COVID-19: An accidental catalyst for change in the Canadian health care system

The needle has moved on the historically entrenched issues of national physician licensure, virtual health care, and our sick-at-work culture within weeks of the announcement of a global pandemic. Let's ensure we retain these important advances.

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Since COVID-19 was declared a pandemic by the World Health Organization, each day has come with new announcements of measures to contain its spread. One by one, universities and schools, businesses, and even our Canadian borders have closed in the spirit of public health and safety. In the midst of these changes, the strength and anticipated strain on our health care system have become a national focus. But the health system has responded expeditiously—within a matter of weeks, the needle has moved on historically entrenched issues including national physician licensure, virtual health care, and our sick-at-work culture. Though certainly a disruptive and unwelcome force, the pandemic has served as a powerful catalyst for change in the Canadian health care system.

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National physician licensure and physician mobility

"Flatten the curve" became a household phrase in the early days of the pandemic, referring to the need to keep the number of infected patients within the limits of our health system's capacity. However, given COVID-19's exponential rate of spread, indifference to national borders, and the disproportionate risk of infection in health care workers,[1] it is clear that our physician workforce will face tremendous strain. Compounded by the fact that at the time of writing over three-quarters of confirmed cases in Canada had occurred in only three provinces,[2] there may be a need for physician deployment and redistribution to areas where the need is greatest.

Under existing systems of physician licensure, redistribution of physicians is not possible. Each of Canada's provinces and territories has unique physician licensing requirements, documentation, and fees,[3] despite licensing exams being national. For physicians, this means that in order to care for patients in other jurisdictions, they must secure additional licences through a costly and time-consuming administrative process.[4] For patients, especially those in Canada's rural and remote areas, this reduces access to physician care.

Although there has been long-standing advocacy for national physician licensure in Canada, the issue has remained unresolved despite overwhelming support from patients,[5] physicians,[6] and medical organizations.[7] However, after COVID-19 re-exposed an enduring need for increased physician mobility to improve access to care, provincial and territorial medical regulators have temporarily agreed to issue fast-tracked emergency licences that enable physicians to provide care across multiple Canadian jurisdictions.[8,9] In line with this, the Canadian Medical Protective Association has allowed its medical-legal protection to extend beyond a physician's typical province or territory of work.[9]

This has been a laudable and agile response to COVID-19, but licensing barriers to physician mobility and access to care should not be rebuilt after the pandemic. Fast-track and portability agreements are valuable stepping stones,[10] but neither offers the same degree of provider mobility and administrative efficiency as national physician licensure. COVID-19 sparked the emergence of policies to better align physician care with patient needs, but even after the pandemic we can continue to take steps toward establishing national licensure as a durable, sustainable solution to improve access to care.

Adoption of virtual care

Virtual care has not yet become routine in Canada, despite its potential to offer timely access to care, the availability of supportive technology, and growing public interest.[11] However, by simultaneously demanding physical distancing and increased access to care, COVID-19 has

unveiled virtual technology as a cornerstone of care.[12] Moreover, by facilitating rapid adoption of virtual care, the pandemic response is inadvertently laying the groundwork for widespread uptake of virtual care, both now and in the future. In particular, COVID-19 has catalyzed progress on three fundamental barriers to scaling up virtual care in Canada: licensure restrictions, compensation for virtual care, and lack of interoperability and digital infrastructure.[13]

National licensure and the adoption of virtual care go hand in hand; allowing physicians to practise in multiple jurisdictions extends the reach of virtual care beyond provincial and territorial borders, thereby promoting access to care in rural and remote areas nationally. Secondly, several Canadian provinces,[14,15] including British Columbia, have responded to COVID-19 by expanding virtual care billing codes as an incentive to this medium of care. Whereas previous billing codes were limited to virtual care through particular mediums or platforms, these expanded codes allow the use of more flexible technologies such as telephone or videoconferencing. Lastly, while there is no quick solution to improving digital infrastructure, it is reasonable to believe that widespread adoption of virtual care will create momentum and increased investment in these tools both during and after the pandemic.

Sick-at-work policies and culture

While doctors all know that staying home when sick will protect us, our colleagues, and our patients, this is not yet a universal practice for many reasons, ranging from cultural to financial. Within medicine, the hidden culture that discourages the use of sick days starts early in medical training.[16] Unfortunately, as a medical student or resident, it was not unusual to hear variations on the old adage, "If you're not too sick to be a patient in the hospital, then you're not too sick to be working in the hospital." Within this deep-rooted culture of feeling guilty, weak, and judged for taking sick days, it is not surprising to find that physicians admit to working while sick, putting themselves in contact with vulnerable populations.[17]

In a matter of weeks, however, COVID-19 shifted this discourse. Those in the medical field have been flooded with messages from our leaders and administrators telling us to stay home if symptomatic or at high risk. Outside the medical community, we are normalizing—even celebrating—those who self-isolate in support of public protection. This new culture has also been supported by progressive public policy; for example, medical organizations are urging employers to abandon the practice of asking for sick notes,[18] public health offices are offering a general sick note to be used by anyone who fulfills its criteria,[19] and provincial governments are changing labor laws for employees to take sick leave.[20]

When the dust settles, these changes should be transformed into sustainable solutions.

While these policy and cultural changes emerged during the pandemic, they help reverse decades of dogma and should remain permanent. There is no better time than now to improve our national sick-at-work culture and advocate for supportive policy changes such as paid sick leave legislation and sick leave employment protection. It is unfortunate that we cannot always rely on individual employers to do the right thing; we need enforceable legislation to support our public duty to stay home when sick. We hope the new norms of physical distancing and self-quarantine being accepted and celebrated represent a turning point for our sick-at-work culture within workplace communities, including health care.

Conclusion

COVID-19 is perhaps the greatest public health challenge in recent human history, with the full force of the pandemic yet to be felt in Canada. The gravity of the situation has pulled an extraordinary response from our health care system; enormous strides have been taken on historically entrenched issues including national physician licensure, virtual care, and our sick-at-work culture. While progress on these issues emerged as an important response to the COVID-19 pandemic, the way in which it is maintained will have a lasting impact on our post-pandemic Canadian health care system. When the dust settles, these changes should be transformed into sustainable solutions. There is opportunity to be found in adversity. ■

Competing interests

Dr Tang previously served as a committee co-chair for Resident Doctors of Canada (RDoC), which included overseeing an advocacy project for national licensure. He later served as a member of the RDoC National Licensure Project Team. In that capacity, he received funding from RDoC to present this advocacy work at academic conferences.

References

1. Bernstein L, Boburg S, Sacchetti M, et al. Covid-19 hits doctors, nurses and EMTs, threatening health system. Accessed 24 March 2020. www.washingtonpost.com/health/covid-19-hits-doctors-nurses-emts-threatening-health-system/2020/03/17/f21147e8-67aa-11ea-b313-df458622c2cc_story.html.
2. Government of Canada. Coronavirus disease (COVID-19): Outbreak update. Accessed 24 March 2020. www.canada.ca/en/public-health/services/diseases/2019-novel-coronavirus-infection.html.
3. Picard A. Why isn't there a single medical licence for all doctors in Canada? The Globe and Mail. 4 January 2019. Accessed 24 March 2020. www.theglobeandmail.com/canada/article-why-isnt-there-a-single-medical-licence-for-all-doctors-in-canada.
4. Ho B, Tepper J, Hinds R. Is it time to implement one national license for Canadian doctors? Healthy Debate. 18 March 2020. Accessed 24 March 2020. https://healthydebate.ca/2020/03/topic/is-it-time-to-implement-one-national-license-for-canadian-doctors.
5. Crowe K. Nova Scotia's health care "crisis" is Canada's crisis too. CBC News. 27 April 2019. Accessed 24 March 2020. www.cbc.ca/news/health/doctor-shortage-cancer-video-nova-scotia-health-yarmouth-ontario-hospital-1.5113552.
6. Canadian Medical Association. Physicians overwhelmingly support national licensure: 2019 CMA Physician Workforce survey results. Accessed 24 March 2020. www.cma.ca/physicians-overwhelmingly-support-national-licensure-2019-cma-physician-workforce-survey-results.
7. Resident Doctors of Canada. National licensure. Accessed 24 March 2020. https://residentdoctors.ca/areas-of-focus/national-licensure.
8. CMAJ News. COVID-19: A timeline of Canada's first-wave response. Accessed 24 March 2020. https://cmajnews.com/2020/03/20/coronavirus-1095847.
9. Crowe K. Provincial borders won't be barriers for doctors if coronavirus hits some areas worse than others. CBC News. Accessed 24 March 2020. www.cbc.ca/news/health/covid-19-coronavirus-doctors-provinces-college-of-physicians-and-surgeons-licence-insurance-1.5495646.

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However, the impact of COVID-19 on their year will bleed into the first year of residency, which is notorious for being one of the most challenging years in all of medical training. The oral component of their spring 2020 certification exams has since been canceled, and the Medical Council of Canada Qualifying Examination Part 1 will be postponed until September this year or possibly later.[13] Those who do not pass will have to juggle rewriting their exams while contending with the grueling demands of their first year in residency.

Looking forward

Medical education will undoubtedly be changed after the COVID-19 pandemic. The abrupt switch to online learning to fulfill curricular goals, coupled with rapid development of new learning technologies, will likely become the norm.[14] There will be a need to supplement traditional medical education with remote learning due to increased demand for clinical experiences as more students across multiple years are accommodated within a limited number of clinical placements, and as preceptors become inundated with patients who are currently refraining from coming to see them due to fear of the coronavirus.[15] With the sudden widespread adoption of telehealth driven by COVID-19, medical students who are becoming well versed in technology in medicine may have an advantage when they transition to practice.[4]

However, each advancement warrants evaluation to ensure continued quality of medical education, some of which cannot be adequately learned without direct patient interaction.[4] As of now, the extent to which changes are accepted into curricula depends on a number of unpredictable factors, including economic stability, availability of technologies and professionals to develop them, buy-in from curriculum developers, and acceptability for medical students. Increased flexibility in curricula, research protocols, and clinical approaches will likely be the future.[14] By documenting these lessons as they are learned, we can contribute to an enhanced response to the next public health crisis that challenges medical education. Our ability to rapidly adapt is proving to be a key attribute in these unprecedented times. ■

Competing interests
None declared.

References

1. Patil NG, Chan Y, Yan H. SARS and its effect on medical education in Hong Kong. Med Educ 2003;37:1127-1128.
2. Mclean M, Jha V, Sandars J. Professionalism under fire: Conflict, war and epidemics. Med Teach 2015;37:831-836.
3. Rieder MJ, Salvadori M, Bannister S, Kenyon C. Collateral damage: The effect of SARS on medical education. Clin Teach 2004;1:85-89.
4. Fitzgerald S. COVID-19: Neurology instructors rethink medical clerkship training as clinical rotations are on pause. Neurology Today 2020;20:14-15.
5. Pei L, Wu H. Does online learning work better than offline learning in undergraduate medical education? A systematic review and meta-analysis. Med Educ Online 2019;24:1666538.
6. Looyestyn J, Kernot J, Boshoff K, et al. Does gamification increase engagement with online programs? A systematic review. PLoS One 2017;12:e0173403.
7. Khamees D, Brown CA, Arribas M, et al. In Crisis: Medical students in the COVID-19 pandemic. AEM Education and Training. 2020.
8. Rose S. Medical student education in the time of COVID-19. JAMA 2020. doi: 10.1001/jama.2020.5227.
9. Gabrielson A, Kohn T, Clifton M. COVID-19 and the urology match: Perspectives and a call to action. J Urol 2020;204:17-19.
10. Leroux G. Why are we integrating of BPAS principles into CaRMS Online? 30 October 2019. Accessed 23 April 2020. https://carms.zendesk.com/hc/en-us/articles/360028215032-Why-are-we-integrating-of-BPAS-principles-into-CaRMS-Online-.
11. Osman L. Coronavirus: Feds seeking medical student volunteers to help fight virus. Global News. 3 April 2020. Accessed 23 April 2020. https://globalnews.ca/news/6775890/medical-student-volunteers-coronavirus/.
12. Federation of Medical Regulatory Authorities of Canada. Licensing the 2020 graduating cohort. Accessed 23 April 2020. https://fmrac.ca/4110-2.
13. Royal College of Physicians and Surgeons of Canada. Impact on Royal College exams. Accessed 23 April 2020. www.royalcollege.ca/rcsite/documents/about/update-coronavirus-e#s1.
14. Goh P, Sandars J. A vision of the use of technology in medical education after the COVID-19 pandemic. MedEdPublish 26 March 2020. doi: https://doi.org/10.15694/mep.2020.000049.1.
15. Krumholz, H. Where have all the heart attacks gone? The New York Times. 6 April 2020. Accessed 23 April 2020. www.nytimes.com/2020/04/06/well/live/coronavirus-doctors-hospitals-emergency-care-heart-attack-stroke.html.

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10. College of Physicians and Surgeons of British Columbia. Registrar's message: Telemedicine and licence portability—the future of medical regulation in Canada. Accessed 24 March 2020. www.cpsbc.ca/for-physicians/college-connector/2019-V07-02/01.
11. Bhatia RS, Falk W. Modernizing Canada's healthcare system through the virtualization of services. C.D. Howe Institute. Accessed 24 March 2020. www.ams-inc.on.ca/wp-content/uploads/2015/12/Modernizing-Canadas-Healthcare-System-through-the-Virtualization-of-Services-by-Will-Falk.pdf.
12. Miller A, Martin D. Putting a crisis to work: COVID-19 can be the push we need to modernize our healthcare system. The Star. Accessed 24 March 2020. www.thestar.com/opinion/contributors/2020/03/17/putting-a-crisis-to-work-covid-19-can-catalyze-modernization-of-our-health-care-system.html.
13. Canadian Medical Association. Virtual care in Canada: Discussion paper. CMA Health Summit 2019. Accessed 24 March 2020. www.cma.ca/sites/default/files/pdf/News/Virtual_Care_discussionpaper_v2EN.pdf.
14. OntarioMD. Virtual care and the 2019 novel coronavirus (COVID-19). Accessed 24 March 2020. https://ontariomd.news.
15. Doctors of BC. Billing changes–COVID-19. Accessed 24 March 2020. www.doctorsofbc.ca/news/covid-19-temporary-billing-changes.
16. Ofri D. Why doctors don't take sick days. The New York Times. Accessed 24 March 2020. www.nytimes.com/2013/11/16/opinion/sunday/why-doctors-dont-take-sick-days.html.
17. Sisson P. How to stop a COVID-19 epidemic: Change our sick-at-work culture. The San Diego Union Tribune. Accessed 24 March 2020. www.sandiegouniontribune.com/news/health/story/2020-03-08/how-stopping-covid-19-is-really-about-changing-the-culture-of-working-sick.
18. Canadian Medical Association. CMA urges all employers to discontinue requirement for sick notes during COVID-19. Accessed 24 March 2020. www.cma.ca/sites/default/files/pdf/Media-Releases/CMA-Sick-Notes-Statement(March-15-2020).pdf.
19. Pringle J. Ottawa public health writes sick note for individuals needing to self-isolate due to COVID-19. CTV News. Accessed 24 March 2020. https://ottawa.ctvnews.ca/ottawa-public-health-writes-sick-note-for-individuals-needing-to-self-isolate-due-to-covid-19-1.4853858.
20. The Canadian Press. Saskatchewan changes rules around sick leave as it reports another COVID-19 case. The Star. Accessed 24 March 2020. www.thestar.com/news/canada/2020/03/17/saskatchewan-changes-rules-around-sick-leave-as-it-reports-another-covid-19-case.html.