BEYOND TECHNOLOGY: DIGITAL HEALTH COMPASSION FOR CANADIAN IMMIGRANTS AND REFUGEES

Ibukun-Oluwa Abejirinde is a Scientist at Women's College Hospital Institute for Health System Solutions and Virtual Care (WIHV) and an Assistant Professor (Status) at the Dalla Lana School of Public Health (DLSPH), University of Toronto.

Emily Ha is a Research Associate at WIHV and a PhD candidate in Epidemiology at DLSPH.

Marlena Dang Nguyen is an Equity Specialist at WIHV and co-chairs its Equity Committee.

Dayajyot Kaur is a Research Assistant at WIHV.

Vanessa Redditt is a Family Physician at Women's College Hospital Crossroads Clinic which provides comprehensive medical services to newly arrived refugee clients. She is also a faculty member at the Department of Family and Community Medicine, University of Toronto, Canada.

Community health centres and settlement providers in Canada embraced rapid uptake of digital health services during the COVID-19 pandemic. While virtual care such as telephone and video health encounters has been largely applauded, there is a need to consider and address its impact on the relational aspects of care and on (in) equitable access and outcomes for marginalized groups such as immigrants and refugees. This article makes a case for understanding the experience and needs of immigrants and refugees with using virtual care in relation to its ability to deliver compassionate care—that is, characterized by trust, dignity, positive patient-provider relationship, empathy, and respect. Authors propose using intersectionality as a framework for this inquiry. By understanding if and how immigrants and refugees experience virtual care through a compassionate lens, we can ensure that their perspectives and needs influence how we design systems of care.

THE ERA OF DIGITAL HEALTH

The COVID-19 pandemic was a wakeup call in health care and a reminder of the need to rethink how we design and deliver health services in equitable and quality-enhancing ways. Remote interactions between patients and their care providers facilitated by communication or information technologies, i.e., virtual care, became the preferred modality for non-emergency, non-tactile health visits.[1] Over the last three years, community health centres and settlement providers adopted and integrated virtual care solutions to ensure continuity of services for immigrants and refugees[2], whilst trying to maintain quality and effectiveness. For many organizations, this transition was rapid.[3] Between March 2020 and 2021, virtual care represented as much as 40% of all health care provider visits in Canada.[4] Most of these were telephone visits, followed closely by video visits.

Reports on the experiences of virtual care have been largely positive—applauding its convenience, ease of use, and

access.[2,5] However, the pandemic has shown us that benefits and disadvantages tend to settle along existing socioeconomic fault lines. Inequities in virtual care access and outcomes were experienced by marginalized communities, including those living in rural areas, the urban poor, Indigenous peoples, racialized communities, and refugees[6,7] as a result of factors such as low access to hardware, limited digital skills, and barriers to privacy and safety.[8,9] A Europe-wide evidence review found that marginalized groups and those who do not speak the dominant language experience reduced access, use, and engagement with digital services.[10]

Over the past decade, the number of immigrants and refugees globally and in Canada has increased dramatically. In 2022 alone, Immigration, Refugees and Citizenship Canada approved over 437,000 applications for permanent resident status[11] and processed nearly 82,000 refugees and refugee claimants.[12] Best estimates suggest there are approximately 500,000 persons with precarious immigration status in Canada.[13] With immigrants and refugees accounting for nearly one-quarter of Canada's population[14], this shift in population demographics presents new opportunities for innovation within health care, such as the use of digital technologies (i.e., digital health).

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Integration into the host country and navigating multiple health and social structures (housing, education, employment, financial services, etc.) can be difficult for newcomers, and contributes to post-migration stress.[15,16] Digitally enabled information supports, and digitized processes can be convenient, easy to scale, and more readily accessible than conventional supports.

As we reflect on lessons from the pandemic response and look forward to post-pandemic recovery, and as virtual interventions become mainstream in health care,[17] it is critical to leave no one behind.[18] Specifically, how do we take into account the needs and unique experiences of migrants and refugees and ensure a positive settlement and healthcare experience by leveraging digital technology?

DIGITAL HEALTH COMPASSION: IS VIRTUAL CARE A BRIDGE OR A WALL?

Concerns surrounding the increasing use of digital health technologies range from fears that it will usurp the role of health providers to the possibility of it amplifying social inequities.[19] Another important consideration is its impact on the relational aspects of care.

The therapeutic alliance—i.e., mutual, cooperative, and safe interaction between the care provider and patient—is critical to patient-centred and quality care.[20] It is related to trust, psychological safety, intentional listening, cultural humility, and open communication. However, while digital health can be a bridge, making connections between patients and providers easier, it can also be a cold brick wall, obstructing the relational aspects of care.[2] For example, establishing and maintaining the therapeutic alliance was one of the main barriers to providing virtual mental health for refugees in Canada.[21] An unintended effect of virtual care, therefore, is that it can interfere with trust and communication. Hence, the principle of compassion is central to the delivery of quality virtual care.

> "Mainstream approaches to conceptualizing compassionate care do not often consider the positionality and unique experiences of complex populations and those who have been made vulnerable by migration."

The book *Without Compassion, There Is No Healthcare*, emphasizes compassion as being integral to digital transformation in healthcare.[22] Compassion, defined as "a state of concern for the suffering or unmet need of another, coupled with a desire to alleviate that suffering",[23] has also been recognised as a metric of quality care. Common descriptors of compassionate care include trust, dignity, positive patient-provider relationships, empathy, and respect, and often result in improved healthcare experiences and outcomes.[24] A common assumption, however, is that compassion means the same thing to everyone. On the contrary; compassion is a dynamic, multidimensional concept subject to individual expectations and experiences.[25] Paton et al., note that "...the meaning of compassion must be considered from multiple perspectives, not imposed by those empowered to define suffering and provide care."[26] Mainstream approaches to conceptualizing compassionate care do not often consider the positionality and unique experiences of complex populations and those who have been made vulnerable by migration. So how do we make compassion central to virtual care when working with immigrants and refugees?

OPERATIONALIZING DIGITAL HEALTH COMPASSION FOR MIGRANTS AND REFUGEES

The rapid shift towards virtualization of health care demands that the perspectives of immigrants and refugees influence how we design systems of care. Differences in cultural norms and practices, language, and skills can shape engagement with digital technologies[27] and how individuals experience

compassionate care.[28] In some cultures, for example, a health care visit without physical examination may not be trusted.[28] Furthermore, compared to the general population, newcomer groups and those with complex social needs may not be as comfortable with or able to access virtual care.[29] It is therefore relevant to explore if and how the digitization of health care impacts the experience of compassionate care for marginalized groups, including immigrants and refugees.

To understand how new innovations and measures affect any population group, it is helpful to first recognize that ethnocultural, environmental, socio-cultural, and economic attributes do not manifest in silos and can be better understood collectively using an intersectional lens. Intersectionality is a framework for understanding how multiple social identities (e.g., race, class, gender, ability, etc.) interact in ways that are interdependent and reinforce privilege or oppression.[30] An intersectional lens will, for example, show that the experiences of an individual who is a migrant and identifies as a woman cannot be understood from the additive perspective, that is, first as a migrant and then as a woman. Rather, the juncture at which these two identities intersect reveal the root of subtle and complex factors that shape the experiences of an immigrant woman. Intersectionality can therefore help us better understand how multiple identities cumulatively influence newcomers' experiences of compassionate care in virtual interactions.

Emotional, physical, psychological, social and systemic circumstances particular to their migration status may intersect with other social categorizations such as ethnicity/race, gender, education, religion, literacy, and thereby modify their experiences of virtual care and their views on digital health compassion. For example, economic immigrants with full legal immigration status may enjoy access to health care and other social protections that are not readily available to those with precarious immigration status. Furthermore, while immigrants generally move by choice, refugees are forced to flee from persecution and/or trauma, enduring stressors that may not be present for other migrant groups. In such cases, their distrust of systems of authority may hamper their experiences of virtual care.

Current strategies to overcome ways in which digital technology may depersonalize the care experience include training in cultural humility and unconscious bias.[31] Generic guidelines have been developed that include practical suggestions for making the virtual experience more relational.[32] These guidelines include eye contact, clear articulation, and ensuring interpreter support, amongst other strategies. None of the recommendations, however, speak directly to the nuances that immigrants and refugees may be grappling with. Interestingly, a multi-provincial study on virtual mental health for refugees reported that some users did not want an interpreter, as it interrupted direct communication with the provider even when they did not fully understand what the provider said.[21] For this group, although it seems counter-intuitive, deviation from the standard guidelines constituted compassionate care.

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To support equitable access to compassionate care and ensure newcomers reap digital dividends, health care practitioners and organizations must be aware of the bridge versus wall effect of virtual care and more broadly, digital health. It is crucial to first understand the needs and expectations that immigrants and refugees have for compassionate care, and how the virtual care encounter can be re-imagined to achieve this. Our team is working closely with three community primary care settings in Toronto that provide health and social services to newcomer groups, to understand if and how immigrants and refugees experience virtual care through a compassionate lens. Study findings will inform strategies for delivering compassionate health care virtually to Canadian newcomers. Working in health care mandates that we are mindful of groups that are excluded in the fast-paced digital transformation agenda, and that we ensure their views and needs are brought to the forefront when designing virtual care.

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