

Equity-Centered Optimization of Virtual Cancer Survivorship Care

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Submitted to: Journal of Medical Internet Research
on: March 09, 2025

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Abstract

This critique examines a realist evaluation study on virtual follow-up (VFU) care for breast and prostate cancer survivors, acknowledging its robust methodology and timely focus on socioemotional provider skills. However, the study's small, homogeneous sample (N=24)—predominantly high-income, educated, and tech-savvy participants—limits generalizability and overlooks systemic barriers faced by marginalized groups, such as racial minorities and rural populations. While the analysis highlights provider "websites manner" as critical, it neglects actionable strategies for empathy training or addressing reimbursement inequities that disincentivize low-tech care options. The equity discussion remains superficial, failing to integrate anti-racist frameworks or Indigenous relational care paradigms, thereby obscuring structural inequities like institutional racism and underfunded rural health systems. The critique underscores the need for future research to prioritize diverse samples, policy-driven interventions (e.g., subsidized broadband), and implementation science frameworks to bridge gaps in telehealth accessibility and optimize equitable cancer survivorship care.

(JMIR Preprints 09/03/2025:73663)

DOI: <https://doi.org/10.2196/preprints.73663>

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Equity-Centered Optimization of Virtual Cancer Survivorship Care

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Keywords:

virtual follow-up care; health equity; cancer survivorship care; telehealth optimization; systemic inequities; patient-centered care; structural barriers; health disparities

Dear Editor,

The study titled “Optimizing Virtual Follow-Up Care: Realist Evaluation of Experiences and Perspectives of Patients With Breast and Prostate Cancer” [1] provides a timely exploration of virtual follow-up (VFU) care for the survivors of breast and prostate cancer and applies a realist evaluation to identify contextual factors, mechanisms, and outcomes. While the methodology is robust in its theory-driven approach, the small, homogeneous sample (N=24) limits generalizability. Participants were predominantly high-income, highly educated, and technologically proficient, which overlooks marginalized populations who face systemic barriers to telehealth access.

Recent literature underscores persistent disparities in virtual care adoption among racial minorities, rural residents, and low-income groups [2,3]. The study’s limited demographic diversity risks reinforcing a “digital divide” narrative without proposing structural interventions, such as subsidized broadband or low-tech alternatives, which are critical to equitable care delivery.

The emphasis on provider “webside manner” and socioemotional skills is a strength that resonates with newer studies advocating for empathy training in virtual settings [4]. However, the paper stops short of detailing evidence-based training frameworks, such as communication modules integrating visual cue awareness or trauma-informed approaches for anxious patients. Furthermore, while the authors recommend improving provider technological competence, they do not address systemic barriers like unequal reimbursement for phone versus video visits, which dis-incentivize low-tech options in Ontario’s funding model.

The paper’s equity discussion is surface-level. It acknowledges disparities, but does not engage with anti-racist or de-colonial approaches to telehealth, which are gaining traction in Canadian health policy. For instance, indigenous communities often prioritize relational care over transactional virtual visits [5], a perspective absent here. Similarly, the study’s focus on individual patient factors (e.g., coping styles) risks obscuring structural inequities, such as institutional racism or underfunded rural health infrastructure, that shape VFU accessibility.

To conclude, this study advances understanding of VFU’s contextual drivers but reflects limitations common to early pandemic-era research. Future work should prioritize diverse samples, integrate implementation science frameworks, and address systemic inequities through policy-oriented recommendations.

Authors' Contributions: All authors contributed equally in writing, proofreading and reviewing this manuscript.

Conflicts of Interest: None

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