Standards of Practice

The minimum standard of professional behavior and good practice expected of Alberta physicians.

Current as of July 1, 2019
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The **Standards of Practice** of the College of Physicians & Surgeons of Alberta (hereafter referred to as the “College”) are the minimum standards of professional behaviour and ethical conduct expected of all physicians registered in Alberta. Standards are enforceable under the *Health Professions Act* and will be referenced in complaints resolution and discipline hearings.

These standards complement the Canadian Medical Association’s *Code of Ethics & Professionalism*, which is the particular code adopted by the College on behalf of its members.

In this document, the term “**regulated member**” means any person who is registered or who is required to be a registered as a member of this College. The College regulates physicians, surgeons and osteopaths. The term “**must**” refers to a mandatory requirement. The term “**may**” means that the physician may exercise reasonable discretion. All references to the “**patient**” in these Standards include the patient’s legal guardian or substitute decision maker, where applicable.

Standards of Practice are purposely concise. When assessing an alleged breach of these Standards, the College considers the context of the matter on a case-by-case basis. Additional advice and information on specific topics can be found in the *Messenger* (the newsletter of the College) and on the College’s website at [www.cpsa.ca](http://www.cpsa.ca).

Standards of Practice will evolve over time, and substantive changes will be adopted only after consultation with the profession and others as prescribed under the *Health Professions Act*. 
Advertising

The Standards of Practice of the College of Physicians & Surgeons of Alberta ("the College") are the minimum standards of professional behavior and ethical conduct expected of all regulated members registered in Alberta. Standards of Practice are enforceable under the Health Professions Act and will be referenced in the management of complaints and in discipline hearings. The College of Physicians & Surgeons of Alberta also provides Advice to the Profession to support the implementation of the Standards of Practice.

(1) A regulated member who is responsible for an advertisement¹ must ensure the information provided:

(a) conforms to the Code of Ethics;

(b) contains factual and relevant information about the nature of the practice;

(c) includes the practice discipline as identified on the member’s practice permit issued by this College;

(d) is accurate, clear and explicitly states all pertinent details of an offer, with disclaimers as prominent as other aspects of the message;

(e) is supported by evidence that is readily available to the public;

(f) is compatible with the best interests of the public and upholds the reputation of the medical profession;

(g) is not false, incomplete, misleading or deceptive;

(h) does not include claims, representations, endorsements or testimonials regarding the service or business;

(i) does not create unreasonable expectations of beneficial treatment such as guarantees or warranties about results; and

(j) does not encourage the indiscriminate or unnecessary use of health services.

(2) A regulated member must promptly comply with direction from the Registrar to:

(a) substantiate any advertising claim or representation;

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¹"Advertisement" is any message (spoken, text or image-based), in any medium, about a regulated member and/or a clinic, group, product or service with which a regulated member is associated, the content of which is controlled directly or indirectly by a regulated member.

Terms used in the Standards of Practice:

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(b) confirm whether a specific advertisement is made by or on behalf of the regulated member; or
(c) change or stop using any advertising message(s) that the Registrar deems in violation of any part of this standard or the Code of Ethics.

(3) A regulated member must not directly or indirectly participate in advertising that:
(a) discredits, disparages or attacks another product, service, facility, clinic, provider or group;
(b) promises or offers more effective services or better results than those available from another provider unless substantiated to the satisfaction of the Registrar based on publically available information; or
(c) offers any inducement to provide a medical service to a patient, including but not limited to:
   (i) time-limited prices for a service;
   (ii) discount coupons, gift certificates, or prizes for a service;
   (iii) communal gatherings ("parties") where consultation or medical services are offered;
   (iv) a service in conjunction with "makeovers" created for entertainment or promotional purposes; or
   (v) events including "education sessions" where registration fees are donated.

(4) A regulated member must not:
(a) disclose the name or identifying features of a patient unless the regulated member has obtained the patient’s prior written consent to use the information for advertising purposes; or
(b) use a protected title listed in Schedule 21 of the Health Professions Act (HPA) alone or in combination with other descriptors to imply specialization in an area or branch of medicine unless recognized by the College or authorized by the Registrar to use that title.

(5) Notwithstanding 4(b), a regulated member may use a protected title as authorized by the Department of National Defence.

(6) A regulated member may indicate a practice interest only if the:
(a) area of interest falls within the context of the member’s practice discipline;
(b) area of interest is a demonstrated, significant focus of the member’s practice; and
(c) regulated member pursues continuing medical education related to the area of interest.

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Boundary Violations: Personal

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A regulated member who is uncertain about the potential for a boundary violation should consult with the College or another relevant advisory body (e.g., Canadian Medical Protective Association).

Physician-Patient Relationship

(1) A regulated member must maintain professional boundaries in any interaction with a patient, including but not limited to:
   (a) providing adequate draping;
   (b) providing privacy while the patient is undressing or dressing;
   (c) obtaining informed consent for intimate or sensitive examinations; and
   (d) using appropriate examination techniques when touching sensitive or personal areas of the body, including but not limited to breasts, genitalia or anus.

(2) A regulated member must consider and minimize any potential conflict of interest or risk of coercion when engaging with a patient in a non-clinical context (i.e., in a personal, social, financial or business relationship).

(3) A regulated member must not:
   (a) enter into a close personal relationship with a patient or any person with whom a patient has a significant interdependent relationship (e.g., parent, guardian, child or significant other);
   (b) socialize or communicate with a patient for the purpose of pursuing a close personal relationship; or

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- "May" means that the physician may exercise reasonable discretion.
- "Patient" includes, where applicable, the patient's legal guardian or substitute decision maker.
(c) **terminate** a physician-patient relationship for the purpose of pursuing a close personal relationship.

(4) A regulated member **must not** enter into a close personal relationship with a former patient unless:

(a) the regulated member has **never** provided the patient with psychotherapeutic treatment;

(b) there is minimal risk of a continuing power imbalance; and

(c) sufficient time has passed since the last clinical encounter, given the nature and extent of the physician-patient relationship.

(5) A regulated member **must not** promote his/her personal or religious beliefs or causes to a patient in the context of the physician-patient relationship.

**Physician-Learner and Physician-Subordinate Relationships**

(6) A regulated member **must not**:

(a) sexualize a teacher-learner relationship by making sexual comments or gestures toward a learner;

(b) enter into a close personal or sexual relationship with a learner while directly or indirectly responsible for mentoring, teaching, supervising or evaluating that learner; or

(c) enter into any relationship with a learner that could present a risk of conflict of interest or coercion while directly or indirectly responsible for mentoring, teaching and/or evaluating that learner.

(7) A regulated member who has a pre-existing (current or past) close personal or sexual relationship with a learner or a subordinate physician **must**:

(a) notify the applicable clinical and academic leaders of the relationship;

(b) remove him/herself from any role teaching or evaluating the subordinate physician or learner; and

(c) remove him/herself from any discussion of the performance of the subordinate physician or learner.

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1 “Learner” includes but is not limited to clinical trainee, medical student, other health professional learner, graduate student, resident or fellow.

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Boundary Violations: Sexual

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Introduction

This Standard of Practice addresses Sexual Abuse and Sexual Misconduct. This Standard of Practice establishes who is considered to be a “patient” for the purposes of a complaint of unprofessional conduct in relation to Sexual Abuse or Sexual Misconduct under the Health Professions Act (“HPA”).

Definitions

“Patient” is defined in section 1(1)(x.1) of the Health Professions Act as:

• “patient” for the purposes of a complaint made in respect of unprofessional conduct in relation to sexual abuse or sexual misconduct, means a patient as set out in the standards of practice of a council;

“Adult interdependent partner” is defined in section 3(1) of the Adult Interdependent Relationships Act as:

• Subject to subsection (2), a person is the adult interdependent partner of another person if

  (a) the person has lived with the other person in a relationship of interdependence
      (i) for a continuous period of not less than 3 years, or
      (ii) of some permanence, if there is a child of the relationship by birth or adoption,

  or

  (b) the person has entered into an adult interdependent partner agreement with the other person under section 7.

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• The College regulates physicians, surgeons and osteopaths.
• “Must” refers to a mandatory requirement.
• “May” means that the physician may exercise reasonable discretion.
• “Patient” includes, where applicable, the patient’s legal guardian or substitute decision maker.
“Regulated member” is a member of the College of Physicians & Surgeons of Alberta registered as a member under section 33(1)(a) of the Health Professions Act.

“Sexual Abuse” is defined in section 1(1)(nn.1) of the Health Professions Act:

- “sexual abuse” means the threatened, attempted or actual conduct of a regulated member towards a patient that is of a sexual nature and includes any of the following conduct:
  
  (i) sexual intercourse between a regulated member and a patient of that regulated member;
  (ii) genital to genital, genital to anal, oral to genital, or oral to anal contact between a regulated member and a patient of that regulated member;
  (iii) masturbation of a regulated member by, or in the presence of, a patient of that regulated member;
  (iv) masturbation of a regulated member’s patient by that regulated member;
  (v) encouraging a regulated member’s patient to masturbate in the presence of that regulated member;
  (vi) touching of a sexual nature of a patient’s genitals, anus, breasts, or buttocks by a regulated member;

“Sexual Misconduct” is defined in section 1(1)(nn.2) of the Health Professions Act as;

- “sexual misconduct” means any incident or repeated incidents of objectionable or unwelcome conduct, behaviour or remarks of a sexual nature by a regulated member towards a patient that the regulated member knows or ought reasonably to know will or would cause offence or humiliation to the patient or adversely affect the patient’s health and well-being but does not include sexual abuse.

“Sexual nature” is defined in section 1(1)(nn.3) of the Health Professions Act as not including “any conduct, behaviour or remarks that are appropriate to the service provided.”

- In other words, touching of the patient’s body by a regulated member does not constitute Sexual Abuse if the touching is appropriate to the health care service being provided. However, regulated members are reminded of the obligation to obtain a patient’s informed consent prior to an examination, assessment, treatment or procedure. (See the CPSA’s standard of practice on Informed Consent and its Advice to the Profession on “Informed Consent for Adults” and “Informed Consent for Minors”.) As noted in “Informed Consent for Adults”, written consent or explicit oral consent should be in place and documented whenever an examination or treatment involves touching the patient (page 4).

“Spouse” is a person who is married.

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- “Must” refers to a mandatory requirement.
- “May” means that the physician may exercise reasonable discretion.
- “Patient” includes, where applicable, the patient’s legal guardian or substitute decision maker.
**Prohibitions**

A regulated member must never engage in sexual conduct with a “patient”. The consequences are as follows:

1. If a regulated member is found by a Hearing Tribunal to have committed unprofessional conduct based in whole or in part on “Sexual Abuse”, then the Hearing Tribunal must cancel the regulated member’s registration and practice permit. The regulated member is never permitted to apply for reinstatement.

2. If a regulated member is found by a Hearing Tribunal to have committed unprofessional conduct based in whole or in part on “Sexual Misconduct”, then the Hearing Tribunal must at least suspend the regulated member’s practice permit for a period of time determined by the Hearing Tribunal to be appropriate. The Hearing Tribunal can impose more severe sanctions than a suspension. If a regulated member’s registration and practice permit are cancelled because of “sexual misconduct” then the regulated member cannot apply for reinstatement for at least 5 years.

All types of sexual relationships with patients are prohibited even if the regulated member believes that the patient is “consenting.” The *Health Professions Act* does not recognize such alleged “consent” as a valid defence because of the existence of the inherent power imbalance that typically exists in the regulated member-patient relationship.

If a regulated member engages in the type of behaviour set out in the definition of Sexual Abuse or Sexual Misconduct with a person who is not his or her patient (such as colleagues, staff, or others) then this conduct may still be considered “unprofessional conduct” by the regulated member but the mandatory sanctions for Sexual Abuse and Sexual Misconduct would not apply. If a Hearing Tribunal found that this conduct constituted “unprofessional conduct”, then a Hearing Tribunal would have the discretion to impose the type of orders that it considers appropriate up to and including suspension and cancellation of registration and practice permit.

If a regulated member engages in inappropriate conduct with a patient that does not fall within the definition of “Sexual Abuse” or “Sexual Misconduct”, a Hearing Tribunal may still consider the conduct to be “unprofessional conduct” subjecting the regulated member to sanctions.

A regulated member must not:

a. enter into a sexual relationship with any person with whom a patient has a significant interdependent relationship (e.g. parent, guardian, child or significant other);

b. request details of a patient’s sexual or personal history unless related to the patient’s care;

c. terminate a regulated member-patient relationship for the purpose of pursuing a sexual relationship.

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- “May” means that the physician may exercise reasonable discretion.
- “Patient” includes, where applicable, the patient’s legal guardian or substitute decision maker.
A violation of (a) to (c) is not considered to be Sexual Abuse but may be considered by a Hearing Tribunal to be unprofessional conduct under the Health Professions Act. A violation of (b) may be found by a Hearing Tribunal to constitute Sexual Misconduct. After making a finding of unprofessional conduct, a Hearing Tribunal can impose a range of sanctions including suspensions and cancellation of registration and practice permit.

Who is considered to be a “patient”?

The Sexual Abuse and Sexual Misconduct provisions in the Health Professions Act apply to “patients”. For the purposes of this standard of practice, an individual is a regulated member’s “patient” in two circumstances:

1. When a regulated member-patient relationship has been formed and has not ended.
2. For a period of 1 year from the date the individual ceased to be the regulated member’s patient.

An individual becomes a patient when a regulated member-patient relationship is formed. This type of relationship is formed when there is a reasonable expectation that care will extend beyond a single encounter and the regulated member has engaged in one or more of the following activities:

1. Gathered clinical information to assess a person;
2. Provided a diagnosis;
3. Provided medical advice or treatment;
4. Provided counselling to the patient;
5. Created a patient file for the patient;
6. Billed for medical services provided to the patient;
7. Prescribed a drug for which a prescription is needed to the patient.

A regulated member who engages in the type of sexual acts described in the definition of “Sexual Abuse” with a patient commits Sexual Abuse.

A regulated member who engages in the type of sexual acts described in the definition of “Sexual Misconduct” with a patient commits Sexual Misconduct.

Sexual Conduct after the End of the Regulated Member-Patient Relationship

If a regulated member has any doubt as to whether or when a regulated member patient relationship ended they may wish to seek advice from the CMPA or the CPSA.

As described above, sexual conduct may still be considered to be inappropriate after the 1 year period has elapsed. Sexual conduct with a former patient is inappropriate if there is more than a minimal risk of a continuing power imbalance. A non-exhaustive list of factors in determining whether there is more than
a minimal risk of a continuing power imbalance is as follows (in this list the patient is referred to as the “individual”):

1. Whether the individual understands the inherent power imbalance that typically exists in a regulated member-patient relationship.
2. Whether sufficient time has passed since the end of the regulated member-patient relationship, given the nature and extent of the regulated member-patient relationship.
3. The nature of the individual's clinical problems.
4. The type of medical care provided by the regulated member.
5. Whether the individual has confided close personal or sexual information to the regulated member.
6. The length and intensity of the former regulated member-patient relationship.
7. Whether this is a situation where there is a likelihood of transference.
8. The vulnerability of the individual including a consideration of whether the individual is a member of a vulnerable population such as, for example: those who have diminished capacity, those who are economically disadvantaged, those suffering from addictions and the homeless.
9. Whether the regulated member-patient relationship was established while the individual was a minor.
10. Whether there is a history of the regulated member prescribing to the patient drugs associated with substance use disorders or substance-related harms.

Sexual conduct with a former patient beyond the 1 year period that is considered inappropriate given all the circumstances is not considered to be Sexual Abuse. However, such conduct may be considered by a Hearing Tribunal to be unprofessional conduct under the Health Professions Act. After making a finding of unprofessional conduct, a Hearing Tribunal can impose a range of sanctions including suspensions and cancellation of registration and practice permit.

Any regulated member who engages in sexual conduct with a former patient after the 1 year period has elapsed runs a risk that the conduct will be considered inappropriate and unprofessional conduct. Regulated members with any doubt as to the propriety of their conduct may wish to seek advice from the CMPA or the CPSA.

Psychotherapeutic Treatment

A regulated member who has provided psychotherapeutic treatment to a patient must never engage in sexual conduct with the former patient regardless of the amount of time that has passed since the end of the regulated member-patient relationship. In other words, for the purposes of the Sexual Abuse provisions in the Health Professions Act, the individual is always considered to be a “patient” regardless of the amount of time that has lapsed since the end of the regulated member-patient relationship.

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- “May” means that the physician may exercise reasonable discretion.
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Episodic Care

For the purposes of the sexual abuse and sexual misconduct provisions, a regulated member-patient relationship is formed when a regulated member provides “Episodic Care” as defined in the standard of practice on Episodic Care. However, the regulated member-patient relationship does not extend beyond the conclusion of the episodic care. The individual is considered a patient during the episodic care. Therefore, a regulated member who engages in the type of activity described in the definition of Sexual Abuse or Sexual Misconduct while providing episodic care will be considered to have committed Sexual Abuse or Sexual Misconduct, as the case may be.

Sexual conduct between a regulated member and a former patient after the completion of episodic care may still be considered to be inappropriate. This conduct is considered to be inappropriate if there is more than a minimal risk of a continuing power imbalance. A non-exhaustive list of factors in determining whether there is more than a minimal risk of a continuing power imbalance is set out in the section “Sexual Conduct after the End of the Regulated member-Patient Relationship.”

Sexual conduct with a former patient after the conclusion of episodic care that is considered inappropriate given all the circumstances is not considered to be Sexual Abuse even if it takes place within 1 year of providing episodic care. However, such conduct may be considered by a Hearing Tribunal to be unprofessional conduct under the Health Professions Act. After making a finding of unprofessional conduct, a Hearing Tribunal can impose a range of sanctions including suspensions and cancellation of registration and practice permit.

The provisions of this Standard of Practice concerning episodic care are only for the purposes of defining who is a patient for the purposes of the sexual abuse and sexual misconduct provisions in the Health Professions Act. The provisions of this Standard of Practice do not diminish any ongoing professional responsibilities of the regulated member under the Episodic Care Standard of Practice.

Medical Treatment of Spouses, Adult Interdependent Partners and those in Pre-Existing Sexual Relationships

For the purposes of the sexual abuse provisions in the Health Professions Act, a person receiving medical treatment from a regulated member is not considered a patient if the regulated member is their spouse or adult interdependent partner or if they are in an ongoing pre-existing sexual relationship with the regulated member.

However, it is considered to be unprofessional conduct for a regulated member to provide medical treatment to a spouse, adult interdependent partner or person with whom they are in an ongoing preexisting sexual relationship unless all the following conditions are met:

1. The treatment is limited to a “minor condition” or an “emergency”.

2. Another physician is not readily available or the individual receiving treatment could suffer harm from a delay in obtaining the services of another physician.

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- “Patient” includes, where applicable, the patient’s legal guardian or substitute decision maker.
“Minor condition” is considered a non-urgent, non-serious condition that requires only short-term, routine care and is not likely to be an indication of, or lead to, a more serious condition requiring medical expertise.

An “emergency” is considered to exist when an individual is experiencing severe suffering or is at risk of sustaining serious bodily harm if medical intervention is not promptly provided.

After making a finding of unprofessional conduct, a Hearing Tribunal can impose a range of sanctions including suspensions and cancellation of registration and practice permit.
Cannabis for Medical Purposes

Health Canada has approved the use of cannabis for medical purposes. Regulated members have the choice to treat or not to treat their patient’s medical condition or symptom(s) with cannabis.

(1) A regulated member who chooses not to treat patient’s medical condition or symptom(s) with cannabis should do so in accordance with the Code of Ethics and Conscientious Objection standards of practice.

(2) A regulated member who chooses to treat patients with cannabis must:

(a) register with the College as an authorizer of cannabis for medical purposes,
(b) attempt and find conventional therapies ineffective in treating the patient’s medical condition or symptom(s),
(c) assess the patient’s risk of addiction using a standard addiction risk tool,
(d) receive informed consent\(^1\) in accordance with the Informed Consent standard of practice,
(e) review available prescription databases, including the Pharmacy Information Network (PIN) and the Triplicate Prescription Program (TPP) to obtain a patient medication profile,
(f) comply with provincial and federal regulations, including Health Canada’s Information for Health Care Professionals and,
(g) complete a patient’s medical document.

(3) A patient’s medical document must include the:

(a) patient’s

(i) given name and surname,

(ii) date of birth, and

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\(^1\) See the College’s Advice to the Profession: Informed Consent for Adults.
(iii) personal health care number,

(b) regulated member’s
(i) registration number,
(ii) given name and surname,
(iii) business address and telephone number and,
(iv) facsimile number and email,
(c) address of the location at which the regulated member treated the patient,
(d) medical condition or symptom(s) cannabis is treating,
(e) daily quantity of cannabis to be used by the patient expressed in grams,
(f) period of use specified as a number of weeks or months (not to exceed one year) beginning on the day the patient’s medical document is signed and,
(g) regulated member’s signature and date of signing.

(4) A regulated member completing a patient medical document **must**:

(a) evaluate the patient on a regular basis to determine the benefits and risks of cannabis as treatment for the medical condition or symptom(s) stated in the patient medical document,
(b) at minimum see the patient every three months following stabilization²,
(c) provide ongoing care to the patient for the underlying medical condition or symptom(s) for which cannabis is the treatment, including a process to identify misuse or abuse of cannabis,
(d) provide the College with a copy of the patient’s medical document within one (1) week of completing the medical document.

(5) A regulated member **must not**:

(a) dispense or provide cannabis to any patient or person or,
(b) apply to become a licensed producer of cannabis.

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² The stabilization phase is defined by the use of a stable amount, medical condition or symptom(s) relief and reasonable confidence that no misuse is occurring.

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- "May" means that the physician may exercise reasonable discretion.
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Charging for Uninsured Professional Services

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(1) Amounts charged for uninsured professional services including block fees must reasonably reflect physician professional costs, administrative costs and the patient's ability to pay. When asked, a regulated member must be able to account for the fee charged for the service.

(2) A regulated member must inform a patient or third party of any fee to be charged before the provision of an uninsured professional service.

(3) A regulated member’s agent may give preliminary information to a patient about the billing policies in his or her medical practice, but the regulated member remains responsible for the final decision and explanation to the patient when the patient disputes a fee or requests clarification.

(4) A general notice to patients in a regulated member’s office is not sufficient by itself to fulfill the requirements in clauses (2) and (3).

(5) A regulated member may not demand payment from an individual patient in advance of urgently required uninsured professional services that are not readily available elsewhere.

(6) A regulated member must not charge a fee to the patient in advance for “being available” to render professional services.

(7) If a regulated member offers a block option, the regulated member must:

(a) allow the patient the choice of paying the block fee or for each professional service individually as provided;

(b) provide the patient with the block fee option in writing;

(c) ensure the patient is given sufficient information to make an informed choice including:

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1 A professional service includes both medical and non-medical services.

2 For the purpose of this standard a block fee is a fixed fee for all designated uninsured services provided during a specified time period.

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(i) a list of fees that will be charged individually for each professional service if the patient declines the block fee option; and

(ii) a copy of this standard.

(8) If a regulated member offers a block fee option, the regulated member must not:

(a) refuse to provide an insured professional service because a patient has not paid a block fee for uninsured services;

(b) include in a block fee any service for which the regulated member is compensated through any other means, including any charge for a professional service which is included as part of an insured professional service; and

(c) promise or provide preferential services to a patient who paid a block fee.
Closing or Leaving a Medical Practice

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(1) For the purpose of this standard, closing or leaving a practice is defined as:

(a) discontinuing the practice of medicine completely with no intention of returning,

(b) a leave of absence for more than twelve (12) months during which there is no establishment of any medical practice in the province of Alberta,

(c) a scope of practice change the College accepts as significant,

(d) moving to a location a significant distance from an existing practice such that existing patients could not reasonably be expected to travel to the new practice location, or

(e) a significant decrease in the volume of medical practice that will require the involuntary diminution of the number of patients in a practice.

(2) A regulated member must notify the College in advance when the regulated member plans to close or leave a medical practice in Alberta.

(3) A regulated member must provide the College with:

(a) information describing how the transfer of patient care will be managed,

(b) information on the location and disposition of patient records and how the patient records may be accessed (as per the Patient Record Retention Standard of Practice),

(c) a forwarding mailing address and contact information for the regulated member, and

(d) all unused Triplicate Prescription forms in the possession of the regulated member if ceasing a medical practice in Alberta.

(4) A regulated member who closes or leaves a medical practice is responsible for the secure storage and disposition of the patient records from that medical practice.

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(5) A regulated member who closes or leaves a medical practice must dispose of medications, equipment and supplies in a safe manner.

(6) A regulated member who closes or leaves a medical practice must provide and document notification of the event to individual patients with whom there is an expectation of ongoing care by that regulated member a minimum of ninety (90) days in advance of closing or leaving the practice.

(a) Notwithstanding clause (6) above, the 90 days’ notice does not apply to a regulated member if the reason for closing or leaving a medical practice is due to circumstances beyond the regulated member’s control. In these cases, patients must be notified as soon as is reasonably possible given the circumstances.

(7) A regulated member who closes or leaves a medical practice and does not maintain custody of the records must ensure there are information sharing agreements relating to management of patient charts; the information sharing agreement must, at a minimum:

(a) identify which regulated member(s) will maintain custody of the patient records;

(b) describe who is responsible for costs if copies of the record are provided to a regulated member who is a party to the agreement; and

(c) reflect costs that are reasonable and consistent with applicable legislation and community standards.

(8) A regulated member owner who asks a regulated member colleague to leave a medical practice must give adequate notice that the regulated member’s services are no longer required; thereby allowing the departing regulated member to meet his or her obligations as per (2) through (6) above.

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The CMA Code of Ethics and Professionalism articulates the ethical and professional commitments and responsibilities of the medical profession. The Code provides standards of ethical practice to guide physicians in fulfilling their obligation to provide the highest standard of care and to foster patient and public trust in physicians and the profession. The Code is founded on and affirms the core values and commitments of the profession and outlines responsibilities related to contemporary medical practice.

In this Code, ethical practice is understood as a process of active inquiry, reflection, and decision-making concerning what a physician’s actions should be and the reasons for these actions. The Code informs ethical decision-making, especially in situations where existing guidelines are insufficient or where values and principles are in tension. The Code is not exhaustive; it is intended to provide standards of ethical practice that can be interpreted and applied in particular situations. The Code and other CMA policies constitute guidelines that provide a common ethical framework for physicians in Canada.

In this Code, medical ethics concerns the virtues, values, and principles that should guide the medical profession, while professionalism is the embodiment or enactment of responsibilities arising from those norms through standards, competencies, and behaviours. Together, the virtues and commitments outlined in the Code are fundamental to the ethical practice of medicine.

Physicians should aspire to uphold the virtues and commitments in the Code, and they are expected to enact the professional responsibilities outlined in it.

Physicians should be aware of the legal and regulatory requirements that govern medical practice in their jurisdictions.

### A. VIRTUES EXEMPLIFIED BY THE ETHICAL PHYSICIAN

Trust is the cornerstone of the patient–physician relationship and of medical professionalism. Trust is therefore central to providing the highest standard of care and to the ethical practice of medicine. Physicians enhance trustworthiness in the profession by striving to uphold the following interdependent virtues:

**Compassion**
A compassionate physician recognizes suffering and vulnerability, seeks to understand the unique circumstances of each patient and to alleviate the patient’s suffering, and accompanies the suffering and vulnerable patient.

**Honesty**
An honest physician is forthright, respects the truth, and does their best to seek, preserve, and communicate that truth sensitively and respectfully.

**Humility**
A humble physician acknowledges and is cautious not to overstep the limits of their knowledge and skills or the limits of medicine, seeks advice and support from colleagues in challenging circumstances, and recognizes the patient’s knowledge of their own circumstances.

**Integrity**
A physician who acts with integrity demonstrates consistency in their intentions and actions and acts in a truthful manner in accordance with professional expectations, even in the face of adversity.

**Prudence**
A prudent physician uses clinical and moral reasoning and judgement, considers all relevant knowledge and circumstances, and makes decisions carefully, in good conscience, and with due regard for principles of exemplary medical care.
B. FUNDAMENTAL COMMITMENTS OF THE MEDICAL PROFESSION

**Commitment to the well-being of the patient**
- Consider first the well-being of the patient; always act to benefit the patient and promote the good of the patient.
- Provide appropriate care and management across the care continuum.
- Take all reasonable steps to prevent or minimize harm to the patient; disclose to the patient if there is a risk of harm or if harm has occurred.
- Recognize the balance of potential benefits and harms associated with any medical act; act to bring about a positive balance of benefits over harms.

**Commitment to respect for persons**
- Always treat the patient with dignity and respect the equal and intrinsic worth of all persons.
- Always respect the autonomy of the patient.
- Never exploit the patient for personal advantage.
- Never participate in or support practices that violate basic human rights.

**Commitment to justice**
- Promote the well-being of communities and populations by striving to improve health outcomes and access to care, reduce health inequities and disparities in care, and promote social accountability.

**Commitment to professional integrity and competence**
- Practise medicine competently, safely, and with integrity; avoid any influence that could undermine your professional integrity.
- Develop and advance your professional knowledge, skills, and competencies through lifelong learning.

**Commitment to professional excellence**
- Contribute to the development and innovation in medicine through clinical practice, research, teaching, mentorship, leadership, quality improvement, administration, or advocacy on behalf of the profession or the public.
- Participate in establishing and maintaining professional standards and engage in processes that support the institutions involved in the regulation of the profession.
- Cultivate collaborative and respectful relationships with physicians and learners in all areas of medicine and with other colleagues and partners in health care.

**Commitment to self-care and peer support**
- Value personal health and wellness and strive to model self-care; take steps to optimize meaningful co-existence of professional and personal life.
- Value and promote a training and practice culture that supports and responds effectively to colleagues in need and empowers them to seek help to improve their physical, mental, and social well-being.
- Recognize and act on the understanding that physician health and wellness needs to be addressed at individual and systemic levels, in a model of shared responsibility.

**Commitment to inquiry and reflection**
- Value and foster individual and collective inquiry and reflection to further medical science and to facilitate ethical decision-making.
- Foster curiosity and exploration to further your personal and professional development and insight; be open to new knowledge, technologies, ways of practising, and learning from others.
C. PROFESSIONAL RESPONSIBILITIES

Physicians and patients

Patient-physician relationship

The patient–physician relationship is at the heart of the practice of medicine. It is a relationship of trust that recognizes the inherent vulnerability of the patient even as the patient is an active participant in their own care. The physician owes a duty of loyalty to protect and further the patient’s best interests and goals of care by using the physician’s expertise, knowledge, and prudent clinical judgment.

In the context of the patient–physician relationship:

1. Accept the patient without discrimination (such as on the basis of age, disability, gender identity or expression, genetic characteristics, language, marital and family status, medical condition, national or ethnic origin, political affiliation, race, religion, sex, sexual orientation, or socioeconomic status). This does not abrogate the right of the physician to refuse to accept a patient for legitimate reasons.

2. Having accepted professional responsibility for the patient, continue to provide services until these services are no longer required or wanted, or until another suitable physician has assumed responsibility for the patient, or until after the patient has been given reasonable notice that you intend to terminate the relationship.

3. Act according to your conscience and respect differences of conscience among your colleagues; however, meet your duty of non-abandonment to the patient by always acknowledging and responding to the patient’s medical concerns and requests whatever your moral commitments may be.

4. Inform the patient when your moral commitments may influence your recommendation concerning provision of, or practice of any medical procedure or intervention as it pertains to the patient’s needs or requests.

5. Communicate information accurately and honestly with the patient in a manner that the patient understands and can apply, and confirm the patient’s understanding.

6. Recommend evidence-informed treatment options; recognize that inappropriate use or overuse of treatments or resources can lead to ineffective, and at times harmful, patient care and seek to avoid or mitigate this.

7. Limit treatment of yourself, your immediate family, or anyone with whom you have a similarly close relationship to minor or emergency interventions and only when another physician is not readily available; there should be no fee for such treatment.

8. Provide whatever appropriate assistance you can to any person who needs emergency medical care.

9. Ensure that any research to which you contribute is evaluated both scientifically and ethically and is approved by a research ethics board that adheres to current standards of practice. When involved in research, obtain the informed consent of the research participant and advise prospective participants that they have the right to decline to participate or withdraw from the study at any time, without negatively affecting their ongoing care.

10. Never participate in or condone the practice of torture or any form of cruel, inhuman, or degrading procedure.
**Decision-making**

Medical decision-making is ideally a deliberative process that engages the patient in shared decision-making and is informed by the patient’s experience and values and the physician’s clinical judgment. This deliberation involves discussion with the patient and, with consent, others central to the patient’s care (families, caregivers, other health professionals) to support patient-centred care.

In the process of shared decision-making:

11. Empower the patient to make informed decisions regarding their health by communicating with and helping the patient (or, where appropriate, their substitute decision-maker) navigate reasonable therapeutic options to determine the best course of action consistent with their goals of care; communicate with and help the patient assess material risks and benefits before consenting to any treatment or intervention.

12. Respect the decisions of the competent patient to accept or reject any recommended assessment, treatment, or plan of care.

13. Recognize the need to balance the developing competency of minors and the role of families and caregivers in medical decision-making for minors, while respecting a mature minor’s right to consent to treatment and manage their personal health information.

14. Accommodate a patient with cognitive impairments to participate, as much as possible, in decisions that affect them; in such cases, acknowledge and support the positive roles of families and caregivers in medical decision-making and collaborate with them, where authorized by the patient’s substitute decision-maker, in discerning and making decisions about the patient’s goals of care and best interests.

15. Respect the values and intentions of a patient deemed incompetent as they were expressed previously through advance care planning discussions when competent, or via a substitute decision-maker.

16. When the specific intentions of an incompetent patient are unknown and in the absence of a formal mechanism for making treatment decisions, act consistently with the patient’s discernable values and goals of care or, if these are unknown, act in the patient’s best interests.

17. Respect the patient's reasonable request for a second opinion from a recognized medical expert.

**Physicians and the practice of medicine**

**Patient privacy and the duty of confidentiality**

18. Fulfill your duty of confidentiality to the patient by keeping identifiable patient information confidential; collecting, using, and disclosing only as much health information as necessary to benefit the patient; and sharing information only to benefit the patient and within the patient’s circle of care. Exceptions include situations where the informed consent of the patient has been obtained for disclosure or as provided for by law.

19. Provide the patient or a third party with a copy of their medical record upon the patient’s request, unless there is a compelling reason to believe that information contained in the record will result in substantial harm to the patient or others.

20. Recognize and manage privacy requirements within training and practice environments and quality improvement initiatives, in the context of secondary uses of data for health system management, and when using new technologies in clinical settings.

21. Avoid health care discussions, including in personal, public, or virtual conversations, that could reasonably be seen as revealing confidential or identifying information or as being disrespectful to patients, their families, or caregivers.
Managing and minimizing conflicts of interest

22. Recognize that conflicts of interest may arise as a result of competing roles (such as financial, clinical, research, organizational, administrative, or leadership).

23. Enter into associations, contracts, and agreements that maintain your professional integrity, consistent with evidence-informed decision-making, and safeguard the interests of the patient or public.

24. Avoid, minimize, or manage and always disclose conflicts of interest that arise, or are perceived to arise, as a result of any professional relationships or transactions in practice, education, and research; avoid using your role as a physician to promote services (except your own) or products to the patient or public for commercial gain outside of your treatment role.

25. Take reasonable steps to ensure that the patient understands the nature and extent of your responsibility to a third party when acting on behalf of a third party.

26. Discuss professional fees for non-insured services with the patient and consider their ability to pay in determining fees.

27. When conducting research, inform potential research participants about anything that may give rise to a conflict of interest, especially the source of funding and any compensation or benefits.

Physicians and self

28. Be aware of and promote health and wellness services, and other resources, available to you and colleagues in need.

29. Seek help from colleagues and appropriate medical care from qualified professionals for personal and professional problems that might adversely affect your health and your services to patients.

30. Cultivate training and practice environments that provide physical and psychological safety and encourage help-seeking behaviours.

Physicians and colleagues

31. Treat your colleagues with dignity and as persons worthy of respect. Colleagues include all learners, health care partners, and members of the health care team.

32. Engage in respectful communications in all media.

33. Take responsibility for promoting civility, and confronting incivility, within and beyond the profession. Avoid impugning the reputation of colleagues for personal motives; however, report to the appropriate authority any unprofessional conduct by colleagues.

34. Assume responsibility for your personal actions and behaviours and espouse behaviours that contribute to a positive training and practice culture.

35. Promote and enable formal and informal mentorship and leadership opportunities across all levels of training, practice, and health system delivery.

36. Support interdisciplinary team-based practices; foster team collaboration and a shared accountability for patient care.
Physicians and society

37. Commit to ensuring the quality of medical services offered to patients and society through the establishment and maintenance of professional standards.

38. Recognize that social determinants of health, the environment, and other fundamental considerations that extend beyond medical practice and health systems are important factors that affect the health of the patient and of populations.

39. Support the profession’s responsibility to act in matters relating to public and population health, health education, environmental determinants of health, legislation affecting public and population health, and judicial testimony.

40. Support the profession’s responsibility to promote equitable access to health care resources and to promote resource stewardship.

41. Provide opinions consistent with the current and widely accepted views of the profession when interpreting scientific knowledge to the public; clearly indicate when you present an opinion that is contrary to the accepted views of the profession.

42. Contribute, where appropriate, to the development of a more cohesive and integrated health system through interprofessional collaboration and, when possible, collaborative models of care.

43. Commit to collaborative and respectful relationships with Indigenous patients and communities through efforts to understand and implement the recommendations relevant to health care made in the report of the Truth and Reconciliation Commission of Canada.

44. Contribute, individually and in collaboration with others, to improving health care services and delivery to address systemic issues that affect the health of the patient and of populations, with particular attention to disadvantaged, vulnerable, or underserved communities.
Complementary and Alternative Medicine

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(1) In this standard, Complementary and Alternative Medicine (hereafter referred to as “CAM”) means a group of diverse medical and healthcare systems, practices, and products that are not presently considered to be part of conventional medicine.

(a) While some scientific evidence exists regarding some CAM therapies, for most there are key questions that are yet to be answered through well-designed scientific studies. These questions include whether these therapies are safe and whether they are effective for the diseases or medical conditions for which they are used.

(b) The list of what is considered to be CAM changes continually, as those therapies that are proven to be safe and effective become adopted into conventional healthcare and as new approaches to healthcare emerge.

(2) A regulated member must not provide a CAM therapy to a patient until the regulated member has been approved by the Registrar to provide such therapy.

(3) Application for approval to provide CAM therapy must provide information about the therapy and the regulated member’s training and experience with the therapy, acceptable to the Registrar.

(4) Where it is uncertain whether the use of nutritional supplements, vitamins, pharmaceuticals or natural health products approved by Health Canada, or physical therapies are CAM therapies, those which are supported by scientific studies published in orthodox medical literature do not require application for approval from the Registrar.

(5) Notwithstanding clause (2), a regulated member who does not hold approval to administer a CAM therapy may provide the CAM therapy without approval from the Registrar to a patient who suffers from a fatal, incurable disease provided that the steps set out in subsection (6) are followed.

(6) A regulated member who provides a CAM therapy to a patient must ensure that the following steps have been fulfilled:

(a) an orthodox medical evaluation of the patient, which must include the taking of an appropriate history, conducting an appropriate physical examination and conducting the

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appropriate diagnostic tests or investigations, as are relevant to the patient’s complaint, presenting condition and history,

(b) an orthodox medical diagnosis has been established,

(c) orthodox medical treatment options have been discussed with the patient,

(d) the unproven status, the safety and the potential toxicity of the CAM therapy have been discussed with the patient,

(e) the regulated member’s professional experience with the use of the CAM therapy and conventional therapy has been declared to the patient; and

(f) the number of treatments, time frame and costs to the patient for the CAM therapy are discussed with the patient.

(7) A regulated member **must** keep a patient record that documents completion of the steps in clause (6).

(8) A regulated member conducting clinical research into the use of a CAM therapy **must** have approval for the research from an approved ethics review board.

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Conflicts of Interest

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(1) A regulated member **must** resolve any real, potential or perceived conflicts of interest\(^1\) in the best interest of the patient.

(2) A regulated member **must** make full, frank and timely disclosure of any conflict of interest, and comply with clause (1) regardless of whether the regulated member has obtained consent to remain in the conflict of interest.

(3) A regulated member **must not**:

(a) seek or accept any benefit for a referral, service or product provided by another regulated professional to a patient, other than for services provided by a partner, associate, employee or locum of the regulated member;

(b) offer an inducement to another regulated professional conditional on providing a referral, service or product to a patient, whether or not such referral, service or product is medically appropriate; or

(c) encourage another person to offer or accept an inducement conditional on providing a referral, service or product to a patient, whether or not such referral, service or product is medically appropriate.

(4) A regulated member **must not** refer a patient to any facility or healthcare business separate and apart from the regulated member’s medical practice in which the regulated member has a direct or indirect financial interest unless the regulated member has the prior approval of the Registrar, and is able to substantiate compliance with the following on request:

(a) any interest or benefit the regulated member receives is directly attributable to the regulated member’s proportionate financial contribution or effort provided to that facility;

(b) there are no terms or conditions that relate any benefit to the regulated member to past or expected volume of patient referrals or other business from the regulated member to the facility; and

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\(^1\) A conflict of interest may arise where a reasonable person could believe that a regulated member’s duty to act in the patient’s best interests may be affected or influenced by other competing interests, including financial, non-financial, direct, or indirect transactions with patients or others.

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(c) there are no terms or conditions that require the regulated member to make referrals to the facility or otherwise generate business for the facility.

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Conscientious Objection

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(1) A regulated member must communicate promptly and respectfully about any treatments or procedures the regulated member declines to provide based on his/her Charter freedom of conscience and religion¹.

(2) A regulated member must not withhold information about the existence of a procedure or treatment because providing that procedure or giving advice about it conflicts with his/her Charter freedom of conscience and religion.

(3) A regulated member must not promote his/her own moral or religious beliefs when interacting with patients.

(4) When Charter freedom of conscience and religion prevent a regulated member from providing or offering access to information about a legally available medical or surgical treatment or service, the regulated member must ensure that the patient who seeks such advice or medical care is offered timely access to:

(a) a regulated member who is willing to provide the medical treatment, service or information; or

(b) a resource that will provide accurate information about all available medical options.


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Continuity of Care

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(1) A regulated member whose practice includes established physician-patient relationships must:

(a) have a system in place to:

   (i) review test results and consultation reports in a timely manner;

   (ii) arrange any necessary follow-up care;

   (iii) notify a patient of any necessary follow-up care; and

   (iv) document all contacts with a patient, including failed attempts to notify a patient about follow-up care;

(b) directly provide or arrange for continuous after-hours care to be provided through an appropriate healthcare provider(s) and/or service with capacity to assess and triage care needs;

(c) ensure handover of relevant patient information to the after-hours healthcare provider(s) or service when a patient's need for after-hours care is reasonably foreseeable;

(d) inform patients how to access the after-hours care;

(e) if using a recorded message to direct patients to a healthcare provider or service such as but not limited to Health Link, an emergency service or after-hours medical clinic, have evidence of an agreement with the identified healthcare provider or service; and

(f) notwithstanding clause (1)(e), immediately refer a patient with an emergent or life-threatening condition to an appropriate emergency service if unable to render care.

1 In an established physician-patient relationship, both the regulated member and patient have a reasonable expectation the care provided will extend beyond a single encounter. These relationships include, but are not limited to:

   (a) longitudinal relationships, based on the identification of a regular attending physician or clinic; and

   (b) sessional relationships for a defined period of time, based on a presenting concern(s), referred consultation or identified medical condition.

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(2) A regulated member **must** have arrangements in place for receiving and responding to critical diagnostic test results reported by a laboratory or imaging facility after regular working hours or in the regulated member’s absence, which include:

(a) clearly identifying on the test requisition documents and informing the patient when the results are expected to fall in the critical range; and

(b) ensuring the laboratory or imaging facility is able to reach a regulated member or a regulated member’s designate, either by:

   (i) participating in a call rota available to the laboratory or imaging facility that identifies who to contact in the regulated member’s absence and their direct contact information; or

   (ii) providing direct contact information to the laboratory or imaging facility for the regulated member or the regulated member’s designate.

(3) A regulated member whose practice includes established relationships with patients who is going to be unavailable for an extended period(s) of time **must**:

(a) enter into an agreement with an appropriate healthcare provider(s) and/or service to provide ongoing care during periods of unavailability and ensure handover at the start and conclusion of the coverage, including management of:

   (i) outstanding tests and test results;

   (ii) outstanding referrals and consultation reports; and

   (iii) any follow-up care required as a result of the above;

(b) provide proof of this agreement to the College on request; and

(c) inform a patient of ongoing care arrangements where a patient would have a reasonable expectation of being informed.
Disclosure of Harm

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(1) When a patient suffers harm, with harm being defined as an outcome that negatively affects the patient’s health and/or quality of life, the responsible regulated member must ensure that the patient receives disclosure of that information.

(a) If the regulated member is the only healthcare professional treating the patient, then it is the regulated member’s responsibility to disclose that information to the patient.

(b) In a team setting, the regulated member must cooperate with other members of the team (in the hospital setting this will also include the administration) to identify the most suitable person(s) to disclose that information to the patient.

(c) In all settings, disclosure of harm is to be considered part of a process that will also address the patient’s immediate and future medical needs, the investigation (if required) of the circumstances that led to the patient suffering harm, and necessary steps to prevent recurrence of the harm if an untoward and avoidable event occurred.

(2) Disclosure must occur whether the harm is a result of progression of disease, a complication of care or an adverse event and whether the harm was preventable.

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- “May” means that the physician may exercise reasonable discretion.
- “Patient” includes, where applicable, the patient’s legal guardian or substitute decision maker.
Dispensing of Schedule 1 & 2 Drugs by a Regulated Member for a Fee

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(1) A regulated member may only dispense Schedule 1 or 2 drugs as defined by the Pharmacy and Drug Act to a patient when those drugs are relevant to the medical consultation or surgical procedure provided to that patient.

(2) A regulated member may charge a fee for dispensing a drug as defined in clause (1); however, a regulated member:

(a) must limit fees to the cost of the drugs to the regulated member;

(b) may include reasonable handling costs such as shipping, containers and containment systems, refrigeration and inventory maintenance costs associated with replacement of expired drugs; and

(c) must maintain a detailed description of the calculation of fees for inspection by the College.

(3) A regulated member must not charge a fee for dispensing a drug or for maintaining required documentation in respect of the inventory control or dispensing of drugs.

(4) A regulated member must not compound drugs unless specifically approved by the College.

(5) A regulated member must personally discuss instructions for use of the drug with the patient.

(6) Any drug dispensed to a patient for a fee must have a label affixed to the drug container or packaging that is legible and identifies the following:

(a) the name, address and telephone number of the clinic from which the drug is dispensed;

(b) the name of the patient;

(c) the name of the prescriber;

(d) the name of all active ingredients, the strength and the manufacturer;

(e) instructions for use;

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(f) the date the drug was dispensed;

(g) the quantity dispensed; and

(h) the expiry date, when appropriate.

(7) Any drug dispensed to a patient for a fee must be dispensed in child-proof containers except where inappropriate for a particular patient.

(8) Each time a drug is dispensed for a fee, the transaction must be recorded in the clinical record or in a separate log that identifies the following:

(a) the name of the patient for whom the drug was dispensed;

(b) the name of the prescriber;

(c) the date the drug was dispensed;

(d) the name, strength and dosage form of the drug dispensed; and

(e) the quantity of the drug dispensed.

(9) Drugs received by the regulated member for dispensing for a fee to a patient must be visually inspected to ensure there has been no damage or contamination.

(10) Drugs in a regulated member’s office must be stored to ensure security and integrity.

(11) Drugs in a regulated member’s office must be stored at appropriate temperatures to ensure stability.

(12) Narcotic and controlled drugs in a regulated member’s office must be stored in accordance with federal regulations.

(13) A regulated member who dispenses a drug must have established policy and procedures for the safe and proper disposal of drugs that are unfit to be dispensed, including outdated or damaged products.

(14) A regulated member must not accept the return of any dispensed drug for the purpose of reuse.

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Standard of Practice

Duty of Treating Physicians and Physicians Working in the Context of a Physician Health Program to Report a Physician to the College

Issued by Council: January 9, 2014

Duty of Treating Physicians and Physicians Working in the Context of a Physician Health Program to Report a Physician to the College

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(1) A physician acting as the treating physician of a physician-patient, or a physician who is a non-treating physician working within a provincial health program, must report a physician to the College when the physician-patient suffers from any medical condition where it is reasonably foreseeable\(^1\) that patients of the physician-patient or others within the context of his/her medical practice\(^2\), could be seriously harmed\(^3\) (whether physically or psychologically) as a result of the medical condition.

(2) The treating physician must make all reasonable efforts to understand the nature and scope of the physician-patient’s practice and seek information, with the consent of the physician-patient, about the impact of the medical condition on the practice.

(3) If the treating physician is unable to ascertain that their own threshold to report has been met, the treating physician must consult with the College to discuss the circumstances. It is not necessary to provide names.

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\(^1\) Reasonably foreseeable: The determination of what is reasonably foreseeable is based on what a reasonable physician would do given the same set of circumstances and requires a judgment call on the part of the physician. The following factors should be considered:

\(a\) whether the physician’s condition is being appropriately managed and harm would only be anticipated if such management was not maintained.

\(b\) whether there is sufficient information available to make a judgment about the physician-patient’s management of their health condition.

\(c\) whether there is sufficient information to suggest that appropriate management will only occur with monitoring or oversight mechanisms in place.

\(d\) whether the harm anticipated, if it materializes, would be irreversible; and/or whether the harm anticipated, if it materializes, would cause more than minimal pain (physical or psychological) or other injury.

\(^2\) The practice of medicine includes not only patient care but all activities, such as working with other health care workers, teaching, research and administrative work done in the context of medical practice.

\(^3\) Serious harm is defined as that which is either irreversible or would result in more than minor pain or injury (whether psychological or physical).

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- “May” means that the physician may exercise reasonable discretion.
- “Patient” includes, where applicable, the patient’s legal guardian or substitute decision maker.
The physician-patient **must** be advised of their duty to self-report and must be supported in their reporting to the College.

The treating physician **must** advise the physician-patient of their intent to report to the College.

**Terms used in the Standards of Practice:**
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Terms used in the Standards of Practice:

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Standard of Practice
Duty to Report a Colleague

Under Review: No
Issued by Council: January 1, 2010
Reissued by Council: September 1, 2012

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Duty to Report a Colleague

(1) A regulated member must report another regulated member to the College when the first regulated member believes, on reasonable grounds, that the conduct of the other regulated member places patients at risk or is considered unprofessional conduct under the Health Professions Act.

(2) Knowledge of conduct that should be reported in clause (1) includes but is not limited to situations in which a regulated member:

(a) makes sexual advances to or enters into a sexual relationship with a patient;

(b) suffers from a physical, cognitive, mental or emotional condition\(^1\) that is negatively impacting the work\(^2\) or is reasonably likely to negatively impact the work of the regulated member;

(c) repeatedly or consistently fails to address his or her behaviour that interferes with the delivery of care to patients, the ability of other regulated member, learners or healthcare workers to provide care to patients; or

(d) is not competent in the care of patients.

(3) When a patient discloses information leading a regulated member to believe on reasonable grounds that another regulated member has committed a sexual boundary violation with the patient, the first regulated member must:

(a) provide the patient with information about how to file a complaint with the College;

(b) offer to file a third person complaint with the patient’s permission, if the patient does not wish to file a complaint personally; or

(c) at a minimum, document the sexual boundary violation indicating that the patient does not wish to report to the College when the patient does not give permission to proceed with a third party complaint; however, the name of the regulated member may be reported to the College without providing the name of the patient.

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1 As in the definition in Self-Reporting to the College.
2 As in the definition in Self-Reporting to the College.
(4) The regulated member -patient **must** be advised of their duty to self-report and must be supported in their reporting to the College.

(5) The treating regulated member **must** advise the regulated member -patient of their intent to report to the College.

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Episodic Care

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(1) A regulated member providing episodic care\(^1\) must:

(a) inform the patient that the regulated member will not provide ongoing care beyond addressing the patient’s presenting concern(s), referred consultation, or identified medical condition(s);

(b) establish whether the patient has a primary care provider and, if so, provide the primary care provider with a record of the encounter, including all information discussed in clause (2);

(c) obtain and document the patient’s presenting concern(s) and/or medical condition(s);

(d) collect and document the patient’s relevant medical history, drug reactions, current medication(s) and pertinent current health problems;

(e) observe, examine and identify relevant positive and negative findings;

(f) establish a reasonable differential diagnosis; and

(g) either provide necessary follow-up care personally or ensure that arrangements are in place for follow-up care.

(2) A regulated member must discuss with the patient:

(a) tests requested;

(b) diagnoses reached;

(c) treatment and advice given;

(d) procedures recommended and performed;

(e) referrals and reports made; and

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\(^1\) Episodic care refers to a single encounter with a patient focused on a presenting concern(s), identified medical condition(s) or referred consultation, where neither the regulated member nor patient have the expectation of an ongoing care relationship.

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(f) follow-up care arranged and/or advised.

(3) A regulated member who has provided episodic care must document the encounter in accordance with the Patient Record Retention standard of practice.

(4) A regulated member who requests a diagnostic test(s), performs a procedure or provides a treatment that requires follow-up, or makes a referral to another healthcare provider must:

(a) have a system in place to:

(i) review and respond to any diagnostic test results and/or consultation reports arising from this encounter;

(ii) review and respond promptly to critical test results reported by a laboratory or imaging facility, including after regular working hours or in the regulated member’s absence;

(iii) arrange any necessary follow-up care either personally or through referral to another healthcare provider; and

(iv) notify the patient of any necessary follow-up care; and

(b) track all contacts and attempted contacts with the patient.

(5) A regulated member who requests a diagnostic test and directs a copy of the result to another regulated member remains responsible for any necessary follow-up care unless the regulated member to whom the copy is directed has formally agreed to accept responsibility for follow-up care arising from the test results.

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Establishing the Physician-Patient Relationship

(1) An established physician-patient relationship\(^1\) is formed when a regulated member initiates care that would be reasonably expected to extend beyond a single encounter.

(2) A regulated member must:

(a) provide care to the best of his or her ability to a patient in an urgent medical situation where no other regulated member is providing care, regardless of whether a physician-patient relationship has been established;

(b) inform potential patients of any conditions or restrictions on the regulated member’s practice permit and/or patient selection criteria established by the regulated member under clause (5); and

(c) accept patients on a “first come, first served basis” within any such selection criteria.

(3) A regulated member who offers introductory appointments must:

(a) advise patients in advance when an introductory appointment is not a medical appointment;

(b) not bill or charge for such an appointment;

(c) comply with all relevant privacy legislation and the Patient Record Retention standard of practice with respect to retaining, disclosing and disposing of information collected during an introductory appointment; and

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\(^1\) In an established physician-patient relationship, both the regulated member and patient have a reasonable expectation the care provided will extend beyond a single encounter. These relationships include but are not limited to:

(a) longitudinal relationships, based on the identification of a regular attending physician or clinic; and

(b) sessional relationships for a defined period of time, based on a presenting concern(s), referred consultation or identified medical condition.

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(d) when deciding not to establish a physician-patient relationship, disclose the reason(s) to the patient unless disclosure of the reasons could reasonably be expected to:

(i) result in immediate and grave harm to the patient’s mental or physical health or safety;
(ii) threaten the mental health, physical health or safety of another individual; or
(iii) pose a threat to public safety.

4. A regulated member must not refuse to establish a physician-patient relationship based on:

(a) any prohibited ground of discrimination including, but not limited to age, gender, marital status, medical complexity, national or ethnic origin, physical or mental disability, political affiliation, race, religion, sexual orientation, or socioeconomic status;

(b) the patient choosing not to pay a block fee or purchase uninsured services;

(c) the patient’s care requiring more time than another patient with fewer medical needs; or

(d) the circumstances of the patient’s injury or medical condition that may require the regulated member to prepare and provide additional documentation or reports.

5. A regulated member may establish patient selection criteria if such criteria are:

(a) not in contravention of clause (4) unless based on matters relevant to the regulated member’s scope of medical practice; and

(b) available to the College on request.

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Human Health Research

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(1) This standard applies to any regulated member involved in human health research as identified through a current and recognized screening tool. As of this date, the recommended tool is the ARECCI (A pRoject Ethics Community Consensus Initiative).

(2) A regulated member who intends to conduct human health research must comply with the Health Information Act including to submit a proposal for review by a research ethics board in the Province of Alberta. Such boards include:

   (a) Health Research Ethics Board of Alberta (HREBA)
   (b) Conjoint Health Research Ethics Board (CHREB), University of Calgary
   (c) Health Research Ethics Board (HREB), University of Alberta

(3) A regulated member must have approval from a research ethics board before commencing human health research.

(4) A regulated member participating in human health research must:

   (a) ensure the welfare of any patient involved in the research study is the primary concern throughout the duration of the study;
   (b) disclose to patients that the study has been reviewed by an ethics board and relevant conditions imposed;
   (c) comply with the requirements of the research ethics board as it relates to initial and ongoing review of the research study; and
   (d) disclose any potential or actual conflicts of interest to the research ethics board.

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Informed Consent

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(1) A regulated member must obtain a patient’s informed consent1 prior to an examination, assessment, treatment or procedure; such consent may be implied, expressed orally or in writing as appropriate.

(2) If a patient is under the age of 18 years, a regulated member must:

(a) determine whether the patient is a mature minor with the capacity to give informed consent1; and

(b) if the patient is not a mature minor, seek informed consent from the patient’s legal guardian, in accordance with legislation1.

(3) If an adult patient lacks capacity to give informed consent, a regulated member must seek informed consent from the patient’s legal guardian or substitute decision maker, in accordance with legislation1.

(4) A regulated member who has reasonable grounds to believe an informed consent decision by a legal guardian or substitute decision maker is not in the best interests of the patient must seek legal advice, such as from the Canadian Medical Protective Association, or advice from the College.

(5) A regulated member obtaining informed consent from a patient, or the patient’s legal guardian or substitute decision maker must ensure the decision maker:

(a) is aware of his/her right to withdraw consent at any time;

(b) is free of undue influence, duress or coercion in making the consent decision;

(c) receives a proper explanation that includes but is not limited to:

(i) diagnosis reached;

(ii) advised interventions and treatments;

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1 See the College’s Advice to the Profession: Informed Consent for Adults and Informed Consent for Minors.

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(iii) exact nature and anticipated benefits of the proposed examination, assessment, treatment or procedure;

(iv) common risks and significant risks;

(v) reasonable alternative treatments available, and the associated common risks and significant risks; and

(vi) natural history of the condition and the consequences of forgoing treatment;

(d) demonstrates a reasonable understanding of the information provided and the reasonably foreseeable consequences of both a decision and a failure to make a decision.

(6) A regulated member who assesses the capacity of a patient to give informed consent must:

(a) use accepted capacity assessment processes;

(b) to the extent possible, conduct the capacity assessment at a time and under circumstances in which the patient is likely to be able to demonstrate full capacity; and

(c) inform the patient of the nature and consequences of the capacity assessment.

(7) A regulated member obtaining informed consent for a patient to participate in health research must comply with the College’s Human Health Research standard of practice.

(8) A regulated member may delegate responsibility for obtaining informed consent to another healthcare professional only when confident the delegate has the appropriate knowledge, skill and judgment to meet the expectations of this standard.
Job Action

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(1) A regulated member must not withdraw services with the direct or indirect purpose of supporting job action if such action could put the immediate health of patients at significant risk.

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- "May" means that the physician may exercise reasonable discretion.
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Medical Assistance in Dying

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(1) A regulated member who receives, considers or fulfils a written request for medical assistance in dying must do so in accordance with legislation.

(2) A regulated member who provides medical assistance in dying must:

(a) discuss and agree on a plan with the patient that considers:

   (i) the patient’s wishes regarding when, where and how the medical assistance in dying will be provided, including the presence of the regulated member and any additional support;

   (ii) an alternate plan to address potential complications; and

   (iii) the patient’s choice to rescind the request at any time, including immediately before the provision of medical assistance in dying;

(b) collaborate with the pharmacist dispensing the medication(s); and

(c) after the patient’s death, notify the Office of the Chief Medical Examiner.

(3) A regulated member who receives an inquiry from a patient with respect to medical assistance in dying must ensure that contact information for the Alberta Health Services medical assistance in dying care coordination service is provided to the patient, or to another person identified by the patient, without delay.

(4) A regulated member who receives an oral or written request from a patient for medical assistance in dying and who declines for reasons of conscience or religion to provide or to aid in providing medical assistance in dying must ensure that reasonable access to the Alberta Health Services medical assistance in dying care coordination service is provided to the patient without delay.

(5) A regulated member may prescribe a drug for use in medical assistance in dying only if the drug has been recommended for the use by the Alberta Health Services medical assistance in dying care coordination service.

\[\text{Office of the Chief Medical Examiner}^1\]

\[\text{The regulated member will not sign the death certificate. The Chief Medical Examiner will determine the cause and manner of death.}\]

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- "May" means that the physician may exercise reasonable discretion.
- "Patient" includes, where applicable, the patient’s legal guardian or substitute decision maker.
(6) A regulated member who provides medical assistance in dying must keep records in the form and manner required by the Minister confirming that the requirements of these standards, and any other standards or legislation applicable to medical assistance in dying, were met.

(7) A regulated member who provides medical assistance in dying must, without delay, provide a member of the Medical Assistance in Dying Regulatory Review Committee designated by the Committee with copies of the records referred to in clause (6).

(8) In these standards, "medical assistance in dying" means

(a) the administering by a regulated member of a substance to a person, at their request that causes their death; or

(b) the prescribing or providing by a regulated member of a substance to a person, at their request, so that they may self-administer the substance and in doing so cause their own death.

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- "Must" refers to a mandatory requirement.
- "May" means that the physician may exercise reasonable discretion.
- "Patient" includes, where applicable, the patient's legal guardian or substitute decision maker.
Medical Services Requiring Accreditation Outside of Hospitals

(1) Outside of hospitals, a regulated member must be approved by the College in order to perform or supervise a diagnostic or treatment procedure that is restricted to facilities accredited by the College.

(2) A list of restricted procedures is maintained in College bylaws.

(3) A regulated member who performs acupuncture on patients must provide satisfactory evidence of training and be approved by the Registrar.

(4) A regulated member who performs hair transplantation must provide evidence of training and compliance with infection prevention and control standards and be approved by the Registrar.

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Non-Treating Medical Examinations

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This Standard of Practice is intended to be in addition to the requirements or obligations on a regulated member agreeing to undertake a NTME under the Minor Injury Regulation or a NTME under Rules 5.41 to 5.44 of the Alberta Rules of Court. The physician is also expected to act in accordance with the provisions of the Minor Injury Regulation and Rules 5.41 to 5.44.

(1) When accepting a request to perform a Non-Treating Medical Examination (hereafter referred to as “NTME”), a regulated member must:

(a) treat the person under the same ethical obligations as would apply to any patient;

(b) provide an objective and scientifically sound report; and

(c) be aware of the terms of authority for the examination set out in contract, statute or Rules of Court, whichever applies.

(2) When agreeing to undertake a NTME, a regulated member must disclose to all parties:

(a) his or her involvement at any time in the medical care of the person undergoing the examination; and

(b) any relationship with the third party outside of a fee for service arrangement.

(3) In advance of the examination, a regulated member must discuss the fee for the NTME with the party requesting the examination.

(4) The regulated member undertaking the NTME must obtain informed consent from the person for the examination, diagnostic interventions and release of the regulated member’s report.

(5) Notwithstanding clause (4), the regulated member is not legally required to obtain consent if a person has been ordered by a court order or statutory direction to undergo a NTME; however, the regulated member is also not required to:

(a) enforce the terms of a court order or statutory direction; or

(b) proceed with an NTME if the person refuses to cooperate with the regulated member undertaking the NTME.

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- The College regulates physicians, surgeons and osteopaths.
- “Must” refers to a mandatory requirement.
- “May” means that the physician may exercise reasonable discretion.
- “Patient” includes, where applicable, the patient’s legal guardian or substitute decision maker.
(6) A regulated member **must not** establish a therapeutic relationship with the person being examined unless:

(a) there is no other regulated member readily available to provide those services; and

(b) then only after concluding the process with the third party.

(7) If a patient requires urgent intervention, the regulated member **must** make arrangements for follow-up care through another regulated member who can treat the patient. If no other regulated member is available or there is no known treating regulated member, the regulated member **must**:

(a) promptly advise the patient of the particulars of the medical issue that requires urgent attention; and

(b) provide necessary care if the situation is emergent or urgent and no alternative is available.

(8) The regulated member **must** retain the following records obtained or created for the NTME for a period of ten (10) years or longer if required by statute:

(a) the final report and any interim reports issued to the third party;

(b) informed consent document;

(c) contract (if it exists in written form) outlining scope, purpose, timeliness, and fee arrangements;

(d) notes of history;

(e) notes of physical examination;

(f) audio and video recordings if made by the regulated member;

(g) a list of sources of ancillary information, including medical reports, records, and any audio or visual information recorded by another person; and

(h) the name of any person who attended with the person being examined.

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Patient Record Content

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(1) A regulated member who provides assessment, advice and/or treatment to a patient must:

(a) document the encounter in a patient record (paper or electronic);

(b) ensure the patient record is:

(i) an accurate and complete reflection of the patient encounter to facilitate continuity in patient care;

(ii) legible and in English;

(iii) compliant with relevant legislation and institutional expectations; and

(iv) completed as soon as reasonable to promote accuracy.

(2) A regulated member must ensure the patient record contains:

(a) clinical notes for each patient encounter including:

(i) presenting concern, relevant findings, assessment and plan, including follow-up when indicated;

(ii) prescriptions issued, including drug name, dose, quantity prescribed, directions for use and refills issued;

(iii) tests, referrals and consultations requisitioned, including those accepted and declined by the patient; and

(iv) interactions with other databases such as the Alberta Electronic Health Record (Netcare).

(b) Information pertaining to the consent process;

(c) a cumulative patient profile (CPP) contextual to the physician-patient relationship (the longer and more complex the relationship the more extensive should be the record) detailing:

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(i) patient identification (i.e., name, address, phone number, personal health number, contact person in case of emergencies);

(ii) current medications and treatments, including complementary and alternative therapies;

(iii) allergies and drug reactions;

(iv) ongoing health conditions and identified risk factors;

(v) medical history, including family medical history;

(vi) social history (e.g., occupation, life events, habits);

(vii) health maintenance plans (immunizations, disease surveillance, screening tests); and

(viii) date the CPP was last updated;

d) laboratory, imaging, pathology and consultation reports;

e) operative records, procedural records and discharge summaries;

f) any communication with the patient concerning the patient’s medical care, including unplanned face-to-face contacts;

g) a six-year history of patient billing encounter data as required by Alberta Health (identifying type of service, date of service and fee(s) charged); and

h) a record of missed and/or cancelled appointments.

(3) Notwithstanding clause (2) a regulated member may indicate that the required documents are available in Netcare or other database that can be reliably accessed for the length of time the record must be maintained.

(4) A regulated member may amend or correct a patient record in accordance with the Health Information Act (HIA) through an initialed and dated addendum or tracked change including the following circumstances:

(a) the correction or amendment is routine in nature, such as a change in name or contact information;

(b) to ensure the accuracy of the information documented; or

(c) at the request of a patient identifying incomplete or inaccurate information.

(5) Notwithstanding (4c), a regulated member may refuse to make a requested correction or amendment to a patient record in accordance with Health Information Act.

(6) A regulated member may append additional information to a patient record in accordance with the HIA.

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Patient Record Retention

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(1) A regulated member must ensure a patient record:

(a) is compliant with relevant legislation;

(b) is stored in a manner that protects patient confidentiality through administrative, technical and physical safeguards;

(c) is under the custody and control of a custodian as defined in the Health Information Act (HIA);

(d) is retrievable and available for authorized sharing within a reasonable time period to facilitate continuity of patient care; and

(e) facilitates the:

(i) collection of data for quality improvement activities; and

(ii) sharing of standardized data sets to the Alberta Electronic Health Record (Netcare) or equivalent.

(2) A regulated member acting as a custodian must have policies and procedures in place in accordance with the HIA that:

(a) includes an information manager agreement, if an information manager has been identified;

(b) establishes processes for the retention, protection, access, disclosure and secure destruction of patient health information; and

(c) clarifies roles, expectations and accountabilities of all parties.

(3) A regulated member acting as a custodian who shares patient information with other custodian(s) must have an information sharing agreement that clarifies access, transfer and return of patient records.

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1 Refers to either a paper-based or electronic record.

2 Regulated members are designated custodians under the Health Information Regulation.

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(4) A regulated member acting as a custodian must designate a successor custodian\(^3\) to ensure the retention and accessibility of patient records in the event the regulated member is unable to continue as custodian.

(5) A regulated member must complete a privacy impact assessment\(^4\) prior to changing or implementing any administrative practice or information system relating to the collection, use and disclosure of individually identifiable patient health information.

(6) A regulated member must ensure patient records are retained and accessible for a minimum of:

(a) ten (10) years from the date of last record entry for an adult patient; and

(b) ten (10) years after the date of last record entry for a minor patient, or two years after the patient reaches or would have reached the age of eighteen (18), whichever is longer.

(7) At the request of a patient, a regulated member must provide the patient with timely access to the patient’s record in accordance with the HIA.

(8) A regulated member may charge a fee in accordance with the HIA for providing a patient with a copy of the patient’s record.

(9) A regulated member must not charge a fee for providing another healthcare provider with limited patient information.

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\(^3\) Reference: *Health Information Act*, Section 35(1)(q)

\(^4\) Reference: *Health Information Act*, Section 64

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Prescribing: Administration

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(1) A regulated member who issues a prescription for a substance regulated under the Food and Drugs Act (Canada) or Controlled Drugs and Substances Act (Canada) must ensure the prescription is accurate, legible and includes the following:

(a) patient’s name;
(b) date prescription is issued;
(c) drug name, dose, form and quantity prescribed;
(d) prescribing physician’s name;
(e) prescribing physician’s:
   (i) address and telephone number; or
   (ii) registration number;
(f) directions for use and number of authorized refills; and
(g) direct authorization by valid signature (handwritten or digitally captured) that enables the dispenser to verify its authenticity.

(2) Prior to transmitting a prescription, a regulated member must:

(a) verify the prescription conveys the intended information; and
(b) facilitate reasonable patient choice regarding dispensing pharmacy.

(3) A regulated member who transmits a prescription must ensure the:

(a) transmission method is secure to protect patient confidentiality and prevent diversion;
(b) transmission for the purpose of dispensing can only be received by the intended licensed pharmacy; and

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transmission is compliant with clause (1) and also includes the:

(i) time and date of the transmission; and

(ii) name and contact information of the intended licensed pharmacy.

(4) A regulated member who transmits a prescription for a drug requiring a Triplicate Prescription Program (TPP) form must include the pharmacy’s copy of the TPP form in the transmission clearly identifying:

(a) the unique triplicate number;

(b) the regulated member’s TPP registration number; and

(c) the patient’s name, date of birth and personal health number.

(5) A regulated member who uses an online platform (i.e., secure messaging) to transmit prescriptions must:

(a) use only secure system-to-system messaging between an Electronic Medical Record (EMR) system and Pharmacy system or the Provincial Electronic Health Record (Netcare);

(b) ensure the EMR has prescription transmission audit capabilities;

(c) ensure the information is encrypted; and

(d) have a current privacy impact assessment that addresses the use of secure system-to-system messaging.

(6) Notwithstanding clause (5), a regulated member must not transmit a TPP form using an online platform.

(7) When issuing a prescription directly to a patient, a regulated member must not:

(a) reference on the prescription a specific pharmacy, pharmacist, distributor, agent or broker in the absence of a compelling clinical reason; or

(b) direct a patient to attend a particular licensed pharmacy unless justified by the limited availability of a product and/or service.

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Prescribing: Drugs Associated with Substance Use Disorders or Substance-Related Harm

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(1) A regulated member must be able to justify prescribing decisions with documentary evidence of a patient’s initial assessment and reassessments as required, including when accepting the transfer of care of a patient from another healthcare provider.

(2) At the time of initial assessment, a regulated member must discuss and determine with the patient the best medication choice considering the:

(a) efficacy of other pharmacological and non-pharmacological treatment options;

(b) common and potentially serious side effects of the medication; and

(c) probability the medication will improve the patient’s health and function.

(3) A regulated member must review the patient’s medication history from the Pharmaceutical Information Network (PIN)/Netcare or from an alternative, independent source (e.g., Triplicate Prescription Program, community or hospital pharmacist):

(a) before initiating a prescription;

(b) before renewing a prescription, unless the regulated member is the primary prescriber; and

(c) at minimum, every three months when the prescription is for the long-term treatment of a patient.

(4) Notwithstanding clause (3), if PIN/Netcare is inaccessible and the patient’s medication history is not available from an alternative, independent source, a regulated member may prescribe the minimum amount of medication required until such information can be obtained.

Includes, but is not limited to, opioids, benzodiazepines, sedatives and stimulants.

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(5) A regulated member who prescribes long-term opioid treatment (LTOT) for a patient with chronic pain, exclusive of treatment for active cancer, palliative or end-of-life care, must also:

(a) establish and measure goals for function and pain for the patient;

(b) evaluate and document risk factors for opioid-related harms and incorporate strategies to mitigate the risks;

(c) prescribe the lowest effective dose and, if prescribing a dose that exceeds the opioid prescribing guidelines endorsed by the Council of this College, carefully justify the prescription and document the justification in the patient record;

(d) at minimum, re-assess the patient within four weeks of initiating LTOT and every three months thereafter;

(e) document the status of the patient's function and pain at each reassessment; and

(f) continue to prescribe LTOT only if there is measurable clinical improvement in function and pain that outweighs the risks of continued opioid therapy.

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Re-Entering Medical Practice or Changing Scope of Practice

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(1) A regulated must notify the College when the physician intends to return to medical practice after an absence or retirement of three (3) years or more.

(2) A regulated who is returning to medical practice after an absence or retirement of three (3) years or more must undergo a review by the Registrar and may be required to complete an assessment and retraining satisfactory to the Registrar prior to returning to medical practice.

(3) A regulated member who intends to substantially change his or her medical practice by adding medical services which the physician has not provided on a frequent or continuous basis over the previous three (3) years:
   
   (a) must notify the Registrar;
   
   (b) must provide documentary evidence satisfactory to the Registrar attesting to the acquisition of training, experience, and/or competence to perform the proposed change in medical services; and
   
   (c) may be required to complete an assessment and training or retraining satisfactory to the Registrar prior to initiating the proposed change in medical services.

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Referral Consultation

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1. A regulated member must recognize his or her limitations in the delivery of patient care and collaborate as appropriate with other healthcare providers for the benefit of the patient.

2. A regulated member must respect a patient’s reasonable request for referral to another healthcare provider for:
   (a) a second opinion about the medical care provided; or
   (b) services outside the scope of practice of the regulated member.

3. Notwithstanding clause 2, a regulated member is entitled to refuse to make a referral that, in his or her opinion, is unlikely to provide a clinical benefit.

4. When a regulated member believes that consultation by another healthcare provider is appropriate but the patient does not, the regulated member must:
   (a) discuss with the patient and document in the patient’s record the difference of opinion and the implications for care; and
   (b) continue to provide medical care that is in the best interest of the patient and within the scope of the regulated member’s practice.

5. A regulated member who refers or accepts a patient for consultation must inform the patient of the regulated member’s role and responsibilities in the patient’s care.

6. A regulated member who refers a patient for consultation must:
   (a) discuss the purpose of the referral with the patient and confirm the patient’s agreement;
   (b) inform the patient about any fees that may not be covered by the Alberta Health Care Insurance Plan if aware such fees are likely to be charged;
   (c) evaluate and workup the patient within the regulated member’s scope of practice, including performing appropriate investigations; and
   (d) make a timely, written request for consultation that includes the following information:
      (i) patient’s name, Personal Health Number and contact information;

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(ii) regulated member’s name and contact information;

(iii) name and contact information of the consultant or consulting service;

(iv) date of referral;

(v) purpose of the referral, including but not limited to specifying if the referral is solely for the purpose of a third-party request;

(vi) pertinent clinical information, including but not limited to relevant investigation results; and

(vii) expected consultation outcomes (e.g., medical opinion only, possible transfer of care, other).

(7) A regulated member who refers a patient for an urgent and/or emergent consultation must:

(a) contact the consultant or emergency service directly to discuss the referral and provide pertinent clinical information; and

(b) to the extent possible, provide relevant documentation.

(8) Notwithstanding clause 6(d), a regulated member may forego a written request for consultation in an urgent and/or emergent situation if the consultant or service agrees to accept care of the patient without a written request.

(9) A regulated member who provides consultations must:

(a) make information available to referring healthcare providers about the process for receiving requests for consultation and ensure:

(i) receipt of a request is acknowledged to the referring healthcare provider within seven (7) days; and

(ii) the decision to accept or deny a request is communicated to the referring healthcare provider within a time commensurate with the urgency of the request, but not longer than fourteen (14) days after the request was received;

(b) be reasonably available to respond to requests for consultation; and

(c) if denying a request for consultation, provide reasons and, whenever possible, alternative suggestions for care or consultation.

(10) A regulated member who accepts a request for consultation must:

(a) contact the patient within a time commensurate with the urgency of the request, but not longer than fourteen (14) days after the request was received, and:

(i) schedule an appointment date or, if an appointment date has not been determined, confirm the referral status with the patient and the referring healthcare provider at least every three (3) months;

(ii) inform the patient of any fees not covered by the Alberta Health Care Insurance Plan;

1 The College will review complaints about management of consultation requests brought by other healthcare providers and patients.

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(b) provide a written report directly to the referring healthcare provider no more than thirty (30) days after initially seeing the patient, that includes the following information:

(i) the identity of the consultant;

(ii) the identity of the patient;

(iii) the identity of the referring healthcare provider and, if known, the identity of the patient’s primary care physician;

(iv) the date of the consultation;

(v) the purpose of the referral as understood by the consultant;

(vi) information considered, including history, physical findings and investigations;

(vii) diagnostic conclusions;

(viii) treatments initiated, including medications prescribed;

(ix) recommendations for follow-up by the referring healthcare provider;

(x) recommendations for continuing care by the consultant;

(xi) recommendations for referral to other consultants; and

(xii) advice given to the patient;

(c) inform the referring healthcare provider when a consultation will extend beyond one appointment and provide interim reports to the referring healthcare provider as required; and

(d) notify the patient and referring healthcare provider when the consultation is complete and patient care is being transferred back to the referring healthcare provider or transferred to another healthcare provider.

(11) Notwithstanding clauses 6(d) and 10(b), a regulated member must respect a patient’s explicit request to withhold pertinent medical information and inform the consulting/referring healthcare provider when information has been withheld.

(12) A regulated member who refers a patient for a non-urgent consultation must not send the same consultation request to multiple providers concurrently.

(13) A regulated member must not:

(a) require a repeat referral for a patient with whom the regulated member already has an established physician-patient relationship for the purpose of gaining an additional consultation fee; or

(b) require a referral from a healthcare provider if the regulated member has arranged to see a patient without a referral.

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2 In an established physician-patient relationship, both the regulated member and patient have a reasonable expectation the care provided will extend beyond a single encounter. Established physician-patient relationships include but are not limited to:

(a) longitudinal relationships, based on the identification of a regular attending physician or clinic; and
(b) sessional relationships for a defined period of time, based on a presenting concern(s), referred consultation or identified medical condition.
Relationships with Industry

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(1) For the purposes of this standard, “industry” means any manufacturer or distributor of healthcare products, including pharmaceuticals and medical devices.

(2) A regulated member must not enter into a relationship with industry if it weakens the fiduciary relationship with any patient of that regulated member.

(3) A regulated member must resolve any conflict of interest resulting from interaction with industry in favor of his or her patients.

(4) A regulated member must always maintain professional autonomy and independence in any relationship with industry.

(5) A regulated member must disclose to a patient any relationship between the regulated member and industry that reasonably could be perceived as having the potential to influence the regulated member’s clinical judgment.

(6) When a regulated member participates in industry sponsored research activities, the regulated member must:

(a) only participate in research activities that are ethically defensible, socially responsible and scientifically valid;

(b) only participate in research activities that have been formally reviewed and approved by an appropriate ethics review body;

(c) enroll patients in research activities only after full, informed, competent and voluntary consent of the patient or authorized agent;

(d) protect the patient’s privacy in accordance with provisions of applicable legislation;

(e) only accept remuneration that covers time and expenses at a reasonable rate;

(f) disclose to research subjects that the regulated member will receive a fee for participation and the source of that fee;

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(g) when submitting and/or publishing information in any media, disclose any relationships with industry providing funding or other consideration for the research performed or the publication submitted;

(h) avoid entering into agreements that limit the regulated member’s right to publish or disclose results of the study or report adverse events that occur during the course of the study; and

(i) only participate in industry sponsored surveillance studies that are scientifically valid and expected to contribute substantially to knowledge about the drug or device.

(7) A regulated member involved in organizing or presenting at a continuing professional development event must:

(a) disclose to participants any financial relationship with industry for products mentioned at the event or with manufacturers of competing products;

(b) not conduct a seminar or similar event directly or indirectly for industry that promotes a product for the purpose of enhancing the sale of that product; and

(c) not accept reimbursement for expenses or honoraria at a rate that could reasonably be perceived as having undue influence.

(8) A regulated member must not claim authorship or contribution to the production of educational materials unless the regulated member has substantially contributed to the material.

(9) A regulated member must ensure that all industry contributions are declared on educational materials.

(10) A regulated member attending a continuing professional development event must not accept reimbursement for expenses from industry unless they are in the employ of the industry or are directly involved in the presentation of the professional development activity.

(11) When considering the use of clinical evaluation packages such as samples of medications or devices, a regulated member must:

(a) recognize the influence on the regulated member’s prescribing choices;

(b) use appropriate clinical evidence to determine the choice of medication or device;

(c) document the type and amount of medication or device in the patient record; and

(d) not receive any form of material gain based on the choice of the product.

(12) A regulated member must not accept any personal gift of any monetary or other value from industry.

(13) Notwithstanding clause (12), a regulated member may accept teaching aids provided by industry.

(14) A regulated member must not accept a fee or other consideration from industry in exchange for seeing an industry representative in a promotional or similar capacity.

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Relocating a Medical Practice

(1) For the purpose of this standard, relocating a practice is defined as moving a practice within a distance that patients could be reasonably expected to travel to the new practice location. If the move is to a location beyond which patients would normally be expected to travel, Closing or Leaving a Medical Practice applies.

(2) A regulated member who relocates a medical practice must notify the College of the move in advance.

(3) A regulated member who relocates a medical practice must provide and document notification of the move to patients and colleagues in the practice a minimum of forty five (45) days in advance of the move. The notice must include the dates of the move, the new location and contact information and the time frame that patients will be permitted to follow the regulated member to the new location.

(a) Notwithstanding clause (3) above, the 45 day notice does not apply to a regulated member if the reason for relocating a medical practice is due to circumstances beyond the regulated member’s control. In these cases, patients must be notified as soon as is reasonably possible given the circumstances.

(4) A regulated member who relocates a medical practice must allow current patients the opportunity to follow him or her to the new practice location for a period of no less than twelve (12) months unless the regulated member has substantially altered his or her scope of practice or the regulated member relocates more than twelve (12) months after leaving or closing an earlier practice.

(5) A regulated member practicing in the location where another regulated member had previously practiced must provide information upon request to any member of the public, profession or another regulated health professional about the new location of the regulated member who has moved, if it is known.

(6) A regulated member who relocates a medical practice where another regulated member is assuming this practice location must ensure there are information sharing agreements relating to management of patient charts for those patients who will continue to have care provided by the relocating regulated member. The information sharing agreement must, at a minimum:

(a) identify which regulated member (s) will maintain custody of the patient records;

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(b) describe who is responsible for costs if copies of the record are provided to a regulated member who is a party to the agreement; and

(c) reflect costs that are reasonable, and consistent with applicable legislation and community standards.

(7) In order to ensure continuity of care, a regulated member practicing in the location where another regulated member had previously practiced must:

(a) provide the departing regulated member with access to and/or copies of outstanding investigations, consultation reports and other information requested by the departing regulated member as it relates to ongoing care for those patients previously attended to by the departing regulated member.

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- "Patient" includes, where applicable, the patient’s legal guardian or substitute decision maker.
Reprocessing of Medical Equipment

The Standards of Practice of the College of Physicians & Surgeons of Alberta ("the College") are the minimum standards of professional behavior and ethical conduct expected of all regulated members registered in Alberta. Standards of Practice are enforceable under the Health Professions Act and will be referenced in the management of complaints and in discipline hearings. The College of Physicians & Surgeons of Alberta also provides Advice to the Profession to support the implementation of the Standards of Practice.

(1) A regulated member who uses reprocessed medical equipment in a non-hospital setting must ensure that procedures for the cleaning, disinfecting and sterilizing of that equipment comply with the manufacturer’s recommendations and quality standards acceptable to the College.

(2) A regulated member must implement or follow all directions given by the Infection Prevention and Control Committee of the College.

Terms used in the Standards of Practice:
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- "Must" refers to a mandatory requirement.
- "May" means that the physician may exercise reasonable discretion.
- "Patient" includes, where applicable, the patient’s legal guardian or substitute decision maker.
Responding to Third Party Requests

The Standards of Practice of the College of Physicians & Surgeons of Alberta (“the College”) are the minimum standards of professional behavior and ethical conduct expected of all regulated members registered in Alberta. Standards of Practice are enforceable under the Health Professions Act and will be referenced in the management of complaints and in discipline hearings. The College of Physicians & Surgeons of Alberta also provides Advice to the Profession to support the implementation of the Standards of Practice.

(1) A regulated member must provide details of his or her findings, assessment, advice and treatment given to a patient when requested by the patient or an authorized agent or required to do so by law.

(2) When responding to requests in clause (1) for information about a patient, a regulated member must respond to the authorized request as soon as possible, generally within thirty (30) days of receiving the request, in one of the following ways:

(a) providing the information requested;

(b) acknowledging the request and giving an estimated date for providing the information requested; or

(c) explaining why all or part of the information will not be provided.

(3) Notwithstanding clause (1), a regulated member is not obligated to:

(a) provide a report containing a medical-legal opinion;

(b) provide an expert opinion; or

(c) become an expert witness in a legal proceeding.

(4) Notwithstanding clause (1), if the request is made under a contractual agreement, regulated member must comply with the specifics of that agreement.

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- "Patient" includes, where applicable, the patient’s legal guardian or substitute decision maker.
Responsibility for a Medical Practice

The **Standards of Practice** of the College of Physicians & Surgeons of Alberta (“the College”) are the **minimum** standards of professional behavior and ethical conduct expected of all regulated members registered in Alberta. Standards of Practice are enforceable under the Health Professions Act and will be referenced in the management of complaints and in discipline hearings. The College of Physicians & Surgeons of Alberta also provides **Advice to the Profession** to support the implementation of the Standards of Practice.

1) A regulated member **must** direct and take responsibility for his/her medical practice, including:
   
   (a) patient care provided, including the assessment, diagnosis, treatment, advice given and referral of the patient; and
   
   (b) compliance with all applicable laws, regulations and standards governing the practice of medicine.

2) A regulated member **must** also direct and take responsibility for the following, except where a Medical Director has responsibility:

   (a) all non-regulated staff supervised by the regulated member by:
      
      i) setting appropriate roles and responsibilities;
      
      ii) ensuring appropriate qualifications; and
      
      iii) overseeing performance;

   (b) all regulated staff participating in the practice by ensuring:
      
      i) appropriate qualifications; and
      
      ii) effective collaboration in a team-based setting;

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The practice of medicine includes, but is not limited to, the provision of patient care by a regulated member of this College and the professional and administrative activities which support that care. A medical practice cannot be delegated to or owned by a non-physician person or business, but is the exclusive domain of a regulated member regardless of practice setting.

**Terms used in the Standards of Practice:**

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- “May” means that the regulated member may exercise reasonable discretion.
- “Patient” includes, where applicable, the patient’s legal guardian or substitute decision maker.
Terms used in the Standards of Practice:

- "Regulated member" means any person who is registered or who is required to be registered as a member of this College. The College regulates physicians, surgeons and osteopaths.
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1. (c) billing for medical practice;
   (d) advertising and promotion of services;
   (e) quality assurance and quality improvement;
   (f) custody of health information, including maintenance and storage of medical records;
   (g) notification to the College at least 30 days prior to:
      i) establishing or moving the physical location of a practice, providing the street address and services to be offered; or
      ii) initiating or resuming a service or procedure that requires accreditation and/or approval by this College, as identified in the CPSA Standards of Practice or College bylaws;
   (h) clear identification to patients and the public coming into the practice setting of the qualifications for all care providers (e.g., nametag or notice) that includes:
      i) for regulated healthcare professionals, their name and professional designation; and
      ii) for non-regulated care providers, their name and job title.

2) Regulated members practising in a multi-physician setting without a Medical Director must designate one individual to represent the practice in interactions with the College, either:
   (a) a medical lead, who is a regulated member, and accepts overall responsibility for any or all of subclauses 2(a) through (h); or
   (b) a contact person who is a regulated member.

3) Notwithstanding the above, clauses (2) and (3) may not apply to a regulated member working in a hospital or facility operated by government or a provincial health authority.

2 Excluding a hospital or facility operated by government or a provincial health authority.
3 See Medical Services Requiring Accreditation Outside of Hospitals, Complementary and Alternative Medicine, Reprocessing of Medical Equipment and College bylaws.
4 For the purposes of this standard, "multi-physician setting" refers to any practice arrangement between regulated members in which they share the use, benefits or costs associated with any of the following:
   (a) advertising;
   (b) office telephone number;
   (c) medical records;
   (d) clinical or administrative functions (i.e., infection prevention and control, billing, etc.)
   (e) premises, equipment, furnishings or other property; and/or
   (f) staff.
Safe Prescribing for Opioid Use Disorder

The Standards of Practice of the College of Physicians & Surgeons of Alberta (“the College”) are the minimum standards of professional behavior and ethical conduct expected of all regulated members registered in Alberta. Standards of Practice are enforceable under the Health Professions Act and will be referenced in the management of complaints and in discipline hearings. The College of Physicians & Surgeons of Alberta also provides Advice to the Profession to support the implementation of the Standards of Practice.

(1) For the purpose of this standard, Opioid Agonist Treatment (OAT) refers to full opioid agonist therapies for opioid use disorder treatment.

(2) This standard does not apply to the partial agonist/antagonist buprenorphine/naloxone (Suboxone®).

(3) A regulated member who prescribes OAT must do so in accordance with recognized, evidence-based guidelines and best practices for Opioid Use Disorder (OUD) treatment.

(4) A regulated member who INITIATES OAT must:

(a) have successfully completed an OUD workshop/course recognized by the CPSA;

(b) provide evidence of experiential training, supervision, mentorship and/or completion of an approved preceptorship-based course;

(c) hold an active CPSA approval to initiate OAT;

(d) as a condition of CPSA approval, maintain competence in OAT through ongoing, relevant education as part of their mandatory Continuous Professional Development (CPD) cycle, and provide evidence upon request;

(e) only initiate OAT for a patient in an appropriate setting with:

(i) access to medical laboratory services and pharmacy services;

(ii) access to at least one other prescriber who is trained and approved to provide OAT, to ensure continuity of care if the initiating prescriber is absent or suspends their practice;

(iii) access to Alberta prescription databases (e.g., Alberta Netcare, Pharmaceutical Information Network);

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(iv) the ability to refer patients to appropriate, multidisciplinary team support (e.g., social worker, addictions counselling); and

(v) other resources and services appropriate to the specific OAT provided;

(f) if transferring OAT maintenance to another prescriber trained and approved to provide OAT:

(i) provide the maintaining prescriber with an information checklist and a letter of support for maintaining OAT for the patient, with a copy of the letter to the CPSA; and

(ii) collaborate with the maintaining prescriber, other regulated health professionals and multidisciplinary team members involved in the patient’s care.

(5) A regulated member who MAINTAINS OAT must:

(a) have knowledge of OAT pharmacology before accepting OAT maintenance for a patient;

(b) have a letter of support and information checklist from the initiating prescriber;

(c) hold an active CPSA approval to maintain OAT;

(d) at minimum, complete an OAT educational module or course recognized by the CPSA within six months of acquiring CPSA approval;

(e) ensure another prescriber approved to maintain OAT is available for continuity of care if the maintaining prescriber is absent or suspends their practice;

(f) collaborate with the initiating prescriber or appropriate delegate, other regulated health professionals and multidisciplinary team members involved in the patient’s care;

(g) access to medical laboratory services and pharmacy services; and

(h) access to Alberta prescription databases (e.g., Alberta Netcare, Pharmaceutical Information Network).

(6) A regulated member who TEMPORARILY prescribes OAT for a patient in an inpatient or correctional facility must:

(a) prescribe only for the duration of the patient’s stay or incarceration, and may prescribe up to the first 120 hours after discharge/release after notifying the patient’s community prescriber;

(b) restrict OAT prescribing to daily, witnessed doses and not provide take-home doses for unwitnessed use;

(c) consult with the patient’s current prescriber or appropriate delegate before making any changes to the OAT prescription, or introducing any new medications with the potential to interact with OAT; and

(d) collaborate with the community prescriber, other regulated health professionals and multidisciplinary team members involved in the patient’s care at transitions between treatment settings.

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- "Patient" includes, where applicable, the patient’s legal guardian or substitute decision maker.
(7) Notwithstanding clause 6 subclause (c), regulated members may proceed without consulting the current prescriber if patients require urgent or emergent care.

(8) A regulated member who prescribes INJECTABLE OAT (iOAT) must:

(a) hold an active CPSA approval to initiate or maintain OAT; and

(b) supervise or provide iOAT only within a facility operated by government or a provincial health authority, or a community setting approved by CPSA.

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- "May" means that the physician may exercise reasonable discretion.
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Sale of Products by Regulated Members

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(1) For the purpose of this standard, products include, but are not limited to, any product, device or appliance offered for the diagnosis, cure, alleviation or prevention of disease, disorders or injuries in a patient.

(2) If a regulated member offers products, other than prescription drugs, for sale to a patient, the regulated member must not sell the product at a price in excess of the fair market price paid by the regulated member plus a reasonable handling cost.

(3) If a regulated member offers products for sale to a patient, the regulated member must, at a minimum, create and maintain records detailing the following:

   (a) the actual cost of the product to the regulated member, including any rebate or price reduction provided to the regulated member;

   (b) the name of the manufacturer and the supplier of the product;

   (c) the date the product was supplied to the regulated member;

   (d) the expiry date of the product, if any; and

   (e) any additional costs incurred by the regulated member, including any formula or calculation used by the regulated member to determine the additional cost added to the price of the product charged to the patient.

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- "May" means that the physician may exercise reasonable discretion.
- "Patient" includes, where applicable, the patient’s legal guardian or substitute decision maker.
Self-Reporting to the College

The Standards of Practice of the College of Physicians & Surgeons of Alberta ("the College") are the minimum standards of professional behavior and ethical conduct expected of all regulated members registered in Alberta. Standards of Practice are enforceable under the Health Professions Act and will be referenced in the management of complaints and in discipline hearings. The College of Physicians & Surgeons of Alberta also provides Advice to the Profession to support the implementation of the Standards of Practice.

(1) A regulated member must report the following personal circumstances to the College at the time of registration or whenever the regulated member becomes aware thereafter:

   (a) any physical, cognitive, mental and/or emotional condition that is negatively impacting\(^1\) the regulated member’s work or is reasonably likely to negatively impact his or her work in the future\(^2\);

   (b) a sexual or inappropriate personal relationship between the regulated member and the patient; or

   (c) any voluntary or involuntary loss or restriction of diagnostic or treatment privileges granted by an administrative authority or any resignation in lieu of further administrative or disciplinary action.

(2) A regulated member must adhere to restrictions imposed by the College, to the satisfaction of the College, or withdraw from medical practice.

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1 Conditions would include, but not be limited to, the following:
   - Blood borne viral infections
   - Conditions affecting primary senses: vision, hearing, etc.
   - Neurological conditions affecting cognition, motor or sensory function, seizure disorder
   - Psychiatric conditions
   - Substance misuse
   - Physical disability
   - Metabolic conditions
   - Etc.

2 "Negative impact" is defined as harm to patients or others as a result of the practice of medicine. The practice of medicine includes research, education and administration, in addition to the practice associated with patients.

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- "May" means that the physician may exercise reasonable discretion.
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Supervision of Restricted Activities

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This standard applies to supervision of restricted activities as defined in section 2 of Schedule 7.1 of the Government Organization Act. It does not imply any expectation or requirement for a regulated member of the College of Physicians & Surgeons of Alberta to supervise other regulated healthcare professionals performing restricted activities within their scope of practice, training and authorization by their regulatory college.

(1) A regulated member may consent to supervising a person performing a restricted activity if the person is:

   (a) another regulated healthcare professional;

   (b) a clinical trainee undergoing training leading to certification in a regulated health profession and the regulated member has taken reasonable steps to confirm that the supervised person is a clinical trainee; or

   (c) an unregulated healthcare provider.

(2) A regulated member who supervises a person performing a restricted activity must:

   (a) be personally:

      (i) competent to perform the restricted activity;

      (ii) authorized to perform the restricted activity without supervision;

      (iii) satisfied with the knowledge, skill and judgment of the supervised person performing the restricted activity; and

      (iv) responsible for the restricted activity performed by the supervised person;

   (b) ensure it is safe and appropriate for the supervised person to perform the restricted activity on the particular patient;

   (c) obtain the patient’s informed consent for the restricted activity to be performed under supervision, unless consent is not possible because of emergency;

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(d) provide a level of supervision commensurate with the skills and abilities of the person performing the restricted activity and the risk of harm to the patient;

(e) remain readily available for consultation during the performance of the restricted activity and for an appropriate follow-up period;

(f) have a quality assurance process in place to ensure the restricted activity is performed safely;

(g) ensure the person performing the restricted activity is clearly identified in the patient’s record; and

(h) ensure the equipment and resources used to perform the restricted activity are safe and appropriate.

(3) A regulated member who supervises an unregulated healthcare provider performing a restricted activity must ensure:

(a) the restricted activity is performed only under a direct order from a physician in the context of an established physician-patient relationship;

(b) there is minimal additional risk to the patient due to the unregulated healthcare provider performing the restricted activity; and

(c) the restricted activity is performed according to an established protocol and does not require medical knowledge or expertise.

(4) A regulated member must not supervise a person performing a restricted activity if that person:

(a) would be in violation of section 46 of the Health Professions Act regarding Mandatory Registration; or

(b) is registered as a regulated health professional in Alberta but is not authorized or permitted by their profession’s regulatory college to perform that restricted activity.

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- "May" means that the physician may exercise reasonable discretion.
- "Patient" includes, where applicable, the patient’s legal guardian or substitute decision maker.
Telemedicine

(1) For the purpose of this Standard, “telemedicine” means the provision of medical diagnosis and patient care through electronic communication where the patient and the provider are in different locations.

(2) A regulated member who practises telemedicine for a patient located within Alberta must:
   (a) hold a valid and active Alberta practice permit with the College; and
   (b) adhere to the College Standards of Practice, Code of Conduct and Code of Ethics.

(3) Notwithstanding clause 2 (a), a regulated member who does not hold a valid and active Alberta practice permit may practise telemedicine for a patient located within Alberta if:
   (a) the total number of telemedicine events are limited to five (5) times per year; or
   (b) the telemedicine event is for emergency assessment or treatment of a patient.

(4) A regulated member who holds a valid and active Alberta practice permit and practises telemedicine for a patient located outside Alberta must comply with the licensing or registration requirements of the jurisdiction in which the patient is located.

(5) A regulated member must not issue or sign a prescription, by electronic or other means, unless the regulated member:
   (a) obtains a medical history and conducts an appropriate examination of the patient adequate to establish a diagnosis and identify underlying conditions;
   (b) ensures there are no absolute contraindications to the treatment recommended or provided; and
   (c) has an appropriate, informed discussion to ensure the patient understands the risks, benefits and course of action if concerns are identified.

(6) Notwithstanding clause 5, a regulated member may issue a prescription without meeting the full scope of the requirements listed above in the following circumstances:
   (a) for emergency treatment of a patient;

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(b) in consultation with another regulated member who has an ongoing relationship with the patient and who has agreed to provide ongoing supervision of the patient’s treatment; or

(c) in an on-call or cross-coverage situation in which the prescribing regulated member has access to the patient’s medical records.

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Terminating the Physician-Patient Relationship in Office-Based Settings

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(1) A regulated member who terminates a relationship with a patient must have reasonable grounds for discharging the patient from his or her medical practice and must document those reasons in the patient’s record.

(2) A regulated member must not discharge a patient:

(a) based on a prohibited ground of discrimination including age, gender, marital status, medical condition, national or ethnic origin, physical or mental disability, political affiliation, race, religion, sexual orientation, or socioeconomic status;

(b) because a patient makes poor lifestyle choices (such as smoking);

(c) because a patient fails to keep appointments or pay outstanding fees unless advance notice has been given to the patient;

(d) because the patient refuses to follow medical advice unless the patient is repeatedly non-adherent despite reasonable attempts by the regulated member to address the non-adherence; or

(e) because the regulated member relocates his or her practice to a new location/setting to which current patients could be reasonably expected to follow.

(3) Notwithstanding clause 2(e), a regulated member may terminate patient relationships if:

(a) the regulated member is changing scope of practice wherein current patients would no longer fit within the new scope; or

(b) a relocation occurs more than twelve (12) months after closing an earlier practice.

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(4) When unilaterally terminating a relationship with a patient, a regulated member must:

(a) give advance written notice of intention to terminate care and provide a timeline that is commensurate with the continuing care needs of the patient;

(b) advise the patient of the reasons for termination of the physician-patient relationship unless disclosure of the reasons could be expected to:

   (i) result in immediate and grave harm to the patient’s mental or physical health or safety

   (ii) threaten the mental health and physical health or safety of another individual; or

   (iii) pose a threat to public safety;

(c) ensure continuity of follow-up care for outstanding investigations and serious medical conditions prior to the termination date or facilitate transfer of care to another regulated member;

(d) provide or arrange for care until the termination of care;

(e) provide emergency services that would otherwise be unavailable to the patient after the termination date; and

(f) establish a process for transfer of the patient’s medical information in response to future requests by the patient or an authorized third party.

(5) Notwithstanding clause (4), a regulated member may immediately discharge a patient if:

(a) the patient poses a safety risk to office staff, other patients or the regulated member;

(b) the patient is abusive to the regulated member, staff or other patients;

(c) the patient fails to respect professional boundaries or

(d) the regulated member is leaving medical practice because of personal illness or other urgent circumstances.

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- "May" means that the physician may exercise reasonable discretion.
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Transfer of Care

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(1) A regulated member transferring full or partial responsibility for a patient’s care to another healthcare provider(s) must:

(a) communicate clearly with the accepting healthcare provider(s) and provide a timely, written summary that includes the following information:

(i) identification of the roles and responsibilities of the regulated member and other healthcare providers involved in the patient’s ongoing care;

(ii) pertinent clinical information, including outstanding test results and active consultations;

(iii) treatment plans and recommendations for follow-up care;

(b) have a discussion with the patient to:

(i) identify the roles and responsibilities of the regulated member and other healthcare providers involved in the patient’s ongoing care; and

(ii) explain treatment plans and recommendations for follow-up care.

(2) A regulated member discharging a patient from a healthcare facility must:

(a) complete a timely discharge summary consistent with the policies of the facility; and

(b) provide relevant healthcare providers with pertinent clinical information, including, but not limited to:

(i) discharge medications;

(ii) outstanding investigations, including responsibility for requisitioning follow-up; and

(iii) active consultations.

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- "May" means that the physician may exercise reasonable discretion.
- "Patient" includes, where applicable, the patient’s legal guardian or substitute decision maker.