PEER REVIEW HISTORY

BMJ Open publishes all reviews undertaken for accepted manuscripts. Reviewers are asked to complete a checklist review form and are provided with free text boxes to elaborate on their assessment. These free text comments are reproduced below.

ARTICLE DETAILS

Title (Provisional)

Can culturally safe general practice telehealth overcome barriers to care for Aboriginal and Torres Strait Islander Australians? A Qualitative Study

Authors

Woodall, Hannah; Evans, Rebecca; McArthur, Lawrie; Sen Gupta, Tarun; Ward, Raelene; Brumpton, Kay

VERSION 1 - REVIEW

Reviewer	**1**
Name	**Partain, Daniel**
Affiliation	**Mayo Clinic Rochester**
Date	**25-Jul-2024**
COI	**None.**

Thank you for the opportunity to review this novel manuscript that explores the perceptions of the unique patient population and serves as an important reminder to the value of cultural curiosity and humility. I have two suggestions to consider.

“Cultural Safety”

• Since “cultural safety” is the key element of the manuscript, I recommend spending significantly more time exploring this concept in the introduction rather than splitting it into two pieces. As it stands now, there is a very brief mention of the terminology immediately in the introduction (page 5, lines 6-17) followed by a later exploration on page 6, most notably lines 41-60.

• Although the authors say that the term “cultural safety” is difficult to define, it is important to provide a general definition for the context of the reader as well as what the authors agree upon are critical elements included in this term.

• Consider comparing with other similar terms such as “cultural competence” (e.g., Evans N, et al. J Pal Med. 2012. PMID 22663018) and “cultural humility” (e.g., Foronda C, et al. J Transcult Nurs. 2016. PMID 26122618).

• The key point of the study was to understand specifically what Aboriginal and Torres Strait Islander people considered culturally safe care. Thus, I would explicitly include a summary statement as a conclusion section. I recommend renaming the section “areas for future development and research” as “Conclusion” and including this summary statement at the top of this section. For example: “Conclusion – Our study found that Aboriginal and Torres Strait islander people perceived culturally safe telehealth to include effective communication from their GP, mutual respect, personalized care, efforts at building relationships, and intentionality of their GP to develop specific cultural and community knowledge. Future studies exploring….”

Discussion / Recommendations for Practice

• The action items should flow directly from the results and discussion. In general, they should also be “SMART” – specific, measurable, achievable, relevant, time-bound.

• Recommendation #1 is a statement, not a recommendation. Consider something like: “Our study found that rural Aboriginal and Torres Strait Islander patients find telehealth to be a vital healthcare resource. Medicare should expand funding to meet the growing needs of historically marginalized communities that may otherwise be unable to access healthcare.

• Recommendation #2 is too vague. Consider something like “Although telehealth offers many patients an opportunity to access healthcare that they may otherwise go without, we call on clinicians to familiarize themselves with some of the disadvantages of telehealth such as lack of interpreter services, a perceived lack of control over the encounter, or worries about the accountability of the GP conducting the visit. Institutions who offer telehealth services should develop robust educational and support mechanisms to mitigate these issues.

• Recommendation #3 is also a statement, not a recommendation. For instance, bullet point A mentions “good consultation skills of the practitioner.” Which skills are “good”? How would a practitioner go about learning or developing those skills? Point B mentions a “pre-existing” relationship. How could a practitioner translate this into action? Could you recommend emphasizing the importance of rapport and relationship building as perhaps even more important in telehealth than in face-to-face encounters? Point C discusses “knowledge.” How can I translate this into action? Could clinicians that care for patients from this patient population benefit from some kind of continuing medical education or direct community engagement?

Reviewer **2**

Name **Thompson, Sandra**

Affiliation **The University of Western Australia, Combined Universities Centre for Rural Health**

Date **29-Sep-2024**

COI **None**

This is a well written study and was undertaken when there had been a substantial pivot to delivery of care via telehealth as a result of during COVID-19, enabled by changes in reimbursement.

While the dates of data collection are in the body of the text, the period when data collection occurred (June 2022 to August 2023), should be stated in the abstract.

- Most of the telehealth was delivered by teleconferencing (88%) and only 12% by videoconference (12%). I suspect the term telephone could be used – as there is no bridge and not multiple parties beyond the patient and general practitioner involved in the consultation. The term telephone is known to everyone and in fact phone is the term used in the interview guide. My person bias is that we don't need to dress it up as teleconferencing which is more ambiguous. Do we know whether the consultations had family members or others at the patient's end of the consultation?

There are a few details related to the methods I would suggest are added.

- How was consent obtained – was it written consent? Who undertook the interviews (was it the Aboriginal practitioner?) and were they face to face or by telephone or videoconference? If done remotely, there could be a bias re attitudes to remote modalities which is a limitation that should be stated.
- Please add some additional information about the Advisory Committee of leaders and community members and how this functioned. Were these from all three service areas?
- The demographic breakdown of the participants is provided but with 17 participants the % should not be reported to 2 decimal places.
- Presumably some participants may have had more than one consultation during the study period. So how was the individual consultation provided in Figure 1 selected? How long after the consultation was the interview undertaken?
- Member checking was offered but what proportion of the participants did comment upon their transcript?

Line 40 – missing a "be" which may <u>be</u> the influence

There is very little about cultural security in the interview guide. This could explain why there is little new in the findings. We already know that (all) patients want to be treated with respect and there is already considerable literature about patients preferring continuity of care with their GP. The introduction states "culturally safe care included their community and cultural knowledge, building and maintaining of clinician-patient relationships, and communication skills". It is unsurprising that these same characteristics are important in telehealth and were identified in the findings and the diagram showing the cultural determinants of culturally safe telehealth. Many of the advantages and disadvantages of telehealth have been previously described although they may be particularly important for Aboriginal and Torres strait Islander people who have low trust.

The elements of culturally safe telehealth describes the need for a pre-existing doctor–patient relationship. This may be hard to achieve in some circumstances, and in fact the quotations in the article indicated this. Both cultural knowledge and community knowledge needs knowledge

and understanding of the local context – this is not just generic knowledge – and I'd suggest this understanding which is captured in the discussion is also included into the Figure and noted in the abstract.

I felt the recommendations could be more focussed on what doctors who are delivering telehealth to Aboriginal patients can do to improve cultural safety in the consultation. And some of the suggestions appear could be focused at management level around the selection and appointment of GPs. The findings show the advantage for health services of reducing GP turnover in primary care.

VERSION 1 - AUTHOR RESPONSE

Response to reviewers: Manuscript bmjopen-2024-089436 "Can culturally safe general practice telehealth overcome barriers to care for Aboriginal and Torres Strait Islander Australians? A Qualitative Study"

Reviewer	Feedback	Response
Reviewer 1	Thank you for the opportunity to review this novel manuscript that explores the perceptions of the unique patient population and serves as an important reminder to the value of cultural curiosity and humility. I have two suggestions to consider. "Cultural Safety" Since "cultural safety" is the key element of the manuscript, I recommend spending significantly more time exploring this concept in the introduction rather than splitting it into two pieces. As it stands now, there is a very brief mention of the terminology immediately in the introduction (page 5, lines 6-17) followed by a later exploration on page 6, most notably lines 41-60.	The authors thank the reviewer for their feedback. Additional background information around the concept of cultural safety has been added to the introduction, and this has been combined into one section
	Although the authors say that the term "cultural safety" is difficult to define, it is important to provide a general definition for the context of the reader as well as what the authors agree upon are critical elements included in this term.	A definition of cultural safety has been included (the AHPRA definition which is used for this study) which also includes critical elements of cultural safety.
	Consider comparing with other similar terms such as "cultural competence" (e.g., Evans N, et al. J Pal Med. 2012. PMID 22663018) and "cultural humility" (e.g., Foronda C, et al. J Transcult Nurs. 2016. PMID 26122618).	Comparisons of different terms and definitions in usage have been added to the introduction
	The key point of the study was to understand specifically what Aboriginal and Torres Strait Islander people considered culturally safe care. Thus, I would explicitly include a summary statement as a conclusion section. I recommend renaming the section "areas for future development and research" as "Conclusion" and including this summary statement at the top of this section. For example: "Conclusion – Our study found that Aboriginal and Torres Strait islander people perceived culturally safe telehealth to	These changes have been made as recommended.

	include effective communication from their GP, mutual respect, personalized care, efforts at building relationships, and intentionality of their GP to develop specific cultural and community knowledge. Future studies exploring…."	
	Discussion / Recommendations for Practice The action items should flow directly from the results and discussion. In general, they should also be "SMART" – specific, measurable, achievable, relevant, time-bound. Recommendation #1 is a statement, not a recommendation. Consider something like: "Our study found that rural Aboriginal and Torres Strait Islander patients find telehealth to be a vital healthcare resource. Medicare should expand funding to meet the growing needs of historically marginalized communities that may otherwise be unable to access healthcare.	Recommendations have been changed to be more in line with SMART as suggested and have also been changed to incorporate recommendations to doctors and health systems (based on reviewer 2 feedback)
	Recommendation #2 is too vague. Consider something like "Although telehealth offers many patients an opportunity to access healthcare that they may otherwise go without, we call on clinicians to familiarize themselves with some of the disadvantages of telehealth such as lack of interpreter services, a perceived lack of control over the encounter, or worries about the accountability of the GP conducting the visit. Institutions who offer telehealth services should develop robust educational and support mechanisms to mitigate these issues	Recommendations have been edited to be more specific as suggested
	Recommendation #3 is also a statement, not a recommendation. For instance, bullet point A mentions "good consultation skills of the practitioner." Which skills are "good"? How would a practitioner go about learning or developing those skills? Point B mentions a "pre-existing" relationship. How could a practitioner translate this into action? Could you recommend emphasizing the importance of rapport and relationship building as perhaps even more important in telehealth than in face-to-face encounters? Point C discusses "knowledge." How can I translate this into action? Could clinicians that care for patients from this patient population benefit from some kind of continuing medical education or direct community engagement?	Recommendations have been edited as suggested to incorporate specific actions of doctors and health systems
Reviewer 2	This is a well written study and was undertaken when there had been a substantial pivot to delivery of care via telehealth as a result of during COVID-19, enabled by changes in reimbursement. While the dates of data collection are in the body of the text, the period when data collection occurred (June 2022 to August 2023), should be stated in the abstract.	The authors thank the reviewer for the feedback provided. Data collection dates have been added to the abstract
	Most of the telehealth was delivered by teleconferencing (88%) and only 12% by videoconference (12%). I suspect the term telephone could be used – as there is no bridge and not multiple parties beyond the patient and general practitioner involved in the consultation. The term telephone is known to everyone and in fact phone is the	The word teleconference has been changed to telephone throughout the manuscript

	term used in the interview guide. My person bias is that we don't need to dress it up as teleconferencing which is more ambiguous	
	Do we know whether the consultations had family members or others at the patient's end of the consultation?	We don't know whether consultations included family or others in the consultation. The authors agree that this would potentially be an interesting area for future study
	There are a few details related to the methods I would suggest are added. How was consent obtained – was it written consent? Who undertook the interviews (was it the Aboriginal practitioner?) and were they face to face or by telephone or videoconference? If done remotely, there could be a bias re attitudes to remote modalities which is a limitation that should be stated.	Written consent was obtained from all participants Interviews were undertaken by HW (first author) as deemed appropriate by the advisory group 16 interviews were in person with only one via telephone (at the participant's request)
	Please add some additional information about the Advisory Committee of leaders and community members and how this functioned. Were these from all three service areas?	Further details have been added. The advisory group were from the partner organisation with whom the study was designed, as it was developed before recruitment of all sites.
	The demographic breakdown of the participants is provided but with 17 participants the % should not be reported to 2 decimal places.	Percentages have been corrected to include no decimal places.
	Presumably some participants may have had more than one consultation during the study period. So how was the individual consultation provided in Figure 1 selected? How long after the consultation was the interview undertaken?	Participants were required to have had at least one telehealth consultation in the preceding 12 months to be included in this study. For Figure 1, any reason provided by a participant for choosing telehealth was included. There may in some cases have been multiple consultations for this reason, but each reason was only coded once per participant as this level of information was not collected.

	Member checking was offered but what proportion of the participants did comment upon their transcript?	Further information in the manuscript has been added. No participants elected to make any changes or comments to their manuscripts.
	Line 40 – missing a “be” which may be the influence	Missing word has been added to the sentence
	There is very little about cultural security in the interview guide. This could explain why there is little new in the findings. We already know that (all) patients want to be treated with respect and there is already considerable literature about patients preferring continuity of care with their GP. The introduction states “culturally safe care included their community and cultural knowledge, building and maintaining of clinician-patient relationships, and communication skills”. It is unsurprising that these same characteristics are important in telehealth and were identified in the findings and the diagram showing the cultural determinants of culturally safe telehealth. Many of the advantages and disadvantages of telehealth have been previously described although they may be particularly important for Aboriginal and Torres strait Islander people who have low trust.	The authors thank the reviewer for this helpful feedback. While we mention the idea of cultural security (amongst other commonly used terms) in the introduction, the interview guide was deliberately kept broad to seek participant’s views in their own words (without adding the potential for biases or perceptions of certain terms). We also acknowledge that this could be an incredibly valuable area for future work in this field.
	The elements of culturally safe telehealth describes the need for a pre-existing doctor– patient relationship. This may be hard to achieve in some circumstances, and in fact the quotations in the article indicated this. Both cultural knowledge and community knowledge needs knowledge and understanding of the local context – this is not just generic knowledge – and I’d suggest this understanding which is captured in the discussion is also included into the Figure and noted in the abstract.	Changes have been made as recommended. The diagram has been changed to incorporate this idea of both culture and community knowledge relating to local context knowledge and this has been reflected in the text.
	I felt the recommendations could be more focussed on what doctors who are delivering telehealth to Aboriginal patients can do to improve cultural safety in the consultation. And some of the suggestions appear could be focused at management level around the selection and appointment of GPs. The findings show the advantage for health services of reducing GP turnover in primary care.	The recommendations have been edited in line with this suggestion and those of reviewer 1, and in particular have been separated to clearly identify recommendations for individual doctors and recommendations for the health system more broadly.

VERSION 2 - REVIEW

Reviewer	**1**
Name	**Partain, Daniel**
Affiliation	**Mayo Clinic Rochester**
Date	**05-Feb-2025**
COI	

I am pleased to review this revision of the manuscript and find it to be significantly improved from the initial submission. In particular, the introduction and discussion/conclusion have been substantively reorganized to make the background and recommendations stronger. I have a few very small suggestions before final publication:

1) Discussion, Page 20, Line 10. My group does research on equitable care for patients with non-English language preferences. In most of the literature I am familiar with, the term "translator" is used for individuals who translate text (e.g. translate patient education materials from English to Spanish). I am more familiar with the term "interpreter", which I see used more in medical settings for oral language exchange. Most of our interpreters see themselves as cultural mediators as opposed to vessels for simple language exchange. If the term "translator" is ubiquitous in Australia, please disregard this suggestion.

2) Discussion, Page 20, Line 15. Is the word "patients" supposed to be "clinicians" here? It seems to me that the call is for healthcare institutions to educate and support clinicians as they endeavor to provide a mix of both telehealth and in-person visits.

3) Discussion, Page 21, Lines 11-12. I wonder if it may also be worth including some language that calls healthcare systems to provide professional development or continuing medical education. For instance, "...to enhance the development of therapeutic relationships which promotes culturally safe telehealth. Moreover, they should offer ongoing clinician education to foster growth of skills that can improve cultural safety such as telehealth-specific communication training or continuing education regarding cultural and community knowledge.

4) Discussion, Page 21, Line 18. I believe "study" should be plural - "Future studies exploring...".

Overall, excellent revision. Thanks again for the opportunity to review.

VERSION 2 - AUTHOR RESPONSE

	Feedback	Response
Reviewer: 1	1) Discussion, Page 20, Line 10. My group does research on equitable care for patients with non-English language preferences. In most of the literature I am familiar with, the term "translator" is used for individuals who translate text (e.g. translate patient education materials from English to Spanish). I am more familiar with the term "interpreter", which I see used more in medical settings for oral language exchange. Most of our interpreters see themselves as cultural mediators as opposed to vessels for simple language exchange. If the term "translator" is ubiquitous in Australia, please disregard this suggestion.	This change has been made as requested (see page 18, line 12)
	2) Discussion, Page 20, Line 15. Is the word "patients" supposed to be "clinicians" here? It seems to me that the call is for healthcare institutions to educate and support clinicians as they endeavor to provide a mix of both telehealth and in-person visits.	This change has been made as recommended (see page 18, line 18)
	3) Discussion, Page 21, Lines 11-12. I wonder if it may also be worth including some language that calls healthcare systems to provide professional development or continuing medical education. For instance, "...to enhance the development of therapeutic relationships which promotes culturally safe telehealth. Moreover, they should offer ongoing clinician education to foster growth of skills that can improve cultural safety such as telehealth-specific communication training or continuing education regarding cultural and community knowledge.	This has been added as recommended (see page 19, lines 9-12)
	4) Discussion, Page 21, Line 18. I believe "study" should be plural - "Future studies exploring...".	This change has been made as recommended (see pg 19, line 18)