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COLLEGE OF PHYSICIANS
& SURGEONS OF ALBERTA

STANDARDS OF PRACTICE

CONSOLIDATED VERSION

Current as of June 27, 2024

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Introduction

The ***Standards of Practice*** of the College of Physicians & Surgeons of Alberta (hereafter referred to as "CPSA") 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.

Regulated members must be aware of and adhere to the *Code of Ethics & Professionalism* or the *Standards of Practice*. Failure to comply with the *Code of Ethics & Professionalism* or the *Standards of Practice* is considered unprofessional conduct under the *Health Professions Act.*

These standards complement the Canadian Medical Association's *Code of Ethics & Professionalism,* which is the particular code adopted by CPSA 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 the College of Physicians & Surgeons of Alberta. CPSA regulates physicians, surgeons, osteopaths and physician assistants. The term "**must**" refers to a mandatory requirement. The term "**may**" means the regulated member 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, CPSA 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* newsletter and on the CPSA website at 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*.

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COLLEGE OF PHYSICIANS
& SURGEONS OF ALBERTA

STANDARDS OF PRACTICE

Advertising

Under Review: No

Issued By: Council: Jan 1, 2010 (*Advertising by Regulated Members*)

Reissued by Council: Jan 1, 2021; Jul 1, 2011; Oct 1, 2015 (*Advertising*)

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COLLEGE OF PHYSICIANS
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Note: a glossary of terms can be found at the end of this document. Glossary terms are indicated in teal with a "G" throughout this document.

1. A regulated member who is responsible for an advertisement[G] **must** ensure the information provided:

    a. conforms to the *Code of Ethics & Professionalism*;

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

    c. includes the practice discipline[G] as identified on the member's practice permit issued by CPSA;

    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 current, best-available medical evidence[G];

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

    g. clearly specifies when services being offered are not or may not be publicly funded through the Alberta Health Care Insurance Plan;

    h. is not false, incomplete, misleading or deceptive;

    i. does not include claims, representations, endorsements or testimonials regarding the service or business;

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j. does not create unreasonable expectations of beneficial treatment, such as guarantees or warranties about results; and

k. does not encourage the indiscriminate or unnecessary use of health services.

2. A regulated member **must:**

a. ensure advertising done on their behalf by a third party complies with this standard;

b. show, in writing, where advertising by a third party was reviewed and approved; and

c. be able to demonstrate this review and approval to CPSA upon request.

3. A regulated member **must** promptly comply with direction from the Registrar to:

a. substantiate any advertising claim or representation;

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 & Professionalism*.

4. 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 publicly available information; or

c. offers any inducement[G] to a patient to receive a medical service, 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.

5. 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[G] to use the information for advertising purposes (documentation of this consent must be noted in the patient's record and available for CPSA to verify upon request); or

   b. use a protected title[G] 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 CPSA or authorized by the Registrar to use that title.

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

7. In advertisements, a regulated member **may** indicate a practice interest[G] in advertisements **only** if:

   a. the area of interest falls within the context of the member's practice discipline;

   b. the area of interest is a demonstrated, significant focus of the member's practice; and

   c. the regulated member pursues continuing medical education related to the area of interest.

GLOSSARY

Advertisement/advertising: any communication made orally, in print, through electronic media or via the internet (including websites and social media), by or on behalf of a registered member, to the public where its substantial purpose is to promote the regulated

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member, the regulated member's services, or the clinic or group where the regulated member practices or with which the regulated member is associated. (From CPSBC's *Advertising* Practice Standard)

Practice discipline: refers to a regulated member's scope of practice (e.g., family practice, general surgery, pediatrics).

Evidence: rigorous, peer-reviewed clinical research that supports a claim and/or service.

Inducement: anything that persuades or influences someone to do something.

Consent: permission for something to happen or agreement to do something; a regulated member must obtain a patient's consent in accordance with the *Informed Consent* standard of practice. For more information, please refer to the Informed Consent for Adults and Informed Consent for Minors Advice to the Profession documents.

Protected title: a protected title is part of the agreement between the province and the regulated profession. This indicates anyone using the title is appropriately trained and registered with the appropriate regulatory body. A person not trained and/or registered cannot use the protected titles listed in Schedule 21 of the *Health Professions Act*.

Practice interest: refers to areas within a regulated member's scope of practice they concentrate on and/or have a special interest in (e.g., gynecology, obstetrics, surgery).

RELATED STANDARDS OF PRACTICE

- *Code of Ethics & Professionalism*
- *Conflict of Interest*
- *Informed Consent*
- *Patient Record Content*
- *Responsibility for a Medical Practice*
- *Sale of Products by Physicians*

COMPANION RESOURCES

- Advice to the Profession:
  - Advertising
  - Informed Consent for Adults

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    - Informed Consent for Minors
- *Health Professions Act*
- Canadian Code of Advertising Standards
- Health Canada Regulation of Health Products Advertising

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COLLEGE OF PHYSICIANS
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STANDARDS OF PRACTICE

Boundary Violations: Personal

Under Review: No
Issued By: Council: January 1, 2010 (*Sexual Boundary Violations*)
Reissued by Council: July 1, 2018 (*Boundary Violations*); April 1, 2019 (*Boundary Violations: Personal* and *Boundary Violations: Sexual*)

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COLLEGE OF PHYSICIANS & SURGEONS OF ALBERTA

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A regulated member who is uncertain about the potential for a boundary violation should consult with CPSA 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);

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- "Patient" includes, where applicable, the patient's legal guardian or substitute decision maker.

b. socialize or communicate with a patient for the purpose of pursuing a close personal relationship; or

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[i];

   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.

RELATED STANDARDS OF PRACTICE

- *Boundary Violations: Sexual*
- *Code of Ethics & Professionalism*
- *Conflict of Interest*
- *Duty to Report a Colleague*
- *Informed Consent*
- *Terminating the Physician-Patient Relationship*

COMPANION RESOURCES

- Advice to the Profession: Boundary Violations: Personal
- Advice to Albertans: Personal & Sexual Boundary Violations
- CMPA's Good Practices Guide: Maintaining appropriate boundaries
- CMPA's Good Practices Guide: Why and when do we need consent?

[i] "Learner" includes but is not limited to clinical trainee, medical student, other health professional learner, graduate student, resident or fellow.

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STANDARDS OF PRACTICE

Boundary Violations: Sexual

Under Review: No

Issued By: Council: April 1, 2019

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COLLEGE OF PHYSICIANS & SURGEONS OF ALBERTA

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ADVISORY NOTE: Complaints received by CPSA on or after April 1, 2019 will be adjudicated based on the sanctions of the *Health Professions Act* regardless of when the alleged incident occurred.

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 *HPA* 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

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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.

"Regulated member" is a member of the College of Physicians & Surgeons of Alberta registered as a member under section 33(1)(a) of the *HPA.*

"Sexual abuse" is defined in section 1(1)(nn.1) of the *HPA* as*:*

- "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 *HPA* 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 *HPA* 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 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.

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 *HPA* 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; or

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

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 *HPA*. 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 *HPA* 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; or

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 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 *HPA*. 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 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 *HPA*, 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.

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 *HPA*. 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 *HPA.* 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 *HPA,* 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.

"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.

RELATED STANDARDS OF PRACTICE

- *Boundary Violations: Personal*
- *Code of Ethics & Professionalism*
- *Duty to Report a Colleague*
- *Duty to Report Self*
- *Informed Consent*
- *Terminating the Physician-Patient Relationship*

COMPANION RESOURCES

- Advice to the Profession: Boundary Violations: Sexual
- Advice to Albertans: Personal & Sexual Boundary Violations
- CMPA's Good Practices Guide: Maintaining appropriate boundaries
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CANNABIS FOR MEDICAL PURPOSES

Under Review: No
Issued By: Council: Apr 3, 2014 (Issued by Council: *Marihuana for Medical Purposes*)
Reissued by Council: Jul 1, 2021; May 3, 2017 (Name change only: *Cannabis for Medical Purposes*)

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PREAMBLE

Health Canada registers individuals to use cannabis for medical purposes based on a medical document or written order from a physician or nurse practitioner. Regulated members are not obligated to authorize cannabis for medical purposes, but declining this treatment must be done in accordance with the *Code of Ethics & Professionalism*[G].

Regulated members must be aware of and comply with the *Cannabis Act* and the *Cannabis Regulations*[G], as well as all other relevant federal and provincial laws regarding the use of cannabis. Part 14 of the *Cannabis Regulations* outlines the legal requirements for a regulated member issuing a medical document or written order for cannabis for medical purposes. The *Cannabis Regulations* only allow a medical document or written order to be issued by a regulated member to an individual under their professional care. For an individual to be under the professional care of a regulated member within the meaning of section 273 of the *Cannabis Regulations*, a regulated member must comply with the requirements outlined in this Standard of Practice.

STANDARD

1. A regulated member **must** notify CPSA's Cannabis for Medical Purposes (CMP) Program[G] prior to issuing a medical document or written order for cannabis for medical purposes by submitting their name, registration number, contact information and address of the location where the regulated member consults with patients.

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2. A regulated member who issues a medical document or written order for cannabis for medical purposes **must** only do so if it is a clinically appropriate treatment[G] for the patient's identified medical condition or symptom(s).
3. A regulated member who issues a medical document or written order for cannabis for medical purposes **must**:

    a. evaluate the patient directly and in person annually;

    b. evaluate the patient at least once every six months to assess the benefits and risks of cannabis as treatment for the identified medical condition or symptom(s);

    c. provide ongoing care to the patient for the underlying medical condition or symptom(s) for which cannabis has been authorized and assess for any emerging substance use disorder(s); and

    d. review available prescription databases (e.g., Alberta Netcare, Pharmacy Information Network (PIN), Tracked Prescription Program (TPP)) at least once every six months to obtain the patient's medication profile.

4. A regulated member **must**:

    a. discuss the risks of using cannabis with the patient and document the discussion in the patient's record[G];

    b. obtain informed consent[G] in accordance with the *Informed Consent* standard of practice;

    c. assess the patient's risk of developing a substance use disorder using a standard risk assessment tool[G];

    d. retain a copy of the medical document[G] issued for cannabis for medical purposes in the patient's medical record; and

    e. document in the patient's record:

        i. a direct, in-person comprehensive medical assessment of the condition to be treated with cannabis, including a history, a physical examination by the regulated member and appropriate clinical investigations;

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ii. the rationale[G] for treatment and daily quantity of cannabis to be used by the patient; and

iii. any previous treatments or therapies that were not helpful in treating the patient's identified medical condition or symptom(s).

5. A regulated member **must not**:

a. apply to become a licensed producer or holder of cannabis;

b. accept any incentives or rebates for providing a medical document or written order for cannabis for medical purposes; or

c. charge patients or licensed producers or holders of cannabis for activities associated with issuing a medical document or written order for medical cannabis for a patient.

GLOSSARY

Cannabis for Medical Purposes (CMP) Program: the Cannabis for Medical Purposes Program provides physicians with supportive resources and education for safe use of medical cannabis in Alberta patients. Physicians who wish to authorize medical Cannabis for a patient are required to notify the CMP program. To notify CPSA of your authorization of cannabis for medical purposes, please use the form on our website or email your name, registration number, contact information and address of the location where the regulated member consults with patients to CMPInfo@cpsa.ab.ca. Review the CMP Program information.

***Cannabis Regulations*:** the Government of Canada's Depart of Justice laws and regulations about cannabis, process of legalization, cannabis in provinces and territories and driving laws. Review the *Cannabis and Legalization and Regulation*.

Clinically appropriate treatment: the Government of Canada's *Cannabis Regulations* allow health care practitioners to authorize cannabis for medical purposes if it is required for the condition for which their patient is receiving treatment; this requires regulated members to use their clinical judgment to determine whether medical cannabis is appropriate for the patient's medical condition or symptom(s).

Code of Ethics & Professionalism: outlines ethical expectations, so physicians can provide the highest standard of care, while fostering patient and public trust in physicians and the profession. Review the Canadian Medical Association's *Code of Ethics & Professionalism*.

Informed consent: a regulated member must obtain consent and ensure the patient is fully informed and understands any medical examination, procedure or treatment before it takes place. Review the standard of practice on *Informed Consent*. More information can be found in the Informed Consent for Adults Advice to the Profession document.

Medical document: this refers to the document authorizing the use of cannabis for medical purposes as required by Health Canada. Review Health Canada's Information for Health Care Practitioners - Medical Use of Cannabis and Sample Medical Document.

Patient record: all regulated members must maintain accurate, up-to-date records of all their patient interactions; documentation must be done in accordance with the *Patient Record Content* standard of practice. Review the *Patient Record Content* standard of practice.

Rationale: an explanation of how and/or why the regulated member made the clinical decision to authorize cannabis for medical purposes.

Standard risk assessment tool: a standard risk assessment tool helps analyze and evaluate factors which have the potential to cause harm to a patient.

RELATED STANDARDS OF PRACTICE

- *Cannabis for Medical Purposes*
- *Advertising*
- *Code of Ethics & Professionalism*
- *Conflict of Interest*
- *Continuity of Care*
- *Establishing the Physician-Patient Relationship*
- *Informed Consent*
- *Patient Record Content*
- *Responsibility for a Medical Practice*

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COMPANION RESOURCES

- Advice to the Profession documents:
  - Cannabis for Medical Purposes
  - Advertising
  - Conflict of Interest
  - Continuity of Care
  - Informed Consent for Adults
  - Legislated Reporting & Release of Medical Information
  - Responsibility for a Medical Practice

- Cannabis – Services and Information (Health Canada)
- Information for Health Care Practitioners – Medical Use of Cannabis (Health Canada)
- Guidance in Authorizing Cannabis Products within Primary Care (The College of Family Physicians)
- The Use of Medical Cannabis with Other Medications: A Review of Safety and Guidelines (Canadian Agency for Drugs and Technologies in Health)
- Medical Cannabis Evidence Bundle (Canadian Agency for Drugs and Technologies in Health)
- Implications of Cannabis Legalization on Youth and Young Adults (Canadian Psychiatric Association)
- The Health Effects of Cannabis and Cannabinoids: The Current state of Evidence and Recommendations for Research (National Academies report summary: free PDF download available with account creation/login)

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STANDARDS OF PRACTICE

Charging for Uninsured Professional Services

Under Review: No

Issued By: Council: January 1, 2010 (*Charging for Uninsured Medical Services*)

Reissued by Council: September 9, 2014 (*Charging for Uninsured Professional Services*)

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The ***Standards of Practice*** of the College of Physicians & Surgeons of Alberta ("CPSA") 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. CPSA also provides **Advice to the Profession** to support the implementation of the Standards of Practice.

1. Amounts charged for uninsured professional services[i] including block fees[ii] **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;

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

   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; or

   c. promise or provide preferential services to a patient who paid a block fee.

RELATED STANDARDS OF PRACTICE

- *Informed Consent*
- *Responsibility for a Medical Practice*

COMPANION RESOURCES

- Advice to the Profession: Charging for Uninsured Professional Services
- Advice to the Profession: Insured Persons
- AMA's Uninsured services
- AH's Health care services covered in Alberta

[i] A professional service includes both medical and non-medical services.

[ii] 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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STANDARDS OF PRACTICE

Closing or Leaving a Medical Practice

Under Review: No
Issued by Council: Jan 1, 2010 (*Closing, Leaving, or Moving a Medical Practice*)
Reissued by Council: Jan 1, 2021, Jan 9, 2014 (*Closing or Leaving a Medical Practice*)

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Note: a glossary of terms can be found at the end of this document. Glossary terms are indicated in teal with a "G" throughout this document.

PREAMBLE

Every physician has the right to close or leave a medical practice or to change their pattern of practice based on personal priorities, financial considerations, health conditions or a variety of other reasons. The choice to close, leave or change a practice does **not** constitute job action unless those actions are intended to compromise access to physician services to further a negotiating position.

In that case, the *Job Action*[G] standard of practice must be followed.

STANDARD

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 time there is no establishment of any medical practice in the province of Alberta;
    c. a significant change in the regulated member's scope of practice;
    d. moving to a location a significant distance[G] 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.

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2. A regulated member who closes or leaves a medical practice **must** take reasonable steps[G] to place patients under acute[G] and/or active[G] care with another healthcare provider: what is reasonable will depend on the reason for the practice closure, patient needs and the healthcare providers or health system resources available in the community. This does **not** require a replacement be in place prior to departure.

3. A regulated member who closes or leaves a medical practice **must** arrange follow-up on any outstanding investigations, test results or reports to ensure continuity of care[G].

4. A regulated member who closes or leaves a medical practice **must:**

    a. notify CPSA a minimum of ninety (90) days in advance of closing or leaving the practice;

    b. provide and document notification[G] of the event to individual patients who have been seen within the past year with whom there is an expectation of ongoing[G] care a minimum of ninety (90) days in advance of closing or leaving the practice;

        i. in instances where a replacement will be in place to take over the practice, the notice period **may** be shortened, but the regulated member **must** use their professional judgment to determine an appropriate timeframe based on their unique clinical practice ; and

    c. provide notification of closing or leaving the practice to all healthcare providers to whom they regularly refer patients or from whom they receive referrals, hospitals where they hold privileges, employers and the Alberta Health Care Insurance Plan, if applicable.

5. Notwithstanding clause 4, 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 (e.g., sudden illness, death, revocation, suspension). In these cases, CPSA, patients and individuals or agencies identified in clause 4(c) **must** be notified as soon as is reasonably possible given the circumstances.

6. A regulated member **must** provide CPSA with:

    a. information describing how the transfer of patient care will be managed, where applicable;

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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. the name and contact information for the regulated member's successor custodian[G];

d. a forwarding mailing address and contact information for the regulated member; and

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

7. A regulated member **must not** accept referrals or new patients if they do not expect to resolve the matter before they close or leave a medical practice.

8. 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.

9. A regulated member who closes or leaves a medical practice and does not maintain custody of the records (e.g., where a new healthcare provider practices in the same location) **must** ensure there are information sharing agreements[G] 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.

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

GLOSSARY

Job action: the threatened or actual withdrawal of services in relation to a dispute in accordance with the *Job Action* standard of practice.

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Significant distance: the distance it would be reasonable for a patient to travel is contextual to the practice area and alternate available resources, as some patients may be willing to travel further distances than others to continue seeing their physician.

Reasonable steps: the physician's attempt(s) to find a suitable healthcare provider to take over care of patients under acute, active care; this will vary depending on patient needs, practice area, availability of alternate resources, etc.

Acute: short-term treatment of a severe or life-threatening injury, illness, routine health problem, recovery from surgery or acute exacerbation of a chronic illness.

Active: providing care to a patient on a regular, including annual, basis, including patients rostered to the physician's panel.

Continuity of care: as indicated in the *Continuity of Care* standard of practice, physicians must have systems in place to receive, review, and follow-up on any investigations, including arranging continuous after-hours care.

Notification: patient notification may be made by way of a detailed letter, secure email, or telephone call detailing the regulated member's last day at the former location, how a new physician may be found (e.g., contacting CPSA's Member Service Agents at 1-800-561-3899 or using the "Find a Doctor" search at http://www.albertafindadoctor.ca), how to obtain outstanding investigation or referral results, and how patients can access copies of their records.

Ongoing: 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 including, but not limited to, longitudinal relationships, based on the identification of a regular attending physician or clinic and sessional relationships for a defined period of time, based on a presenting concern(s), referred consultation or identified medical condition.

Successor custodian: under the *Health Information Act* and the *Patient Record Retention* standard of practice, physicians are required to have agreements and arrangements in place with another custodian to deal with contingencies (e.g., illness, death, relocation to a geographically distant location) to allow for continuity of care and to ensure patients have ongoing access to their health information. For more

information and a sample Successor Custodian Agreement, please refer to the Physicians as Custodians of Patient Records Advice to the Profession document.

Information sharing agreement (ISA): as required by the *Patient Record Retention* standard of practice, an ISA provides clarity on how custodians will manage shared patient records and what will happen in the event the professional arrangement between the custodians changes (e.g., the partnership dissolves). For more information and a sample Information Sharing Agreement, please refer to the Physicians as Custodians of Patient Records Advice to the Profession document.

ACKNOWLEDGEMENTS

CPSA acknowledges the assistance of the College of Physicians and Surgeons of British Columbia, the College of Physicians and Surgeons of Ontario and the College of Physicians and Surgeons of Nova Scotia in preparing this document.

RELATED STANDARDS OF PRACTICE

- *Continuity of Care*
- *Patient Record Retention*
- *Relocating a Medical Practice*
- *Responsibility for a Medical Practice*

COMPANION RESOURCES

- Advice to the Profession: Physicians as Custodians of Patient Records
- Custody of Patient Records Form
- To access the Notification of Change Form, please log into your physician portal
- Professional Corporation Address Change Form

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COLLEGE OF PHYSICIANS
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STANDARDS OF PRACTICE

Code of Ethics & Professionalism

Under Review: No

Issued By: Council: January 1, 2010 (*Code of Ethics*)

Reissued by Council: July 1, 2019 (*Code of Ethics & Professionalism*)

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1. A regulated member **must** comply with the *Code of Ethics & Professionalism* adopted by CPSA in accordance with section 133 of the *Health Professions Act* and CPSA Bylaws.

RELATED STANDARDS OF PRACTICE

- *Conflict of Interest*

COMPANION RESOURCES

- Code of Conduct

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ASSOCIATION MÉDICALE CANADIENNE | CANADIAN MEDICAL ASSOCIATION

CMA CODE OF ETHICS AND PROFESSIONALISM

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 inter-professional 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.

Approved by the CMA Board of Directors Dec 2018

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COLLEGE OF PHYSICIANS
& SURGEONS OF ALBERTA

STANDARDS OF PRACTICE

Conflict of Interest

Under Review: No

Issued By: Council: Jan 1, 2010 (*Conflict of Interest Involving Financial or Personal Gain by Physicians*)

Reissued by Council: Jan 1, 2021; Oct 8, 2015 (*Conflict of Interest*)

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Note: a glossary of terms can be found at the end of this document. Glossary terms are indicated in teal with a "G" throughout this document.

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. A conflict of interest—real, potential or perceived—can exist even if the regulated member is confident their professional judgment is not being influenced by the conflicting interest or relationship[1].

2. A regulated member **must** resolve any real, potential or perceived conflict of interest in the best interest of the patient.

3. A regulated member **must:**

   a. make full, frank and timely disclosure of any real, potential or perceived conflict of interest to the patient;

   b. document the details of the disclosure made to the patient in the patient's record; and

   c. comply with clause (2) regardless of whether the regulated member has obtained consent from the patient to remain in the conflict of interest.

4. A regulated member **must not**:

   a. accept or offer commissions, rebates, fees, gifts or other inducements[G] related to patient referrals or devices, appliances, supplies, pharmaceuticals,

[1] From CPSO's Physicians' Relationships with Industry: Practice, Education and Research (September 2014)

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diagnostic procedures or therapeutic services;

b. 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;

c. 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

d. 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.

5. 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 there are no viable alternatives to meet the patient's needs and the following conditions are all met:

a. any benefit the regulated member receives due to their financial interest is based on the regulated member's financial contribution or effort provided to that facility and not on the volume of patient referrals or other business from the regulated member;

b. there are no terms or conditions that require the regulated member to make referrals to the facility or otherwise generate business for the facility; and

c. the regulated member fully discloses the interest they have in the facility or healthcare business to the patient prior to the referral.

GLOSSARY

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the conflicting interest or relationship. (From CPSO's *Relationships with Industry* practice standard)

Inducements: anything that persuades or influences someone to do something.

RELATED STANDARDS OF PRACTICE

- *Advertising*
- *Boundary Violations: Personal*
- *Code of Ethics & Professionalism*
- *Patient Record Content*
- *Sale of Products by Physicians*

COMPANION RESOURCES

- Advice to the Profession:
  - Advertising
  - Boundary Violations: Personal
  - Conflict of Interest
- Canadian Medical Association's Guidelines for Physicians in Interactions with Industry

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COLLEGE OF PHYSICIANS
& SURGEONS OF ALBERTA

STANDARDS OF PRACTICE

Conscientious Objection

Under Review: No

Issued By: Council: January 1, 2010 (*Moral or Religious Beliefs Affecting Medical Care*)

Reissued by Council: June 1, 2016 (*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 religion[i].

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.

RELATED STANDARDS OF PRACTICE

- *Boundary Violations: Personal*
- *Code of Ethics & Professionalism*
- *Medical Assistance in Dying*

[i] Canadian Charter of Rights and Freedoms, Part I of *The Constitution Act*, 1982.

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COLLEGE OF PHYSICIANS
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STANDARDS OF PRACTICE

Continuing Competence

Under Review: No

Issued By: Council: Mar. 31, 2023

Updated: June 27, 2024 (program name change only)

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COLLEGE OF PHYSICIANS
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PREAMBLE

The *Health Professions Act* (HPA) requires CPSA to establish a Continuing Competence Program requiring participation from regulated members to maintain their competence and enhance the provision of professional services[1] throughout their careers. The HPA authorizes CPSA's Competence Committee to conduct practice visits, examinations, interviews or other competence assessments of regulated members[2].

The Competence Committee governs and provides direction for CPSA's Continuing Competence Program. The Continuing Competence Program has two objectives: to establish a program requiring participation from all regulated members, to maintain their competence and enhance the provision of professional services throughout their careers (e.g., quality improvement), and to identify members whose competence may require further assessment and support (e.g., practice changes, quality assurance, education and remediation). The *Continuing Competence* standard of practice addresses the requirement for regulated members to participate in CPSA's Continuing Competence Programs.

The Continuing Competence Program is comprised of three components:

- Continuing Professional Development
- General Assessment
- Competence Assessment

[1] Per Section 50(1) of the *HPA*.
[2] Per Section 50(2) of the *HPA*.

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Information related to participation in a Continuing Competence Program is confidential under Part 3 of the HPA, unless the Competence Committee feels a referral to the Complaints Director is necessary based on information obtained through the Continuing Competence Program that:

- the regulated member has intentionally provided false or misleading information;
- the regulated member displays a lack of competence that has not been remedied by participating in a Continuing Competence Program;
- the regulated member may be incapacitated; or
- the conduct of the regulated member constitutes unprofessional conduct that cannot be readily remedied by means of a Continuing Competence Program[3].

Failure or refusal to comply with Continuing Competence Program requirements is considered unprofessional conduct and may result in sanctions.

Additional information, general advice and/or best practices can be found in the companion resources listed below.

CONTINUING COMPETENCE PROGRAM

Continuing Professional Development (CPD)

Regulated members are required to continue acquiring knowledge and skills throughout their careers. Details on how to fulfill the requirements below can be found in the Continuing Competence Program Manual.

1. A regulated member on a general register, provisional register, telemedicine register or limited practice register with an active practice permit **must** undertake CPD by participating in and complying with the requirements of one of[4]:
    a. the Maintenance of Proficiency (Mainpro+) of the College of Family Physicians of Canada; or
    b. the Maintenance of Certification (MoC) of the Royal College of Physicians & Surgeons of Canada.
2. A regulated member **must** keep records, in a form satisfactory to the Registrar, of any activities undertaken for the purpose of CPD for a period of six (6) years[5].

[3] In accordance with Section 51.1(1) of the *HPA*.
[4] Refers to regulated members registered on both physicians, surgeons, osteopaths and physician assistants registers, where these exist.
[5] In accordance with CFPC's Mainpro+ User's Manual (2019).

3. A regulated member **must,** on the request of and in accordance with the directions of the Registrar, provide copies of the records referred to in clause (2).

4. A regulated member **must** submit a copy of the certification of completion of an applicable CPD program to CPSA upon request.

5. A regulated member's failure or refusal to comply with clauses (2)-(4) is considered unprofessional conduct and may result in sanctions.

General Assessment

General Assessment includes, but is not limited to, CPSA's Physician Practice Improvement Program (PPIP) and Physician Prescribing Practices (PPP) program.

Physician Practice Improvement Program (PPIP)[6]

6. A regulated member on a general register **must** participate in PPIP over a continuous five-year cycle, in accordance with requirements outlined in the Continuing Competence Program Manual[7].

7. A regulated member on a provisional, limited, telemedicine or physician assistant register **may** be required to participate in PPIP over a continuous five-year cycle, in accordance with requirements outlined in the Continuing Competence Program Manual[8].

8. Notwithstanding clauses (6) and (7), a regulated member required to participate in PPIP **may**, if extenuating circumstances exist, submit a request in writing to the Registrar and Continuing Competence Committee to vary the period in which the physician practice improvement activity must be completed.

9. In accordance with the Continuing Competence Program Manual, a regulated member required to participate in PPIP **must** complete each of the following separate activities at least once over a five-year continuous cycle:

    a. a practice-driven quality improvement activity;

    b. a CPSA *Standards of Practice* quality improvement activity; and

[6] While titled "Physician Practice Improvement Program" and "Physician Prescribing Practices Program," these assessments would apply to physician assistants when identified.
[7] Refers to regulated members registered on both physicians, surgeons, osteopaths and physician assistants registers, where these exist.
[8] Refers to regulated members registered on both physicians, surgeons, osteopaths and physician assistants registers, where these exist.

c. a personal development activity.

10. A regulated member **must** retain all documentation related to PPIP activities for a period of six (6) years.

11. Upon request, a regulated member **must** provide documentation of PPIP activities to CPSA.

12. A regulated member's failure or refusal to comply with clauses (10) and (11) is considered unprofessional conduct and may result in sanctions.

Physician Prescribing Practices (PPP)[6]

The PPP program establishes parameters to identify at-risk prescribing and monitors the prescribing of certain medications by regulated members.

13. A regulated member **may** be required to participate in an educational intervention in accordance with the Continuing Competence Program Manual.

Competence Assessment

Competence assessments include, but are not limited to, Individual Practice Review (IPR), Physician Assessment and Feedback (PAF) and the Health & Practice Condition Monitoring Program (HPCM). Details on how to fulfill the requirements below can be found in the Continuing Competence Program Manual.

14. When directed, a regulated member **must** participate in a competence assessment (e.g., IPR, PAF, HPCM) in accordance with the requirements outlined in the Continuing Competence Program Manual, for the purpose of evaluating the regulated member's competence:

    a. competence assessments may require evaluations, including:

        i. practice visits;

        ii. examinations;

        iii. an individualized assessment of professional competence, which may include (but is not limited to) assessments of:

            1. professional knowledge or skills;

            2. communication skills;

3. mental and physical health; professional ethics; or
4. practice management;

iv. interviews; or

v. any other type of evaluation as required by the Competence Committee.

Actions to be taken

15. If the results of a general assessment or competence assessment are unsatisfactory, a regulated member **must** undertake any remedial action directed by the Competence Committee or Registrar, including, but not limited to:

a. successful completion of Continuing Competence Program requirements or professional development activities;

b. successful completion of any examinations, testing, assessment, training, education or treatment to enhance competence in specified areas;

c. practising[G] under the supervision of another regulated member;

d. practice restrictions or limitations;

e. participation in HPCM;

f. reporting on specified matters on specified dates, to the Competence Committee or Registrar;

g. correction of any problems identified in the practice visit; or

h. demonstration of competence gained in a specific area.

Regulated members' responsibility for costs

16. A regulated member **must** pay the costs as directed by CPSA of:

a. a competence assessment; and

b. any action that the regulated member must undertake in response to a direction by the Competence Committee or Registrar under clause (15).

GLOSSARY

Practising: the action of providing medical care—what a regulated member does (verb); "practice" refers to a regulated member's business (noun). For example, a doctor with a private practice practises privately.

RELATED STANDARDS OF PRACTICE

- *Code of Ethics & Professionalism*
- *Duty to Report Self*

COMPANION RESOURCES

- CPSA Continuing Competence Program Manual
- Duty to Report a Colleague/Self Advice to the Profession document

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COLLEGE OF PHYSICIANS
& SURGEONS OF ALBERTA

STANDARDS OF PRACTICE

Continuity of Care

Under Review: No
Issued By: Council: Jan. 1, 2010 (*After-Hours Access to Care* and *Preventing Follow-Up Care Failures*)
Reissued by Council: Apr. 1, 2022; June 1, 2015 (*Continuity of Care*)

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PREAMBLE

All regulated members have a professional and ethical obligation to ensure continuity of care for their patients. Regulated members are expected to use their professional judgment to determine how best to do this while acting in good faith to facilitate access to coordinated care.

Patients who receive greater continuity of care have better health outcomes, higher satisfaction rates and the care they receive is more cost effective. Continuity of care is achieved in two principle ways:

- Through a *continuous caring relationship* with an identified health care professional; and
- Through a *seamlessly integrated service* (e.g., team-based care[G]) enabled by the coordination and sharing of information between different providers.

Continuity of care does not mean individual regulated members need to personally be available at all times to provide continuous access or on-demand care to patients. Doing so would compromise the health of regulated members and negatively impact the quality of care provided to patients.

To facilitate continuity of care and minimize risks to patient safety, CPSA has set out expectations for regulated members, recognizing their role in facilitating continuity of care includes being available and responsive to patients' needs, promoting the seamless integration of care within accountable multidisciplinary teams, including the sharing of necessary information to assure quality patient care, and ensuring patients are provided with information on how to access care when their physicians are unavailable.

STANDARD

1. A regulated member who orders an investigation **must**:
    a. explain the reason and implication(s) of the investigation to the patient and document the discussion in the patient's record, in accordance with the *Patient*

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Record Content standard of practice;

b. for patients who have a risk of receiving a clinically significant investigation result[G], have a system in place to track results when they are not received when expected[1];

c. review investigation results and consultation reports in a timely manner[G];

d. arrange and notify the patient of any necessary follow-up care;

e. document all contacts with the patient, including failed attempts to notify them about follow-up care, in accordance with the *Patient Record Content* standard of practice;

f. directly provide or arrange for continuous after-hours care through an appropriate healthcare provider(s) and/or service[G] with capacity to assess and triage care needs;

g. ensure handover of relevant patient information[G] to the after-hours healthcare provider(s) or service when the patient's need for after-hours care is reasonably foreseeable[G];

h. ensure patients are provided with information on how to access care after hours; and

i. if using a recorded message to direct patients to a healthcare provider or service, have evidence of an agreement[G] with the identified healthcare provider or service.

2. A regulated member who participates in a team-based care[G] environment **must** assure processes and procedures are in place that ensure safe care of patients, including:

   a. a process for team-based review of investigation results and consultation reports;

   b. a process for the timely sharing of patient health information with other providers to support quality patient care; and

   c. clear processes within the team for timely follow up care.

3. A regulated member, including those involved in a team-based care[G] environment, who copies another healthcare provider (e.g., when requesting an investigation, providing treatment requiring follow-up, etc.) **remains** responsible for any necessary follow-up care **unless** the healthcare provider/team to whom the copy is directed formally agrees to accept responsibility for follow-up care.

[1] From CPSO's *Managing Tests* policy (September 2019).

4. Where another healthcare provider agrees (see "Evidence of an agreement" in glossary) to accept responsibility for follow-up care, the regulated member **must** ensure handover is done in accordance with the *Transfer of Care* standard of practice.

5. A regulated member who receives an investigation result in error (e.g., same or similar name or contact information) **must** inform the laboratory or diagnostic facility of the error in a timely manner.

6. A regulated member **must** have a process in place for receiving and responding to critical investigation results[G] reported by a laboratory or imaging facility after regular working hours or in the regulated member's absence[2].

7. A regulated member who will be unavailable during temporary absences **must**:

    a. enter into an agreement (see "Evidence of an agreement" in glossary) with an appropriate healthcare provider and/or service to provide ongoing care during periods of unavailability, ensuring handover at the start and conclusion of the coverage, including management of:

        i. outstanding investigations and investigation results;

        ii. outstanding referrals and consultation reports; and

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

    b. have a plan or coverage in place that allows other healthcare providers to communicate or request information pertaining to patients under their care during a temporary absence[G]; and

    c. inform a patient of ongoing care arrangements where they would have a reasonable expectation[G] of being informed.

8. A regulated member **must not** charge patients for insured after-hours access.

9. A regulated member **must not** order a diagnostic test or make a referral request in another healthcare provider's name.

[2] From CPSO's *Availability and Coverage* policy (September 2019).

10. Notwithstanding clause (9), the regulated member **may** order a diagnostic test or make a referral in another healthcare provider's name in certain circumstances, **if** they carbon-copy ("CC") themselves **and** there is evidence of an agreement[G], including, but not limited to:
    a. providing locum coverage;
    b. assignment of a post-graduate training program participant to a service; or
    c. practising in a team-based care[G] environment, in accordance with clause (2).

GLOSSARY

Clinically significant investigation result: a test result determined by a reasonable physician to be one which requires follow-up in a timely fashion, urgently if necessary. Physicians determine the clinical significance of a test result using their clinical judgment and knowledge of the patient's symptoms, previous test results, and/or diagnosis[1].

Critical investigation results: results of such a serious nature that immediate patient management decisions may be required[1].

Evidence of an agreement: documentation in which the healthcare provider or service agrees to accept responsibility for follow-up care (e.g., an email).

Reasonable expectation: typically in established physician-patient relationships where a patient would see the regulated member during their absence. Can also include patients awaiting investigation results.

Reasonably foreseeable: the likelihood the patient will experience issues, adverse effects, etc. in the context of that particular patient's health care.

Relevant patient information: pertinent clinical information including, but not limited to, the patient's name and contact information, the regulated member's contact information (in the event of an emergency), relevant/outstanding investigations, treatment plans/recommendations, etc.

[Appropriate] service: for the purposes of this standard, "service" includes, but is not limited to, Health Link, an emergency service, after-hours medical clinics. Evidence of an agreement with an appropriate service is required.

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Team-based care[3]**:** the provision of health programs and services by two or more healthcare providers who work collaboratively with patients and their circle of care to deliver coordinated, high-quality health service. For the purpose of this standard, team-based care requires processes outlining clear expectations for each team member's responsibilities and accountabilities.

Temporary absence: vacations and leaves of absence (e.g., parental leave, educational leave), as well as unplanned absences due to, for example, illness or family emergencies. This does not include suspensions of a physician's certificate of registration. For expectations relating to suspensions, please see the *Closing or Leaving a Medical Practice* standard[2].

Timely manner: a timeframe commensurate with the urgency of the presenting issue.

ACKNOWLEDGEMENTS

CPSA acknowledges the assistance of the College of Physicians and Surgeons of Manitoba, the College of Physicians and Surgeons of New Brunswick, the College of Physicians and Surgeons of Ontario, and the College of Physicians and Surgeons of Saskatchewan in preparing this document.

RELATED STANDARDS OF PRACTICE

- *Code of Ethics & Professionalism*
- *Episodic Care*
- *Establishing the Physician-Patient Relationship*
- *Patient Record Content*
- *Referral Consultation*
- *Responsibility for a Medical Practice*
- *Virtual Care*

COMPANION RESOURCES

- Advice to the Profession documents:
  - Continuity of Care
  - Episodic Care
  - Responsibility for a Medical Practice

[3] From the Institute of Medicine's Core Principles & Values of Effective Team-Based Health Care discussion paper (October 2012).

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    - Virtual Care
- Advice to Albertans: Virtual Care
- CMPA's The Most Responsible Physician
- AMA's After Hours Support for Continuity of Care
- Health Link's FAQs for Clinical Groups

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COLLEGE OF PHYSICIANS
& SURGEONS OF ALBERTA

STANDARDS OF PRACTICE

Disclosure of Harm

Under Review: No

Issued By: Council: January 1, 2010

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COLLEGE OF PHYSICIANS
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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; and

   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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COLLEGE OF PHYSICIANS
& SURGEONS OF ALBERTA

STANDARDS OF PRACTICE

Dispensing of Schedule 1 & 2 Drugs by a Physician for a Fee

Under Review: No

Issued By: Council: January 1, 2010

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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 CPSA.

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 CPSA.

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:

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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;

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.

RELATED STANDARDS OF PRACTICE

- *Prescribing: Administration*
- *Prescribing: Drugs Associated with Substance Use Disorder or Substance-Related Harms*
- *Sale of Products by Physicians*

COMPANION RESOURCES

- General Infection Prevention & Control Standards
- Health Canada's Safe Disposal of Prescription Drugs
- Health Canada's Physical Security Directive

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COLLEGE OF PHYSICIANS
& SURGEONS OF ALBERTA

STANDARDS OF PRACTICE

Duty to Report a Colleague

Under Review: No
Issued By: Council: Jan 1, 2010
Reissued by Council: Sep 1, 2012; Oct 1, 2020
Updated: June 27, 2024 (program name change only)

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COLLEGE OF PHYSICIANS
& SURGEONS OF ALBERTA

The ***Standards of Practice*** of the College of Physicians & Surgeons of Alberta ("CPSA") 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. CPSA also provides **Advice to the Profession** to support the implementation of the Standards of Practice.

A regulated member who is uncertain about legislated reporting requirements not addressed in this standard should refer to the Legislated Reporting & Release of Medical Information Advice to the Profession document or consult with the Canadian Medical Protective Association.

Reporting Requirements

1. A regulated member **must** notify[i] the Registrar, or the delegate, of the applicable college of the following circumstances as soon as the regulated member has reasonable[ii] grounds to believe a regulated health professional of any college[iii]:

    a. presently has a physical, cognitive, mental and/or emotional[iv] condition[v] that negatively impacts, or is likely to negatively impact[vi], their work[vii];

    b. is charged with or convicted of a criminal offence[viii];

    c. is demonstrating a repeated inability to provide patients with what is reasonably considered competent care;

    d. is demonstrating an unwillingness or inability to address behaviour that interferes with patient care or negatively impacts the ability of other regulated members, learners or healthcare workers to provide patient care; or

    e. is behaving in a manner outside of providing patient care that could reasonably be considered unprofessional conduct under the *Health Professions Act* (*HPA*)[ix].

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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.

2. A regulated member **must** report another regulated health professional to the relevant college as soon as the regulated member has reasonable grounds to believe the regulated health professional is engaging in behaviour that constitutes sexual abuse or sexual misconduct of a patient, as required by the *HPA*.

3. In accordance with the *HPA*, a report under clause 2 is **not** required (but **may** be made)[x] if information respecting the conduct of another regulated health professional is obtained in the course of the regulated member providing professional services to the other regulated health professional.

4. When a patient discloses information that leads a regulated member to reasonably believe a regulated health professional has committed sexual abuse or sexual misconduct against a patient, the regulated member **must**:

   a. provide the patient with information on how to file a complaint with the appropriate regulatory college;

   b. document the account of the sexual boundary violation in the patient's record; and

   c. advise the patient of the regulated member's duty to report the incident to the appropriate regulatory college.

5. Notwithstanding subclause 4(c), while the name of a regulated health professional who is reasonably believed to have engaged in sexual abuse or sexual misconduct against a patient **must** be reported to the relevant college per the *HPA,* this **can** be done without providing the name of the patient.

6. If a regulated member is unsure if they should report a colleague, regulated health professional or regulated health professional-patient, they **must** seek appropriate advice (e.g., the Canadian Medical Protective Association or CPSA).

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

7. A regulated member treating another physician or other regulated health professional, or a regulated member working within a provincial Physician Health Program in a non-treating capacity (e.g., the AMA's Physician and Family Support Program), **must** make all reasonable efforts to understand the nature and scope of the regulated health professional-patient's practice and, with the consent of the

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regulated health professional-patient, seek information regarding the impact of any medical condition on their practice.

8. The treating physician, or a regulated member working within a provincial Physician Health Program in a non-treating capacity, **must** notify the regulated health professional-patient's regulatory college when the regulated health professional-patient presently has a physical, cognitive mental and/or emotional condition where it is reasonably foreseeable that patients, or others within the context of the regulated health professional-patient's medical practice, could be seriously harmed[xi] (physically or psychologically) as a result of the medical condition[xii].

9. Notwithstanding clause 8, the treating physician **must** advise the regulated health professional-patient of their duty to self-report to their regulatory college and document this advice in the patient's record.

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[i] "Notify" has been used to signify that contacting CPSA does not automatically result in a formal report, complaint, etc. "Report" is used in clauses specific to the *HPA* to mirror its language.

[ii] "Reasonable grounds" connotes a belief in a serious possibility based on credible evidence or the point where credibly-based probability replaces suspicion. It is the reasonable belief that an event is not unlikely to occur for reasons that rise above mere suspicion.

[iii] Please refer to Section 127.2(1) of the *Health Professions Act* (*HPA*).

[iv] Per Recommendation 5 of the Health Law Institute's "Physicians with Health Conditions: Law and Policy Reform to Protect the Public and Physician-Patients."

[v] Conditions would include, but not be limited to, the following:

(a) blood borne viral infections in those individuals performing exposure-prone procedures
(b) conditions affecting primary senses: vision, hearing etc.
(c) neurological conditions affecting cognition, motor or sensory function, seizure disorder
(d) psychiatric conditions
(e) substance use disorder
(f) physical disability
(g) metabolic conditions

[vi] 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. (Per Recommendation 3 of the Health Law Institute's "Physicians with Health Conditions: Law and Policy Reform to Protect the Public and Physician-Patients.")

[vii] 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.

[viii] Please refer to Section 127.1(4) of the *HPA*.

[ix] Please refer to Section 1(1)(pp) of the *HPA*.

[x] Please refer to Section 127.2(2) of the *HPA*.

[xi] Serious harm" is defined as that which is either irreversible or would result in more than minor pain or injury (psychological or physical).
[xii] Section 35(1)(m) of the *HIA* allows disclosure of medical information without consent if the regulated member believes it will avert or minimize an imminent danger to the health or safety of any person.

RELATED STANDARDS OF PRACTICE

- *Boundary Violations: Personal*
- *Boundary Violations: Sexual*
- *Code of Ethics & Professionalism*
- *Duty to Report Self*

COMPANION RESOURCES

- Physician and Family Support Program (AMA)
- Reporting Another Physician (CMPA)
- Health and Practice Condition Monitoring Program (CPSA)
- Advice to the Profession documents:
    - Duty to Report a Colleague/Self
    - Boundary Violations: Personal
    - Boundary Violations: Sexual

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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.

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COLLEGE OF PHYSICIANS
& SURGEONS OF ALBERTA

STANDARDS OF PRACTICE

Duty to Report Self

Under Review: No
Issued By: Council: Jan 1, 2010 (*Self-Reporting to the College*)
Reissued by Council: Sep 1, 2012; Oct 1, 2020 (*Duty to Report Self*)
Updated: June 27, 2024 (program name change only)

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1. A regulated member **must** notify[i] the Registrar, or delegate, of CPSA of the following personal circumstances as soon as reasonably possible once they become aware thereafter:

   a. sexual abuse of or sexual misconduct with a patient as defined in the *Health Professions Act* (*HPA*)[ii];

   b. presently has a physical, cognitive, mental and/or emotional[iii] condition[iv] that negatively impacts, or is likely to negatively impact[v], the regulated member's work[vi];

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

   d. any findings of professional negligence or malpractice[vii];

   e. any findings of unprofessional conduct by a regulatory authority in another jurisdiction or by any other college under the *HPA*;

   f. any charges or convictions of a criminal offence[viii];

   g. demonstrating a repeated inability to provide patients with what is reasonably[ix] considered competent care;

   h. unwillingness or inability to address behaviour that interferes with patient care or negatively impacts the ability of other regulated members, learners or healthcare workers to provide patient care; or

   i. behaving in a manner outside of providing patient care that could reasonably be considered unprofessional conduct under the *HPA*[x].

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2. A regulated member who breaches practice restrictions, limitations or conditions imposed by CPSA or any other authority **must** notify CPSA.

3. If the regulated member is unsure if they should self-report, they **must** seek appropriate advice (e.g., the Canadian Medical Protective Association or CPSA).

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[i] [i] "Notify" has been used to signify that contacting CPSA does not automatically result in a formal report, complaint, etc. "Report" is used in clauses specific to the *HPA* to mirror its language.
[ii] Please refer to Section 127.2(1) of the *Health Professions Act* (*HPA*).
[iii] Per Recommendation 5, page 4 of the Health Law Institute's "Physicians with Health Conditions: Law and Policy Reform to Protect the Public and Physician-Patients."
[iv] Conditions would include, but not be limited to, the following:
   a. blood borne viral infections in those individuals performing exposure-prone procedures
   b. conditions affecting primary senses: vision, hearing etc.
   c. neurological conditions affecting cognition, motor or sensory function, seizure disorder
   d. psychiatric conditions
   e. substance use disorder
   f. physical disability
   g. metabolic conditions
[v] "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. (Per Recommendation 3, page 3 of the Health Law Institute's "Physicians with Health Conditions: Law and Policy Reform to Protect the Public and Physician-Patients.")
[vi]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.
[vii] Per requirements of Section 127.1 of the *HPA*.
[viii] Please refer to Section 127.1(4) of the *HPA*.
[ix] "Reasonable" connotes a belief in a serious possibility based on credible evidence or the point where credibly-based probability replaces suspicion. It is the reasonable belief that an event is not unlikely to occur for reasons that rise above mere suspicion.
[x] Please refer to Section 1(1)(pp) of the *HPA*.

RELATED STANDARDS OF PRACTICE

- *Boundary Violations: Personal*
- *Boundary Violations: Sexual*
- *Code of Ethics & Professionalism*
- *Duty to Report a Colleague*

COMPANION RESOURCES

- Physician and Family Support Program (AMA)
- Canadian Medical Protective Association

- Health and Practice Condition Monitoring Program (CPSA)
- Advice to the Profession documents:
  - Duty to Report a Colleague/Self
  - Boundary Violations: Personal
  - Boundary Violations: Sexual

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COLLEGE OF PHYSICIANS
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STANDARDS OF PRACTICE

Episodic Care

Under Review: No
Issued By: Council: Jan. 1, 2010
Reissued by Council: Apr. 1, 2022; June 1, 2015

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Note: a glossary of terms can be found at the end of this document. Glossary terms are indicated in teal with a "G" throughout this document.

PREAMBLE

All regulated members, including those who provide episodic care[G], have a professional and ethical obligation to ensure continuity for care to their patients and are expected to use professional judgment in determining how best to accomplish this while acting in good faith to facilitate access to coordinated care.

In accordance with the *Continuity of Care* standard of practice, regulated members are responsible for the episodic care provided and any follow-up care needed unless another healthcare provider has formally agreed to assume that responsibility. Ultimate responsibility for appropriate continuity of care and follow up of medical care and investigations lies with the ordering regulated member.

Additional information, general advice, and/or best practices can be found in the Episodic Care Advice to the Profession document.

STANDARD

1. A regulated member who requests an investigation, performs a procedure, provides treatment that requires follow-up or makes a referral to another healthcare provider **must** do so in accordance with the *Continuity of Care*, *Referral Consultation* and *Transfer of Care* standards of practice.

2. A regulated member providing episodic care **must**:

    a. inform the patient that episodic care is intended to address the patient's presenting concern(s), referred consultation or identified medical condition(s);

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b. explain the limitations of the episodic medical care they are providing and the extent of any follow-up processes they will manage;

c. establish whether the patient has a primary care provider and, if so, provide the primary care provider with a record of the encounter if it is in the patient's best interests[G] to do so;

d. document subclauses (a) through (c) in the patient's record in accordance with the *Patient Record Content* standard of practice; and

e. either provide necessary follow-up care personally or ensure arrangements are in place for follow-up care in accordance with the *Continuity of Care* standard of practice.

3. A regulated member, including those involved in a team-based care environment, who copies another healthcare provider (e.g., when requesting an investigation, performing a procedure, providing treatment requiring follow-up, making a referral, etc.) **must** do so in accordance with the *Continuity of Care* standard of practice.

4. Where another healthcare provider agrees to accept responsibility for follow-up care, the regulated member **must** document the transfer of care in the patient's record.

5. A regulated member **must** provide or arrange for continuous after-hours care in accordance with the *Continuity of Care* standard of practice.

GLOSSARY

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, in accordance with the *Establishing the Physician-Patient Relationship* standard of practice.

Patient's best interests: will differ from patient to patient and will depend on the regulated member's clinical judgment, but the default expectation is to provide the patient's primary care provider with the record of the encounter to ensure they have the information necessary to ensure continuity of care for their patient. When a record of the encounter is not shared with the primary care provider, the member should thoroughly document the rationale behind their decision to withhold the information in the patient's record.

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ACKNOWLEDGEMENTS

CPSA acknowledges the assistance of the College of Physicians and Surgeons of British Columbia, the College of Physicians and Surgeons of Manitoba, the College of Physicians and Surgeons of Nova Scotia, the College of Physicians and Surgeons of Ontario, the College of Physicians and Surgeons of Prince Edward Island, and the College of Physicians and Surgeons of Saskatchewan in preparing this document.

RELATED STANDARDS OF PRACTICE

- *Cannabis for Medical Purposes*
- *Continuity of Care*
- *Establishing the Physician-Patient Relationship*
- *Patient Record Content*
- *Patient Record Retention*
- *Prescribing: Administration*
- *Prescribing: Drugs Associated with Substance Use Disorder or Substance-Related Harms*
- *Referral Consultation*
- *Responsibility for a Medical Practice*
- *Safe Prescribing for Opioid-Use Disorder*
- *Transfer of Care*
- *Virtual Care* (pending)

COMPANION RESOURCES

- Advice to the Profession documents:
  - Episodic Care
  - Cannabis for Medical Purposes
  - Continuity of Care
  - Physicians as Custodians of Patient Records
  - Prescribing: Administration
  - Prescribing: Drugs Associated with Substance Use Disorder or Substance-Related Harms
  - Referral Consultation
  - Responsibility for a Medical Practice
  - Safe Prescribing for Opioid Use Disorder

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    - Virtual Care
- CMPA's The Most Responsible Physician

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COLLEGE OF PHYSICIANS
& SURGEONS OF ALBERTA

STANDARDS OF PRACTICE

Establishing the Physician-Patient Relationship

Under Review: No
Issued By: Council: January 1, 2010 (*Establishing the Physician-Patient Relationship in Office-Based Settings*)
Reissued by Council: June 1, 2015 (*Establishing the Physician-Patient Relationship*)

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1. An established physician-patient relationship[i] 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/ 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;

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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

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 CPSA on request.

RELATED STANDARDS OF PRACTICE

- *Charging for Uninsured Professional Services*
- *Episodic Care*
- *Patient Record Retention*
- *Terminating the Physician-Patient Relationship*

[i] 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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STANDARDS OF PRACTICE

Female Genital Mutilation

Under Review: No

Issued By: Council: May 1, 2023

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PREAMBLE

Female genital mutilation[G] (FGM), also referred to as female circumcision or female genital cutting, is internationally recognized as a harmful practice and violation of human rights.[1] The immediate and long-term health risks and complications of FGM can be serious and life-threatening.[2]

FGM is classified as aggravated assault under section 268(1) of the *Criminal Code of Canada* (*Criminal Code*). Under the *Criminal Code*, any person who commits an aggravated assault is guilty of an indictable offence and is liable to imprisonment for a term not exceeding 14 years, including medical professionals and family members. Involvement in FGM is also a contravention of the Canadian Medical Association's *Code of Ethics & Professionalism*.

Section 268(3) of the *Criminal Code* excludes medically appropriate treatment involving the labia majora, labia minora, or clitoris on a patient who has provided informed consent that is consistent with the *Informed Consent* standard of practice.

The *Health Professions (Protecting Women and Girls) Amendment Act, 2022* (Act) requires that regulatory colleges have standards of practice to address FGM by their members. These standards advise that, under the amended *Health Professions Act* (HPA)[3], a person

[1] The World Health Organization's "Eliminating female genital mutilation: an interagency statement" (2008).
[2] From the Journal of Obstetrics and Gynaecology of Canada's "Guideline No. 395, Female Genital Cutting" (June 15, 2019).
[3] *Health Professions Act*, Section 11(2), Dec. 15, 2022.

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

who has been convicted of a criminal offence related to the procurement or performance of FGM is not eligible for registration as a regulated member.

This standard has been developed to provide support for better physical and mental health care by regulated members of individuals who have undergone FGM.

For additional guidance, please refer to the "Companion Resources" at the end of this document.

STANDARD

1. A regulated member **must not** procure, perform, assist in, refer or accept referrals for FGM, including reinfibulation[G].

2. A regulated member **must** report to a law enforcement agency (e.g., appropriate child welfare protection service) when a child has recently been subjected to, or the regulated member has reasonable grounds to believe the child may be subjected to, FGM, regardless of where the procedure has been or may be undertaken.

3. A regulated member who has reasonable grounds to believe another regulated health professional is procuring, performing, assisting, referring or accepting referrals for FGM **must** report the regulated health professional in accordance with the *Duty to Report a Colleague* standard of practice.

4. A regulated member whose practice may include treating patients who have undergone FGM **must** educate themselves on:

    a. how FGM presents;

    b. possible complications of FGM;

    c. how to properly manage these complications or, if outside the regulated member's scope, refer to an appropriate healthcare provider (e.g., gynecologist, urologist) in accordance with the *Referral Consultation* standard of practice;

    d. resources to support the mental health of patients who have undergone FGM; and

    e. resources to support the patient and their family with the aftercare required following FGM.

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5. A regulated member **must** support patients and families who are at risk of or have undergone FGM by:

   a. providing culturally safe counselling about the dangers of the practice;

   b. connecting patients to mental health supports; and

   c. connecting patients to resources.

GLOSSARY

Female genital mutilation (FGM): means the excision[G], infibulation[G] or mutilation[G], in whole or in part, of the labia majora, labia minora, clitoral hood or clitoris of a person, **except** where valid consent is given **and** a surgical or other procedure is performed by a regulated member under the HPA, performed for the benefit of the physical health of the person **or** for that person to have normal reproductive functions or normal sexual appearance or function **or** the person is at least 18 years of age **and** there is no resulting bodily harm.[4]

Reinfibulation: the restitching together of the two sides of the vulva, labia minora, or labia majora on a person who was previously infibulated and subsequently deinfibulated[G], such as after the birth of a child.[5]

Excision: the external part of the clitoris and labia minora are partially or totally removed, with or without excision of the labia majora.[6]

Infibulation: consists of narrowing the vaginal opening through the creation of a covering seal. The seal is formed by cutting and repositioning the labia minora, or labia majora, sometimes through stitching, with or without removal of the clitoral prepuce/clitoral hood and glans.[5]

Continues on following page

[4] From *Health Professions (Protecting Women and Girls) Amendment Act, 2022*.
[5] From the World Health Organization's "Female Genital Mutilation" (Jan. 31, 2023).
[6] From End FGM European Network's "Types of FGM."

Mutilation: in the context of this standard, comprises all procedures that involve partial or total removal of the external female genitalia or other injury to the female genital organs for non-medical reasons[7].

Deinfibulated: refers to the practice of cutting open the sealed vaginal opening of an individual who has been infibulated, which is often necessary for improving health and well-being as well as to allow intercourse or to facilitate childbirth.[5]

ACKNOWLEDGEMENTS

CPSA acknowledges the assistance of the College of Physicians and Surgeons of Manitoba, the College of Physicians and Surgeons of Ontario, and the Journal of Obstetrics and Gynaecology Canada in preparing this document.

RELATED STANDARDS OF PRACTICE

- *Boundary Violations: Personal*
- *Duty to Report a Colleague*
- *Informed Consent*

COMPANION RESOURCES

- Advice to the Profession documents:
  - Female Genital Mutilation (TBD)
  - Boundary Violations: Personal
  - Duty to Report a Colleague/Self
  - Informed Consent for Adults
  - Informed Consent for Minors
  - Legislated Reporting and Release of Medical Information
- Advice to Albertans: Female Genital Mutilation (TBD)
- The Journal of Obstetrics and Gynaecology of Canada's Guideline No. 395 – Female Genital Cutting (Feb. 2020)
- The World Health Organization's "Female Genital Mutilation" (May 2022)

[7] UNICEF's "What is female genital mutilation?"

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STANDARDS OF PRACTICE

Human Health Research

Under Review: No
Issued By: Council: September 1, 2012 (*Health Human Research Ethics Review*)
Reissued by Council: October 1, 2015 (*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[i].

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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RELATED STANDARDS OF PRACTICE

- *Code of Ethics & Professionalism*
- *Conflict of Interest*
- *Informed Consent*

COMPANION RESOURCES

- Alberta Clinical Research Consortium
- ARECCI Ethics Screening Tool
- Tri-Council Policy Statement: Ethical Conduct for Research Involving Humans (CIHR, NSERC, SSHRCC)

[i] As of this date, the recommended tool is the ARECCI (A pRoject Ethics Community Consensus Initiative).

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STANDARDS OF PRACTICE

Informed Consent

Under Review: No

Issued By: Council: January 1, 2010

Reissued by Council: June 1, 2016

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1. A regulated member **must** obtain a patient's informed consent[i] 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 consent[1]; and

   b. if the patient is not a mature minor, seek informed consent from the patient's legal guardian, in accordance with legislation[1].

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 legislation[1].

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 CPSA.

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;

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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;

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;

vi. natural history of the condition and the consequences of forgoing treatment; and

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 CPSA'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.

RELATED STANDARDS OF PRACTICE

- *Code of Ethics & Professionalism*
- *Human Health Research*
- *Medical Assistance in Dying*
- *Responsibility for a Medical Practice*
- *Supervision of Restricted Activities*

COMPANION RESOURCES

- Advice to the Profession: Informed Consent for Adults
- Advice to the Profession: Informed Consent for Minors
- Advice to the Profession: Legislated Reporting & Release of Medical Information
- Office of the Public Guardian's Guide to Capacity Assessment under the Personal Directives Act
- Office of the Public Guardian's Resources for Capacity Assessors
- CMPA's Consent: A guide for Canadian Physicians
- CMPA's Informed consent: Overview and objectives
- CMPA's Informed consent: Why and when do we need consent?

[i] See CPSA's Advice to the Profession: Informed Consent for Adults and Informed Consent for Minors.

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STANDARDS OF PRACTICE

Infection Prevention and Control (IPAC)

Under Review: No
Issued By Council: Jan. 1, 2010 (*Reprocessing Medical Equipment*)
Reissued By Council: Nov. 1, 2022 (*Infection Prevention and Control*)

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PREAMBLE

Regulated members are expected to ensure and promote effective infection prevention and control (IPAC) policies, systems and practices.

Infection prevention and control is a multi-faceted approach that includes, but is not limited to, hand hygiene, point-of-care risk assessments, environmental cleaning and disinfection, and reprocessing of reusable medical devices.

This standard sets out the specific requirements regulated members must adhere to in order to prevent the potential spread of infection between themselves, patients and staff in clinical settings.

Additional information, general advice and/or best practices can be found in the companion resources listed below.

STANDARD

1. A regulated member practising in a community medical clinic[1] **must** practise in accordance with the Infection Prevention & Control Requirements for Medical Clinics.

2. In situations where a location offers both community medical care and accredited services, a regulated member **must** ensure all requirements related to infection prevention and control are followed accordingly.

3. A regulated member who practises in a community medical clinic[1] and uses reprocessed, reusable medical devices **must** ensure procedures for the cleaning, disinfecting and sterilizing of those devices comply with the Reusable and Single-

[1] "Community medical clinics" include any location where a regulated member provides professional services, which is not a hospital or an accredited medical facility as defined under section 8 of Schedule 21 of the HPA.

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Use Medical Device Requirements for Medical Clinics.

4. A regulated member who practises in a community medical clinic[1] and uses single-use medical devices **must** follow Part A of the Reusable and Single-Use Medical Device Requirements for Medical Clinics.

5. A regulated member **must** ensure ongoing quality assurance through monitoring practices and changing practice accordingly.

6. A regulated member **must** fully cooperate with any IPAC-related practice visit or inspection, in accordance with the *Health Professions Act*[2], including:

   a. allowing assessors to enter and assess the premises;

   b. allowing assessors access to examine all activities, equipment, policies and/or procedures, records, correspondence and other documents or electronic data related to IPAC, and to make copies; and

   c. providing all information requested by the assessor, including answering the assessor's questions.

ACKNOWLEDGEMENTS
CPSA acknowledges the assistance of the College of Physicians & Surgeons of British Columbia and the College of Physicians & Surgeons of Saskatchewan in preparing this document.

RELATED STANDARDS OF PRACTICE

- *Practising Outside of Established Conventional Medicine*

COMPANION RESOURCES

- Accreditation: Non-Hospital Surgical Facilities
- Infection Prevention & Control Requirements for Medical Clinics
- Self-assessment of your medical clinic's IPAC measures
- Requirements for Medical Devices
- Guidance for Medical Clinics: Reusable and Single-Use Medical Device Requirements

[2] *Health Professions Act*, Part 3.0: Continuing Competence and Practice Visits, and Part 3.1: Inspectors.

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STANDARDS OF PRACTICE

Job Action

Under Review: No

Issued by Council: Jan 1, 2010

Reissued by Council: Jan 1, 2021; Apr 1, 2017

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Note: a glossary of terms can be found at the end of this document. Glossary terms are indicated in teal with a "G" throughout this document.

PREAMBLE

This standard applies to "job action[G]," which is the threatened or actual withdrawal of services[G] to further a negotiating position during a dispute. The ultimate responsibility for any withdrawal rests with each regulated member to ensure their actions are consistent with the ethical and professional standards expected of regulated members.

A regulated member's decision to close or leave a medical practice or to change their pattern of practice based on personal or financial considerations does **not** constitute job action unless these actions are intended to compromise access to physician services to further a negotiating position. Regulated members must abide by the relevant standards of practice when closing, leaving[G] or making changes to their scope of practice.

The *Job Action* standard of practice does not affect the ability of regulated members to advocate for their patients' interests, their own interests or the interests of the health care system as a whole; however, if this advocacy is accompanied by job action, as defined, the provisions of this standard of practice apply.

Wherein evaluating a dispute involving a limitation or withdrawal of regulated member services CPSA determines the alternative resources established are ineffective or inadequate, such that an undue risk of harm to patients has been created, CPSA **may** insist that some or all of the regulated members involved in the withdrawal of service must continue to provide medical services that are in alignment with this standard of practice. In these circumstances, in accordance with its legislated responsibility to establish and enforce ethical and professional standards of practice, CPSA **must** consider the prevention of patient harm as its primary responsibility and take whatever action is available under the *Health Professions Act* to meet that responsibility.

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STANDARD

A regulated member **must not** engage in job action, except under extremely controlled circumstances. The following **must** be considered prior to the contemplation of any form of job action:

1. Regulated members **must** fulfill their professional responsibilities[G] and uphold the reputation of the profession by providing services to those in need of urgent/emergent[G] care during job actions.

2. In determining what constitutes urgent/emergent or necessary medical care, regulated members **must** use their clinical judgment, informed by the existing health status and specific needs of patients, and regulated members' individual and collective responsibilities to provide care.

3. When contemplating a job action, regulated members **must** first explore all alternative options that may be available to resolve the concern that has motivated their desire to withdraw services.

4. If the concern cannot otherwise be resolved, regulated members **must** consider the following before making the decision to withdraw services:

    a. what is in the best interests of patients;

    b. whether patients will be abandoned;

    c. whether patients will be deprived of access to urgent/emergent medical care; and

    d. whether patients will be put at risk of harm.

5. If, after carefully considering the above factors, regulated members decide that proceeding with a withdrawal of services is **not** contrary to their professional responsibilities, they **must** take into consideration the impact on patients in their unique clinical circumstances and consider the following:

    a. the nature and location of the practice and the patient population served; and

    b. the availability and adequacy of alternative resources for the care, ongoing monitoring and transfer of patients.

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6. In order to protect patients in the event of a withdrawal of services, regulated members **must**:

   a. make arrangements for communication or consultation with other care providers to ensure the appropriate transfer of care[G] of patients. This **may** require physician-to-physician communication in situations where a regulated member is required to re-assess patients;

   b. provide written notification of the intended withdrawal of services to CPSA, appropriate health authority medical leaders and others involved in the delivery of hospital and medical services: the period of notice may vary depending upon the specific circumstances, but **must** be reasonable to allow the hospital or health authority an opportunity to review with the regulated members the nature, extent and impact of the proposed action and to consider any arrangements that need to be made in response;

   c. maintain awareness of the impact of the withdrawal of services on an ongoing basis to ensure the initial arrangements for patient care continue to be adequate; and

   d. if urgent/emergent care requirements are not being met, alter the arrangements to ensure patients receive adequate care.

7. An entire group[G] of regulated members or an entire hospital department **must not** engage in a withdrawal of services for the purpose of job action unless all the requirements of clauses 3-6 are met.

8. Regulated members **may** want to obtain independent legal advice from the Canadian Medical Protective Association (CMPA) or legal counsel regarding their legal responsibilities.

GLOSSARY

Job action: the threatened or actual withdrawal of services to further a negotiating position during a dispute.

Withdrawal of services: for the purpose of this standard, withdrawal of services is defined as a limit to the services an individual physician or group of physicians provide to further a negotiating position during a dispute.

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Closing/leaving practice: the discontinuation of practice with no intention of returning, a leave of absence more than 12 months or a significant move from the current practice patients could not reasonably be expected to travel. See the *Closing or Leaving a Medical Practice* standard of practice for more information.

Urgent/emergent: a condition is considered "urgent" when it is not life-threatening, but requires care in a timely manner (within 24 hours); "emergent" care is medical care that, if not provided, would likely result in the need for crisis intervention due to concerns of potential danger to self, others or grave disability.

Professional responsibilities: in accordance with the *Standards of Practice, Code of Ethics & Professionalism* and the *Code of Conduct*.

Transfer of care: the transfer of full or partial responsibility for a patient's care to another healthcare provider, consisting of clear communication (including a timely written summary) to the accepting healthcare provider, as well as identifying roles and responsibility to the patient, as expressed in the *Transfer of Care* standard of practice.

Entire group: the makeup of a group is contextual and will depend on the resources available to the community.

ACKNOWLEDGEMENTS

CPSA acknowledges the assistance of the College of Physicians and Surgeons of British Columbia, the College of Physicians and Surgeons of Ontario and the College of Physicians and Surgeons of Nova Scotia in preparing this document.

RELATED STANDARDS OF PRACTICE

- *Code of Ethics & Professionalism*
- *Conflict of Interest*
- *Continuity of Care*
- *Transfer of Care*

COMPANION RESOURCES

- Advice to the Profession documents:
  - Continuity of Care
  - Job Action

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STANDARDS OF PRACTICE

Medical Assistance in Dying (MAID)

Under Review: No
Issued by Council: June 1, 2016
Reissued by Council: Apr. 1, 2023

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PREAMBLE

For the purpose of this standard, "medical assistance in dying" (MAID) means the administration of medications by a regulated member to a person, or the prescribing or providing of medications, and within the parameters set out in the Legislation and Regulations, by a regulated member, to a person at their request, to intentionally cause the person's own death. Section 241.2 of the *Criminal Code of Canada* (*Criminal Code*) creates the legal authority for MAID, and all regulated members must understand the scope and requirements outlined in section 241.2.

With the addition of section 241.2 of the *Criminal Code*, MAID was first legalized in Canada in 2016 for individuals with terminal illnesses. In 2021, section 241.2 of the *Criminal Code* was amended to include non-terminal physical conditions excluding mental illness. Bill C-7 was introduced in Oct. 2020 to remove the mental illness exemption; however, Bill C-39 has extended the eligibility for persons whose sole underlying condition to be a mental illness until Mar. 2024.

At this time, mature minors[G], advance directives and patients whose sole underlying medical condition is a mental illness remain ineligible for MAID under the *Criminal Code*.

Regulated members have a right under the *Canadian Charter of Rights and Freedoms* to freedom of conscience and religion and, as such, are not obligated to administer or participate in MAID processes. Regulated members must follow the *Conscientious Objection* standard of practice if they decline a request for MAID services: the regulated member's conscientious objection must not impede the rights of patients to receive

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unbiased information about and timely access to any legally permissible and available health services, including MAID.

Just as regulated members have the right to act according to their conscience, they must also respect differences of opinion among colleagues and patients, while meeting their duty of non-abandonment to the patient by acknowledging and responding in a manner that is just to the patient's medical concerns and requests regardless of the regulated member's moral construct[1].

For additional guidance, please refer to the "Companion Resources" at the end of this document.

STANDARD

1. A regulated member who receives an inquiry from a patient regarding MAID **must** provide the patient, or their representative, with contact information for the Alberta Health Services' (AHS) MAID care coordination service, as soon as reasonably possible.

2. A regulated member who declines a request for MAID for reasons of personal conscience or religion or lack of resources/expertise **must** do so in accordance with the *Conscientious Objection* standard of practice.

3. A regulated member who receives, evaluates or acts upon a written request[G] for MAID **must** do so in accordance with relevant legal requirements which include, but are not limited to, the *Criminal Code*.[2]

4. A regulated member who provides MAID **must**:

    a. follow the safeguards outlined in the *Criminal Code* when determining a patient's eligibility;

    b. collaborate with the AHS MAID care coordination service;

[1] From the Canadian Medical Association's *Code of Ethics & Professionalism* (2018).
[2] Please see the "Medical Assistance in Dying" section of the *Criminal Code of Canada*.

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c. discuss with the patient and agree on a plan that considers:

   i. the patient's wishes regarding when, where and how MAID will be provided, including the presence[G] of the regulated member and any additional patient support;

   ii. an alternate plan to address potential complications; and

   iii. the patient's understanding that they may choose to rescind the request at any time, including immediately before the provision of MAID;

d. ensure the patient has capacity[G] and obtain consent[G] in accordance with the *Informed Consent* standard of practice and relevant legal requirements set out in the *Criminal Code*;

   i. in the case of self-administration, MAID **may** be provided on the basis of a valid waiver of final consent or advance consent;

e. ensure that, immediately before providing MAID, the patient is given an opportunity to withdraw their request and consents to receive MAID;

f. collaborate with the pharmacist dispensing the medication(s); and

g. after the patient's death, notify the Office of the Chief Medical Examiner.

   i. The regulated member will not sign the death certificate: the Chief Medical Examiner will determine the cause and manner of death.

5. Under the *Criminal Code,* a regulated member **must not** provide MAID:

   a. to a mature minor[G];

   b. based on an advance directive; or

   c. when a mental illness is the sole underlying medical condition.

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6. A regulated member **must not** prescribe medications for use in MAID unless they are recommended by the AHS MAID care coordination service[3].

7. A regulated member who provides MAID **must** complete all federal reporting requirements, including the AHS MAID Reporting Form[4] .

GLOSSARY

Mature minor: an individual under the age of 18 who can understand and appreciate the nature, risks and consequences of a proposed treatment/procedure and can provide consent without the input of their legal representative. For more information, please refer to the Informed Consent for Minors Advice to the Profession document.

Written request: while a patient may inquire about MAID orally, a request to proceed with MAID must be in writing in accordance with the *Criminal Code*.

Presence: a regulated member is not required to be present if the patient chooses the self-administered protocol[5].

Capacity: the ability to understand information that is relevant to the decision. It is the legal status of being able to provide informed consent or refusal of healthcare interventions[6].

Consent: for the purpose of this standard, in order for a patient to provide informed consent, they must be capable [refer to "capacity"], they must have been given an adequate explanation about the nature of the proposed intervention and its anticipated outcome, as well as the significant risks involved and alternatives available, and the consent must be voluntary.[6] No other individual is permitted to provide consent other than the patient requesting MAID.

[3] To review the current medication protocol, please log into the physician portal.
[4] For more information, please visit AHS's "MAID Reporting for Alberta Practitioners" web page.
[5] Refer to AHS's "Role of the Medical Examiner related to Medical Assistance in Dying" (Aug. 2018)
[6] From the "Final Report of the Expert Panel on MAID and Mental Illness" (May 2022)

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RELATED STANDARDS OF PRACTICE

- *Code of Ethics & Professionalism*
- *Conscientious Objection*
- *Informed Consent*

COMPANION RESOURCES

- Advice to the Profession: Medical Assistance in Dying
- Advice to Albertans: Medical Assistance in Dying
- Advice to the Profession: Informed Consent for Adults
- Advice to the Profession: Informed Consent for Minors
- Medication Protocols as of July 2019 – please review "Additional Resources" in the Physician Portal (requires regulated member login credentials to access)
- AHS's Medical Assistance in Dying
- AHS's MAID Reporting for Alberta Practitioners
- AH's Guide to Capacity Assessments under the Personal Directives Act
- CMPA's Good Practices: Informed Consent Overview and Objectives

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COLLEGE OF PHYSICIANS
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STANDARDS OF PRACTICE

Non-Treating Medical Examinations

Under Review: No

Issued By: Council: January 1, 2010

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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 an NTME under the *Minor Injury Regulation* or an NTME under Rules 5.41 to 5.44 of the *Alberta Rules of Court*. The regulated member is also expected to act in accordance with the provisions of the *Minor Injury Regulation* and *Alberta Rules of Court* 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 an NTME, a regulated member **must** disclose to all parties:

   a. his/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.

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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 an 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.

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.

RELATED STANDARDS OF PRACTICE

- *Code of Ethics & Professionalism*
- *Charging for Uninsured Professionals Services*
- *Establishing the Physician-Patient Relationship*
- *Informed Consent*
- *Patient Record Retention*
- *Responding to Third Party Requests*
- *Transfer of Care*

COMPANION RESOURCES

- Advice to the Profession: Medical Examinations by Non-Treating Physicians
- Advice to the Profession: Informed Consent for Adults
- Advice to the Profession: Informed Consent for Minors

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STANDARDS OF PRACTICE

Patient Record Content

Under Review: No
Issued By: Council: January 1, 2010 (*Patient Records*)
Reissued by Council: July 1, 2011; January 1, 2016 (*Patient Record Content* and *Patient Record Retention*)

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The *Patient Records* standard was split into *Patient Record Content* and *Patient Record Retention* in January 2016. Please refer to both standards for all expectations related to patient records.

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;

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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:

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 the *HIA*.

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

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RELATED STANDARDS OF PRACTICE

- *Continuity of Care*
- *Episodic Care*
- *Non-Treating Medical Examinations*
- *Patient Record Retention*
- *Referral Consultation*
- *Virtual Care*

COMPANION RESOURCES

- Advice to the Profession:
  - Episodic Care
  - Electronic Communications & Security of Mobile Devices
  - Lost or Stolen Medical Records
  - Virtual Care
- CMPA's Smartphone recordings by patients
- CMPA's eLearning Modules
- CMPA's Medical records articles
- HQCA's Abbreviations in healthcare
- OIPC's Communicating with patients via email – know the risks
- OIPC's Email communication FAQs

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STANDARDS OF PRACTICE

Patient Record Retention

Under Review: No

Issued By: Council: January 1, 2010 (*Patient Records*)

Reissued by Council: July 1, 2011; January 1, 2016 (*Patient Record Content and Patient Record Retention*)

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The *Patient Records* standard was split into *Patient Record Content* and *Patient Record Retention* in January 2016. Please refer to both standards for all expectations related to patient records.

1. A regulated member **must** ensure a patient record[i]:

   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[ii] **must** have policies and procedures in place in accordance with the *HIA* that:

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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.

4. A regulated member acting as a custodian **must** designate a successor custodian[iii] 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[iv] 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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RELATED STANDARDS OF PRACTICE

- *Closing or Leaving a Medical Practice*
- *Continuity of Care*
- *Episodic Care*
- *Non-Treating Medical Examinations*
- *Patient Record Content*
- *Referral Consultation*
- *Relocating a Medical Practice*
- *Virtual Care*

COMPANION RESOURCES

- Advice to the Profession:
  - Physicians as Custodians
  - Electronic Communications & Security of Mobile Devices
  - Lost or Stolen Medical Records
  - Virtual Care
- Custody of Patient Records form
- Generic Information Management Agreement template
- Vendor Information Management Agreement template
- Information Sharing Agreement for Electronic Medical Records sample
- PCN Information Sharing Agreement template
- Disclosure Agreement sample
- CMPA's Electronic Records Handbook
- CMPA's Smartphone recordings by patients
- OIPC's Privacy Impact Assessments

[i] Refers to either a paper-based or electronic record.

[ii] Regulated members are designated custodians under the *Health Information Regulation*.
[iii] Reference; *Health Information Act*, Section 35(1)(q)
[iv] Reference: *Health Information Act*, Section 64

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COLLEGE OF PHYSICIANS
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STANDARDS OF PRACTICE

Practising Outside of Established Conventional Medicine

Under Review: No

Issued By: Council: Jan 1, 2010 (*Complementary and Alternative Medicine*)

Reissued by Council: Jan 1, 2021; Jan 9, 2014

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Note: a glossary of terms can be found at the end of this document. Glossary terms are indicated in teal with a "G" throughout this document.

1. Practising outside of established conventional medicine includes practices that are not included in widely accepted clinical practice guidelines and can include complementary and alternative medicine and emerging therapies.

2. For the purposes of this standard, the following definitions apply:

    a. "Conventional medicine" refers to the type of treatment, diagnostic analysis and conceptualization of disease or ailment that is considered "mainstream" medicine. This type of medicine is generally provided in hospitals and specialty or primary care practices. It is sometimes also referred to as "evidence[G]-based."

    b. "Complementary and alternative medicine" (hereafter referred to as "CAM") refers to healthcare approaches developed outside of mainstream or conventional medicine that are used for specific conditions or overall well-being[1].

        i. "Complementary" refers to a non-conventional practice used in conjunction with mainstream conventional medicine.

        ii. "Alternative" refers to a non-conventional complementary therapy used in the absence of mainstream conventional medicine.

        iii. Off-label use[G] of Schedule 1 or Schedule 2 drugs is **not** considered CAM.

[1] https://nccih.nih.gov/health/integrative-health

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c. "Emerging therapies" refers to therapies developed within mainstream medicine with support from clinical research but currently lacking in rigorous, peer-reviewed evidence to support their use.

3. A regulated member who offers a therapy that is outside of conventional medicine to a patient **must:**

   a. practise in a manner that is informed by current best-available medical evidence and upholds their professional, ethical and legal obligations;

   b. always act within the scope of their practice based on their qualifications, skill, knowledge and level of competence; and

   c. respect the autonomy of the patient in making decisions about their health care, including choosing a therapy that is outside of conventional medicine instead of, or in addition to, conventional medicine.

4. All patient assessments and diagnoses **must** be consistent with the standards of conventional medicine and be informed by current best-available evidence. A regulated member **must**:

   a. offer a conventional medical approach before offering any therapy outside of conventional medicine;

   b. conduct a clinical assessment of the patient that includes taking an appropriate patient history and performing/ordering any necessary diagnostic tests, investigations or procedures that are required to establish a conventional diagnosis;

   c. offer therapeutic options that are informed by current best-available evidence prior to offering therapies outside of established conventional medicine; and

   d. counsel the patient, to the best of their ability and knowledge, about the risks and benefits of any diagnostic testing/investigation or therapeutic procedure so the patient can give informed consent[G].

5. A regulated member **must** document the details of the consent process, including rationale for providing therapy outside of conventional medicine as explained to the patient, in the patient's record.

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6. A regulated member is **not** obligated to make a referral that, in their opinion, is unlikely to provide a clinical benefit.

7. A regulated member conducting clinical research into the use of a therapy outside of conventional medicine **must** comply with the *Human Health Research* standard of practice.

8. A regulated member **must not**:

    a. delay the use of conventional therapy, or replace its use with therapy outside of conventional medicine, except at the direction of the patient;

    b. exploit the emotions, vulnerability or finances of a patient for personal gain; or

    c. recommend therapeutic options that have been proven to be ineffective through rigorous, peer-reviewed evidence.

GLOSSARY

Evidence: rigorous, peer-reviewed clinical research that supports a claim and/or service.

Off-label use: refers to any use of a medication beyond what Health Canada has reviewed and authorized to be marketed in Canada and as indicated on the product label. (From Canadian Agency for Drugs and Technology in Health)

Informed consent: permission for something to happen or agreement to do something; a regulated member must obtain a patient's consent in accordance with the *Informed Consent* standard of practice. For more information, please refer to the Informed Consent for Adults and Informed Consent for Minors Advice to the Profession documents.

RELATED STANDARDS OF PRACTICE

- *Advertising*
- *Charging for Uninsured Professional Services*
- *Conflict of Interest*
- *Human Health Research*

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- *Informed Consent*
- *Patient Record Content*
- *Referral Consultation*

COMPANION RESOURCES

- Advice to the Profession:
  - Practising Outside of Established Conventional Medicine
  - Advertising
  - Charging for Uninsured Professional Services
  - Informed Consent for Adults
  - Informed Consent for Minors
- *Health Information Act*
- Canadian Medical Association's Complementary and Alternative Medicine policy document
- Canadian Medical Protective Association's Duties and Responsibilities: Alternative medicine – what are the medico-legal concerns?

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COLLEGE OF PHYSICIANS
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STANDARDS OF PRACTICE

Prescribing: Administration

Under Review: No
Issued By: Council: January 1, 2010 (*Faxing Prescriptions*)
Reissued by Council: March 10, 2016 (*Prescribing*); April 1, 2017 (name change only: *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.

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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

   c. 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 TPP Alberta (TPP) form **must** include the pharmacy's copy of the TPP form in the transmission clearly identifying:

   a. the unique TPP tracking number;

   b. the regulated member's regulatory body 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.

RELATED STANDARDS OF PRACTICE

- *Cannabis for Medical Purposes*
- *Dispensing of Schedule 1 & 2 Drugs by a Physician for a Fee*
- *Prescribing: Drugs Associated with Substance Use Disorders or Substance-Related Harms*
- *Safe Prescribing for Opioid Use Disorder*
- *Sale of Products by Physicians*
- *Telemedicine*

COMPANION RESOURCES

- Advice to the Profession: Prescribing: Administration
- Advice to the Profession: Electronic Communications & Security of Mobile Devices
- 2017 Canadian Guidelines for Opioids for Chronic Pain

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STANDARDS OF PRACTICE

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

Under Review: No
Issued By: Council: April 1, 2017 (*Prescribing: Drugs with Potential for Misuse or Diversion*)
Reissued by Council: September 6, 2018 (name change only: *Prescribing: Drugs Associated with Substance Use Disorders or Substance-Related Harm*)

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

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., Tracked Prescription Program, community or hospital pharmacist):

    a. before initiating a prescription;

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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.

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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RELATED STANDARDS OF PRACTICE

- *Dispensing of Schedule 1 & 2 Drugs by Physicians for a Fee*
- *Prescribing: Administration*
- *Safe Prescribing for Opioid Use Disorder*
- *Sale of Products by Physicians*

COMPANION RESOURCES

- Advice to the Profession: Prescribing: Drugs Associated with Substance Use Disorders or Substance-Related Harms
- Good Prescribing Practices
- TPP Alberta
- U of C's Wise Prescribing: Opioid Skills for the Frontline Clinician online learning module

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

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STANDARDS OF PRACTICE

Re-Entering Medical Practice or Changing Scope of Practice

Under Review: No

Issued By: Council: January 1, 2010

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1. A regulated **must** notify CPSA 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/ 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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RELATED STANDARDS OF PRACTICE

- *Closing or Leaving a Medical Practice*

COMPANION RESOURCES

- Practice Readiness Assessment
- Return to Practice application form
- Change in Scope of Practice application form

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STANDARDS OF PRACTICE

Referral Consultation

Under Review: No

Issued By: Council: January 1, 2010 (*The Referral Consultation Process*)

Reissued by Council: January 1, 2017 (*Referral Consultation*)

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1. A regulated member **must** recognize his/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/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.

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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;

      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**[i]**:**

   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 Alberta Health Care Insurance Plan;

   b. provide a written report directly to the 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 the 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[ii] 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.

RELATED STANDARDS OF PRACTICE

- *Charging for Uninsured Professional Services*
- *Code of Ethics & Professionalism*
- *Continuity of Care*
- *Establishing the Physician-Patient Relationship*
- *Informed Consent*
- *Patient Record Content*
- *Responding to Third Party Requests*
- *Transfer of Care*

COMPANION RESOURCES

- Advice to the Profession: Referral Consultation
- AHS's QuRE Quality Referral Pocket Checklist
- CFPC's Guide to enhancing referrals and consultations between physicians
- CMPA's Physicians and nurse practitioners: Working collaboratively as independent health professionals
- CMPA's The Most Responsible Physician

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[i] CPSA will review complaints about management of consultation requests brought by other healthcare providers and patients.
[ii] 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.

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COLLEGE OF PHYSICIANS
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STANDARDS OF PRACTICE

Relationships with Industry

Under Review: No

Issued By: Council: January 1, 2010

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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/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;

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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;

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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RELATED STANDARDS OF PRACTICE

- *Conflict of Interest*
- *Human Health Research*
- *Informed Consent*
- *Patient Record Content*
- *Prescribing: Administration*

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STANDARDS OF PRACTICE

Relocating a Medical Practice

Under Review: No
Issued by Council: Jan 9, 2014
Reissued by Council: Jan 1, 2021

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Note: a glossary of terms can be found at the end of this document. Glossary terms are indicated in teal with a "G" throughout this document.

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, the *Closing or Leaving a Medical Practice*[G] standard applies.

2. A regulated member who relocates a medical practice **must:**

    a. notify CPSA a minimum of forty-five (45) days in advance of relocating the practice[G];

    b. provide and document notification[G] of the event to individual patients who have been seen within the past year with whom there is an expectation of ongoing[G] care a minimum of forty-five (45) days in advance of relocating the practice; and

    c. provide notification of relocating the practice to all healthcare providers to whom they regularly refer patients or from whom they receive referrals, hospitals where they hold privileges, employers and the Alberta Health Care Insurance Plan, if applicable.

3. Notwithstanding clause 2, the 45 days' 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 (e.g., fire, flood, loss of tenancy). In these cases, CPSA, patients and individuals or agencies identified in clause 2(c) **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 them to the new practice location for a period of no less than

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twelve (12) months.

5. A regulated member practicing in the location where another regulated member had previously practiced **must** provide contact 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[G] relating to management of patient records 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;

    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[G], a regulated member practicing in the location where another regulated member had previously practiced **must** 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.

GLOSSARY

Closing/leaving practice: the discontinuation of practice with no intention of returning, a leave of absence more than 12 months or a significant move from the current practice patients could not reasonably be expected to travel. See the *Closing or Leaving a Medical Practice* standard of practice for more information.

Relocating practice: moving a practice within a distance that patients could be reasonably expected to travel to the new practice location.
Notification: patient notification may be made by way of a detailed letter, secure email, or telephone call detailing the regulated member's last day at the former

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location, contact information of the new location, and how patients can access copies of their records if they opt not to follow the physician to the new location.

Ongoing: 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 including, but not limited to, longitudinal relationships, based on the identification of a regular attending physician or clinic and sessional relationships for a defined period of time, based on a presenting concern(s), referred consultation or identified medical condition.

Information sharing agreement (ISA): as required by the *Patient Record Retention* standard of practice, an ISA provides clarity on how custodians will manage shared patient records and what will happen in the event the professional arrangement between the custodians changes (e.g., the partnership dissolves). For more information, please refer to the Physicians as Custodians of Patient Records Advice to the Profession document.

Continuity of care: as indicated in the *Continuity of Care* standard of practice, physicians must have systems in place to receive, review, and follow-up on any investigations, including arranging continuous after-hours care.

RELATED STANDARDS OF PRACTICE

- *Closing or Leaving a Medical Practice*
- *Continuity of Care*
- *Patient Record Content*
- *Patient Record Retention*
- *Re-Entering Medical Practice or Changing Scope of Practice*
- *Responsibility for a Medical Practice*

COMPANION RESOURCES

- Advice to the Profession: Physicians as Custodians
- Custody of Patient Records form
- To access the Notification of Change Form, please log into your physician portal
- Professional Corporation Address Change form

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STANDARDS OF PRACTICE

Responding to Third Party Requests

Under Review: No

Issued By: Council: January 1, 2010

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1. A regulated member **must** provide details of his/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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RELATED STANDARDS OF PRACTICE

- *Charging for Uninsured Professional Services*

COMPANION RESOURCES

- Advice to the Profession: Legislated Reporting and Release of Medical Information

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STANDARDS OF PRACTICE

Responsibility for a Medical Practice

Under Review: No

Issued By: Council: January 1, 2010 (*Direction & Control of a Medical Practice*)

Reissued by Council: July 1, 2018 (*Responsibility for a Medical Practice*)

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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;

    c. billing for medical practice;

    d. advertising and promotion of services;

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e. quality assurance and quality improvement;

f. custody of health information, including maintenance and storage of medical records;

g. notification to CPSA at least 30 days prior to:

i. establishing or moving the physical location of a practice[i], 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 CPSA, as identified in the *CPSA Standards of Practice* or CPSA bylaws[ii]; and

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.

3. Regulated members practising in a multi-physician setting[iii] without a Medical Director **must** designate one individual to represent the practice in interactions with CPSA, 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.

4. 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.

RELATED STANDARDS OF PRACTICE

- *Advertising*
- *Charging for Uninsured Professional Services*
- *Closing or Leaving a Medical Practice*
- *Patient Record Retention*
- *Re-Entering a Medical Practice or Changing Scope of Practice*
- *Referral Consultation*
- *Relocating a Medical Practice*
- *Supervision of Restricted Activities*

COMPANION RESOURCES

- Advice to the Profession:
  - Advertising
  - Charging for Uninsured Professional Services
  - Medical Practice Observation
  - Physicians as Custodians
  - Referral Consultation
  - Responsibility for a Medical Practice
- CMPA's The Most Responsible Physician

[i] Excluding a hospital or facility operated by government or a provincial health authority.
[ii] See *Medical Services Requiring Accreditation Outside of Hospitals*, *Practising Outside of Established Conventional Medicine*, *Reprocessing of Medical Equipment* and CPSA bylaws.
[iii] 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.

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STANDARDS OF PRACTICE

Restricted Activities

Under Review: No
Reissued by Council (*Restricted Activities*) Mar. 31, 2023
Reissued by Council (*Supervision of Restricted Activities*): Apr. 1, 2017
Issued by Council (*Supervision of Restricted Activities*): Jan. 1, 2010

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COLLEGE OF PHYSICIANS
& SURGEONS OF ALBERTA

The ***Standards of Practice*** of the College of Physicians & Surgeons of Alberta ("CPSA") 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. CPSA also provides **Advice to the Profession** to support the implementation of the Standards of Practice.

Note: a glossary of terms can be found at the end of this document. Glossary terms are indicated in teal with a "G" throughout this document.

PREAMBLE

This standard applies to both the performance and supervision of restricted activities[G] as defined in the *Health Professions Restricted Activity Regulation*. It does not imply any expectation or requirement for a regulated member of CPSA to supervise other regulated healthcare professionals performing restricted activities within their scope of practice, training and authorization by their regulatory college.

Supervision occurs in different formats (e.g., in person, on site, remotely, etc.) based on the person being supervised, the restricted activity being performed and the supervising regulated member's confidence in the person's skills and abilities. The level of supervision may vary as the person's skills and abilities improve. It is important for the supervising regulated member to be aware that they are responsible and liable for the actions of the person they are supervising.

Additional information, general advice and/or best practices can be found in the companion resources listed below.

STANDARD

Self-restriction

1. Despite any authorization to perform restricted activities:

    a. a physician, surgeon or osteopath **must only** perform a restricted activity that the physician, surgeon or osteopath is competent[G] to perform and that is appropriate to the clinical circumstance and the regulated member's scope of practice; and

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- "Regulated member" means any person who is registered or who is required to be registered as a member of this College. CPSA regulates physicians, surgeons, osteopaths and physician assistants.
- "Must" refers to a mandatory requirement.
- "May" means that the physician or physician assistant may exercise reasonable discretion.
- "Patient" includes, where applicable, the patient's legal guardian or substitute decision maker.

b. a physician assistant **must only** perform a restricted activity that the physician assistant is competent to perform and that is appropriate to the clinical circumstance and scope of practice of the supervising physician, surgeon or osteopath.

2. A regulated member who performs a restricted activity **must** do so in accordance with the *Standards of Practice*.

Restricted Activities

3. A regulated member on the physicians, surgeons and osteopaths register **may**, in the practice of medicine or osteopathy and in accordance with the *Standards of Practice*, perform the following restricted activities:

   a. to cut a body tissue, to administer anything by an invasive procedure on body tissue or to perform surgical or other invasive procedures on body tissue below the dermis or the mucous membrane or in or below the surface of the cornea;

   b. to insert or remove instruments, devices, fingers or hands:

      i. beyond the cartilaginous portion of the ear canal;

      ii. beyond the point in the nasal passages where they normally narrow;

      iii. beyond the pharynx;

      iv. beyond the opening of the urethra;

      v. beyond the labia majora;

      vi. beyond the anal verge; or

      vii. into an artificial opening of the body;

   c. to insert into the ear canal, under pressure, liquid, air or gas;

   d. to set or reset a fracture of a bone;

   e. to reduce a dislocation of any joint;

f. to use a deliberate, brief, fast thrust to move the joints of the spine beyond the normal range but within the anatomical range of motion, which generally results in an audible click or pop;

g. to prescribe a Schedule 1 drug within the meaning of the *Pharmacy and Drug Act*;

h. to dispense, compound, provide for selling or sell a Schedule 1 drug or Schedule 2 drug within the meaning of the *Pharmacy and Drug Act*;

i. to administer a vaccine or parenteral nutrition;

j. to prescribe, compound or administer blood or blood products;

k. to prescribe or administer diagnostic imaging contrast agents;

l. to prescribe or administer anaesthetic gases, including nitrous oxide, for the purposes of anaesthesia or sedation;

m. to prescribe or administer radiopharmaceuticals, radiolabelled substances, radioactive gases or radio aerosols;

n. to order or apply any form of ionizing radiation in medical radiography, nuclear medicine or radiation therapy;

o. to order or apply non-ionizing radiation in lithotripsy, magnetic resonance imaging or ultrasound imaging, including any application of ultrasound to a foetus;

p. to prescribe or fit an implant-supported prosthesis;

q. to perform a psychosocial intervention with an expectation of treating a substantial disorder of thought, mood, perception, orientation or memory that grossly impairs judgment, behaviour, capacity to recognize reality or ability to meet the ordinary demands of life;

r. to manage labour or deliver a baby; or

s. to prescribe or dispense corrective lenses.

Supervision of restricted activities

4. A physician, surgeon or osteopath **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.

5. A physician, surgeon or osteopath 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;

    d. ensure the patient is provided with the name and role (e.g., physician assistant, student, etc.) of the person performing the restricted activity;

    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.

6. A physician, surgeon or osteopath supervising a non-regulated person performing a restricted activity **must** ensure:

   a. the restricted activity is performed only under a direct order from a physician, surgeon or osteopath in the context of an established physician-patient relationship;

   b. there is minimal additional risk to the patient due to the non-regulated person performing the restricted activity; and

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

7. A physician, surgeon or osteopath **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.

Supervision of Physician Assistants

8. A regulated member on the physician assistants register **may**, in the practice of physician assisting and in accordance with the *Standards of Practice*, perform the

restricted activities referred to in clause (3) under the supervision of a physician, surgeon or osteopath registered to practise in Alberta.

9. A physician, surgeon or osteopath who supervises a physician assistant under this section **must** do so in accordance with the *Standards of Practice*.

10. A physician, surgeon or osteopath **may only** supervise a physician assistant to perform a restricted activity if:

    a. they are competent to perform the restricted activity; and

    b. it is appropriate to their scope of practice.

11. A physician assistant **must not** perform a restricted activity that the supervising physician, surgeon or osteopath is not competent to perform or that is not appropriate to the scope of practice of the supervising physician, surgeon or osteopath.

Supervision of Learners

12. A person who is registered on the physicians, surgeons and osteopaths student register is authorized to perform the restricted activities set out in clause (3), in the practice of medicine or osteopathy, but **must** be under the supervision of a physician, surgeon or osteopath registered to practise in Alberta and in accordance with the *Standards of Practice*.

13. A person who is registered on the physician assistants student register is authorized to perform the restricted activities set out in clause (3), in the practice of physician assisting, but **must** be under the supervision of a physician, surgeon, osteopath or physician assistant-instructor registered to practise in Alberta and in accordance with the *Standards of Practice*.

14. A physician, surgeon or osteopath who supervises students under this section **must** do so in accordance with the requirements for the supervision of students approved by the Council.

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Supervision of Non-regulated Persons

15. A person who is **not** prohibited under Section 1.6 of the HPA[1] is permitted to perform a restricted activity described in clause (3) **only** if that person:

    a. while performing a restricted activity, has the consent of, and is being supervised (in accordance with clause (16)) by, a physician, surgeon or osteopath who is registered to practise in Alberta and is authorized to do that restricted activity independently; and

    b. is engaged in providing health services to another person.

16. When a physician, surgeon or osteopath supervises a person referred to in clause (15) performing a restricted activity, the person being supervised:

    a. **must not** be a regulated member registered on the physicians, surgeons and osteopaths student register; and

    b. **must** be authorized to perform the restricted activity being performed.

17. If the person being supervised is a regulated member of another college, the physician, surgeon or osteopath **must:**

    a. be satisfied the other college is aware that the person is performing the restricted activity under supervision;

    b. supervise the person who is performing the restricted activity by being readily available for consultation by the person who is under supervision; and

    c. comply with the clauses of this standard governing the provision of supervision by regulated members of persons performing restricted activities in accordance with the *Health Professions Restricted Activity Regulation*.

[1] Please note: this clause has been updated to identify the applicable legislation (Aug. 22, 2024).

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GLOSSARY

Competent: the regulated member is adequately qualified, suitably trained and has sufficient experience to safely perform work without supervision.[1]

Restricted activities: high risk activities performed as part of providing a health service that require specific competencies and skills to be carried out safely[2].

RELATED STANDARDS OF PRACTICE

- *Code of Ethics & Professionalism*
- *Dispensing of Schedule 1 or 2 Drugs by a Physician for a Fee*
- *Duty to Report a Colleague*
- *Duty to Report Self*
- *Establishing the Physician-Patient Relationship*
- *Informed Consent*
- *Patient Record Content*
- *Prescribing: Administration*
- *Prescribing: Drugs Associated with Substance Use Disorder or Substance-Related Harms*
- *Responsibility for a Medical Practice*
- *Safe Prescribing for Opioid Use Disorder*

COMPANION RESOURCES

- Advice to the Profession documents:
  - Restricted Activities (TBD)
  - Duty to Repot a Colleague/Self
  - Informed Consent for Adults
  - Informed Consent for Minors
  - Prescribing: Administration
  - Prescribing: Drugs Associated with Substance Use Disorder or Substance-Related Harms

[1] From the Alberta *Occupational Health & Safety Code* (Dec. 1, 2021).
[2] From Alberta Health's "Regulated health professions and colleges" page ("Restricted Activities" section).

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  - Responsibility for a Medical Practice
  - Safe Prescribing for Opioid Use Disorder
- Canadian Medical Protective Association:
  - Who is the most responsible physician?
  - Medico-legal handbook for physicians
  - Delegation and supervision of trainees
  - Delegation and supervision – Responsibilities of supervisors and trainees
  - Delegation and supervision – The role of the patient

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STANDARDS OF PRACTICE

Safe Prescribing for Opioid Use Disorder

Under Review: No
Issued by Council: Apr. 1, 2019
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The scope of this standard is Safe Prescribing for Opioid Use Disorder. Management for acute/chronic pain and/or palliative care are not included under this standard.

Note: a glossary of terms can be found at the end of this document. Glossary terms are indicated in teal with a "G" throughout this document.

PREAMBLE

Opioid use disorder (OUD) G is one of the most challenging forms of addiction and a major contributing factor to the rise in opioid-related morbidity and mortality. In recent years, the non-medical use of pharmaceutical opioids and the emergence of highly potent, illegally manufactured opioids have increasingly impacted the landscape of opioid use.

Effective Oct. 5, 2022, the Government of Alberta introduced new requirements for narcotic transition services (NTS) G through an amendment to the *Mental Health Services Protection Regulation* (Regulation), which are enacted under the *Mental Health Services Protection Act*. Regulated members are responsible for informing themselves and complying with the legislative requirements that apply to their practice.

Alberta Health Services (AHS) is the only service provider licensed by Alberta Health to provide NTS in the province. The amendment allows the use of methadone and slow-release oral morphine for the treatment of OUD in all settings. The Regulation prohibits the use of other full agonist opioid drugs G (e.g., hydromorphone, fentanyl and diacetylmorphine) for the treatment of OUD outside of NTS facilities. The use of full agonist opioid drugs for indications other than OUD (e.g., management of acute/chronic pain and/or palliative care) is not affected by the Regulation.

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OUD is best conceptualized as a treatable chronic illness, which has the potential to be in sustained, long-term remission with appropriate treatment. For more information, refer to the Diagnostic and Statistical Manual (DSM-5) on Diagnostic Criteria for OUD.[1]

For the purpose of this standard, Opioid Agonist Treatment (OAT)[G] refers to full opioid agonist drugs for OUD treatment. This standard **does not** apply to the partial opioid agonist[G] or antagonist drug[G] options for OUD (e.g., buprenorophine/naloxone (Suboxone®), buprenorphine extended-release injection (Sublocade®) buprenorphine implant (Probuphine®), naltrexone (Revia®), etc.).

The intention of the standard is to provide regulated members with clear requirements that allow for safe and responsible management of OUD with evidence-based, full opioid agonist drugs. The standard is deliberately nonprescriptive in requiring use of specific treatment guidelines, as the treatment modalities for OUD are changing rapidly. Regulated members are expected to provide care based on the latest evidence-based guidelines and practices, and in compliance with the legislation.

For more information and guidance, please see the Advice to the Profession and other resources in the "Companion Resources" section at the end of this document.

STANDARD

1. A regulated member who prescribes OAT **must** do so in accordance with evidence-based guidelines and practices[2] for OUD treatment.

2. A regulated member who INITIATES OAT **must**:

    a. have successfully completed an OUD workshop/course recognized by CPSA[2];

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

    c. have CPSA OAT prescribing approval to initiate[G];

    d. as a condition of CPSA OAT prescribing approval to initiate, maintain competence in OAT through ongoing, relevant education as part of their

[1] DSM-5 Clinical Diagnostic Criteria for Opioid Use Disorder
[2] Refer to Opioid Agonist Treatment Program for related standards of practice, advice to the profession, guidelines, and additional resources.

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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, in accordance with the *Continuity of Care* standard of practice, if the initiating prescriber is absent or suspends their practice;

   iii. access to Alberta prescription databases;

   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 with CPSA OAT prescribing approval:

   i. transfer care in accordance with the *Transfer of Care* standard of practice;

   ii. 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 CPSA; and

   iii. collaborate with the maintaining prescriber, other healthcare providers and multidisciplinary team members involved in the patient's care.

3. A regulated member who MAINTAINS [G] patients on 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. have CPSA OAT prescribing approval to maintain [G];

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d. at minimum, complete an OAT educational module or course recognized by CPSA[2] within six months of acquiring CPSA approval;

e. ensure another prescriber approved to maintain OAT is available, in accordance with the *Continuity of Care* standard of practice, if the maintaining prescriber is absent or suspends their practice;

f. collaborate with the initiating prescriber or appropriate delegate, other healthcare providers and multidisciplinary team members involved in the patient's care;

g. have access to medical laboratory services and pharmacy services; and

h. have access to Alberta prescription databases.

4. A regulated member without CPSA OAT prescribing approval **may** prescribe OAT for a patient in an inpatient or correctional facility for a period no greater than:

a. the duration of the patient's stay or incarceration; and

b. five (5) days or 120 hours following the patient's discharge/release, for the purposes of transition of care.

5. When prescribing OAT for a patient under clause 4, a regulated member without CPSA OAT prescribing approval **must**:

a. specify in the OAT prescription that doses must be:

i. daily; and

ii. witnessed when administered to the patient (and not provided for take-home unwitnessed use);

b. ensure continuity of care by:

i. notifying the patient's community prescriber[G] of discharge/release; or

ii. if the patient does not have a community prescriber, make appropriate arrangements for transfer of care to another health care provider;

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c. consult with the patient's current prescriber or appropriate delegate before:

   i. making any changes to the OAT prescription; or

   ii. introducing any new medications with the potential to interact with OAT; and

d. collaborate with those involved in the patient's care at transitions between treatment settings, in accordance with the *Continuity of Care* standard of practice, including:

   i. the community prescriber;

   ii. other regulated health professionals; and

   iii. multidisciplinary team members.

6. Notwithstanding subclause 5(c), regulated members without CPSA OAT prescribing approval **may** proceed without consulting the current prescriber if patients require urgent or emergent care.

7. A regulated member who prescribes full agonist opioid drugs, for the treatment of OUD, **must** have either CPSA OAT prescribing approval to initiate or CPSA OAT prescribing approval to maintain.

8. A regulated member who prescribes a full agonist opioid drug, other than methadone or slow-release oral morphine, for OUD treatment **must** do so within a program licenced by the government, as required by provincial regulation.[3]

GLOSSARY

Opioid Use Disorder (OUD): a medical condition defined by a problematic pattern of opioid use leading to clinically significant impairment or distress[4].

[3] For more information, please refer to the Safe Prescribing for Opioid Use Disorder Advice to the Profession document.
[4] DSM-5 Clinical Diagnostic Criteria for Opioid Use Disorder

Narcotic Transition Service (NTS): means services to treat OUD with one or more designated narcotic drugs (i.e., any full agonist opioid drug, with the exception of methadone or slow-release oral morphine). NTS does not include the use of designated narcotic drugs if medically indicated for the purpose of stabilizing a patient suffering from opioid withdrawal during the patient's admission to an approved hospital for other indications[5].

Full agonist opioid drugs: pharmaceutical agents which bind to and activate the mu-opioid receptors, preventing withdrawal symptoms to alleviate cravings (e.g., methadone, slow-release oral morphine, hydromorphone, fentanyl and diacetylmorphine).[6]

Opioid Agonist Therapy (OAT): the provision of medications to treat OUD.

Partial opioid agonists: pharmaceutical agents that bind to opioid receptors but activate them to a lesser degree than full opioid agonists (e.g., buprenorphine).

Antagonist drugs: pharmaceutical agents that block the activation of opioid receptors to treat OUD (e.g., naltrexone).[6]

CPSA OAT prescribing approval to initiate: CPSA approval provided to regulated members who have demonstrated successful completion of learning and experiential requirements (e.g., Alberta Opioid Dependency Treatment Virtual Training Program or other recognized workshop/coursework).[7] These regulated members are able to initiate AND maintain patients on OAT.

Maintains: to continue to provide OAT to a patient who has been initiated and stabilized on OAT.

CPSA OAT prescribing approval to maintain: CPSA approval provided to regulated members who have demonstrated successful completion of learning requirements (i.e., modules 5 and 8 of the Alberta Opioid Dependency Treatment Virtual Training Program) and have received a letter of support from the patient's OAT initiating prescriber.[7] These regulated members are able to maintain patients on OAT; they are not able to initiate patients on OAT.

Community prescriber: for the purposes of this standard, this is defined as the initiating or maintaining prescriber who works in a community setting, including AHS Opioid Dependency Programs, an NTS, community ODP clinics or family physicians.

[5] *Mental Health Service Protection Regulation* (Jan. 16, 2023)
[6] NIDA's "How do medications to treat opioid use disorder work?" (Dec. 2021)
[7] CPSA's Opioid Agonist Treatment Program

RELATED STANDARDS OF PRACTICE

- *Continuity of Care*
- *Prescribing: Administration*
- *Prescribing: Drugs Associated with Substance Use Disorder or Substance-Related Harm*
- *Transfer of Care*

COMPANION RESOURCES

- Alberta Health's fact sheet on Narcotic Transition Services (NTS)
- *Mental Health Service Protection Regulation*
- Advice to the Profession: Safe Prescribing for Opioid Use Disorder
- Patient FAQs: Safe Prescribing for Opioid Use Disorder
- Information Checklist
- Sample Letter of Support
- Prescribing Resources and Tools
- U of C's Wise Prescribing & Describing: Opioid Skills for the Frontline Clinician online learning course
- CPSA's Opioid Agonist Treatment Program

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STANDARDS OF PRACTICE

Sale of Products by Physicians

Under Review: No

Issued By: Council: January 1, 2010

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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.
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RELATED STANDARDS OF PRACTICE

- *Advertising*
- *Conflict of Interest*
- *Dispensing of Schedule 1 & 2 Drugs by a Physician for a Fee*
- *Relationships with Industry*

COMPANION RESOURCES

- Advice to the Profession: Advertising

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COLLEGE OF PHYSICIANS
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STANDARDS OF PRACTICE

Terminating the Physician-Patient Relationship in Office-Based Settings

Under Review: No
Issued By: Council: January 1, 2010
Reissued by Council: January 9, 2014

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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 subclause 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

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- "Patient" includes, where applicable, the patient's legal guardian or substitute decision maker.

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

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.

RELATED STANDARDS OF PRACTICE

- *Code of Ethics & Professionalism*
- *Continuity of Care*
- *Establishing the Physician-Patient Relationship*

COMPANION RESOURCES

- Sample Patient Termination Letter

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STANDARDS OF PRACTICE

Transfer of Care

Under Review: No
Issued By: Council: January 1, 2010
Reissued by Council: October 1, 2016

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COLLEGE OF PHYSICIANS & SURGEONS OF ALBERTA

The ***Standards of Practice*** of the College of Physicians & Surgeons of Alberta ("CPSA") 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. CPSA also provides **Advice to the Profession** to support the implementation of the Standards of Practice.

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

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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.

RELATED STANDARDS OF PRACTICE

- *Continuity of Care*
- *Episodic Care*
- *Referral Consultation*
- *Responsibility for a Medical Practice*

COMPANION RESOURCES

- Advice to the Profession:
  - Episodic Care
  - Referral Consultation
  - Responsibility for a Medical Practice
- CMPA's The Most Responsible Physician

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STANDARDS OF PRACTICE

Virtual Care

Under Review: No

Issued By: Council: Jan. 1, 2010 (*Telemedicine*)

Reissued by Council: Jan. 1, 2022 (*Virtual Care*); June 5, 2014

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Note: a glossary of terms can be found at the end of this document. Glossary terms are indicated in teal with a "G" throughout this document.

PREAMBLE

The regulation and provision of virtual care[G] is quickly evolving as the medical profession continues to learn about the strengths and limitations of virtual care delivery. CPSA will revisit this standard on a regular basis to keep pace with this evolution.

This standard of practice must be read in conjunction with the *Continuity of Care* and *Episodic Care* standards of practice, as providing virtual care establishes a physician-patient relationship.

CPSA recognizes the importance of virtual medicine in providing care and access to care, especially for patients in remote and underserviced areas, patients with disabilities, patients in institutional settings, limited psychosocial supports or economic means, and in a pandemic, or other state of emergency. Virtual medicine is to be used to optimize and complement in-person patient care[i].

Regulated members who provide virtual care are held to the same ethical and professional standards and legal obligations, and the standards of care remain the same, as they are in the provision of in-person care. Ideally, virtual care is a modality that should be thoughtfully used to promote continuity of care within the context of a therapeutic relationship[G]. Regulated members providing virtual care need to be realistic about their ability to provide safe and effective care[G].

In addition, regulated members are expected to consult with the appropriate Medical Regulatory Authorities (i.e., where both they and the patient are located) and the Canadian Medical Protective Association or other applicable insurance provider for unique situations that include, but are not limited to, the provision of virtual care such as when

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either the physician or patient is temporarily[G] outside of Canada, medical assistance in dying, involuntary psychiatric assessment, etc.

Note: For the purpose of this standard, virtual care includes medical services to patients as well as inter-professional and intra-professional consultations (e.g., assessing, diagnosing, giving advice, tele-radiology, etc.).

STANDARD

Prior to engaging in virtual care

1. A regulated member providing virtual care **must** do so to the same standard to which they provide care in person, in accordance with the obligations of the *Code of Ethics and Professionalism* and CPSA's *Standards of Practice* and *Code of Conduct*.

2. Physicians providing virtual care to Alberta patients located in Alberta **must** be registered as members of CPSA.

3. Notwithstanding clause (2), an out-of-province physician who **does not** hold a valid and active practice permit with CPSA **may** provide virtual care to a patient located in Alberta:

    a. if the care sought is not readily available in Alberta (e.g., specialty care);

    b. to provide follow-up care or continuity of care for which an established physician-patient relationship exists; or

    c. if the virtual care encounter is for emergency assessment or treatment of the patient where there are no other care options available.

4. A regulated member providing virtual care **must** be aware of and comply with licensing requirements of the jurisdiction in which the patient is located.

5. A regulated member providing virtual care across the Alberta border **must** ensure they have appropriate liability protection[G] to provide care across jurisdictions.

6. A regulated member providing virtual care **must** first ensure they have a physical clinic, or an agreement with a physical clinic within reasonable travel proximity of the patient, to fulfill the need for in-person care when appropriate[G], required or requested by the patient.

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7. A regulated member providing virtual care **must**:

    a. ensure they have sufficient training, knowledge, judgment and competency[G] (including technological) to manage patient care virtually;

    b. consider the technologies available to the patient;

    c. adhere to best practices for technological security and use an appropriate platform or infrastructure suitable to engage in virtual care; and

    d. submit a Privacy Impact Assessment (PIA)[ii] to the Office of the Information and Privacy Commissioner of Alberta prior to adopting new information and communication technologies for the purposes of virtual care.

Ethical, professional and legal obligations

8. A regulated member providing virtual care **must**:

    a. provide the patient with their name, location and licensure status during the initial virtual care encounter;

    b. take reasonable steps to confirm the identity and location of the patient during each virtual care encounter;

    c. confirm the patient's physical setting is appropriate given the context of the encounter and ensure consent to proceed, in accordance with the *Informed Consent* standard of practice;

    d. offer the patient the opportunity for in-person care; and

    e. ensure there is a plan in place to manage adverse events or emergencies and make patients aware of appropriate steps to take in these instances.

During & after providing virtual care

9. A regulated member providing virtual care **must** ensure virtual care allows appropriate assessment[G] of the presenting problem.

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10. A regulated member providing virtual care **must**:

    a. create, maintain and provide a copy of the patient's medical record in accordance with the *Patient Record Content* and *Patient Record Retention* standards of practice;

    b. perform an appropriate assessment of the patient, including ordering necessary investigations, prior to initiating treatment or making a referral to another healthcare provider;

    c. communicate with other treating or referring healthcare providers and provide follow-up and after-hours care as medically appropriate, including:

        i. informing the patient of appropriate follow-up, in accordance with the *Continuity of Care* and *Referral Consultation* standards of practice;

        ii. having arrangements in place for receiving and responding to critical test results reported by a laboratory or imaging facility after regular working hours or in the regulated member's absence; and

    d. provide details of their findings, assessments, advice or treatment given when requested in accordance with the *Responding to Third Party Requests* standard of practice.

11. A regulated member, including those involved in a team-based care environment, who copies another healthcare provider (e.g., when requesting an investigation, performing a procedure, providing treatment requiring follow-up, making a referral, etc.) **must** do so in accordance with the *Continuity of Care* standard of practice.

Prescribing & authorizing

12. A regulated member issuing a prescription, electronically or by other means, **must** do so in accordance with the *Prescribing: Administration*, *Prescribing: Drugs Associated with Substance Use Disorder or Substance-Related Harms*, *Safe Prescribing for Opioid Use Disorder* and *Cannabis for Medical Purposes* standards of practice.

13. A regulated member **must not** prescribe opioids or other controlled medications[G] to patients **unless**:

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a. they have examined the patient in person;

b. they have a longitudinal treating relationship with the patient; or

c. they are in direct communication with another regulated-health professional who has examined the patient.

GLOSSARY

Appropriate assessment: based on the patient's presenting concern, an appropriate assessment may include, but is not limited to, taking a patient history, physical exam or performing/ordering any necessary diagnostic tests, investigations or procedures that are required to help establish a diagnosis and/or guide management.

Appropriate liability protection: CMPA protection may not apply depending on where the regulated member is located and how long they have been/will be there and where the patient is located and how long they have been/will be there. Regulated members are expected to confirm coverage with their liability provider (e.g., the Canadian Medical Protective Association) or employer (if applicable) prior to providing virtual care.

Controlled medications: for the purpose of this standard, "controlled medications" includes all Schedule/Type 1 and 2 drugs.

Effective care: regulated members will need to consider the appropriateness of virtual care within the context of that particular patient's health care (e.g., abnormal or critical investigation results that, if not addressed, could result in patient harm).

Temporarily: refers to situations where the person is out of the country, but retains residence in the province of Alberta the majority of the time (e.g., vacation, school, etc.).

Therapeutic relationship: a trust-based relationship between a patient and directed healthcare provider that is caring, positive and advances the best interests of the patient.

Sufficient training, knowledge, judgment and competency: regulated members providing virtual care are expected to be knowledgeable of and maintain competence in the technologies they use. Related training can be part of the regulated member's plan to meet mandatory Continuing Professional Development (CPD) requirements. Contact MainPro+ or the Maintenance of Certification Program (as applicable) to determine credit eligibility for specific courses or programs.

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Virtual care: for the purpose of this standard, "virtual care" is defined as any interaction between patients and members of their circle of care occurring remotely, using any form of communication or information technology with the aim of facilitating or maximizing the quality of patient care.

When appropriate: physicians must use their clinical judgment when considering whether virtual care is appropriate based on the patient's location, presenting health concern, need for physical examination and the physician's ability to arrange same, access to relevant patient information (e.g., pharmaceutical, laboratory, diagnostic imaging, etc.), and other available resources (e.g., technology, support staff, other healthcare services, etc.) while the physician is out of the province.

ACKNOWLEDGEMENTS

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RELATED STANDARDS OF PRACTICE

- *Cannabis for Medical Purposes*
- *Conflict of Interest*
- *Continuity of Care*
- *Episodic Care*
- *Establishing the Physician-Patient Relationship*
- *Informed Consent*
- *Patient Record Content*
- *Prescribing: Administration*
- *Prescribing: Drugs Associated with Substance Use Disorder or Substance-Related Harms*
- *Referral Consultation*
- *Responsibility for a Medical Practice*
- *Safe Prescribing for Opioid Use Disorder*

COMPANION RESOURCES

- Advice to the Profession:

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  - Virtual Care
  - Electronic Communications & Security of Mobile Devices
  - Cannabis for Medical Purposes
  - Conflict of Interest
  - Continuity of Care
  - Episodic Care
  - Informed Consent for Adults
  - Informed Consent for Minors
  - Physicians as Custodians of Patient Records
  - Prescribing: Administration
  - Prescribing: Drugs Associated with Substance Use Disorder or Substance-Related Harms
  - Safe Prescribing for Opioid Use Disorder
  - Responsibility for a Medical Practice
- Advice to Albertans: Virtual Care
- CMA's Virtual Care Playbook
- CMPA's The Most Responsible Physician
- OIPC's Privacy Impact Assessment

[i] From CPSM's *Virtual Medicine* standard of practice (November 1, 2021).
[ii] Per Section 64 of the *Health Information Act*.

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