career benefits of IHT such as career advancement, exposure to different medical challenges and having an impact on Indigenous health.

**Testing Current Materials** - Opinions of current marketing materials were mixed with some groups believing it to be adequate while others felt it was not influential, or was too “sugar coated” or generic. Suggested improvements included an online video showing people from communities, real life accounts from experienced registrars, and emphasising that junior doctors and registrars would join a team as opposed to being socially and professionally isolated. Suggested messages included: “contributing to health outcomes”, “where the need is greater”, and “charity begins at home”.

**“Want to make a difference?” as a positioning statement** - Registrars and junior doctors were generally cynical of the slogan “Want to make a difference?” with many finding it too generic, ambiguous, and not relating specifically to Indigenous health. Others felt it was overreaching and would make people feel overwhelmed. One group of junior doctors felt the slogan needed to be placed in a broader context such as working towards a common goal of closing the gap between Indigenous and mainstream health (as part of a greater team effort, not an individual responsibility).

**“Closing the gap” as a positioning statement** - Most participants preferred “Closing the gap” to “Want to make a difference?” Registrars and junior doctors felt “Closing the gap” was realistic, grounded in a harsh reality, and recognised the difference in life expectancy between Indigenous and non-Indigenous Australians.

**“Cultural safety”** - Several registrars interpreted cultural safety as meaning Indigenous and non-Indigenous Australians acknowledging, being respectful of, and understanding each others’ cultures. Many registrars and junior doctors had not actually heard the term or felt it had negative connotations that might discourage people from undertaking an IHT post.

**Cultural education** - Most registrars and junior doctors felt ‘cultural education’ was a better term than ‘cultural safety’. Registrars felt that cultural education referred to learning about other cultures rather than suggesting that there might be problems or something to fear. ‘Cultural education’ had more positive connotations that ‘cultural safety’ for most.

**Exposure to IHT Marketing Materials** - Registrars and junior doctors indicated they had limited exposure to IHT marketing materials. One group found it difficult to find relevant information, or they had only received generic pamphlets. Several wanted to talk to someone about IHT as a first step, with information pamphlets and handbooks being used as a follow-up source of information once their interest had been peaked.
DETAILED RESULTS

South Australia: Junior Doctors

ISSUE 1: IHT EXPERIENCE / EXPOSURE.

What kind of exposure or experience have you had with Indigenous people, health and/or cultural education?

Junior doctors had been exposed to some Indigenous health during hospital rotations, particularly in emergency departments (ED), and psychiatry units.

Most had experienced cultural education at university. For some this was practical with placements offered for between 2 and 8 weeks in Indigenous communities and health centres. One remembered little from the cultural education taught at university as it was limited to a few lectures and essays. Another had attended medical school in New Zealand and noted that Indigenous health and culture there was integrated into all aspects of medical education, meaning that most medical students and doctors in New Zealand were aware of Indigenous issues (whether interested or not).

There was a general sense that those already interested in Indigenous culture and health would seek it out, and that the quality of cultural education depended on individual universities.

Typical comments

- Sometimes in ED. Really quick, getting the right answers is difficult unless questions are targeted.
- Worked in NT and SA Psych unit with a few Aboriginal patients - quick learning curve. Shaped your ideas on Indigenous health.
- Any information you get is good, makes Indigenous health less unknown
- University – I don’t remember much. One essay and a couple of lectures. Med students aren’t that interested in cultural issues, more interested in disease. Mix the medicine in with cultural education.
- Our university offers everyone rotations for 2 weeks to 8 weeks to provide Indigenous clinical cases. People who did the course were interested in Indigenous health. Our uni is known for cultural education.
I studied at medical school [overseas] where Indigenous culture was taught throughout medical school. Acknowledging our Indigenous culture is political issue, so there are outcomes to meet.

**ISSUE 2: PERCEPTIONS OF IHT.**

Describe your perceptions of IHT training.

Junior doctors had varied perceptions of Indigenous health (IH). All agreed that IH was an ‘unknown’ and that the issues faced in IH could not be appreciated until experiencing them first hand.

Most perceived IHT to involve challenges. Examples included overcoming language barriers and understanding cultural differences such as respecting seniority and appropriately treating members of the opposite sex. Junior Doctors mentioned different priorities and health perspectives of some Indigenous people, including the importance of spirituality, not wanting to stay for long periods of time in hospital, poor living conditions, and the lack of fresh produce in remote areas.

The complexity and severity of medical conditions faced in the Indigenous population was attractive to most participants. Well supported IH training was very important to all participants, with most agreeing doctors should be informed of the level of support available for negotiating language and cultural issues. Support could be in the form of a cultural mentor such as a community elder, as well as a translator.

**Typical comments**

- Different priorities, different perspective on what good health means. They want to leave hospital quickly.
- Embarrassment for Australia - lower life expectancy than non-Indigenous Australians.
- Language barrier and communication. Male and female cultural issues and seniority. You need an appropriate interpreter. Spirituality is massive for Aboriginals. Deters me from Indigenous health.
- You don’t appreciate the issues until you travel out there and gain experience. (All agree)
- I still don’t feel comfortable with cultural issues even through I’ve had experience. Everyone was welcoming – but I was still uncomfortable. It is better to have more Aboriginal doctors.
INDIGENOUS HEALTH TRAINING
FOCUS GROUP REPORT

- We need to be upfront and honest about Indigenous health. It is a challenge. Severity of disease is a selling feature, but you need support.
- Feeling unprepared is everyone’s worst nightmare - with medical issues that are really intimidating. Support is needed to overcome cultural and language barriers. Someone you can be honest with.
- It is a matter of priorities. You tell people to eat fruit, not sugary food, but it’s unavailable in community shops. (Most agree)

ISSUE 3: MAJOR BARRIERS.
Are there any major barriers (real or perceived) that would stop you or did stop you from undertaking an IHT post? How could these be broken down?

While no barriers relating to urban placements were mentioned, all junior doctors indicated remote location was a major barrier, particularly for those who had partners and families. Cultural issues and personal safety in communities were also a concern. One junior doctor believed remote areas were not conducive to good health outcomes due to the lack of fresh food.

To overcome these barriers, junior doctors suggested promoting the financial incentives available (or providing more) to encourage doctors with dependants to consider rural posts. Better clarification on cultural issues, ensuring language barriers are overcome, and addressing personal safety concerns would also assist. One junior doctor suggested issues be addressed on an Indigenous health website for doctors to refer to before and during an IHT post. Another suggested having a controlled and supported introductory period in IHT.

Typical comments

- It’s hard to tell people our perspective on health when there is so much in their environment that could be more conducive to better health outcomes. Such as having fresh food in shops.
- Remoteness and the holistic approach appeals to some people. Some people want to deal with diseases and family issues. It is daunting early on. You need controlled exposure.
- Remoteness is an issue and it is difficult to address with partners and children – You may have to send children to boarding school.
- We need more financial incentive and make people aware of them. (all agree)
INDIGENOUS HEALTH TRAINING
FOCUS GROUP REPORT

- There are cultural and language misunderstandings – such as cataracts. A patient of mine thought their eyeball would be replaced with a cat’s eye. Cultural clarification needed.
- Safety is an issue. Alcohol and violence. Female doctors and families going to settlements. It is localised to specific areas but there are also general health issues. A website would be good for resources and support.
- We don’t understand culture and language barriers, particularly in remote communities.

ISSUE 4: PERCEIVED COMPETENCE.
To what extent would your confidence in your clinical skills, or your level of awareness of Indigenous cultures affect your decision to pursue IHT?

Junior doctors said they would pursue an IHT post if they knew adequate support would be provided, such as pre-placement education on diseases they were likely to encounter and what to do when equipment is not available.

Typical comments
- Support is an incentive you want to see as much as possible or as long as we have lots of support.
- We need some pre-education on diseases to better prepare before people go out. I need to also know what I should do if equipment is not available.

ISSUE 5: SUPPORT FOR GP REGISTRARS IN IHT.
How supportive do you perceive IHT to be? How important would this factor be in influencing your decision to pursue an IHT post?

All junior doctors felt support in an IHT post was crucial to their decision to undertake a post. The general perception was that when support networks were in place, they were very helpful. Remoteness was not perceived as such a major issue for this group when 24 hour telephone support was available.
Typical comments

- Is essential for an IHT post.
- There is 24 hour support in the Northern Territory. Always someone on the phone.
- In Alice you had other support around unless if you were the specialist.
- As a junior doctor you need another person to run things by if you are unsure. Someone available when you are on call. It’s reassuring in remote areas to have support and to get a couple of weeks off and not be on call 24/7.

South Australia: Registrars

ISSUE 1: INTEREST IN IHT.

Have you considered or undertaken an IHT post? Why / why not?

Registrars interested in IHT cited a desire to learn about Indigenous people and cultures and how this affected their health needs. Others mentioned they had grown up with Indigenous people or were Indigenous themselves. One registrar had experienced a positive placement in an Aboriginal Medical Service (AMS) as RMO.

Some registrars mentioned the need to contribute to Indigenous health outcomes, pointing to the need for Australian doctors to address the ‘3rd world’ standards of health and living in Australia before assisting developing nations overseas.

One registrar was not interested in IHT because they believed most posts were rural, while another described IHT as inadequate, unavailable and undesirable.

Typical comments

- I always had an interest and have also done RMO placements in Indigenous Health. One of the reasons why I went into GP.
- I grew up in Darwin and had always been exposed to Indigenous people and some communities. I did an internship in Darwin and wanted to follow through.
- It was my focus throughout medical school – want to improve Indigenous health.
- To learn about Indigenous culture. What they felt was important and integral to health needs. It differs from the western view in some places.
• There’s no glamour in IHT posts. 3rd world health conditions in some place. Junior doctors have gone to Asia and Africa and bragged about this and we have people in the same conditions here. We need to clean up our own country and address the hypocrisy in Indigenous health. Market this – keep our talents here.

• I considered it. Interested in the history of Indigenous people and wanted to see for myself what it was like – the main reasons. There’s lots of bad media and stereotypes. The culture is interesting.

• Not really of particular interest to me. Don’t know a lot about Indigenous health. Most opportunities are rural so I haven’t thought about it. If it was part of curriculum I might be interested.

• Indigenous health is inadequate, unavailable, and undesirable.

• Made choice due to word of mouth recommendation – but it wasn’t a true reflection of what it was like - some say what people want to hear.

**ISSUE 2: IHT EXPERIENCE / EXPOSURE.**

*How much and what kind of exposure or experience have you had with Indigenous people, health or cultural education?*

Registrars had a range of different experiences and training relating to Indigenous health. A few registrars had grown up with Indigenous people, or were Indigenous. Most registrars felt their experience or exposure to Indigenous health and cultures was limited. Many had received cultural education during medical school in the form of cultural awareness and communication sessions. Some commented these sessions were “one offs” that lasted only a few days, or that sessions were overwhelming and negative. Some had undertaken PGPPP and medical school placements in Indigenous health and found the experiences generally positive, with one comment that IHT was confronting and despite enjoying the experience they would not return to it.

On the whole, registrars indicated it would be useful for IHT to be incorporated into early stages of medical training so people could be exposed to Indigenous cultures and health before treating Indigenous patients.
Typical comments

- As part of medical school and internship. RMO placement in Darwin hospital. Grew up in Darwin.
- Went to school with Indigenous kids. IHT info every year at med school. During internship and GP training.
- It is important to get exposed early on before you start treating people. There are good and bad ways of teaching cultural awareness. If it only brings up all current problems, people feel overwhelmed. It puts them off.
- GP training was good. I had an Indigenous health experience. It showed me the positive side and how it can make a difference.
- It is good learning about culture and barriers in communication. Helps form stronger patient relationships.
- Good going into Aboriginal communities to see how they live - what services they do/ don’t have.
- Little exposure since graduating. Maybe 1-2 Aboriginal patients. I worked in the country a lot as student.
- You don’t get through study without seeing Indigenous patients. (2 registrars)
- I worked with a local Indigenous-run rural health school. It was positive. From this I chose IHT.
- Only an educational weekend to immerse you in Aboriginal culture and found it negative (2 registrars - found it negative)
- I’m doing IHT now. I have 40% Aboriginal patients so I have a lot of exposure.
- PGPPP gave me some idea about remote areas. It’s very different access to specialists.
- I had a 2 day session which included patient communication and Indigenous cultural awareness
- Rural Indigenous culture is very confronting. You enjoy it but would never go back. You must be strong.
ISSUE 3: MAJOR INFLUENCES.

What are / were the major influences in choosing your current training post?

Would your peers and family support you in undertaking an IHT post?

Most registrars had the support of family and friends to undertake an IHT post, while one mentioned their peers had mixed opinions regarding IHT. One registrar had been positively influenced by an Indigenous peer, another felt the support of the practice itself was important, and another was driven by a desire to balance good clinical experience with maintaining strong family and friendship ties.

**Typical comments**

- RMO placement was good – good people to work with, but I couldn’t choose the practice.
- I have very supportive family and friends. Family supported me doing an IHT post. Views were mixed amongst other peers.
- The practice and its friendliness are important.
- I have a good friend from med school who is Aboriginal and trained with her a lot. It made me interested.
- There’s a balance between the desire to get good clinical experience and maintain family relationships and friendships.

ISSUE 4: PERCEPTIONS OF IHT.

Describe your perceptions of IHT training.

Most registrars perceived IHT as challenging in terms of cultural and communication barriers. Some found it daunting, while one saw it as ‘real health’ and a chance to ‘make a difference’.

Most were unable to recall any promotional IHT material, and thought some sort of promotion was needed to make people at least aware of IHT. Suggestions included formal and informal presentations by doctors with IHT experience, as well as posters and publications with photos of doctors from many cultural and social backgrounds (i.e. not stereotypical ‘IH’ doctors). Some felt perceptions could be changed using marketing.
Typical comments

- It is challenging. Different to normal general practice. It’s worthwhile – real health – you can actually make a difference.
- There are communication and cultural barriers (2 registrars)
- IHT really needs advertising (2 registrars). Have people who are really working in Indigenous health talking about it.
- It seems daunting. It can depend on actual past or present experience.
- Put publications and posters with photos of people I can relate to in it.

ISSUE 5: MAJOR BARRIERS.

Are there any major barriers (real or perceived) that would stop you or did stop you from undertaking an IHT post?

A couple of registrars indicated remoteness of location was a major barrier. Others had concerns with trying to negotiate an IHT placement with their RTP. One registrar said the largest barrier was that the training on offer and post locations were unclear.

Typical comments

- Location. The distance would have put me off. My husband couldn't get a job (2 registrars)
- Biggest barrier is the training on offer is unclear. Locations unclear. Not enough info generally.
- I wanted to do this as my first term. I spoke to the post myself and the RTP and worked it out.
- I had a problem with negotiating it with the RTP. They thought I wouldn’t get the volume of patients before exams. I needed to be more flexible in this when trying to meet training requirements.
ISSUE 6: LOCATION.

How much would location affect your decision to choose an IHT post? How much does your domestic situation affect your choice of training location?

For several registrars, location of their training placement was very important. Some registrars indicated that separation from their partner and family base made IHT posts unattractive. Other registrars felt location was not as big an issue if they provided good clinical experience, were supportive, safe and socially inclusive. One found the support of the hospital a selling point of urban IHT posts, while others were unsure of the differences between an urban and a rural IHT post.

Typical comments

- Location is definitely a big decision point. Family. Priorities change as you get older. (2 registrars)
- I’m in an urban placement now in Indigenous health with acute and community medicine but with full support of a hospital.
- Registrars feeling they are safe is important. Being inclusive socially.
- If it was a great rotation (clinically) I wouldn’t mind where it was. I would go anywhere for 6 months.
- I haven’t done any urban based posts but feel they are very different to rural posts.

ISSUE 7: PERCEIVED COMPETENCE.

To what extent would your confidence in your clinical skills, or your level of awareness of Indigenous cultures affect your decision to pursue IHT?

Most registrars thought their confidence in clinical skills and level of cultural awareness would not largely affect their decision to pursue an IHT post. Most perceived IHT to be a learning experience that was supportive and nurturing. Some felt the complexity of medicine in IHT was both attractive and daunting, particularly in remote posts where other specialists are not accessible.
Typical comments

- It wasn't really a factor when I did IHT. I still had supervisors plus also had more time with each patient.
- Wouldn't affect my decision at all. I would need development but that wouldn't put me off. (2 registrars)
- You’re there to learn. It’s very nurturing but you feel daunted. There’s not enough exposure to complex medicine.
- You may not be able to get them to a specialist and may end up doing the job of the actual specialist.

ISSUE 8: SUPPORT FOR GP REGISTRARS IN IHT.

How supportive do you perceive IHT to be? How important would this factor be in influencing your decision to pursue an IHT post?

Registrars were positive about the perceived level of support saying they believed it would be on par with other posts and in some cases better. A couple of registrars said the support they had received in IHT was good. One registrar said the level of support was very important in influencing their decision to pursue an IHT post.

Typical comments

- It’s the same level of support as in every other post. Great supervisors to debrief with. 4
- They are very structured places to learn. The IHT post that I did was the best post I have ever done.
- You have to be very careful not to leave registrars to consult on their own.
- Hugely important – the biggest thing when you going into a practice.
- If it's very supportive, you’ll go anywhere if you feel you have adequate supervision. All posts are variable.
- Make it clear that the mentors are there. Make it clear that mentors will inform you.
ISSUE 9: HOW TO BEST MARKET IHT.

How could IHT be promoted to you in a way that would make you decide to pursue an IHT post?

A clear message from registrars was that marketing should focus on the support a doctor will receive from other health professionals in IHT placements. Registrars mainly wanted to hear from experienced IHT doctors about their first hand experiences in Indigenous health. Others commented that posters were useful to have in tea rooms. Several thought that access to online Indigenous health information would be useful.

It was suggested that marketing focused on the diversity in IHT including the differing health needs in each community, as well as the variety of locations available. Some suggested marketing should emphasise the variety of clinical skills that would be utilised and learnt during IHT. Others suggested giving an honest portrayal of IHT and addressing both positive and negative aspects was very useful.

Typical comments

- Push the fact that Aboriginal health is more than just doctors and patients. You need Aboriginal health workers and nurses and other support offices such interpreters. It’s more of a team thing.
- A combination of something written (poster/pamphlet) and speaking to Indigenous health doctors or practice.
- Have information sessions at the start of the placement training time. Early so you can plan your training.
- Show there is support and that you’re not isolated – not a cheesy tourism campaign.
- Highlight the different skills you can use. A place where you can use all your medical knowledge
- Mention urban options.
- I have seen some posters – always interesting and a good read in the tea room. Although we have a short attention span.
- Have a website. Make people aware. Have snippets of people and situations
- Every IHT post is different. Indigenous people have different needs. Break the perception that IHT is just one thing – it is many things.
- There are a lot of sites to see and other excursions.
• Being honest about what to expect. The medicine sells itself. Just be realistic about the support structure and show how to make friends and integrate in the social scene.

• Our RTP has an education weekend. The IHT post did a presentation. It was good as some supervisors interacted with the registrars. The problem is that registrars are encouraged and GPET and RTPs haven't created enough accredited IHT posts for registrars to train in. Back up the marketing with enough posts.

• Increase awareness. Make everyone aware. Generally not enough info about it.

ISSUE 10: ‘WANT TO MAKE A DIFFERENCE?’

How effective is the tagline “Want to Make a Difference?” in promoting IHT posts? How could the tagline be improved?

Registrars generally felt the slogan ‘Want to make a Difference?’ was ineffective. It was described by some as corny, ambiguous, one sided and suggests a doctor has a heavy responsibility to ‘make a difference’. One registrar thought it was a catchy slogan. Another thought it would only appeal to final year high school students. An alternative slogan suggested was ‘not your everyday general practice’, while others suggested being more specific about how to make a difference, including the difference IHT makes to a registrar’s own life and skills set.

Typical comments

• It’s not effective. Quite corny. We all want to make a difference but it isn’t the only reason we go into health. We enjoy science and people. Too much responsibility.

• Use something challenging like ‘not your everyday general practice’. How it makes a difference to our own life.

• It’s good. Catchy. Emphasises importance.
ISSUE 11: ‘CLOSING THE GAP’.

How does “Want to Make a Difference?” compare to the current COAG campaign’s message “Closing the Gap”? How effective do you think the slogan “Closing the Gap” would be in promoting IHT posts?

The registrars felt that this message was more effective as it was more practical in recognising the existence of a gap between health care for Indigenous and non-Indigenous people. Registrars also believed “Closing the Gap” presented a clearer message than “Want to make a Difference”. However, one respondent thought that the tagline “Closing the Gap” was depersonalising.

Typical comments

- Closing the gap is more effective. Just a bit more practical. It recognises that there is a gap.
- Good – not as good as first one. OK though.
- Close the gap is relevant now. Sounds more powerful.
- “Closing the Gap” depersonalises it. You can be part of something – personal responsibility is wavered.
- “Closing the Gap” is good. Doctors are practical and like simple concepts. It just gets to the point.

ISSUE 12: ‘CULTURAL SAFETY’.

What does ‘cultural safety’ mean to you? How does it impact on you?

For many registrars ‘cultural safety’ meant Indigenous and non-Indigenous people being respectful, acknowledging and understanding each other’s cultures. Some registrars believed the term could potentially set up a barrier or be a deterrent because of the negative way it could be defined. One registrar felt the term was off-putting to working in Indigenous health.
Typical comments

- Awareness – what your cultural beliefs are yourself and what others’ cultural beliefs are and trying not to offend or upset the other person because of your own beliefs.

- For others who aren’t interested in IHT it might detract. It seems like you always have to think of those issues instead of general practice.

- ‘Cultural awareness’ is better than ‘cultural safety’.

- It is a put-off. Most people would be aware that there are issues. You don’t want to make it sound scarier than what it is. The issue is emphasised a lot – not sure if it’s actually over emphasised though.

- ‘Cultural Safety’ means being aware of all difference aspects - history, Indigenous health and people, colonisation, the institutionalised racism, the differences in an area or community and work safety. Knowing all different aspects that are needed to perform IHT post well to have an enjoyable fulfilling experience in an IHT post.

- Culture cuts both ways. Cultural safety of patient and doctors. Creating an environment where despite difference in culture, it’s a place people feel safe.

- It can be a barrier to some people. My friend is Aboriginal so I ask her when I’m uncertain about cultural issues. Being a woman is a big advantage. Male patients will seek you out if they are happy to see you. It’s harder for male doctors.

- ‘Cultural safety’ – causing no undue harm. Most doctors have privileged backgrounds and have no idea what is going on in Indigenous history and the effects it has in health. Be mindful how you interact with people.

- Useful term but needs to have an explanation – break it down for us.
ISSUE 13: ‘CULTURAL EDUCATION’.

How does this term compare to the term ‘Cultural Safety’? Which term would be more effective to encourage registrars into an IHT post?

One registrar indicated that cultural education meant learning about other cultures rather than suggesting that there might be problems and something you have to worry about. Another registrar said it was a better term than cultural safety.

Registrars suggested that in addition to being more interactive, the cultural education sessions ought to be more practical. They also suggested that having time to get first-hand experience and then having time to think about it before coming back to discuss issues they faced would be beneficial.

Typical comments

- Cultural education is a better term than cultural safety. Learning about other cultures, not just problems.
- Cultural safety makes you think you should be worried about something. Overlaps cultural awareness.
- Cultural education is all done in one big block. It should be spread out over two sessions to absorb it.
- It can be overwhelming. Bombarded with lots of info. Tell us how to practically deal with situations.
- Cultural education has been a little bit interactive but not as much as it could be.
- I have done so many cultural education sessions, I know about the history, but not what to do today.

ISSUE 14: FINAL COMMENTS

Other ways to increase the uptake of IHT?

One registrar suggested that short-term placements in Aboriginal health should be pushed, especially before the registrars go to general practice. This would give doctors time to see if they were interested in pursuing an IHT post.

Several registrars thought that information and guidelines about working in Indigenous health could be made a regular feature in the RTP newsletter. Another registrar said there wasn’t enough information available about IHT.
Typical comments

- Push the 3 month placements available as junior doctors so we can try it for a short time and not be committed to anything. It gives them time to see if they are interested or not.
- Maybe have a regular feature in Australia Family Physician or the RTP newsletter about Indigenous health.

Australian Capital Territory: Junior Doctors

ISSUE 1: WARM UP AND TOP-OF-MIND ISSUES.

What do you know about Indigenous Health Training (IHT) available in Australia? Have you ever considered doing IHT training? Why / why not?

Junior doctors were not very familiar with IHT in the AGPT program. They perceived it involving remote postings being challenging in terms of culture and language and an opportunity to gain additional skills.

There was a general consensus that Indigenous health was relevant but that information on IHT was difficult to find. Some had sought out Indigenous health information either online or from practices, but found little. It was suggested that comprehensive IHT information be more easily accessible to junior doctors.

A further suggestion was that Indigenous health be integral in all areas of medical training, to help to remove concern and uncertainty.

Typical comments

- I looked for information about scholarships and placements on the internet but couldn't get any.
- I didn't know where to start to get information.
- It was part of the study curriculum at medical school but was done poorly.
- I don't know much about Indigenous health placements as I haven't looked into it.
- Junior doctors need to have access to comprehensive information about Indigenous Health Training.
### ISSUE 2: INTEREST IN IHT.

**Have you considered or undertaken an IHT post? Why / why not?**

Two thirds of the group were not interested in IHT due to the perception that placements were predominantly in remote locations. Some thought they would be interested only if short term placements were offered (up to 6 months), while others who were not interested had family, lifestyle and safety concerns. Those junior doctors who showed interest in IHT had experienced difficulty finding information or were under the impression that posts were difficult to obtain.

**Typical comments**

- I’m interested in working in a small community but couldn’t find any information.
- I’ve always been interested in IHT but it’s hard to get a post.
- Remote placements are a concern. IHT would affect my lifestyle.

### ISSUE 3: IHT EXPERIENCE / EXPOSURE.

**How much and what kind of exposure or experience have you had to Indigenous people, health or cultural education?**

The majority of junior doctors had little exposure to Indigenous cultures and health issues. Most knowledge about Indigenous issues had been gained through university seminars, books and the media. Generally this information was considered limited and repetitive. Only one junior doctor had experience in Indigenous health, gained from a week-long medical school placement at a rural GP practice. One junior doctor believed Indigenous communities appreciate doctors who showed cultural understanding, while another felt communities would be accepting of cultural mistakes by doctors in training, as long as doctors showed an openness to learn and a genuine regard for their culture.
Typical comments

- Most of my knowledge was gained through books and the media and university seminars.
- 3rd year medical student placement. A good experience - open, honest and friendly approach.
- Encounters are influenced by history instead of just a two-person interaction. It wouldn’t deter me.
- Be open-minded and keep learning. People who know you have a genuine regard will accept stuff-ups.
- I’ve never encountered Indigenous patients at hospital. I wasn’t trained in Australia. I see only negative media.
- Communities want cultural understanding. Appreciate when you understand each community is different.

ISSUE 4: MAJOR INFLUENCES.

What are / were the major influences in choosing your current training post?
Would your peers and family support you in undertaking an IHT post?

The major influences for junior doctors when choosing a training post were lifestyle and family situations.

Typical comments

- It can be off-putting for people if they have partners and family. (Most agree).

ISSUE 5: PERCEPTIONS OF IHT.

Describe your perceptions of IHT training.

The majority of junior doctors perceived IHT to involve treating chronic and complex medical conditions. There was also the perception that the Indigenous view of medicine conflicts with the Western view, and that there can be resistance by Indigenous patients to treatment.

Some junior doctors believed IHT was only offered in remote locations, while others argued this was a misconception as the majority of the indigenous population lived in urban areas. One junior doctor felt IHT was ‘an unknown’, and had only heard negative feedback from colleagues who had undertaken IHT.
**Typical comments**

- There is a general perception that they do not want to be treated by Western medicine as it conflicts with their traditional methods. They resist treatment.
- There is a misconception where Indigenous treatment equals remote placements when in reality a large portion of them live in urban areas.
- IHT posts are in rural and remote locations. Remote placements are a concern.
- It’s a complex system. Still a lot to be learnt about Indigenous treatment.
- Unappealing since they’re unknown places. Colleagues who have done IHT posts say they have not been accepted by the community.
- It’s associated with certain health risks such as smoking, alcohol and substance abuse and sexually transmitted diseases.
- Diseases and problems mainly occur in NT whereas the largest population is in NSW. There’s little health knowledge among Indigenous people.
- The term “Indigenous Health” means more chronic conditions which are more in line with the developing world.
- They need to make IHT integral in all medical training.

**ISSUE 6: MAJOR BARRIERS.**

Are there any major barriers (real or perceived) that would stop you or did stop you from undertaking an IHT post? How could these be broken down?

Major barriers for junior doctors included; location of posts (remote) due to family and lifestyle reasons, not being accepted by a community, the feeling of responsibility when treating Indigenous patients (particularly those who resist treatment) and the general lack of information about IHT. Urban posts held no barriers for most.

**Typical comments**

- We need more information on their culture and customs. There is a general perception that they do not want to be treated by Western medicine as it is conflicting with their traditional methods.
- I don’t want to be separated from family and networks and I’m unsure of schooling for children.
- A belief that they resist treatment.
ISSUE 7: LOCATION.

How much would location affect your decision to choose an IHT post? How much does your domestic situation affect your choice of training location?

Most junior doctors were concerned by remote locations, particularly those with families. Concerns related to adequate schooling for children and employment for partners.

Typical comments

- There's no barrier in an urban environment.
- I don't want to be separated from family and networks. I'm unsure of schooling for children.
- Generally practitioners would prefer a 6 month, short term placement but Indigenous health treatment requires more stable placements.
- I'm fearful of going to unknown places.
- It can be off-putting for people if they have partners or family.

ISSUE 8: PERCEIVED COMPETENCE.

To what extent would your confidence in your clinical skills, or your level of awareness of Indigenous cultures affect your decision to pursue IHT?

Most junior doctors seemed more confident in their clinical competence than in their level of cultural knowledge. Junior doctors showed a general interest in being better informed about how cultural matters affected the practice across all specialisations. Internationally trained doctors felt particularly lacking in indigenous health and cultural knowledge.
INDIGENOUS HEALTH TRAINING
FOCUS GROUP REPORT

**Typical comments**

- Lack of cultural knowledge. I need more information on their culture and customs.
- It’s a complex system. Still a lot to be learned about Indigenous treatment.
- I’d have no problem working with the community even if I didn’t know anyone there.
- I would want to know a little bit about Indigenous health to apply it to my specialisation as it does crop up in every discipline and should not be a separate topic.

**ISSUE 9: HOW TO BEST MARKET IHT.**

**How could IHT be promoted to you in a way that would make you decide to pursue an IHT post?**

Junior doctors preferred verbal communication about IHT (in the form of presentations or informal conversations) to printed materials such as posters and handbooks.

Several junior doctors agreed that marketing IHT separately from other skills and specialisations created a wider gap between Indigenous and mainstream health, while one junior doctor argued Indigenous health could be its own specialisation. Marketing IHT from a clinical perspective was also suggested, with the emphasis on what doctors could gain from IHT.

**Typical comments**

- Have people speak to us instead of just posters.
- Generally through what others say.
- It is very dangerous to separate Indigenous health from other forms of health as it causes an even greater divide.
- Have obvious information available on websites that junior doctors use.
- Make IHT integral in all medical training. Instead of making people ‘feel bad’ about Australian history (i.e. guilty) why not comment on what they can achieve as doctors in an Indigenous health setting?
- Enabling practitioners to do 6 month or short-term placements.
- Provide more information about IHT posts.
• Instead of classifying the placement as an Indigenous one, market it as a specialisation. Many people are interested in studying either sexual health or diabetes – both of which are common Indigenous problems. This can attract more people in working in those remote areas as a way to increase their specialization.

Australian Capital Territory: Registrars

ISSUE 1: INTEREST IN IHT.

Have you considered or undertaken an IHT post? Why / why not?

Half of the registrars had undertaken an IHT post, while the others were unaware that IHT existed despite having some knowledge of Indigenous health.

All registrars either showed an interest in Indigenous health, or had already undertaken IHT. Registrars who had undertaken IHT expressed frustration at the lack of patient compliance, poor pay and lack of patient feedback. Others felt that IHT was attractive as it would strengthen their cultural knowledge and advance them professionally due to the complex nature of medical conditions faced.

Typical comments

• Not interested at all due to previous work with Aboriginals. It was heart-breaking – poor pay, poor compliance in the community, rates of horrible things happening are high. Difficult emotionally but no gain.
• I’m about to finish 6 months as IHT registrar. I didn’t find it heart-breaking, just frustrating as Aboriginal people do not follow up appointments.
• I will train in IHT but not pursue it long-term. I don’t really love it.
• I’ll pursue a career in IHT. Their problems are due to economic deprivation.
• There’s no reward for what you are doing (monetarily or in terms of patient feedback).
• You learn about Indigenous society, learn how to manage complex medical conditions.
• Push yourself professionally.
• I would like to do training in NT but did not know it was available.
• I know of Aboriginal health but not aware of a ‘course’ or unit in GP training.
• Not interested at all due to previous work with Aboriginal people.
• I did not know it existed.
• It is piecemeal, challenging, frustrating.
• Stressful, complex, difficult, useful.

ISSUE 2: IHT EXPERIENCE / EXPOSURE.

How much and what kind of exposure or experience have you had to Indigenous people, health or cultural education?

Registrars had varying exposure to Indigenous people and health, including growing up with Indigenous people, cultural education at university, other employment positions, and medical placements (PGPPP and IHT). University cultural education was a negative experience for two registrars, where they were made to feel responsible for poor Indigenous health.

Typical comments

• IHT exposure before medical training was my first lecture in Indigenous Health. The new Indigenous lecturer was screaming at me for 2 hours saying Indigenous health problems were white people’s fault.
• Early exposure to IHT in medical school puts GP’s off further training.
• I worked 3 months as health and safety officer for a mining company and became friends with the fellow workers. There were local Aboriginal people and I was exposed to their living environments.
• I currently work in a community controlled Aboriginal clinic.
• I did a 3 month placement. I made real contact and loved the training. A positive introduction is why I’m pursuing IHT.
• I grew up in a rural area so was exposed early in life. I did a rural placement while at medical school but I’m not intending to pursue an IHT post due to money and burnout.
ISSUE 3: MAJOR INFLUENCES.

What are the major influences in choosing your current training post?
Would your peers and family support you in undertaking an IHT post?

Location was a major factor for most registrars, largely due to family reasons such as access to education for children and employment for partners, as well as wishing to maintain personal contacts.

**Typical comments**

- I chose a training post area due to personal reasons – relationship with current GP.
- I cannot do it long-term due to my husband requiring work in urban locations.
- I feel my family and dependents wouldn’t support a decision to do IHT due to the remote locations and lack of access for children’s education.

ISSUE 4: PERCEPTIONS OF IHT.

Describe your perceptions of IHT training.

Some registrars perceived IHT to be challenging, complex medically and generally useful. Negative impressions of IHT were that it was frustrating, stressful, difficult and underpaid. Registrars with IHT experience had found the work to be ‘thankless’.

Others felt that once accepted into a community the IHT experience could be very rewarding, with others considering it a good way to build professional resilience and help acutely ill people.

Most registrars thought that marketing wouldn’t change people’s perceptions and that advertising not useful.

**Typical comments**

- Hard work, stressful, complex. Medically useful because if I can survive this I can survive anything. I like it, despite not being paid well.
- Piece meal, challenging, frustrating and different challenges at every post.
- Poorly paid hard work and frustrating.
- Stressful, complex, difficult, useful. My experience was initially identical to my perception, but it was useful. I get too stressed and involved. It’s a personality type.
- It can be rewarding as the community is fun. You can help people who are very sick and if
you’re accepted into the community it is positive.

- I was shocked and thought the experience was worse then what I’d thought initially.
- GP’s aren’t valued. They are secondary and no one thanks them.
- I don’t agree marketing can change people’s perceptions or solve problems – feel advertising is a waste of money.

**ISSUE 5: MAJOR BARRIERS.**

*Are there any major barriers (real or perceived) that would stop you or did stop you from undertaking an IHT post? How could these be broken down?*

Major barriers included poor pay and lack of incentives such as recognition by colleges of additional skills learnt, as well as location due to family considerations and isolation. Not feeling properly rewarded and ‘burn out’ were also concerns, as were racism, cultural and physical safety.

**Typical comments**

- The majority of GP’s think pay is terrible and burnout an issue.
- I cannot do it long-term due to my husband requiring work.
- My family wouldn’t support my decision to do IHT due to the remote locations and lack of access for children to be educated.
- Personality type.
- Violence, fear of culture and racism.
- Culture problems are over emphasised, which aren’t really issues.
- People don’t think they should help them as they don’t help themselves.
- Fear of hard work not being rewarded.
- Need concrete incentives (pay, good skills developed, pass exams).
ISSUE 6: LOCATION.

How much would location affect your decision to choose an IHT post? How much does your domestic situation affect your choice of training location?

All registrars thought that location affected their decision to choose an IHT post. Most registrars were either uninterested or unable to undertake a rural or remote IHT placement due to; access to employment and education for family, lack of medical resources, and isolation. Some registrars considered urban placements to be attractive as short term training options only.

Typical comments

- I would do a remote post only on a short-term basis.
- I would only move to a remote area if pay was substantially better.
- Not interested in urban locations – short-term is exciting but not long-term in urban Aboriginal communities.
- It would be preferable (less resistant) to do a post where there is a better medical set up.
- I have children and a wife, but they are fine.
- I’m single without kids. Family would support me but with strong reservations due to the emotional effects it would have on me. It is a difficult & pressured job, socially isolated, no resources for someone who is very sick.
- I cannot do it long-term due to my husband requiring work in an urban environment.
- I feel family or dependents wouldn’t support their decision to do IHT due to the remote locations or a lack of access for children to be educated.

ISSUE 7: PERCEIVED COMPETENCE.

To what extent would your confidence in your clinical skills, or your level of awareness of Indigenous cultures affect your decision to pursue IHT?

All registrars agreed that their level of clinical skills would not affect their decision to undertake an IHT post.
ISSUE 8: SUPPORT FOR GP REGISTRARS IN IHT.
How supportive do you perceive IHT to be? How important would this factor be in influencing your decision to pursue an IHT post?

Registrars commented that the amount of support varied between posts depending on location. Some had experienced professional isolation during IHT, while others had received similar accounts from peers who had undertaken IHT. Most agreed that support should be guaranteed to registrars, not just verbally, but be integrated into the accreditation requirements of an IHT post.

**Typical comments**

- I felt professionally isolated.
- It varies depending on where you are and the facilities available.
- Might be isolated a little but this is based on word of mouth not my own experience.
- I must have support accredited so that it is real, not a verbal guarantee only. An independent review of support for accreditation.

ISSUE 9: HOW TO BEST MARKET IHT.
How could IHT be promoted to you in a way that would make you decide to pursue an IHT post?

Registrars suggested face to face presentations at RTP inductions were a useful way to market IHT. One registrar thought promoting IHT via emails would work well.
Victoria: Registrars

**ISSUE 1: INTEREST IN IHT.**

**Have you considered or undertaken an IHT post? Why / why not?**

Most registrars were interested in IHT and were aware of IHT training offered in AGPT (except one registrar). Some had experienced Aboriginal health through the PGPPP program as a junior doctor which heightened their interest in IHT. One registrar had experienced violence in an urban AMS, but was not deterred from IHT due to a more positive PGPPP experience as a junior doctor. One registrar felt Indigenous Health was an important area to train in, with another commenting that, given current resources, Indigenous Health could be promoted in a much more positive light (not just a focus on problems).

**Typical comments**

- IHT is not done very well. Lectures are not enjoyable. Practical is more important than theory. I would want to work in it if these were adapted.

- I have not done a post but chose Aboriginal subjects at university. IHT makes more barriers and a feeling of being overwhelmed, of not being able to help all issues. I don’t want to be e offensive, culturally inappropriate or put up cultural barriers. Lectures make GP’s feel apologetic for what hasn’t been done.

- I feel with more resources they have they can do something. Indigenous health is always seen as negative as you only hear about the problems.

- We don’t learn about what is being done and the benefits it is having on current health situations, which is a barrier – a problem they cannot help.

- As part of med school I did 1 year as an intern. 90% of people are Indigenous. In VIC I did 6 months of it but moved on as I had other requirements to fulfil. I did enjoy the NT experience but not VIC. I found VIC people that came through were very different – more abusive. I experienced violence, physical threats. The organisation wasn’t supportive.

- I would still go back to NT. I absolutely loved my work at the Royal Darwin hospital. I’m not going to be moving location generally anyway so won’t pursue it.
There should be some more training earlier in medical training. In terms of just getting a better understanding of statistics of outcomes of Aboriginal health – what problems affect Aboriginal population and also socio-culture understanding you feel intimidated if you have no exposure to Indigenous culture. Breaking that barrier and ignorance is important.

- Working in communities.
- I’m not sure where you get trained. I did brief training but not clinical-based.
- Classroom shift creates more problems than it solves.
- Victorian Aboriginal health takes registrars in the 2nd half of their training. Also Royal Darwin hospital provides IHT options. I did my med school as part of Flinders and they are aligned with Darwin hospital.
- Did 6 month public health PGPPP placement in Broome in 2008. When I was there I decided to do a 6 months placement in Kunnunurra. PGPPP program is really good for getting people into rural and remote areas. Prevocational training programs are mostly 10 week placements. Not very well advertised.
- Always been interested in Indigenous affairs. It’s a huge area of need. I don’t get exposed to it as much in other places – I’d like to learn more about Indigenous cultures and people. It’s a really important area to work in.

**ISSUE 2: IHT EXPERIENCE / EXPOSURE.**

*How much and what kind of exposure or experience have you had to Indigenous people, health or cultural education?*

One registrar said they had completed post graduate medicine with a large Indigenous health component. Another had completed placements as a medical student and as a junior doctor. While one had a positive experience, the other was unsupportive and physically unsafe. Other registrars indicated they had limited exposure in the form of university lectures on Indigenous Health and cultural safety. They found these lectures to focus on negative aspects of IHT and made them feel apologetic.
Typical comments

- I had a heavy Indigenous health component during post grad medicine. Spent 6 months to 1 year in NT. No experience before med school.
- Not a lot of previous experience. I did lectures on cultural safety.
- Cultural safety reeled out statistics about how bad Indigenous health is. It doesn’t encourage people to go out there. It doesn’t prepare you for post.
- At med school I did 1 year as an intern in the NT. 90% of patients were Indigenous. It was positive. In VIC I did 6 months but found patients very different – more abusive. The practice wasn’t supportive.
- IHT is not done very well. Lectures not enjoyable. Practical is more important than theory. I would want to work in it if these were adapted.
- The only Aboriginal subjects I did were at university. Made more barriers and a feeling of being overwhelmed of not being able to help access all issues.
- Lectures make GP’s feel apologetic for what hasn’t been done.

ISSUE 3: MAJOR INFLUENCES.

What are the major influences in choosing your current training post? Would your peers and family support you in undertaking IHT?

Some registrars said they had been influenced by colleagues and supervisors who had previous experience working in Indigenous health. Another indicated location to be a major influence.

Some registrars believed their peers and family would support them, while others didn’t due to their pre-conceptions about the Indigenous population and health.

Typical comments

- Location is important. At the moment I’m working in community health which is quite interesting and also in private practice which has better pay.
- My supervisor in post grad research encouraged me to do medicine and Indigenous Health.
- I have spoken to people who have done IHT. It’s a big factor to hear colleagues’ perspectives on training.
- Word of mouth – relevant in any post you go into.
Generally my family have been very supportive.

I had no support from family due to pre-conceptions.

ISSUE 4: PERCEPTIONS OF IHT.

How would you describe your perceptions of IHT?

Several registrars perceived IHT training to be challenging, but were not deterred as many had heard enthusiastic feedback from colleagues who had undertaken IHT. A few had perceived IHT to be daunting before experiencing it first-hand.

All registrars believed cultural education made GPs worry unnecessarily and suggested including more practical health focus in these sessions. One registrar felt lecturers and western society generally underestimated Indigenous knowledge of medicine.

It was agreed by most that an Indigenous perspective could be integrated into GP clinical workshops, with Indigenous speakers and patients present.

Overall, registrars felt it possible to alter their perceptions through better marketing campaigns, but only if it was delivered in the form of presentations and informal question and answer sessions by peers who had completed an IHT post. Video diaries of day to day life in an IHT post were also suggested.

Typical comments

- Lecturers and western society underestimate what they know.
- If you’re nice to people of any culture they will be nice back.
- The week of cultural training made GP’s worry unnecessarily. We need to learn more about communicating with patients individually.
- Experience is definitely the most important. Lots of word of mouth. Big issue.
- Before I saw it as challenging. After it was very rewarding, worthwhile but frustrating at times.
- It was not as daunting as I thought it might be. Now I think about going back.
- Marketing might only change it if it was people sharing experiences.
- Messages encouraging people to be interested in the area is missing.
• Great to integrate Indigenous perspective when dealing with any clinical topic in any health areas.

• It definitely could be changed. People think IHT’s really hard. People who work there know it's hard but speak really enthusiastically about it.

• Hearing real people (preferably young peers) speak about it is the most effective way. Tell us about challenges. Ask questions.

ISSUE 5: MAJOR BARRIERS.

What would be the major barrier to IHT? How could this be broken down?

A couple of registrars indicated location as a major barrier due to isolation, unfamiliarity, and a consequent lack of family support. The length of IHT placements was also a factor but registrars were divided as some wanted shorter term placements whilst others wanted longer. One registrar felt they did not have enough cultural awareness, while another wanted at least one year’s experience working as a GP to become clinically competent before considering an IHT post.

Several registrars believed that listening to personal experiences from peers who had undertaken an IHT placement would be the best way to overcome uncertainty about IHT placements.

Typical comments

• We don’t learn about what is being done and the benefits it is on current health situations, which is a barrier – a problem they cannot help.

• Should be some more training earlier in medical training – feel intimidated – have no exposure to Indigenous cultures – breaking that barrier – ignorance.

• Have shorter-term placements -1 month at a time as a taster.

• Have longer placements to experience properly and build trust.

• Location – and information - need to be more informed about city AMS.

• People like living in big cities but there is little continuity of care and services are very poorly run. In the city so safety was a concern.

• I didn’t have any initial barriers.
• Major thing is that posts are very far away. No family but was scared to go.
• Read a book which was a terrible and freaked me out.
• Hearing stories helps to balance it.
• Was nervous about training and debriefing support - adjusting to a new clinic
• Clinical competence concerns – wanted to have a year working as a GP first.
• Not confident at all in Indigenous cultural awareness – opportunity to learn.

ISSUE 6: LOCATION.

How much would location affect your decision to choose an IHT post? How much does your domestic situation (family) affect your choice of training location?

Registrars felt location was an important factor in deciding to choose an IHT post. Concerns were held about the effect of remote postings on lifestyle and domestic arrangements. There were also concerns for personal safety and isolation. One registrar believed it was easier to convince students to undertake a placement before their lifestyle changed.

Typical comments

• To be honest it is reasonably important. I just moved from one side of the city to another but I need to travel for an hour. So yes, it’s very important.
• I wanted to live in Darwin – it’s a very fun place. When you get older it gets more difficult. It’s easier to convince students before their lifestyle changes.
• It definitely has a big impact.
• A couple of places I could have gone to were in the middle of nowhere and were rough towns. I didn’t want to go there. It might deter others as well.
• Location would affect my decision. Domestic situation has a big effect.
ISSUE 7: PERCEIVED COMPETENCE.

To what extent would your confidence in your clinical skills and / or level of awareness of Indigenous cultures affect your decision to pursue IHT?

While a few registrars were comfortable with their clinical skills and awareness of Indigenous cultures, all wanted more clinical training. Registrars wanted more training for rural placements where resources and access to specialists was limited or non-existent. It was also suggested that lectures be taken by someone who has worked as a GP in an indigenous community for an extended period of time. Another suggestion was to make registrars aware of the support available to them in IHT and use cultural mentors such as Aboriginal health workers.

Typical comments

- There’s a difference between rural and urban Indigenous people and resources available. You require different skills and knowledge when there are limited or no resources or specialists.
- There’s a fear of coping with complexities, non-compliant patients and cultural differences.
- I want more medical training than cultural.
- IHT helps to challenge skills such as handling drug abuse and alcohol problems.
- This never was a barrier for me. You learn on the job.
- Before I went it sounded complicated with special rules about how to deal with people. It’s not that complicated. You can get advice from Aboriginal health workers.
- It’s useful to let people know that there is plenty of support. Don’t be afraid.
ISSUE 8: SUPPORT FOR GP REGISTRARS IN IHT.

How supportive do you perceive IHT to be? How important would support be in influencing your decision to pursue IHT?

A couple of registrars said they were nervous because they were not informed about how the IHT program was going to work. They wanted better clarification prior to placement about who was available for help and support. Other registrars said they wanted more support on complex cases. Another felt their supervisor was overloaded and had little time to teach.

Most registrars agreed that support was an important factor influencing their decision to pursue and IHT post.

Typical comments

- Nervous - need to clearly identify support prior to post.
- Too much support doesn’t help and causes trainees to ‘tip-toe’ around patients.
- I didn’t feel abandoned but if you put forward a complaint, the people you are complaining to are the people abusing you. It’s difficult.
- Clinically – all OK in terms of support. The place is run by people from the community and they are very close to the community.
- In my practice my medical supervisor was overloaded and had little time to teach.
- More complex cases may need more support initially. Still would go through.
ISSUE 9: HOW TO BEST MARKET IHT.

How could IHT be promoted to you in a way that would make you decide to pursue an IHT post?

All registrars agreed that marketing needs to emphasise that parts of Australia are living in 3rd world conditions. However many registrars believed positive messages highlighting what could be achieved and how rewarding the work was would be very beneficial. This also related to the images being presented in promotional material. Registrars wanted to see positive images not just pictures of malnourished children.

All registrars wanted to see personal accounts from people who had done IHT placements used to promote IHT posts to remove preconceived negative perceptions.

Typical comments

- Marketing about how rewarding IHT is and the improvements made to Indigenous Health overall. More inspiring marketing.
- There needs to be more practical marketing for trainees. Information on where they’ll live, what is provided, what to expect, support, everyday operations.
- Marketing needs to emphasise there is 3rd world living in Australia.
- Personal accounts from people who have done the post. Staff saying there is a lot of support and patients are not all angry.
- Marketing to be brought out early in training to keep people motivated.
- Positive messages are important. General perceptions are very negative.

ISSUE 10: TESTING CURRENT MATERIALS.

Please indicate positive and negative aspects of current marketing materials. Could they be improved? How?

The only comments relating to this section were that positive pictures attracted registrars’ attention as well as images showing happy registrars who enjoyed their work.
ISSUE 11: ‘WANT TO MAKE A DIFFERENCE’.

How effective is the tagline ‘Want to Make a Difference’ in promoting IHT posts? How could the material or the tagline be improved?

One registrar felt ‘Want to make a Difference’ was a good slogan for people already in that frame of mind. Another felt it was overreaching and might deter people who do not think they can make a huge difference by themselves. They commented that it was better to emphasise the health needs and personal rewards you can get from undertaking an IHT post.

Typical comments

- It’s good for people already in that frame of mind or to get people to think about it.
- It appeals that we can try and help but a little bit jaded and overreaching.
- It’s emphasising the health needs. Is effective, positive learning experience for us culturally, socially and clinically.
- It’s professionally rewarding whether they feel it or not. But part of something.

ISSUE 12: ‘CLOSING THE GAP’.

How does ‘Want to Make a Difference’ compare to the current COAG campaign’s message ‘Closing the Gap’? How effective do you think the slogan ‘Closing the Gap’ would be in promoting IHT posts?

Registrars liked the slogan ‘Closing the Gap’. One registrar said it reminded them that Aboriginal people have lower life expectancy and motivates them to support the plight of Aboriginal people.

Typical comments

- That’s good. Both slogans are important - equivalent.
- I think of mind the gap in the London tube - but it’s good
- ‘Close the Gap’ is better and reminds me that Aboriginal Australians die 20 years earlier than non-Aboriginal people. This horrifies me and motivates me to help the plight of Aboriginal people.
ISSUE 13: ‘CULTURAL SAFETY’.

What does ‘cultural safety’ mean to you? How does it impact on you?

All registrars felt that the word ‘safety’ gave a negative perception and caused people to worry about offending patients. One registrar commented that everyone has their own culture so the emphasis should be on being polite. Another registrar indicated that there were differences between Indigenous cultures and you couldn’t learn everything about them all.

Typical comments

- People become more worried about offending patients after training.
- It should be ‘awareness’ not ‘safety’ because the negative stigma attached with the word ‘safety’ causes people to worry.
- Everyone has their own culture so the emphasis should be on being respectful.
- Cultural education is different to understanding. It’s learning about a specific culture. You can’t learn everything about every Indigenous culture.
- Cultural safety means people are safe, whatever culture background.

ISSUE 14: ‘CULTURAL EDUCATION’.

How does this term compare to the term ‘Cultural Safety’? Which term would be more effective to encourage registrars into an IHT post?

Most Registrars thought that ‘cultural education’ was a better term than ‘cultural safety’ as it had more positive connotations. One registrar disagreed.

Typical comments

- Better term than cultural safety.
- Cultural safety is the term I would prefer - positive connotations – more than cultural awareness - it’s proactive.
- Feel safe and secure and encouraged to be who they are.
- I think people are turned off by ‘cultural safety’. They tune out. Cringe.
ISSUE 15: EXPOSURE TO IHT MARKETING MATERIALS.

What Indigenous health information did you have access to?

Registrars had received very little information. Mainly from course materials. One registrar had received nothing about Indigenous health training.

Typical comments

- No. Just received course materials and the like and some exposure as a med student.
- Nothing from Indigenous health training.

Northern Territory: Junior Doctors

ISSUE 1: INTEREST IN IHT.

What do you know about IHT available in Australia?

All junior doctors were interested in working in Indigenous health but did not elaborate further. One junior doctor was currently undertaking a PGPPP.

Typical comments

- I’m in PGPPP at the moment. I’m motivated being from Melbourne. It’s very different.
- Working in remote communities different is from in the city. There is a big black hole in my knowledge base.
- I’ve heard about Indigenous issues but didn’t learn about them at Uni.
ISSUE 2: IHT EXPERIENCE / EXPOSURE.
How much and what kind of exposure or experience have you had to Indigenous people, health or cultural education?

The amount of exposure junior doctors had with Indigenous health varied. Some junior doctors had spent time in Indigenous areas or received significant training while others had very little experience or exposure. One said it would be a good idea to have cultural awareness training early if it is relevant to a work placement.

Typical comments

- I did a three month term with PGPPP in NT. Very different medicine. It made me more interested in doing Indigenous health.
- I had a strong focus on Indigenous health throughout university.
- I came from overseas so haven’t had much exposure. Indigenous people don’t like to come into hospital. They have more acute problems.
- I had good training in WA. Frequent sessions, there was some overlap. Went on some rural visits.
- Did Aboriginal history studies at school but it was not sufficiently covered at university.
- My university didn’t have any Indigenous health placements.
- Better to spend time out at Indigenous communities rather than doing lectures or sessions.
- Outside of uni and work I had no Indigenous interaction really.
- Should have cultural awareness training relevant to placement early in training.

ISSUE 3: MAJOR INFLUENCES.
What are the major influences in choosing your current training post? Would your peers and family support you in undertaking IHT?

One junior doctor said they had been influenced by meeting doctors who had extensive experience working in IHT practices. Hearing from senior doctors and peers about their experiences was also useful. Most had the support of family and their partner.
INDIGENOUS HEALTH TRAINING
FOCUS GROUP REPORT

Typical comments

- Influences – not by people – something I thought out myself.
- I met a lot of other doctors doing similar work. Speaking to them inspired me.
- It would be good to hear from senior doctors so they could tell you more.
- Really useful to speak to peers to best prepare you for what it’s like.
- No issues with my family and friends. Many came and visited me and were very supportive of me. My partner is a doctor as well. She came to visit me and I had good support.

ISSUE 4: MAJOR BARRIERS.

What would be the major barrier to IHT? How could this be broken down?

Junior doctors believed stereotypes regarding IHT placements need to be overcome. Another junior doctor highlighted location and being away from partners and family as a major barrier particularly over long periods. A suggested solution to overcome this would be for junior doctors to have duel placements.

Typical comments

- Stereotypes need to be overcome.
- The barrier is location. Being away from partners and family. This would be alleviated if you could get duel placements.
- Junior doctors are preparing themselves to get on to training programs. Doing a rotation in PGPPP won’t help get on another training program.

ISSUE 5: PERCEIVED COMPETENCE.

To what extent would your confidence in your clinical skills and / or level of awareness of Indigenous cultures affect your decision to pursue IHT?

Junior doctors expressed a range of issues relating to perceived competence. It was felt that they needed more specific training on Indigenous health issues such as pathology and language prior to doing a post. Junior doctors wanted good supervision and support from community elders, local people and Indigenous health workers regarding cultural awareness.
Typical comments

- You need specific training. More than general training before doing an IHT post. More specific training on specific pathology and language.
- It would be great to meet with community elders at the start of the post.
- I got conflicting information from local people when I went to my Derby post.
- Would be good to have Indigenous health workers.
- Depends on how much supervision you’ll have. If you have no supervision it would be different. At first I felt fine, had good supervision, then I had to work on my own. I was not as confident in this supervision. Have backup. Wasn’t a deterrent.

ISSUE 6: SUPPORT FOR GP REGISTRARS IN IHT.

How supportive do you perceive IHT posts to be? How important would support be in influencing your decision to pursue IHT?

Support was an important factor in deciding to undertake an IHT post. Junior doctors also suggested that people should be informed of the support available at posts to encourage interest.

Typical comments

- As a junior doctor it’s pretty important especially at the start of the rotation.
- Whatever you do, you need good support. You need cultural support also so you can deal better with patients.
- Inform people of the support available. I would not be interested otherwise.

ISSUE 7: HOW TO BEST MARKET IHT.

How could IHT be promoted to you in a way that would make you decide to pursue an IHT post?

Junior doctors believed promotion should focus on positive elements such as advancing career, training, exposure to different pathology and seeing the country. Several wanted to talk to people who have first-hand experience and to be given access to internet information instead of handbooks or posters.
Typical comments

- Focus on positive elements. It can help advance your career, training or expose you to different pathology.
- 50/50 – You need to talk about work and lifestyle
- I like to talk to interesting people with first-hand experience. I wouldn’t bother looking at handbooks or posters. Want to hear positives and negatives.
- Doctors want points with few words.
- Showing materials with too much text. Want pictures (a 4WD or a fish).
- Would be good to have access to an internet link to get more information.
- No pictures of snakes and spiders.
- Tell us about the country. Fly into different communities. Fly in and see the land.

ISSUE 8: TESTING CURRENT MATERIALS.

Please indicate positive and negative aspects of current marketing materials. Could they be improved? How?

A strong message that came from junior doctors was that IHT promotion should encourage them to ‘join a team’ as many junior doctors said they would not undertake IHT if they were going to be the only doctor. One registrar suggested using the slogan ‘contributing to health outcomes’ and ‘where the need is greater’.

Typical comments

- Have seen GPET material that has included stuff on Indigenous health with a slant on social justice and different pathology. I wouldn’t feel comfortable going to a remote post as a single person. I’d want to be part of a team. I don’t like dealing with emergency surgeries and anaesthetics.
- There’s no way I’d go somewhere and be the only doctor.
- You would have to be part of a team. I wouldn’t consider an IHT post as a sole doctor.
- You’re dealing with really complex problems (medically, socially and economically) but don’t have the expertise to deal with it if you don’t have a senior doctor available.
- ‘Contributing to health outcomes and where the needs greater’ – I think it’s a good message
 ISSUE 9: ‘WANT TO MAKE A DIFFERENCE’.
How effective is the tagline ‘Want to Make a Difference?’ in promoting IHT posts? How could the material or the tagline be improved?

Junior doctors believed the message needs to be put into a broader context such as working in a team. Another junior doctor said it would be difficult to make a significant difference in a short period of time and the slogan needed to reflect more realistic expectations.

Typical comments

- Need to put message in a broad context and put emphasis on working in a team. Not ‘Come Make a Difference’. Its idealist and silly.
- Come to do a placement for a short period of time – make a difference can lead to inappropriate expectations. Maybe you only make a difference on an individual level and leave disappointed and not want to come back. Have realistic expectations.

 ISSUE 10: ‘CLOSING THE GAP’.
How does ‘Want to Make a Difference’ compare to the current COAG campaign’s message ‘Closing the Gap’? How effective do you think the slogan ‘Closing the Gap’ would be in promoting IHT posts?

All junior doctors thought ‘Close the Gap’ was more realistic and implied that junior doctors were part of a bigger issue and would be working towards something.

Typical comments

- ‘Close the Gap’ sounds like you’re part of a bigger thing and sounds more realistic. (All registrars agreed).
- Close the gap is more appropriate as it highlights the key issue. Moving towards something, long term, collective, nationally working toward something.
Experiencing it for yourself, not what you read or see on TV or hear from academics. Challenge what you read and hear.

**ISSUE 11: ‘CULTURAL SAFETY’**.

**What does ’cultural safety’ mean to you? How does it impact on you?**

None of the junior doctors had heard of the term cultural safety but believed cultural awareness was a better term.

**Typical comments**

- Does it mean preserving culture?
- Treading lightly around cultural issues?
- You need to be safe about some issues.
- How to avoid mistakes?
- Cultural awareness is better.
Northern Territory: Registrars

ISSUE 1: WARM UP AND TOP-OF-MIND ISSUES.

What do you know about IHT available in Australia?

No registrars had worked in an IHT post but all were interested. One registrar indicated they were Indigenous.

Typical comments

- Rewarding at times, complex and interesting medical issues.
- High acuity patients. A need for cultural sensitivity, for a wide skill base, personal physical and emotional resilience.

ISSUE 2: INTEREST IN IHT.

Have you considered IHT? Why / why not?

All registrars were interested in undertaking an IHT post. One would consider undertaking a short-term rural IHT post and other registrars had other career goals.

Typical comments

- (No-one has worked in IHT post but all are interested).
- I’d go rural, short term but location and frustrations make me not want to pursue a long term post.
- We have other career aims that outweigh choice of Indigenous health posts.
ISSUE 3: IHT EXPERIENCE / EXPOSURE.

How much and what kind of exposure or experience have you had to Indigenous people, health or cultural education?

One registrar had considerable exposure to Indigenous health while growing up in Darwin and had undertaken an Aboriginal medical training placement. Another identified as Indigenous while others had little exposure except for cultural awareness sessions at medical school. Most thought the cultural awareness sessions were done poorly and were repetitive. They suggested that they be centrally coordinated to overcome this problem and made more relevant to posts.

**Typical comments**

- I was raised in Darwin and I had lots of exposure to Indigenous health. I’ve done rural rotations in QLD including Aboriginal health ones. Cultural awareness sessions were useful but can become repetitive.

- I have not had much exposure. Have done a number of cultural awareness sessions but repetitiveness made people disengaged.

- It would be good for one central organisation to do cultural awareness training to stop repetitiveness. It should be made relevant to where you’re working. Can build on training over the years with the one organisation.

- Hardly any sessions were given in medical school. Sessions vary in quality and usefulness and should be tailored better.
ISSUE 4: MAJOR INFLUENCES.

What are the major influences in choosing your current training post?
Would your peers and family support you in undertaking IHT?

Registrars choose their current training posts because they were easy, not stressful and flexible. Some registrars’ families would be supportive and others not.

Typical comments

- I chose the easiest post last year because I was really burnt-out. I wanted to do a remote critical care post and I know how stressful these posts are so I didn’t want to do any early on. Wanted to set up good habits and good service provision early on by choosing a post where patients demanded high quality health care.
- Initially I just wanted to try different places but then liked the flow of the current post, not as stressful and very flexible. Not treated as a money machine.
- Yes if in Darwin but no if out of Darwin. My partner couldn’t get a job.
- My family would be supportive depending on location.

ISSUE 5: PERCEIVED COMPETENCE.

To what extent would your confidence in your clinical skills or level of awareness of Indigenous cultures affect your decision to pursue IHT?

There was mix of views relating to perceived competence. Some registrars said they were comfortable with their levels of knowledge while others were not. A couple of registrars felt clinical skills were very important in IHT placements. Doctors needed to feel supported in order to confidently undertake IHT.

Typical comments

- Clinical skills are more important in IHT post than others.
- Very important especially when you’re in remote communities. I’m not confident with my skills at this stage to do a remote post. It would be OK in larger rural posts where there is more support. I take guidance from local health workers or others.
- Clinically I feel OK but there are a few things I wouldn’t feel comfortable with. Threatening and emergency situations.
• Good cultural education helps but it’s also about being sensitive and listening. You learn on the job.
• Culturally I’d feel OK. Every community is different and you need enough cultural sensitivity to be functional and gain trust. The rest will come.

ISSUE 6: SUPPORT FOR GP REGISTRARS IN IHT.

How supportive do you perceive the IHT program and posts to be? How important would support be in influencing your decision to pursue IHT?

The only comment on this issue was that post support was critical especially with Indigenous health care workers.

ISSUE 7: HOW TO BEST MARKET IHT.

How could IHT be promoted to you in a way that would make you decide to pursue an IHT post?

Registrars indicated they wanted images of positive life experiences and the landscape. They also wanted accounts from people who have had Indigenous health experience. Being made aware of the benefits and pitfalls of Indigenous health was also mentioned.

Typical comments

• Images of positive life experiences.
• Accounts from people who have done Indigenous health is much better than posters.
• We need to know benefits and pitfalls.
• Images of the bush.
ISSUE 8: TESTING CURRENT MATERIALS.

Please indicate positive and negative aspects of current marketing materials. Could they be improved? How?

Registrars believed handbooks were too generic and ‘sugar coated’. Information needed to be more specific and honest. They wanted to see real life accounts from people who had positive and negative experiences.

Typical comments

- There are booklet and handbooks. Most people only flicked through them.
- Materials are all so generic. We need relevant details.
- It’s pretty – I like the colour and pictures.
- Too many words. I wouldn’t find time to look at it.
- Need honest accounts not ‘sugar coated’ words.
- PGPPP Journal has 100 word real life accounts with pictures that were really useful.
- They should publish accounts from people who had bad experiences.

ISSUE 9: ‘WANT TO MAKE A DIFFERENCE’.

How effective is the tagline ‘Want to Make a Difference?’ in promoting IHT posts? How could the material / the tagline be improved?

Registrars generally commented that the slogan ‘want to make a difference’ was too generic.
ISSUE 10: ‘CULTURAL SAFETY’.

What does ‘cultural safety’ mean to you? How does it impact on you?

Registrars felt the term was confusing and were unsure of its meaning. One registrar believed it related to protecting your own and other people’s safety.

Typical comments

- I have heard it before but I don’t know what it means. What’s the difference between ‘Cultural Awareness’ and ‘Cultural Safety’
- Protecting yours and others’ safety.
- It’s confusing. Doesn’t make sense.
Western Australia: Junior Doctors and Registrars.

ISSUE 1: IHT EXPERIENCE / EXPOSURE.

Have you considered IHT? Why / why not?

Several registrars had gained exposure through university, PGPPP or cultural awareness sessions. One registrar had grown up around Aboriginal people. A couple of registrars wanted more training before placements, especially for overseas trained doctors. Another registrar believed cultural awareness sessions should focus less on negative statistics and more on what will impact on the relationship between a non-Indigenous doctor and an Indigenous patient.

Typical comments

- I grew up around Aboriginal people. Medical school training in IHT was not compulsory so no one turned up (3 to 8 max). A disaster. On the first session people turned up, there were arguments based on different opinions. Then no one turned up. Everyone needs some sort of cultural awareness doing medical practice.
- I had a weekend workshop with a trip away. I camped with Aboriginal elders. Good cultural education
- PGPPP had one session on Indigenous health.
- Cultural awareness education
- I know things that I have observed or read.
- We need some training before rural placement – before starting. Especially for overseas trained doctors.
- Training should not just lie on the political correctness line. Not just give statistics and why it is. Often it is just blaming or repeating what everyone knows. Instead cultural awareness should be about what will impact the relationship between a black patient and a white doctor and how to deal with that situation. There are a lot of differences between Indigenous communities. Have specific training before specific placement.
ISSUE 2: MAJOR INFLUENCES.

What are the major influences in choosing your current training post?
Would your peers and family support you in undertaking IHT?

Registrars were influenced by the challenge of treating different illnesses that would not be seen in the city. Another registrar was influenced by growing up around Aboriginal people.

One registrar said her husband would disapprove if she chose to undertake an IHT post as he had negative childhood experiences with Aboriginal people.

**Typical comments**

- I love Aboriginal people. Grew up around Aboriginal people. I was a nurse before being a doctor. I thrive on controlled chaos. Connection from when I grew up. Rewarding to make small one on one changes. Even though you might not be able to make big world changes. Making a difference is good.

- There are different sorts of diseases that you don’t see in the city. Manage different illnesses and learn. It’s more extreme and challenging.

- My husband’s experience with Aboriginal people is based on bad childhood experiences: fights etc. Therefore he would disapprove if I made this choice. Personal experience based on people getting their wallets stolen, stones thrown at.
ISSUE 3: PERCEPTIONS OF IHT.

How would you describe your perceptions of IHT?

Some registrars perceived an IHT training post as challenging or rewarding. Some registrars highlighted the high prevalence of kidney problems and dialysis in Indigenous communities. Having the option of short term placements for junior doctors, being given sessions from passionate presenters and publishing people’s experiences in booklets were suggested as ways to encourage more doctors to consider undertaking an IHT post.

Typical comments

- Challenging – chaotic – frustrating
- Communication problems. ‘Pus’, lacerations and dialysis.
- Dialysis. Not waiting for things to get really bad to come and see the doctor
- Communication problems. Rewarding and challenging,
- If I were to experience Indigenous health in a different setting, a few days here and there, I could then realize that it is rewarding. Spending more time, experiencing something different could change my mind but marketing wouldn’t do it.
- Like GP, when you are studying, it doesn’t sound exciting. My IHT impression is the same as GP but without the boring bits. You could market it like general practice – doing a lot of different things.
- It’s challenging. Be honest about what to expect in IHT. Challenge is as attractive thing for doctor though.
- Junior doctors should be given an opportunity to sample IHT and get a better idea. Then you could commit to a long term career. That could encourage them. Have a small placement for junior doctors.
- Experiences that people have can be used for marketing. This is what can be used to market. And also making the compulsory training at medical school interesting and relevant. Not boring. Good quality as well.
- Finding a passionate presenter. Someone who is good at it, fresh approach.
ISSUE 4: MAJOR BARRIERS.

What would be the major barrier to IHT? How could this be broken down?

Several registrars indicated location and subsequent factors such as relocating family and access to schooling and services as barriers. Other registrars stated they ‘burned out’ quickly as it was a very challenging and demanding role. One highlighted political issues as a barrier. There were no specific suggestions on solutions to break down these barriers offered.

Typical comments

- Location.
- Access to schooling and services
- It requires moving family. Is a huge decision.
- Burnt out quickly even though it’s a great life and rewarding job. It can be very isolating.
  A Lack of medical and social support, family.
- It’s a very challenging role. Being the doctor for everyone all the time.
- There’s a chaotic appearance about Aboriginal health clinics. A sense that everything is out of control. Day to day chaos. No forward planning.
- The politics is something that worries me. Strange politics are going on in there. Funding arguments. Who is getting paid? I have no time for that, just want to work. Is a bit off-putting.

ISSUE 5: PERCEIVED COMPETENCE.

To what extent would your confidence in your clinical skills and level of awareness of Indigenous cultures affect your decision to pursue IHT?

Several registrars indicated confidence in clinical skills and cultural awareness were not an issue. They felt they had adequate levels of support and they learned the necessary skills quickly. One registrar believed they would not offend by an Aboriginal person as long as their intentions were good. Conversely, one stated they had very little confidence.
Typical comments

- Probably not an issue. Nowhere in WA are RFTS flights more than 8 hours away. There is always some level of support around. Normal level of skills needed as any practice. It is like normal GP.

- You may not have the skills when you go in but you learn pretty quick. Same as in a practice with mostly old people. You learn and adapt.

- You will never get busted by a black fellow in an Aboriginal health centre if your intentions are good. But if they think you are there only because you have to be, then it won’t go down very well. Aboriginal saying: ‘it takes a year to figure out whether we like you and then another two years before we trust you’. Placements of 6 months!

- I have very little confidence. Struggled in my previous experiences. But there for the patient. Bumbled through but got the job done. Trying my best. Always a little bit worried by my lack of skills not being able to provide required help.

- Key to Aboriginal health service delivery is communication. Simple communication. Some words are not used.

- Not just for Aboriginal. For any patient. A lot of doctors just don’t explain. Doctors have to be aware of how to communicate.

- Not necessarily taught. For some people it doesn’t come naturally. For some it does.

- Easier to explain things in simple words to patient. Then ask the patients to re-explain what you just told them. Then you can make sure that they got it. Make them repeat.
ISSUE 6: SUPPORT FOR GP REGISTRARS IN IHT.

How supportive do you perceive the IHT program and posts to be? How important would support be in influencing your decision to pursue IHT?

Registrars believed support to be very important in an IHT placement. It was highlighted that registrars wanted a GP and Aboriginal mentor and for these people to be available most of the time.

Typical comments

- It should be supportive. In the beginning there should be a supervisor that you can easily go and talk to. Someone who has been there for a long time, in the community. As a GP you need to know about a patient’s family etc. Need a supervisor that knows family, how things work. At least in the beginning.

- Ideally you want a GP mentor and an Aboriginal mentor. Because sometimes the Aboriginal mentor and GP mentor are not working around exactly the same agenda. Aboriginal health workers and doctors need to be on the same line. There is politics behind Aboriginal medical services. These are quite political places. You need to go in there with your eyes open about the fact that politics are going on and understand that and not get caught in it.

- I don’t know much about it. It is a lot about perceptions. Politics are something I am aware of. Beyond the compulsory support required by any training GP, don’t know what else we could need.

- Based on the fact that they have a lot of multiple and different pathologies, I wouldn’t feel comfortable if the supervisor was offsite for a certain proportion of time in any placement. I want the supervisor there.

- Your support network is what you make of it. In current places, my support network is everybody. Debrief with different people about different issues. You would hope that everybody is big enough to do that.

- Registrars shouldn’t be in placements where there are no supervisors on site. True in any placement but particularly in Aboriginal health because of the higher acuity of problems and also less likelihood that you can bring these people back in tomorrow or next week.

- They won’t come to see you until it is very bad or too late.
ISSUE 7: HOW TO BEST MARKET IHT.

How could IHT be promoted to you in a way that would make you decide to pursue an IHT post?

Registrars suggested that other registrars or junior doctors’ personal experiences with IHT should be the focus of promotional material.

Typical comments

- People’s experience and telling stories of what they did in Kalgoorlie. Diagnosing acute kidney failure by themselves. Makes it something real with someone else’s experience. Someone passionate telling you the real things that happened. It is not just like normal general practice. It is very interesting medically.
- Reality from people who have been there and done it.

ISSUE 8: TESTING CURRENT MATERIALS.

Please indicate positive and negative aspects of current marketing materials. Could they be improved? How?

Many registrars were satisfied with the information currently available on IHT. They believed the information was comprehensive and liked that the booklets have varying levels of detail (e.g. detailed and summary) available. One though believed if someone was not interested in undertaking an IHT, then no promotional material would change their mind.

A registrar suggested the slogan ‘charity begins at home’ relating to idea that many doctors venture overseas for volunteer work when they should be doing it in Australia.

Typical comments

- If you actually get all the things that are displayed in the booklet then it is fine: communication, skills practice, knowing about Aboriginal culture.
- They look good but I am reading that on the back of having not had any positive Aboriginal work experiences. It is hard to change years of perception.
- The materials themselves are quite good.
- If you put a face to it, someone sharing their own experiences, then I would believe it much more.
• Need someone who is dynamic.
• Nice materials. Catchy pamphlets. But if you are not interested in the first place, it wouldn’t change your opinion anyway.
• It is good that there is information that is rich and accessible. If you are not really sure and you are just gathering information, you need something quick to look at. But for someone who needs to know more, like pay conditions etc. it is good to have a more detailed one. Could have more pictures though, it is a bit dry.
• If I was responsible for doing IHT in Australia, I would be getting all Aboriginal controlled health services in Australia to create one training service programme and have one training service provider for Aboriginal health in Australia. The sole focus is to fill places in Indigenous health.
• Marketing IHT for people should use guilt. Lots of people want to go and work in a third world country as volunteer doctor. Why not do it in Australia, three hours down the road. ‘Charity begins at home’. No need to take a plane.

ISSUE 9: ‘WANT TO MAKE A DIFFERENCE’.

How effective is the tagline ‘Want to Make a Difference?’ in promoting IHT posts? How could the material or the tagline be improved?

Opinion was divided over the slogan ‘want to make a difference’. Registrars indicated they liked it while others were critical. One felt insulted that they thought the slogan implies a doctor is only making a difference if they are working in Indigenous health. Other registrars believed it needed to be less ambiguous and alter it so the slogan is not a rhetorical question, but provides a solution.

Typical comments

• It does not appeal. Seems lame. Not bold enough
• I find it insulting as it suggests that I am not making a difference because I am not working in Indigenous health.
• I don’t mind it. It is a little bit of guilt. You can make a difference.
• I Like it.
• It is a rhetorical question. If it had an answer to it, then I would like it more.
• Could be an effective tagline. Needs to be less ambiguous. Answer that rhetorical question with ‘Aboriginal health, opportunities’.

**ISSUE 10: ‘CLOSING THE GAP’**.

*How does ‘Want to Make a Difference’ compare to the current COAG campaign’s message ‘Closing the Gap’? How effective do you think the slogan ‘Closing the Gap’ would be in promoting IHT posts?*

Opinion was again divided over the slogan ‘Closing the Gap’ with some registrars liking it but most describing it as ambiguous, political and tired.

**Typical comments**

- I hate ‘closing the gap’. It sounds like ‘we are a political party and we want to spend money so we are going to close the gap and spend money’.
- I don’t like the phrase. What is the gap? Not clear enough. Ambiguous.
- I like it as a political thing.
- Like it. Effective on an Aboriginal health poster. It has to be paired together with that. Actual statement by itself doesn’t mean much.
- It sounds like political catchcry to me.
- It sounds a bit old, a bit tired.

**ISSUE 11: ‘CULTURAL SAFETY’**.

*What does ‘cultural safety’ mean to you? How does it impact on you?*

Registrars defined cultural safety as the mutual respect of cultures and respecting and protecting cultures. Having confidence and good communication skills was suggested as means of achieving cultural safety. Other registrars indicated the phrase meant nothing to them.

**Typical comments**

- Means nothing. I don’t understand what it means. Sounds like keeping someone’s culture safe, protecting their culture, knowing that you are not changing their culture.
• Personally, it means ‘me respecting your culture and you respecting my culture’ and doing that in a way that we can communicate together so that neither of us is in any danger of our culture being offended.

• Two things come to my mind. Cultural safety training: ‘do not make eye contact, the woman who is called mother is not necessarily the one that gave birth etc.’ All clichés thing. Cultural safety: respecting and protecting culture. Aboriginal culture is probably the least important in my practice and in my day to day work. 46% of patients are born overseas. The irony is that Aboriginal culture is the one that is sexy and gets votes.

• Work on cultural safety should apply to all cultures.

• To understand cultural safety, you need to respect different cultural backgrounds.

• It is working with lots of refugees, having confidence in yourself and where you are in your own culture, and asking questions. Having the confidence to know that you don’t really know what the other person wants. This applies also to Aboriginal culture, particularly in the city when you are getting people that have been flown down from God knows where. You don’t know what the culture is.

• Cultural safety is a crap word. It doesn’t mean anything. I don’t like it.

• Cultural awareness could be better.

• It doesn’t apply to me. Anyone that is a nice human being and can relate to people is probably culturally safe without having to bother knowing what it means.

• It is almost like having communication skills training to learn how to be kind to someone. You know that because you are a person.

• It is cultural awareness where at least you know what you are talking about.

• Respect would be better.
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Queensland: Junior Doctors

ISSUE 1: WARM UP AND TOP-OF-MIND ISSUES.

What do you know about Indigenous Health Training (IHT) available in Australia?

Have you ever considered doing IHT training? Why / why not?

A couple of junior doctors said they were aware of available IHT. One remarked they could study an advanced URMAC or ACTP in Indigenous health. Others indicated they could undertake post graduate study at certain universities such as Flinders.

There was a mix of junior doctors had and had not considered doing IHT training.

Typical comments

- Yes, I know that you can do an advanced URMAC (?) or ACTP in Indigenous health and there’s a diploma for advancing it, so you can get rural general status. Other than that you can also get a remote component of training as well which sort of incorporates it, but it’s not specifically just for Indigenous people.

- That is the advanced health years and GP training. There is a lot of post graduate study you can do as a doctor as well. Lots of masters and diplomas and particular things like paediatrics get picked up through a lot of those things and doing them by correspondence.

- Not really. I’m not really considering it as I’m not doing rural work, so that kind of rules out Indigenous health to a pretty large extent.

- Yeah maybe.

- Not really. I just haven’t really thought about it. I guess part of it is because of the rural aspect as well. I don’t really want to. I guess I probably will get placed in a rural area some time during my training, but I hadn’t specifically thought of it.
ISSUE 2: INTEREST IN IHT.

Have you considered or undertaken an IHT post? Why / why not?

Some junior doctors believed IHT was a challenge and a lot of fun. Others felt it was about giving back to the community and improving life expectations and health outcomes. One junior doctor said they were contracted in a rural Indigenous placement as part of the placement, but not specifically because it was an IHT post.

Typical comments

- It’s a challenge and a lot of fun.
- I’m contracted out there. But Indigenous health by itself isn’t a reason why I went out there. It just happens to be part of the package.
- Giving back to the community. Helping Indigenous people raising their life expectancies and improving better health outcomes.

ISSUE 3: IHT EXPERIENCE / EXPOSURE.

How much and what kind of exposure or experience have you had to Indigenous people, health or cultural education?

Several junior doctors had experienced cultural lectures and information sessions. One experienced a ‘rural week’. Junior doctors indicated it would useful if sessions were taught by registrars who had worked in Indigenous placements as opposed to professors. Another idea suggested was to introduce a compulsory two-week placement in order to give people exposure to determine whether they would like to undertake an IHT post.

Typical comments

- It was okay. They just showed some of the main diseases and how they interact with them and cultural differences. It wasn’t in depth, it was just an introduction.
- I had more formal ones. I was up at Mt. Isa last year and there’s a fair bit of emphasis on IHT exposure for anyone who’s new coming up there. As well as previously doing some work at another AMS. There was no clinical. It was all cultural training. They sort of leave clinical training up to whatever you do work wise because it wasn’t just doctors. It was nurses, pharmacists.
Everyone together. It was just cultural training. Cultural training is great, but I guess it’s a long term thing that takes commitment and focus to establish understanding and trust in those sorts of communities anyway.

During our rural week we went up to Toowoomba and we had one session and a series of lectures.

I didn’t think it was necessarily. It might be, but I guess every Indigenous community is different. I didn’t think that I needed any more cultural education. I didn’t need any more education on the particular diseases as such.

I think that maybe what would be good is rather than having professors teaching you is to get a doctor who actually works out there.

I don’t know long term whether that would help. You’ve got to get people interested in rural health.

You could make it compulsory.

**ISSUE 4: MAJOR INFLUENCES.**

**What are the major influences in choosing your current training post?**

**Would your peers and family support you in undertaking an IHT post?**

Junior doctors mentioned a range of different influences. These included variety of work, perceived isolation, and lack of support in IHT placements, family considerations and lifestyle issues. Junior doctors did not indicate whether their family or peers would support their decision to undertake an IHT post.

**Typical comments**

- I’m doing general practice. I’m just looking for variety. It’s about young people, old people, all sorts of diseases, it’s everything. I think for me the focus is more staying somewhere semi-urban rather than going rural.

- To get Indigenous health you have to go out to the country. The real Indigenous communities are rural. Especially for a lot of young doctors. They’re just starting to get money. I think that the isolation and lack of support scares a lot of people.

- Family is always a consideration. I’ve got a couple of young kids and you need to be somewhere where there’s a good education. In a lot of those real remote communities it would be a matter of correspondence for children.
I think lifestyle is quite important. Probably not very good to be talking about in medicine, but lifestyle in the long term some of these communities you might be the only doctor around for ages and you feel like you can’t go away.

ISSUE 5: PERCEPTIONS OF IHT.

Describe your perceptions of IHT training.

Opportunities to learn and help others, exposure to more advanced diseases, rural locations and challenging work were ways junior doctors described IHT. Opinions were mixed about whether marketing could change people’s perception. One junior doctor believed the key is to market IHT placements in a way that challenges preconceived ideas. It was also suggested that marketing needed to reduce the information gap between what is taught at medical school and what doctors are likely to experience. Conversely, one believed that people had already decided whether they want to do Indigenous training while studying in medical school.

Typical comments

- It’s an opportunity to learn as well as an opportunity to help and an opportunity to be helped. That’s all I can think of.
- I would have thought that the Indigenous training is going to end up having to be rural almost. There would have to be cultural stuff to it. Obviously there’d be stuff to do with disease, say more advanced diseases. I guess there are some specific diseases. The more tropical diseases I guess. The impression I always got though university was that it was slow.
- A lot of your ideas of IHT you get when you’re going through medical school and people generally know whether they want to go do Indigenous health. They’re that way inclined. I think that it comes down to the person, the lifestyle choice. They’ve already made their minds up themselves.
- I think that you could market it, because you can market ‘if you come to this rural area that has not very good health infrastructure then you can come here and make a difference, not just for one person but for all of their family’. I think you can market that.
- It’s certainly a bit more challenging I think. When I was over at Anulla we had traumas coming in and beaten up. Not just urban city doctors seeing coughs and colds.
I did a general practice rotation at the Aboriginal Torres Strait Islander health centre in West End. They offer a lot of support and a lot of monetary incentives to deal with particular issues. To deal with diabetes and asthma far beyond any other general practice. It would entice the same ones who would be enticed by the marketing I think.

If the marketing is about what it's actually like and changing the preconceived ideas then that might make a difference.

There's a big gap from what people are being taught at med school, so if you want more people to go into Indigenous health you're going to have to do the marketing or PR job when you've got them as interns.

There are not enough doctors in Indigenous health, not enough appropriate health care.

Rural, issues e.g. poor health access, communication-cultural differences.

ISSUE 6: PERCEIVED COMPETENCE.

To what extent would your confidence in your clinical skills, or your level of awareness of Indigenous cultures affect your decision to pursue IHT?

Generally junior doctors were comfortable and confident with their clinical skills stating that the main challenge was to handle more advanced medical conditions. Additionally, cultural sensitivity was regarded as important and to accept that Indigenous people were different in order to better understand and respect Indigenous views.

Typical comments

- My first point is exposure to more advanced medical conditions than we'd see in the average Caucasian population. Same medical conditions, but more advanced and signs that you wouldn't usually see.

- Well I guess just the cultural sensitivity. The way we've been taught, they kind of work in a different way to other people. That's the way they've put it to us, so we should learn about that and come to terms with. So we don't just brush it off and think that what they are saying or what they think is insignificant.
ISSUE 7: SUPPORT FOR GP REGISTRARS IN IHT.

How supportive do you perceive IHT to be? How important would this factor be in influencing your decision to pursue an IHT post?

Although junior doctors did not specifically comment on IHT support, some saw the need to have special support structures and communication systems in place to manage vulnerable groups. One junior doctor perceived that some universities did not treat IHT seriously or did not consider it as a serious career choice and another reported that their university did not provide a rural or Indigenous experience.

Typical comments

- I’m still a medical student. The way they teach us is that Indigenous people are a vulnerable group and we need to have special support structures set up for them. We need to liaise with their community health teams. We haven’t really been taught much about it so I don’t really know much about how to do it. I’m from Griffith Uni. We didn’t have any real Indigenous training from what I can recall. We don’t do a rural stint. About as rural as we get is Tweed Heads or Toowoomba. There’s not a lot of training as far as Indigenous health or even awareness of it as a potential career pathway to specialise in.

- I don’t think that schools encourage us to think about Indigenous health as anything but an airy fairy choice and as a social worker. I worked as a social worker before, so I copped a lot of it.

ISSUE 8: HOW TO BEST MARKET IHT.

How could IHT be promoted to you in a way that would make you decide to pursue an IHT post?

Junior doctors wanted positive images of happy healthy people doing activities in the community. These images would be designed to communicate that IHT is safe and would challenge incorrect perceptions. It was also suggested IHT would need to be marketed as positive for a doctor’s career and lifestyle. One junior doctor said they would have preferred to be directed to specific resources as opposed to having generalised information sessions.
Typical comments

- You need to be told where the resources are and look at them yourself rather than having sessions.
- I would have got information if I were interested.
- Good to get community members to take you out to communities. Should be no expense to the person – like having a camp.
- Need to market it as positive lifestyle and career option
- Images of happy healthy people doing activities in a community, no abuse. Happy fat babies.
- Images that let doctors know it’s safe and to challenge incorrect perceptions. We were given messages that it wasn’t safe.

ISSUE 9: ‘CLOSING THE GAP’.

How does “Want to Make a Difference?” compare to the current COAG campaign’s message “Closing the Gap”? How effective do you think the slogan “Closing the Gap” would be in promoting IHT posts?

Junior doctors preferred the slogan “Want to make a Difference” compared to “Closing the Gap” which they felt was media saturated.

Queensland: Registrars

ISSUE 1: INTEREST IN IHT.

Have you considered or undertaken an IHT post? Why / why not?

Several registrars believed more frequent, short-term posts would allow more people to be exposed to Indigenous health. A few registrars thought IHT should be compulsory.

Typical comments

- Shorter terms would allow more people to be exposed to it.
- People will be more inclined to go if they are posted more often.
- IHT is currently voluntary but it should be made compulsory.
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- General practice registrars need to have a decent insight into Indigenous health. We need to spend time in an AMS to see patients. See how it runs. It doesn’t have to be a full 6 months post. Even a week in an AMS for every GP registrar would be beneficial. Experience in dealing with patients who are non-compliant.

ISSUE 2: IHT EXPERIENCE / EXPOSURE.
How much and what kind of exposure or experience have you had to Indigenous people, health or cultural education? Should IHT be introduced into earlier stages of medical training?

Many registrars had been exposed to Indigenous issues through lectures and cultural awareness sessions at university. Some registrars admitted they had forgotten much of the information. Others had exposure through short term placements in hospital or from attending communities, which they considered useful.

Typical comments

- A half-day session that was part of basic training.
- I didn’t learn much about Indigenous health. At least I don’t remember a lot of it.
- I had a short-term stint in Mt Isa in a hospital. I haven’t been to any training though.
- I’ve had minimal exposure. Mostly through medical training.
- Through med school and rural med school training. It is useful to have earlier exposure.
- I went up to a community. There were 3 registrars there. I had a tour of facilities and it was well organised. They were used to registrars coming through. Very informative. A nice day trip.
- Medical school and uni. We had to do lectures on IHT. It was also part of an examination.
- There were placements with other students in Alice and Darwin and I went there. All exposure has been through my medical training though.
- Mainly through lectures we had at uni, cultural awareness stuff, as well as about awareness and historical awareness.
• There is a compulsory Aboriginal health unit in our curriculum. We had at least one or two sessions on cultural awareness. I can’t really remember the lectures, they didn’t go into detail. They basically covered some conditions common in the population. It increased my awareness of health problems and gave me a basic idea of working in Indigenous health.

ISSUE 3: MAJOR INFLUENCES.

What are the major influences in choosing your current training post? Would your peers and family support you in undertaking an IHT post?

For most, family, location of training and interest in Aboriginal cultures were the major influences in choosing a training post. Registrars indicated their families would be generally supportive of them undertaking an IHT post.

Typical comments

• Family is a strong influence. They would want me to have an urban placement. Location is very important.
• Mainly lifestyle and family.
• Having an interest in Aboriginal cultural influenced me most.
• Yep – family and peers supported me. It wouldn’t matter what they really thought. They would never stop me anyway.

ISSUE 4: PERCEPTIONS OF IHT.

Describe your perceptions of IHT training.

All registrars perceived the mortality rate to be higher in Indigenous communities than mainstream society. Several registrars perceived an IHT placement to be challenging and very different from other posts. Some registrars agreed that IHT would be similar to dealing with any other culture different to their own and that it was a learning process. Others felt the community and cultural differences provide the opportunity to develop professionally.
Typical comments

- They are very different to other posts.
- You would be dealing with different severity of diseases, patterns and illnesses.
- Patient mortality would be higher. (all agree).
- Depending on where you are, challenges and benefits to learning will vary.
- There is chronic disease, social/cultural context to consider, infant mortality, poverty. It would be life changing.
- There would be focus on an extra degree of training and procedural skills. There would be challenges to do with remoteness and poverty. There would be rewards too (lifestyle). You could have a contribution to closing the gap.
- Challenges, cultural differences, rewarding, learning, extending.
- Decision making process would be similar. It would be different in terms of issues and in terms of chronic health management and cultural issues. In the end though it would be the same as working in any other cultural other than my own.
- Any culturally different posts would be different. You learn along the way. You would feel more confident after doing cultural training.
- In other more mainstream training posts, cultural barriers may not be so great.

ISSUE 5: MAJOR BARRIERS.

Are there any major barriers (real or perceived) that would stop you from undertaking an IHT post?

Registrars identified location and children and family attachments as major barriers in undertaking IHT posts. One Indigenous registrar said working in their own community was a barrier due to its hierarchy and expectations placed on them by their community. As a result they would want to undertake their placement within a different community.

Typical comments

- Location is a big barrier.
- GP’s with family and other ‘attachments’ going on a longer placement is out of the question.
- Having kids is a barrier.
I cannot go to remote locations due to my own health issues which require me to stay near a city. But my attraction initially had to do with having more access to rural procedural medicine.

Going into my own community is a barrier. I’d much prefer to go into a different community. You have a hierarchy in your community. Everyone knows your business. It’s expected to go home to your own community – meet the aunty. If you’re removed from your own personal situation you can’t be accused of favouring your family members etc.

ISSUE 6: LOCATION.

How much would location affect your decision to choose an IHT post? How much does your domestic situation affect your choice of training location?

Most registrars felt location was an important factor in influencing their decision. One registrar commented that the remoteness of a location affected the availability of resources. Others commented that many people are reluctant to leave their partner and children, particularly when in some cases there will be a duplication of living costs. Another said they would feel personally and professionally isolated in a remote area. This group of registrars seemed to focus on IHT posts being a primarily rural lifestyle. Not many recognised the possibility of IHT in an urban setting.

Typical comments

- There are different issues in city and remote locations
- The remoteness of the location has an effect on resources.
- Indigenous training is not normally received and this would be enticing for registrars to do an IHT post.
- Location is a big deal. No one wants to leave their family and children. It costs you money. Two phone bills, double rent, 6 months away and 3 hours from home. If it were closer it would be much easier. It’s not healthy being forced to do a rural post.
- Location is quite important. You need to enjoy where you’re living. It’s pretty easy for me to move. If I was thinking about a remote area I might be professionally or personally isolated. That would be something to consider.
ISSUE 7: PERCEIVED COMPETENCE.

To what extent would your confidence in your clinical skills, or your level of awareness of Indigenous cultures affect your decision to pursue IHT?

Feeling confident regarding clinical and cultural skills in an indigenous setting was important to all registrars in terms of affecting their decision to pursue an IHT post.

Most though felt they would feel confident as long as they were adequately supervised. Several suggestions were made for including an introductory period for registrars to engage with the community, speak with elders and to familiarise themselves with the local community, before embarking on clinical activities. Some felt that undertaking after-hours clinics on their own would be daunting without support.

Typical comments

- (All agree) they would feel confident but supervision should be part of training.
- An after-hours clinic on your own would be daunting.
- Specific cultural awareness training is important. Spending time with the community to learn the culture half a day per week and build trust while in the post during an initial introduction would be useful.
- My experience with an Aboriginal family showed the importance of having an elder inform the trainees about the culture. This gives them authority and engages them. The community won’t feel threatened and trainees get a better idea of how it works.
- A placement should include an introduction into the community, an orientation to a new environment and learning about new resources available. During this week the trainee wouldn’t be ‘the doctor’. It must be coordinated well with a supervisor and member of the community.
- My confidence culturally wasn’t high – had a little experience before in the hospital. It depends on your location. NT was quite different to Brisbane.
ISSUE 8: SUPPORT FOR GP REGISTRARS IN IHT.

How supportive do you perceive IHT to be? How important would this factor be in influencing your decision to pursue an IHT post?

Several registrars were unsure about the levels of support available during an IHT placement. All registrars though agreed that if they were confident that continuous support existed, they would definitely consider an IHT placement. Family support was considered important as well.

Typical comments

- I don’t know how supported we would be
- I perceive and would expect (hope) that a trainee would be highly supported.
- If someone was uncertain but felt like they would be very supported, that would encourage them to want to go.
- (All registrars) agreed if they knew the support was there they would definitely consider an IHT post.
- Support for family members left behind so that someone is checking up on them too is important.
- Ongoing support and training would be handy.
- More culturally specific support would be desirable. Make people know so they are aware.

ISSUE 9: HOW TO BEST MARKET IHT.

How could IHT be promoted to you in a way that would make you decide to pursue an IHT post?

Advertising the attractiveness of the lifestyle and provide information what doctors can do outside of work hours on placements were ideas suggested by several registrars. Other registrars felt listening to personal accounts from experienced registrars would be beneficial. Offering practical information on issues such as travel, accommodation, supports services and professional contacts available was important. Organising the curriculum to allow registrars visit a community for a weekend was also suggested as a useful way to promote IHT posts.
Typical comments

- The skills a trainee will receive over and above the standard need to be advertised.
- The lifestyle is attractive and should be advertised – what people can do outside of work when they are on their placement, downtime options.
- Focus on the positives not the negatives.
- Peoples’ personal accounts work best.
- Practical information is needed for the practical things; accommodation, travel, lifestyle.
- Provide a package for trainees with contact details, supervisor numbers. Give an opportunity for people to go on the weekend before applying (all agree).
- After-hours sessions should be part of the curriculum about IHT to encourage people to think about it. This would encourage undecided people (all agree).

ISSUE 10: ‘WANT TO MAKE A DIFFERENCE?’

How effective is the tagline “Want to Make a Difference?” in promoting IHT posts? How could the tagline be improved?

Registrar thought the slogan captured a sense of adventure and hinted at the scope of improvements possible in this health area. Suggested improvements included making the slogan more specific to Indigenous health.

Typical comments

- It’s a reference to the significant areas for improvement possible in Indigenous health. It shows the scope for good practitioners to help with that.
- It’s good in that it emphasises making a difference – fairly catchy. Fairly effective slogan.
- It’s trying to get people’s attention which is an important part of choosing a placement. Captures a sense of adventure.
- The area of need is not very specific to Aboriginal health though.
- You could mention Aboriginal health and culture in the actual slogan to make it a bit more specific to Aboriginal health.
ISSUE 11: ‘CLOSING THE GAP’.
How effective do you think the slogan “Closing the Gap” would be in promoting IHT posts? How could the tagline be improved?

Registrars were generally supportive of the positioning statement ‘closing the gap’. For most it ‘raised a national conviction that something needs to be done’ (in particular about the gap in life expectancy between Indigenous and non-Indigenous Australians). Registrars also suggested that positive examples of changes being made should be emphasised or promoted. A minority of registrars felt the slogan was an “armband” and overused in the media.

Typical comments

- (Most registrars agree) Closing the Gap is an incentive for doing IHT.
- It is an armband slogan.
- The gap is closing but it is a long way off. (All agree).
- It creates a national conviction that something is needed to be done.
- If you want to make a difference it is more involving of individuals, speak to me more personally.
- All agree it would be hard to find a GP who isn’t stirred by this slogan.
- Positive examples of changes being made needs to be marketed
- The term is a bit overwhelming.
- Close the gap is used a lot in the media. It may be a bit overused. It sounds positive.
- Closing the gap goal is to eventually have no difference in life expectancy between Indigenous Australians and rest of Australia.

ISSUE 12: ‘CULTURAL SAFETY’.
What does ‘cultural safety’ mean to you?

Registrars felt cultural safety meant being aware of and dealing with cultural differences of patients to ensure a good service is provided and to prevent culturally sensitive issues causing a problem. Only one registrar said they had not heard of the term before.
Typical comments

- Effectively dealing with cultural difference.
- It is not a term I’m familiar with.
- Cultural safety applies to working with any cultural group.
- It’s for different cultural groups to your own. You have to have some understanding of each to provide the best service you can.
- There are some things you can learn about but some things you can’t be aware of because you are from a different culture.
- Some things you may never be able to learn. Some things take a lot of time to learn.

ISSUE 13: ‘CULTURAL EDUCATION’.

How does this term compare to the term ‘Cultural Safety’? Which term would be more effective to encourage registrars into an IHT post?

Several registrars felt cultural education was difficult for lecturers to explain and that a short-term placement would be beneficial in understanding the term. Another registrar said that cultural education varied depending on location. Comments were made that registrars sometimes felt ‘attacked’ or blamed during cultural education sessions and that this caused them to feel offended.

Typical comments

- (3 registrars agree) It’s hard for lecturers to explain. A short-term placement would be beneficial in helping people understand ‘cultural education’.
- Q. What sort of cultural education is needed before going to a post
- It’s very different between an urban Brisbane IHT post compared with a remote clinic. You need different types of training.
- It’s site specific. Location is important. The cultural session in Brisbane was ok but some people had a different session. It was too confronting, we felt we were being accused as non-Indigenous people. GP registrars were feeling offended and attacked.
ISSUE 14: EXPOSURE TO IHT MARKETING MATERIALS.

What Indigenous health information do or did you have access to?

Registrars commented that they had seen advertising pamphlets relating to placements in Aboriginal health which discussed adventure and making a difference.

Typical comments

- Pamphlets advertising placements in Aboriginal health
- Adventure
- Making a difference.
ATTACHMENT 1: DISCUSSION GUIDE

Warm up – Unprompted issues/ideas

Motivations for current training post

To start with, could you consider the following two questions and write down your responses (3 to 5 points):

1. What do you know about Indigenous Health Training (IHT) available in Australia?
2. Have you ever considered doing IHT training?

Discuss

Issue 1. Interest in IHT

Interest / openness to IHT

Could everyone please write down their answers to the following questions:

1. Those who considered undertaking an IHT post but did not follow it – why didn’t you follow it in the end?
2. Have you considered or undertaken an IHT post? Why / why not?
3. Those who are currently training in an IHT post – what were your reasons for doing so?
4. Those who are still deciding on a career path – what are your thoughts on IHT?

Discuss - Look for specific reasons, feedback from those who had undertaken IHT? Family decisions, salary, expenses, fears, uncertainty of what to expect etc. – try not to prompt

Issue 2. IHT experience / exposure

Type of experiences/exposure

1. How much and what kind of exposure or experience have you had to:
   a) Indigenous health?
   b) Indigenous cultures? Or Indigenous people generally?
   c) Any Indigenous cultural education - formal or informal?

Knowledge passed on from someone else? Work or personal experience? Promotional materials (i.e. GPET handbook etc.), specific cultural awareness/safety training – try not to prompt. Explore whether exposure was positive or negative.

2. Would it be useful for IHT to be incorporated into earlier stages of medical training?
**Issue 3. Major influences**

**Influences**

1. What are / were the major influences in choosing your current training post?
   - I.e. Peers, family, colleagues, registrars with previous experience in your area, marketing materials, rotational experience etc.
2. Would your peers and family support you in undertaking an IHT post?

**Issue 4. Perceptions of IHT**

**Top-of-mind perceptions about**

1. Write down some key words (3-5) that describe your perceptions of IHT training.

   *Discuss*

2. How do these compare to the perceptions you have or had of other training posts, including:
   a) Your current training post (when you were deciding)
   b) The training post or career path you are considering (if not IHT)
   c) Those who are in an IHT post
   - What were your perceptions of IHT posts when you made your decision?
   - Have your perceptions changed since commencing the post?
   - How?
3. To what extent did or would these perceptions affect your training decisions? Would or did you challenge them (i.e. by asking someone about the post? Sourcing more information)
4. Could your perceptions be changed through marketing campaigns?
   a) If no, why not?
   b) If yes or maybe – How?

**Issue 5. Major barriers**

**Barriers (real or perceived)**

1. Are there any major barriers (real or perceived) that would stop you or did stop you from undertaking an IHT post?
2. For those who are doing IHT, were there any initial barriers and how did you overcome these?
3. If you had to choose one, what major barrier would need to be broken down to motivate you to undertake an IHT post? How to do this?

**Issue 6. Location**

**Importance of location**

1. How important was the location of your training placement?
2. Did or would location affect your decision to choose an IHT post? (and was it a factor for those who did undertake IHT?)
3. How much does your domestic situation affect your choice of training location?

Moderator Notes:

**Issue 7. Perceived competence**

**Clinical and cultural competence**

1. To what extent would the following affect your decision to pursue an IHT post?
   a) Your confidence in your clinical skills
   b) Your level of awareness of Indigenous cultures

*Discuss*

**Issue 8. Support for GP Registrars in IHT**

**Support**

1. How supportive do you perceive IHT to be?
2. How does this compare to perceptions of support in other training posts?
3. How important would this factor be in influencing your decision to pursue an IHT post?

**TESTING CURRENT MARKETING / COMMUNICATION MATERIALS**

**Issue 9. How to best market IHT?**

**Marketing IHT**

1. How could IHT be promoted to you in a way that would make you decide to pursue an IHT post?
   a) What images would you want or need to see?
   b) What messages would you want or need to hear?
   c) What is the best way, in your opinion to market IHT?
      - In what format (brochure, handbook, poster, in person etc.)? OR
      - If in person, then by whom? (*general word of mouth, RTP / GP presentation etc.*)

2. Can you think of any materials relating to other GP training posts that:
   a) Got your attention?
   b) Informed and influenced your decision?

**Issue 10. Testing Current Materials**

**GPET Marketing materials (handbook etc.)**

1. I have some printed materials about IHT produced by GPET.
2. Could you please have a look at these materials (*pass around*) and write down:
   a) The messages you receive from these materials
      - Positive and negative aspects
      - What is / is not effective
INDIGENOUS HEALTH TRAINING
FOCUS GROUP REPORT

- What attracts you / what detracts you

Discuss ideas:
- Themes and messages - what does / does not appeal
- How could these be improved:
  - What other Images you want see?
  - What other messages do you want to hear? (either through taglines or imagery)

TESTING CURRENT MESSAGES RELATING TO INDIGENOUS HEALTH / CULTURES:

Issue 11. ‘WANT TO MAKE A DIFFERENCE?’

‘WANT TO MAKE A DIFFERENCE?’ – GPET materials (posters etc.)
1. I will now show you some of the GPET produced IHT materials displaying the “Want to Make a
   Difference” tagline Show materials
   a) What does “Want to Make a Difference” mean to you?
   b) What does / doesn’t appeal:
      - About the tagline
      - About the materials themselves (i.e. does the imagery convey the message?)
   c) How could the tagline be improved?
2. How effective is the tagline “Want to Make a Difference” in promoting IHT posts?

Issue 12. ‘Closing the Gap’

‘Close the GAP’ – show materials (posters etc.)
1. How does “Want to Make a Difference?” compare to the current COAG campaign’s message
   “Closing the Gap”?
2. What does ‘Closing the Gap’ mean to you?
3. How effective do you think the slogan “Closing the Gap” would be in promoting IHT posts?
   - Compared to “Want to Make a Difference”?

Issue 13. ‘Cultural Safety’

Perceptions of the term ‘Cultural safety’
1. What does ‘cultural safety’ mean to you?
2. What connotations does this message have for you? How does it impact on you?

Discuss
- Positive or negative way?
- Attracts or detracts from working in Indigenous health / communities?

Issue 14. ‘Cultural Education’
Perceptions of the term ‘Cultural Education’ and how important it is to IHT

1. What does ‘Cultural Education’ mean to you?
2. How does this term compare to the term ‘Cultural Education’?
3. Which term would be more effective to encourage registrars into an IHT post?
4. What amount of ‘Cultural Education’ do you think would be sufficient before undertaking an IHT post?

Issue 15. Exposure to IHT Marketing Materials

IHT Marketing materials

1. Currently or at the time you made your training decision, what Indigenous health information do or did you have access to?
   a) How would you describe the quality of these materials, and
   b) How readily available are they?
2. Are you or were you aware of available IHT information? How / by whom? (RTP, ME etc.)
3. How do you usually find out about training information? – do GPET produced information materials affect your decision making process? How much/in what way?

Issue 16. Final comments - Other Ideas to encourage positive / change current perceptions of the IHT post – and encourage participation

IHT networking / information tool

1. Other ways to increase the uptake of IHT?
2. It has been suggested that an IHT magazine be introduced as a tool to keep doctors in all stages of their training informed and interested in what is happening in Indigenous Health and IH training.
   a) How useful / influential would this tool be?
   b) Would have a magazine such as this have been of interest to you when you were deciding which General Practice post to pursue?