Canadian Clinicians Adopting Virtual Health Care during COVID-19 Pandemic: Salute to Our Fast Learners

Farah Ahmad

School of Health Policy and Management, York University

For correspondence:
Farah Ahmad, MBBS, MPH, PhD
School of Health Policy and Management, York University
Email: farahmad@yorku.ca

Abstract:

With the arrival of COVID-19, the highly contagious virus and the ensuing pandemic, the landscape of virtual health care in the Canadian primary care sector started to change rapidly– an evolution as compared to the lag seen over last few decades. Major push factors include the safety needs of patients and clinicians while ensuring access to care, and policy shifts by the government's provision of billing codes for virtual care and by the regulatory bodies to allow use of non-clinical virtual tools. Despite challenges associated with such rapid transitions, primary care clinicians are showcasing their skill acquisition in respect to the uptake of virtual tools at an unprecedented pace and in new circumstances. Nonetheless, they are grappling with several 'backend' aspects like determining what care to offer and how to ensure patient privacy, security, and consent when using non-clinical virtual tools (e.g. Facetime or Skype). Their efforts are commendable given their professions are known to experience work related stress in pre-pandemic circumstances as well. While their present contributions are creating a new virtual care path for improving the healthcare delivery system, there is an urgent need to better understand their struggles with the delivery of virtual care under the pandemic in order to protect them from burnout by providing better support systems.

Keywords: COVID-19, Virtual Health Care, Primary Care, Canada

The COVID-19 pandemic seems to be a "tipping point" for the broad adoption of virtual tools within Canada's primary care sector. The term virtual health care (VHC) and its synonymous telemedicine, online health care and digital health, refer to the remote delivery of healthcare services and/or information by using information communication technologies. In other words, VHC today includes the use of audio, video and texting tools between a clinician and patient synchronously or asynchronously. Although Canada had a ground-breaking start in developing technologies for remote delivery of care decades ago (House & Roberts, 1977), there has been a lag in the uptake of VHC in primary care in comparison to other developed countries (Schoen et al, 2012). Even with 85% of family physicians using electronic medical records (EMRs) in 2017, only a handful used its interactive features to communicate with patients (Canada Health Infoway, 2017). In 2019 only 13%, 7% and 4% of Canadians reported the availability of features like electronic appointment, email messaging, and video visits at their family physician offices, despite 75%, 64% and 44% desiring those features, respectively (Canada Health Infoway, 2019*)*.

The landscape has rapidly changed with the arrival of COVID-19. According to Canada Health Infoway in May 2020, an increase in the provider use of phone (15% to 40%), video (3% to 11%) and texting (1% to 5%) is noted between pre to post COVID-19 time periods (Canada Health Infoway, 2020). The big push factors consist of 1) the need to keep patients and clinicians safe from the contagion, while continuing to ensure access to care; 2) the government's provision of billing code for virtual care; and 3) the permission from professional regulatory bodies to use non-clinical virtual tools throughout the pandemic. Some pre-pandemic enabling factors for the fast shift

towards use of VHC in primary care include the 2019 Digital First health strategy by Ontario (Ministry of Health, 2019) and the 2020 Roadmap for virtual care by the joint taskforce of the Canadian Medical Association (CMA), the College of Family Physicians, and the Royal College of Physicians and Surgeons (Canadian Medical Association, 2019).

These rapid transitions did not come without challenges. Clinicians are learning the use of virtual tools at an unprecedented pace and in new circumstances. Some challenges include determining what care to offer using virtual tools and how to ensure patient privacy, security, and consent when using non-clinical virtual tools (e.g. Facetime or Skype). The *scope of virtual practice* is specified by the CMA as "presently limited to encounters that require only history, gross inspection and/or data that patients can gather with cameras and common devices (e.g., glucometers, home blood pressure machines, thermometers and scales)." (Canadian Medical Association, 2020, p. 1). There is an emphasis on the provision of VHC that must not compromise the *standard of care* while embracing principles of equity and fairness. As a result, the burden of sound clinical judgements is heightened for the clinicians since the shift to primary virtual care became heightened. The *application of non-clinical tool*s for VHC has added further complexity for clinicians. They are expected to evaluate the quality of technology (e.g. image resolution, time-lag, and connection reliability) when making clinical assessments. In addition, based on the duty to keep patient information private and confidential, tools must include end-to-end encryption and the storage companies that offer reliable security, enduring access to data, and so forth. Their enthusiasm to ensure patients' access to care seems to be overriding the demand of gaining technological 'expertise' for the adoption of

VHC. Another aspect of their learning is acquiring the ***patient consent*** for the use of non-clinical virtual tools. Regulatory bodies recommend written enduring (i.e. ongoing) consent for practices offering continuing primary or chronic disease care, and verbal consent at the beginning of an e-visit for one-time encounters. At the same time, jurisdictional elements must be taken into consideration, likely resulting in information overload for the clinicians.

The fast learning of primary care clinicians to integrate VHC in their practice is commendable, especially when they are known to experience work related stress even at normal times (National Academies of Science, Engineering, and Medicine, 2019; West, Dyrbye, & Shanafelt, 2018; Shanafelt, 2012). While their present contributions are foraging a new path to improve the healthcare delivery system, there is an ongoing urgent need throughout the pandemic to better understand their struggles to, protect them from burnout, and provide support systems. Despite several hospitals initiating support programs for healthcare providers based on recent/past outbreak guidelines (British Psychological Society, 2020, Maunder, 2004), the same level of effort is missing for the primary care clinicians. Under the challenging circumstances of the COVID-19 pandemic, clinicians' cognitive functioning and clinical reasoning skills are at the core to meet the bar of expected standards of care despite the 'new normal'. The emergent synergies in the primary care digitization could lead to multiple innovative ways of incorporating virtual tools for the delivery of care post pandemic, provided clinician stress is kept under control.

References

British Psychological Society: Covid19 Staff Wellbeing Group. (2020). The psychological needs of healthcare staff as a result of the Coronavirus pandemic. Available at https://www.bps.org.uk/

Canada Health Infoway. (2017). EMR Use in Canada Continues to Grow. Available at https://www.infoway-inforoute.ca/en/what-we-do/news-events/newsroom/2017-news-releases/7578-emr-use-in-canada-continues-to-grow

Canada Health Infoway. (2019). 2019 Survey of Canadians Summary Report. Available at https://www.infoway-inforoute.ca/en/what-we-do/news-events/webinars/3786-access-to-digital-health-services-2019-survey-of-canadians-summary-report/view-document

Canada Health Infoway. (2020). Experiences of health care during COVID-19 reported by Canadians. Available at https://infoway-inforoute.ca/en/component/edocman/3815-covid-19-tracking-survey-results/view-document?Itemid=101

Canadian Medical Association. (2019). Roadmap for expanding virtual medical services. Report Prepared by the Task Force for Virtual Care 2019. Available at https://www.cma.ca/news/demand-here-technology-exists-cma-led-task-force-releases-roadmap-expanding-virtual-medical

Canadian Medical Association. (2020). How to set up virtual care in your practice. Available at https://www.cma.ca/how-set-virtual-care-your-practice

House, A., & Roberts, J. (1977). Telemedicine in Canada. *Canadian Medical Association Journal, 117(4),* 386-388.

Maunder, R. (2004) The experience of the 2003 SARS outbreak as a traumatic stress among frontline healthcare workers in Toronto: lessons learned. *Philosophical transactions of the Royal Society of London, 359,* 1117-1125. DOI: 10.1098/rstb.2004.1483

Ministry of Health. (2019). Ontario Expanding Digital and Virtual Health Care. Available at https://news.ontario.ca/mohltc/en/2019/11/ontario-expanding-digital-and-virtual-health-care.html

National Academies of Science, Engineering, and Medicine. (2019). Taking action against clinician burnout: a systems approach to professional wellbeing. Washington, DC: The National Academies Press. https://doi.org/10.17226/25521.

Schoen, C., Osborn, R., Squires, D., Doty, M., Rasmussen, P., Pierson, R., & Applebaum, S. A. (2012). Survey of Primary Care Doctors in Ten Countries Shows Progress in use of Health Information Technology, Less in Other Areas. *Health Affairs, 31(12),* 1-12. DOI: 10.1377/hlthaff.2012.0884

Shanafelt, T.D., Boone, S., Tan, L., Dyrbye, L.N., Sotile, W., Satele, D., et al. (2012). Burnout and satisfaction with work-life balance among US physicians relative to the general US population. *Archive of Internal Medicine, 172,* 1377-1385. DOI: 10.1001/archinternmed.2012.3199

West, C.P., Dyrbye, L.N., & Shanafelt, T.D. (2018). Physician burnout: contributions, consequences and solutions. *Journal of Internal Medicine, 283,* 516-29. DOI: 10.1111/joim.12752