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BYLAW 11

Standards of Practice of Medicine

Adopted by the Councillors of the College of Physicians and Surgeons of Manitoba
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Definitions

1 The following definitions apply in this by-law:

“Act” means *The Medical Act*.

“college” means the College of Physicians and Surgeons of Manitoba.

“health care professional” means a person who engages in health care as a practising member of a health profession regulated under an act of the legislature.

“institutional setting” means

- (a) a facility that is designated as a hospital under *The Health Services Insurance Act*; or
- (b) a hospital or health care facility operated by the government, the government of Canada, a municipal government, a regional health authority or CancerCare Manitoba.

“medical care” means any health care that a member provides in the course of his or her practice as a member.

“member” means a member or associate member of the college.

“representative” means a person referred to in section 60 of *The Personal Health Information Act*.

“telemedicine” means the provision of medical care by means of electronic communication where the patient and the member are at different locations, including but not limited to treating, advising, interviewing and examining the patient.

“non-traditional therapy” means complementary and alternative medicine that is not considered to be part of prevailing medical practice and that is not supported by empirical evidence.

Medical Care

- 2(1) A member must provide good medical care to a patient and include in the medical care that he or she provides:
- (a) an assessment of the patient that includes the recording of a pertinent history of symptoms and psychological and social factors for the purpose of making a conventional diagnosis, when required;
 - (b) the physical examination of the patient that is required to make or confirm a diagnosis;
 - (c) the taking into account of the patient's values, preferences and culture;
 - (d) sufficient communication with the patient or his or her legal representative about the patient's condition and the nature of the treatment and an explanation of the evidence-based and conventional treatment options, including the material risks, benefits and efficacy of the options in order to enable informed decision-making by the patient;
 - (e) timely communication with the patient about the care;
 - (f) a timely review of the course and efficacy of treatment;
 - (g) the referral of the patient to another member or health care professional, when appropriate; and
 - (h) the documentation of the patient record at the same time as the medical care is provided or as soon as possible after the care is provided.
- 2(2) For the purpose of clause (1)(d), "material risks" are to be determined by the member having consideration for the special circumstances of each patient and the potential seriousness of risk for a reasonable person in the same circumstances.
- 2(3) A member must not refuse to provide medical care for an existing patient because the care will or may require the member to complete documentation in addition to the patient record, unless an arrangement described in subsection (4) applies.
- 2(4) A member may arrange for another member to provide medical care to a patient if the arrangement is acceptable to the patient and to the other member.

Multiple Concerns in a Medical Visit

- 3(1) Members are not required to address all patients concerns in one visit, but must place the patient's best interest before his/her own and implement practices to ensure that urgent matters are appropriately addressed in a timely fashion, and less urgent matters are deferred to a later scheduled appointment.
- 3(2) Members who establish a process for dealing with circumstances where a patient presents with multiple concerns must establish a process which accords with the responsibility of the member:

- (a) to gather sufficient information from the patient to triage patient concerns;
 - (b) to decide which concerns must be dealt with at that visit and which concerns can safely wait; and
 - (c) to schedule appointment(s) to address concerns not dealt with, within a time frame appropriate for the condition.
- 3(3) Members must not have office policies or office signage which attempt to limit a patient to discussing one problem in one patient visit, as they do not accord with the member's responsibility to triage when multiple concerns are presented.

Assessing Competence or Mental Capacity

- 4 To determine a patient's competence or mental capacity, a member must:
- (a) attempt to obtain the patient's agreement to participate in the assessment;
 - (b) assess the patient's competence or mental capacity to understand:
 - (i) information relevant to the topic at hand;
 - (ii) the decisions to be made; and
 - (iii) the risks and benefits of actions that may be undertaken or the medical care that could be provided;
 - (c) assess the patient's competence or mental capacity to justify his or her choices;
 - (d) use accepted clinical means to determine a patient's competence or mental capacity.

Follow-up to Diagnosis and Test Results

- 5(1) A member who orders a diagnostic test or makes a referral to another health care professional must have a system in place to review the test results and the results of referrals to other health care professionals and have reasonable arrangements in place to follow-up with the patient when necessary.
- 5(2) A member who orders a diagnostic test and directs a copy of the results to another member remains responsible for any follow-up care required, unless the member to whom a copy of the results is directed has agreed to accept responsibility for the patient's follow-up care.

Informed Consent

- 6(1) Consent to examination or treatment may be implied or may be expressed orally or in writing.
- 6(2) Before performing an examination or providing treatment a member must ensure that the patient or a substitute decision maker has provided consent except where the member is permitted by law to act without consent. A member must:

- (a) be aware of authoritative advice on informed consent, such as that of the Canadian Medical Protective Association, before establishing a policy on consent procedures in his or her medical practice;
 - (b) consider the risks to the patient, the potential for pain and discomfort, and the invasiveness of the procedure when deciding on the type of consent required;
 - (c) if relying on implied consent, be certain that the actions of the patient would be interpreted by others as having implied permission for the member's actions;
 - (d) ensure that written consent is obtained before performing a surgical operation except in circumstances where it is not possible or practical to obtain such consent;
 - (e) consider the knowledge and expertise of trainees and staff if delegating the consent procedure.
- 6(3) A member must determine a patient's capacity and competence to give consent.
- 6(4) A member must respect the right of a patient to withdraw consent at any time.
- 6(5) In obtaining full and informed consent for procedures of higher risk of harm for the patient, a member must discuss, at a minimum:
- (a) the exact nature and the anticipated benefits of the proposed examination or treatment;
 - (b) reasonable and accepted alternative examinations or treatments that are generally available;
 - (c) the natural history of the medical condition at issue;
 - (d) consequences of not undertaking the examination or treatment;
 - (e) the common and significant risks of the examination or treatment alternatives;
 - (f) serious risks, even if unlikely;
 - (g) special risks, that although uncommon, may have particular relevance to the patient;
 - (h) any questions the patient may have.
- 6(6) A member who obtains consent from a patient for participation in research must also comply with direction and advice from the applicable research ethics board.
- 6(7) In advancing knowledge in any area of medicine, members who provide treatment of less well proven efficacy and safety must ensure that the patient is told the degree to which the tests, treatments or remedies have been evaluated and the degree of certainty and predictability that exists about their efficacy and safety.

Maintaining Boundaries:**A. Current Patients**

- 7(1) A member must maintain appropriate professional boundaries in any interaction with a current patient. Examples of prohibited conduct include:
- (a) initiating any form of sexual advance toward a patient;
 - (b) responding sexually to advances made by a patient; and
 - (c) not taking appropriate steps to respect the patient's privacy and dignity when conducting or offering to conduct a physical examinations.
- 7(2) A member must not sexualize any interaction with a current patient. Inappropriate member-patient interactions of a sexual nature encompass a spectrum of behaviours, which may include:
- (a) providing inadequate draping;
 - (b) not providing privacy while the patient is undressing or dressing;
 - (c) not offering the presence of a chaperone during a sensitive examination;
 - (d) being judgmental of a patient's sexual orientation or activities;
 - (e) sexualizing comments, gesture or tone of voice;
 - (f) requesting details of a sexual history when not medically indicated;
 - (g) not obtaining informed consent for intimate or sensitive examinations;
 - (h) using unorthodox examination techniques including inappropriate touching of the breasts, genitalia, or anus;
 - (i) sexualizing body contact, including kissing, hugging or fondling. This does not prohibit hugging in appropriate circumstances where there is no sexual aspect to the physical contact;
 - (j) socializing with a patient in the context of developing an intimate relationship;
 - (k) making member-patient sexual contact;
 - (l) scheduling appointments for examinations outside normal office hours.
- This list is not exhaustive.

B. Former Patients

- 8(1) Since the member-patient relationship is a fiduciary relationship and the characteristics of such a relationship may extend beyond the point in time when the member-patient relationship ends, a member must not initiate any form of sexual advance toward a former patient where there is a risk of power imbalance from the former member-patient relationship.
- 8(2) Where there is no continuing power imbalance, a member must not have any sexual or intimate involvement with the former patient for a period of time after the last member-patient encounter. The period of time depends on the nature and extent of the member-patient relationship.

C. Psychotherapeutic Relationship

- 9 A member who has had a psychotherapeutic relationship with a patient must not engage in a sexual or intimate relationship with that patient at any time during or after the psychotherapeutic relationship.

Disclosure of Harm to a Patient

- 10(1) A member who is responsible for a patient who has suffered harm must ensure that the patient receives disclosure of harm in a prompt manner, and in accordance with the following principles:
- (a) Disclosure must occur whether the harm is a result of progression of disease, a complication of care, a failure to follow up, or an adverse event and whether or not the harm was preventable.
 - (b) If the member is the only health care provider treating the patient, it is the member's responsibility to disclose harm to the patient.
 - (c) In a team setting, the 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 or persons to disclose that information to the patient.
 - (d) Where a member believes another health care provider has caused harm to a patient and has not yet disclosed that harm to the patient, the member must discuss the issue with that health care provider and must encourage that health care provider to disclose the harm. If the other health care provider does not disclose the harm, the member must do so.
 - (e) 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.
- 10(2) When a patient suffers harm and wishes to see another member, the member must ensure that the patient is transferred to another member able to provide the required care.

Collaborative Care

- 11 When a member and one or more health care providers are involved in the health care of a patient, the member must:
- (a) treat other health care providers with respect;
 - (b) recognize the skills, knowledge, competencies and roles of others involved in the patient's care, and communicate effectively and appropriately with the other health care providers;
 - (c) document, on the patient record, the member's contribution to the patient's care; and

- (d) explain to the patient or his or her representative the member's role and responsibility.

A. Patient Rights in the Referral Process

- 12(1) If a member or a patient suggests a referral to another health care professional, the member must discuss the purpose of the consultation with the patient.
- 12(2) When a member believes that referral to another health care provider is appropriate but the patient does not, the member must discuss and document in the patient's record the difference of opinion and the implications for the patient's care and
 - (a) a member must continue to provide care within any limits imposed by the patient's decision; but
 - (b) the member must not practice beyond his or her competence or provide care that the member does not believe is in the best interest of the patient.
- 12(3) Despite the Code of Ethics requirement that a member must respect a patient's reasonable request to be referred to other health care providers or to receive a second opinion, a member is entitled to refuse to make a referral that, in his or her opinion, is unlikely to provide a clinical benefit to the patient.
- 12(4) A member must tell the patient about any fees that may not be covered by Manitoba Health if the referring member knows the consultant will likely charge fees that will be payable by the patient.
- 12(5) A member must recognize that the patient has the right to disagree with the choice of consultant or service to whom a referral is made, and the member must try to accommodate the patient's request.

B. Obligations of Referring Member

- 13(1) A member must make or confirm a request for a consultation, in writing, to the consultant or service unless the circumstances are urgent and the consultant agrees to accept care of the patient after oral discussion.
- 13(2) In the case of a referral for emergency care, the member must discuss the referral with the consultant or the emergency physician (if referral to an emergency department is being made) or otherwise ensure acceptance of care by the consultant or service.
- 13(3) A referring member must perform a preliminary work-up of the patient within his or her scope of practice and the available resources and ensure those results are available to the consultant or service.

- 13(4) If a consultation is requested solely for the purpose of providing information to a third party (for example an insurance company), the referring member must, at the time of the request for consultation, clearly identify that the consultation is requested for that purpose.
- 13(5) Except in an emergency situation, a referral request by a member must be provided in writing and include at least the following information:
- (a) the identity of the referring member;
 - (b) the identity of the patient, including the Manitoba Health number and contact information;
 - (c) the identity of the consultant or service to whom the patient is being referred;
 - (d) the date of the referral;
 - (e) the purpose of the referral as intended by the referring member, including whether an opinion only or transfer of care is requested;
 - (f) pertinent clinical information, including results of clinical investigations.

C. Obligations of Consultant Member

- 14(1) A consultant member or member's service must respond to the patient and member verbally or in writing to a request by a member for a non-urgent consultation within 30 days of receipt of the request, and must notify the patient and the referring member of the anticipated appointment date.
- 14(2) If a request for a consultation is declined, the consultant member must provide reasons and whenever possible, provide suggestions to the referring member for alternative consultants or services.
- 14(3) If a consultant member agrees to see a patient, the consultant or a designate must contact the patient directly to schedule the appointment (including information such as the date, time, and place, and special instructions) and send a copy of that information to the referring member, unless otherwise agreed to by the referring member.
- 14(4) If a consultant member arranges to see a patient without a referral, the consultant must not insist on a request for consultation from the patient's primary care physician.
- 14(5) Except in the circumstance of receipt of consultations through a process whereby a service assigns the patient to a consultant, a member who is a consultant must make information available about the process by which referrals are accepted; for example, by telephone, facsimile, secure e-mail or verbally and the member should generally be available to respond to requests for consultations.
- 14(6) A consultant member must, as soon as possible but generally within 30 days of having seen a patient for the first time, report in detail to the referring member all pertinent findings and recommendations with respect to a patient seen by the consultant.

- 14(7) If the consultant's conclusions require further investigation or treatment, the consultant must provide an interim report to the referring member and a final written report at the conclusion of the consultant's involvement.
- 14(8) Unless a patient explicitly requests otherwise, a consultant member's report must include, when applicable:
- (a) the identity of the consultant;
 - (b) the identity of the patient;
 - (c) the identity of the referring member and, if different, the identity of the patient's primary care physician;
 - (d) the date of the consultation;
 - (e) the purpose of the referral as understood by the consultant;
 - (f) information considered, including history, physical findings, and investigations;
 - (g) diagnostic conclusions;
 - (h) the treatments initiated, including medications prescribed;
 - (i) recommendations for follow-up by the referring member;
 - (j) recommendations for continuing care by the consultant;
 - (k) recommendations for referral to other consultants, but, except in the case of an emergency, such referral must only be made with the approval of the referring member;
 - (l) the advice given to the patient.

Nothing in this section prohibits a consultant from referring a patient directly to another consultant if it is in the best interests of the patient's health to do so expeditiously. In the case of a direct referral from one consultant to another, the referring consultant must immediately inform the initial referring member of the direct referral.

- 14(9) If a patient explicitly requests all or some information not to be disclosed, the consultant member must advise the referring member that the patient withholds consent for release of information.
- 14(10) If the consultant member requires further investigation before reaching a definitive diagnosis, the consultant must not delegate arrangement and follow-up of those investigations to the referring member without prior agreement with the referring member.
- 14(11) A consultant member must obtain informed consent for any procedure from the patient directly and cannot rely on the referring member to obtain the consent.
- 14(12) A consultant member must explain to the patient the consultant's role, if any, in the continuing care of the patient and the advisability of follow-up care by the consultant.

- 14(13) A consultant member must contact the referring member at the time the patient is returned to the referring member for ongoing care and provide written information as soon as possible thereafter to assist with the patient's continuity of care.

D. Referral for Non-Traditional Therapy

- 15 A member, acting honestly and without conflict of interest, may refer a patient to a practitioner who provides non-traditional therapy when there is no reason to believe that a referral would pose a greater risk to a patient's health or safety than the traditional or prevailing practice.

E. Institutional Settings - Transfer of Care

- 16(1) Except in circumstances where the institutional setting has a procedure in place to ensure transmission of information required for continuity of care, a member who:
- (a) transfers care to another member either within the same institutional setting or to another institutional setting must ensure the accepting member has the necessary clinical information to assume care, including a summary of laboratory test results, active medical problems and a treatment plan for the patient.
 - (b) discharges a patient from an institutional setting with the expectation of follow-up care by another member outside that institutional setting, or provides care in an emergency setting and has ordered tests which require follow-up or recommended follow-up care by another member, including the patient's primary care physician, must:
 - (i) prepare a legible summary of laboratory test results, active medical problems and treatment plans at discharge for the accepting member before the follow-up care appointment is expected to occur;
 - (ii) if the follow-up care is required within two (2) weeks of discharge, contact the accepting member directly to facilitate the patient's follow-up care appointment and to transfer necessary medical information.
- 16(2) Subsection 1 is not intended to make the member responsible for delays in the transcription and delivery of the discharge summary that are not under his or her control.

Conscience-Based Objection

- A. A conscience-based objection is an objection to participate in a legally available medical treatment or procedure based on a member's personal values or beliefs.
- B. A member must not promote his or her own values or beliefs when interacting with a patient.

- C. On the grounds of a conscience-based objection, a member who receives a request about a medical treatment or procedure that a patient needs or wants may refuse to:
- (a) Provide it;
 - (b) personally offer specific information about it; or
 - (c) refer the patient to another member who will provide it.
- D. A member who refuses to refer a patient to another member or to personally offer specific information about a medical treatment or procedure on the grounds of a conscience-based objection must:
- (a) clearly and promptly inform the patient that the member chooses not to provide a medical treatment or procedure on the grounds of a conscience-based objection;
 - (b) provide the patient with timely access to a resource¹ that will provide accurate information about a medical treatment or procedure;
 - (c) continue to provide care unrelated to a medical treatment or procedure to the patient until that physician's services are no longer required or wanted by the patient or until another suitable member has assumed responsibility for the patient;
 - (d) make available the patient's chart and relevant information (i.e., diagnosis, pathology, treatment and consults) to the member(s) providing a medical treatment or procedure to the patient when authorized by the patient to do so; and
 - (e) document the interactions and steps taken by the member in the patient's medical record, including details of any refusal and any resource(s) to which the patient was provided access.

Practice Coverage - Critical Test Results

- 18(1) "Critical test results" are test results that are significantly out of the normal range and which need to be communicated to the member urgently.
- 18(2) Each member, including members who provide episodic care, is responsible to ensure that specific arrangements are in place for the member to receive communication respecting critical test results.
- 18(3) The member who receives communication respecting critical test results is responsible to promptly assess whether the results require urgent follow up and take the appropriate action on behalf of the patient.

¹ Acceptable resources may include but are not limited to other members, health care providers, counsellors and publicly available resources which can be accessed without a referral and which provide reliable information about the available medical treatments or procedures.

- 18(4) When ordering tests, members must
- (a) provide the diagnostic facility with a telephone number at which the member or the member's designate may be reached and which may be used by the diagnostic facility to communicate critical test results to the member or the member's designate;
 - (b) provide pertinent information about the patient for use by the diagnostic facility to help determine whether a test result is critical.
- 18(5) If a member is unable to be personally available to receive the critical test results, the member must make arrangements with another member to be available to receive the critical test results and to provide the appropriate follow-up communication and care to the patient promptly.
- 18(6) Each member must establish a reasonable system for communicating test results to his or her patients.

Non-Traditional Therapies

- 19(1) Before a member proposes a non-traditional therapy to a patient, the member must:
- (a) make a conventional diagnosis using good medical care described in section 2;
 - (b) inform the patient about prevailing medical practice as it relates to the health care needs of the patient;
 - (c) inform the patient about the nature of the non-traditional therapy and how it relates to or is consistent with traditional therapies and prevailing medical practice, and, if applicable,
 - (i) the cost of the non-traditional therapy,
 - (ii) the number of appointments or treatment required for the non-traditional therapy, and
 - (iii) the period of time over which the non-traditional therapy would be required; and
 - (d) document the information provided to the patient in the patient record.
- 19(2) A member who provides a non-traditional therapy to a patient must do so within the context of providing good medical care in the manner described in section 2.
- 19(3) A member may conduct clinical research into the effectiveness of a non-traditional therapy only if the research is approved by the ethics research board. The board must meet current standards for medical research and be acceptable to the college.

Prescribing

A. Prescription Content

- 20 A member must include on a written prescription:
- (a) the name and address of the patient;
 - (b) if the patient is a child, the patient's weight;
 - (c) if age would impact dosage, the age of the patient;
 - (d) the date;
 - (e) the name of the drug or ingredient(s) and, where applicable, strength;
 - (f) quantity of the drug to be dispensed;
 - (g) dosage instructions;
 - (h) refill instructions, which must include the number of refills and, where applicable, interval between refills;
 - (i) his or her printed name or a legible signature. Rubber stamp signatures are not acceptable;
 - (j) if the prescriber is an associate member:
 - (i) treatment goal and/or diagnosis and clinical indications;
 - (ii) the name and telephone number of the supervision physician.

B. Sample Medication

- 21(1) A member must:
- (a) keep sample medication in a secure location;
 - (b) dispose of sample medication in a safe and environmentally acceptable manner;
 - (c) not offer to sell or barter sample medication for any purpose whatsoever.
- 21(2) A member must ensure that if a sample drug is provided to the patient:
- (a) it is provided with clear instructions for its use, including any precautions;
 - (b) it has an unexpired date of use.

C. Direct Patient Contact

- 22(1) Prescribing medication or counter-signing a prescription without direct patient contact does not meet an acceptable standard of care. Subject to subsection (2), there is no direct patient contact when the member relies upon a mailed, faxed or an electronic medical questionnaire or telephone advice to the member.
- 22(2) An exception to the requirement for direct patient contact exists for members who:
- (a) are fulfilling responsibility as part of a call group;
 - (b) treat their own patients after normal office hours;
 - (c) are in an academic teaching environment; or

- (d) are prescribing Naloxone as part of a harm reduction strategy for substance abuse.
- 22(3) In order to meet an acceptable standard of practice, the member must demonstrate that there has been:
- (a) a documented patient evaluation by the Manitoba member signing the prescription, including history and physical examination, adequate to establish the diagnosis for which the drug is being prescribed and identify underlying conditions and contra-indications;
 - (b) sufficient direct dialogue between the Manitoba member and patient regarding treatment options and the risks and benefits of treatment(s);
 - (c) a review of the course and efficacy of treatment to assess therapeutic outcome, and
 - (d) maintenance of a contemporaneous medical record that is easily available to the Manitoba member, the patient, and the patient's other health care professionals.

D. Verbal Prescriptions

- 23(1) A member must relay the following types of verbal prescriptions directly to a pharmacist:
- (a) new prescriptions;
 - (b) all oral narcotic renewals or controlled drugs for which a M3P is not required;
 - (c) changes to a prescription.
- 23(2) Transmittal of other prescription renewals may be delegated to an agent, who must identify himself/herself to the pharmacy. The member assumes responsibility for the agent's actions in regards to the transmittal.

E. Method of Prescribing M3P Drugs (AM.06/16)

- 24(1) Medications which must be prescribed using a Manitoba Prescribing Practices Program (M3P) prescription may not be sent via facsimile transmission, except when the prescription is for a resident of a personal care home.
- 24(2) Notwithstanding the provisions of s.24 (1), a prescription for methadone or Suboxone prescribed for the purposes of a methadone/ buprenorphine maintenance program as set out in the College of Physicians and Surgeons of Manitoba guideline entitled Manitoba Methadone & Buprenorphine Maintenance Recommended Practice Guide, may be sent via facsimile transmission.

F. Dispensing Physicians

25 A member may dispense or sell a drug or vaccine only if the member is authorized to do so under *The Pharmaceutical Act* and in compliance with the requirements of that Act and regulations made thereunder.

Marijuana (Cannabis) for Medical Purposes

26(1) Although members may authorize the use of medical marijuana, they are not required to do so if they do not feel it is warranted for a patient.

26(2) Prior to authorizing marijuana for a patient, a member must:

- (a) make a conventional diagnosis using the principles of good medical care set out in s. 2 of this by-law;
- (b) ensure that other conventional therapies have been tried for the patient's condition;
- (c) discuss with the patient all potential risks and benefits and the lack of clear scientific evidence supporting the efficacy of the proposed treatment;
- (d) document on the patient record the discussions with the patient and the medical reasons for which the marijuana is authorized.

26(3) A member may not be legally or beneficially involved in any way with a licensed producer and may not directly make any application to become a licensed producer.

26(4) A member must keep a separate log for all authorizations for the use of medical marijuana which must include the following information:

- patient's name;
- patient's personal health identification number;
- condition for which the marijuana was authorized;
- quantity and dosages of marijuana authorized.

The separate record must be available for inspection by the College at any time.

26(5) A member must establish a process to report any misuse or abuse of medical marijuana by the patient.

26(6) The member must not:

- (a) authorize marijuana if the member is not the primary treating physician for the condition for which the marijuana is authorized;
- (b) examine the patient at the premises of a licensed producer or a location provided by or subsidized by a licensed producer;
- (c) dispense or provide marijuana to any patient.

Patient Records

A. Record Content

- 27(1) A member must appropriately document the provision of patient care in a record specific to each patient. Whether in paper or electronic form, the record must be legible, accessible to ensure continuity of care, and in English.
- 27(2) A member must document on the patient record the medical care given to the patient containing enough information for another member to be sufficiently informed of the care provided.
- 27(3) A patient record must contain or provide the following information
- (a) patient demographic information including:
 - (i) full name as it appears on the patient's health insurance registration card;
 - (ii) current address;
 - (iii) personal health identification number or other unique identifier;
 - (iv) date of birth;
 - (v) telephone number and any alternative telephone contact numbers; and
 - (vi) next of kin.
 - (b) all dates the patient was seen or was in communication with the member and the identity of the member attending the patient on those dates.
 - (c) patient clinical information including:
 - A. documentation of presenting complaints and relevant functional inquiry;
 - B. significant prior history/active problem list;
 - C. current medications, allergies and drug sensitivity, where relevant;
 - D. relevant social history including alcohol or drug use or abuse;
 - E. relevant family history;
 - F. findings on physical examination, including relevant abnormalities or their absence;
 - G. diagnoses (tentative, differential or established);
 - H. treatment advised and provided, including medication prescribed;
 - I. if a prescription is issued:
 - (A) the name of the medication;
 - (B) the dose of medication to be taken at each administration;
 - (C) the frequency that medication is to be taken or administered;
 - (D) the duration of the period for which the patient is to take the medication;
 - (E) whether or not refills have been issued or approved;
 - J. investigations ordered and results obtained;
 - K. instructions, precautions and advice to the patient, including instructions for follow-up;
 - L. responses of the patient to the advice given, if refused;
 - M. reports received or sent in regard to the patient's medical care;

- N. particulars of any sample medication provided to the patient.
- (d) the following reports and information:
 - (i) laboratory and imaging reports;
 - (ii) pathology reports;
 - (iii) letters of referral and consultation reports;
 - (iv) hospital summaries;
 - (v) surgical notes.
- (e) on the referring member's record a summary of any telephone consultation between two members with respect to a specific patient, and on the consultant's record, enough information to validate that the consult occurred.

27(4) A member who uses templates in a patient record must modify the content to reflect the actual circumstances of a patient encounter.

27(5) A member must not copy and paste the note of a prior visit by the patient unless the entry is modified to reflect the actual circumstances of the later visit.

B. Alteration of Records

28 Original patient records must not be altered after an entry is made. If any change, addition or deletion to a patient record is required, the original entry must be identifiable and legible and the identity of the person making the change, addition or deletion to the record and the date of the change, addition or deletion must be clearly set out. All of the entries must be readily accessible to any person reviewing or auditing the record.

C. Record Retention and Security

29(1) A patient record must be retained by the member having last custody of the record for at least 10 years after the date of the last entry on the record, and patient records of minors must be retained for at least 10 years after the date the minor becomes 18 years old.

29(2) A member must retain control of all his or her patient records unless:

- (a) they are maintained by another member; or
- (b) the member is employed or engaged in an institutional setting at which the patient records are maintained.

29(3) A member must maintain safeguards to protect confidentiality and to protect against reasonably anticipated threats to the security, integrity, loss, or unauthorized use, disclosure, modification or unauthorized access to personal health information.

D. Ownership of Records

- 30(1) Members in group medical practice must determine the ownership of patient records within that practice so that:
- (a) if a member or members leave the practice, ownership of the patient records will be clear to all members in the practice and to the patients;
 - (b) departing members and their patients have reasonable access to patient records.
- 30(2) If a member works as a physician for a facility owned by the federal or provincial government or for a company, the member is not required to be the owner of the patient records.
- 30(3) If a member practices in an office within a provincial health authority facility and the ownership of the patient record is not clear, the member must negotiate an information sharing agreement that includes rules about access to and custody of patient records.
- 30(4) A member who works in a practice described in subsection 3 or 4 is expected to fulfill all obligations respecting the completion of patient records, the maintenance of security of patient records and the confidentiality of information contained in patient records even if the member does not own the patient record.

E. Access to or Copy of Record (AM12/16)

- 31(1) While a member may be the owner or custodian, or both, of a patient record, the patient whose information is contained in that record owns the information. On the request of a patient, subject to the limitations set out in *The Personal Health Information Act*, the member must:
- (a) allow the patient to inspect the patient record;
 - (b) provide to the patient a copy of the patient record.
- 31(2) A member may charge a fee as permitted by *The Personal Health Information Act* for a patient's request for access to or a copy of his or her record, unless the member terminated an individual patient from an ongoing practice, in which case no fee may be charged. This exception does not prohibit a member from charging a fee to patients when the member is closing, leaving or moving a medical practice.

F. Discharge Summary

- 32 The member responsible for the care of a patient in a hospital or health care facility must complete a discharge summary in a timely manner consistent with the policies of the institution.

G. Electronic Records

- 33 The same standards apply to electronic records as apply to paper records.

- 34 Electronic medical records must have comprehensive audit capability, including a system which enters all access onto a permanent file log, identifying and recording where the access originated and by whom, and if alterations are made to the record, identifying whom, what was altered, and when the alteration was made.

H. Telemedicine

- 35 For greater certainty, a member who provides medical care by telemedicine must comply with the requirements in this by-law for patient records.

I. Additional Obligations

- 36(1) The obligations in this by-law respecting patient records are in addition to any other requirements relating to patient records under *The Act*, *The Personal Health Information Act*, and any other enactment, by-law, standard of practice or code of ethics with which a member must comply.
- 36(2) A member attending a patient at a hospital shall complete the medical records for which that member is responsible in accordance with the requirements of by-laws of the hospital.

J. Transfer of Patient Records (AM12/16)

- 37(1) If a patient or his or her representative requests a member to transfer patient records to another member, the requested member must ensure that the request is completed promptly as required in the circumstances but no later than 30 days after the member receives the request.
- 37(2) A member may charge a reasonable fee in respect of a transfer in accordance with the any applicable privacy or other legislation.
- 37(3) A member must not charge another health care provider for the exchange of limited patient information such as a copy of a discharge summary.

Record of Appointments

- 38(1) A member must keep a record of his or her appointments with those persons seeking medical care indicating, for each day, the names of patients or persons seen and patients for whom medical care was provided.
- 38(2) The record of appointments must be retained by the member, or another member who has possession of them, for at least 10 years after the date the record was made.

Confidentiality and Privacy:

A. Transmission of Health Information

39(1) “Electronic transmission of prescription” includes all forms of prescription transmission for outpatients and persons receiving care in an ambulatory community practice.

39(2) A member who uses electronic transmission of prescriptions:

- (a) must ensure the prescription is transmitted to the pharmacist in a clear, unambiguous manner and the mode of transmission is secure and maintains confidentiality;
- (b) must have written policies regarding transmission of health care data, and comply with *The Personal Health Information Act* duties to adopt security safeguards that ensure the confidentiality, security, accuracy and integrity of personal health information, including written security policies and procedures;
- (c) must adhere to the requirements of *The Personal Health Information Act* and regulations made pursuant to that legislation;
- (d) must ensure that:
 - (i) the prescription is sent directly from the prescriber’s office to a single licensed pharmacy of the patient’s choice;
 - (ii) the prescription is sent only to a pharmacist practicing in a Manitoba licensed pharmacy;
 - (iii) the prescription is transmitted to the pharmacy in a clear, unambiguous manner;
 - (iv) the mode of transmission is secure and maintains confidentiality;
 - (v) the prescription contains the information required by s. 20 of this by-law and prescriptions sent by facsimile also contain:
 - i. the prescriber’s name, address, fax number and telephone number;
 - ii. time and date of transmission;
 - iii. the name of the intended pharmacy;
 - iv. signed certification that:
 - A. the prescription represents the original of the prescription drug order;
 - B. the addressee is the only intended recipient and there are no others; and
 - C. the original prescription will be invalidated, securely filed and not transmitted elsewhere at another time.
- (e) send facsimile prescriptions only from a machine authorized by the member.

39(3) Before leaving a message on voice mail or telephone answering machines, a member must be confident that the voice mail or answering machine is confidential to the patient.

39(4) An electronic transmission of prescription(s), for a patient is only valid if the prescription includes the patient's personal health information number (PHIN). If the patient does not possess a PHIN or is not willing to provide their PHIN, the member must cooperate with the pharmacist to issue a signed "pen and paper" prescription or a verbal prescription communicated between the prescriber and pharmacist.

B. Medical Information to Third Parties and Sickness Certificates

- 40(1) When providing medical information to any third party, a member must:
- (a) ensure that there is consent from the patient to provide information to the third party unless otherwise required by law;
 - (b) limit the information provided to that covered by the patient's consent;
 - (c) limit information to that specifically required by the third party within the scope of the patient's consent;
 - (d) ensure that all statements made are accurate and based upon current clinical information about the patient;
 - (e) limit the statements to and identify the time period with respect to which the member has personal knowledge;
- 40(2) When providing a sickness certificate (i.e. a document provided by the member at the request of the patient to provide to the patient's employer and/or insurer specific information to verify the patient's illness/injury):
- (a) avoid diagnostic terms;
 - (b) Information provided may indicate:
 - (i) prognosis relative to the work situation;
 - (ii) activity limits and ability limits;
 - (iii) risk factors (to the patient and to others).
 - (c) have accurate information about the requirements of the patient's job before giving an opinion on fitness to work;
 - (d) be aware of and take into account the provisions of *The Personal Health Information Act*.
- 40(3) When providing a sickness certificate on the basis of a history provided by telephone or following an office visit where clinical evidence of the illness does not continue to be evident, specifically say so in the sickness certificate. A member must not imply that the member has evidence of an actual diagnosis if the information is restricted to history or examination that is non-contributory.

C. Observers

- 41 Members who permit any other individuals such as, but not limited to, international medical graduates, to observe patient care in clinical practice must:
- (a) ensure the observers do not participate in taking the patient's history or examination of the patient and do not contribute to the delivery of care, or perform any service related to patient care;
 - (b) obtain express consent from each patient before permitting a third party to observe the member-patient encounter, or to have access to patient record and document that consent on the patient's medical record. Each patient is entitled to withhold or withdraw consent. A patient's decision to provide, withhold or withdraw consent must not alter the patient's access to health care in any manner;
 - (c) not enter an observation arrangement until the observer has signed a confidentiality agreement and agreed to comply with all provincial legislation, including *The Personal Health Information Act*.

Responding to Requests for Information or Opinion

- 42(1) A member must provide details of his or her assessment, diagnosis, advice and other medical care provided to a patient when requested to do so by the patient, the patient's representative or lawyer, or if required by law.
- 42(2) Notwithstanding subsection (1), a member is not required but is encouraged to provide, at the request of a patient or his or her representative or lawyer:
- (a) a medical-legal opinion;
 - (b) an expert opinion; or
 - (c) expert evidence in a legal proceeding.

Non-Treating Medical Examinations

- 43(1) When accepting a request to perform a non-treating medical examination (a "NTME"), the member undertaking the examination must:
- (a) examine the person under the same ethical obligations that 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 a contract or referral, legislation, or court rules, as the case may be.
- 43(2) Before undertaking a NTME, a member must disclose to all parties:
- (a) his or her involvement at any time in the medical care of the person who will undergo the examination;
 - (b) any relationship with the third party outside of a fee for service for the NTME.

- 43(3) In advance of the examination, a member and the party requesting the examination must agree on the fee for the NTME.
- 43(4) A member undertaking a NTME must obtain from the person concerned informed consent for the examination, diagnostic intervention and release of the member's report, unless the informed consent is not required as a result of a court order or legislation.
- 43(5) A member undertaking a NTME must not access records about the patient which are not provided by the third party requesting the NTME or the patient.
- 43(6) A member is not required to:
- (a) enforce the terms of a court order or legislative requirement;
 - (b) proceed with a NTME if the person refuses to cooperate with the member performing the NTME.
- 43(7) A member who conducts a NTME must not establish a therapeutic relationship with the person who is the subject of the NTME unless:
- (a) there is no other member available to provide those services, or the treatment is authorized by legislation; and
 - (b) the relationship starts after the member concludes the NTME.
- 43(8) If a patient who is the subject of a NTME requires urgent intervention, the member must make arrangements for follow-up through another member who can treat the patient, but if no other member is available or there is no known treating member, the 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.
- 43(9) A member performing a NTME must retain the following records obtained or created for the NTME, for at least 10 years or longer if required by legislation:
- (a) the final report and any interim reports issued to the third party by the member;
 - (b) informed consent document;
 - (c) the contract (if it exists in written form) outlining scope, purpose, timeliness, and fee arrangements;
 - (d) notes of the medical history of the person being examined;
 - (e) notes of the physical examination;
 - (f) audio and video recording if made by the member;
 - (g) a list of sources of ancillary information, including medical reports, records, and any audio or visual information recorded by another person;
 - (h) the name of any person who accompanied the person being examined during the examination.

Practice Environment

A. Safe, Appropriate and Sanitary

- 44(1) A member may engage only in medical care that, in the member's reasonable and professional judgment, is safe, appropriate and sanitary.
- 44(2) A member must take reasonable steps to ensure that a system is in place for the proper maintenance, cleaning and calibration of equipment used in the medical care he or she provides.

B. Medical Practice in Non-Institutional Settings

- 45(1) If a member establishes a medical practice in a non-institutional setting, the premises in which the medical care is provided must be safe, appropriate and sanitary.
- 45(2) If a member engages in medical care in a non-institutional setting, the member must maintain full direction and control of his or her medical practice, including:
- (a) the medical care provided to or for a patient;
 - (b) the safety and quality of the premises in which the member practises and of the equipment and the supplies used, including proper maintenance, cleaning and calibration of equipment used in the medical care he or she provides;
 - (c) documentation in, access to and security of patient records, including documenting medical care provided to a patient, patient appointment schedules, patient billing and payment records for the medical care of a patient;
 - (d) any advertising of or for the medical practice;
 - (e) billing for any medical care that is not an insured service under *The Health Services Insurance Act*; and
 - (f) the qualifications and performance of each staff member supervised by the member.
- 45(3) A member is not required to own any supplies, equipment or premises used by the member in a medical practice.
- 45(4) A member who practices in a non-institutional setting and who does not own the supplies, equipment or premises used in that practice must:
- (a) promptly notify the owner if one or more of the supplies, the equipment or the premises impede the member in providing safe medical care;
 - (b) not provide any specific medical care which cannot be safely provided with the available supplies, equipment or premises.

- 45(5) A member who removes tissue from a patient in a non-institutional setting, must forward the tissue to an accredited laboratory for examination applying the same standards as required for tissues removed in hospitals.

C. Non-Institutional Setting: Medical Director

- 46(1) A member must not practice in any non-institutional setting where two or more physicians practice together, irrespective of the ownership of the non-institutional setting unless the non-institutional setting has a duly qualified medical practitioner in good standing designated as "Medical Director".
- 46(2) The Medical Director must:
- (a) ensure that only qualified members provide medical care in the non-institutional setting;
 - (b) ensure that, regardless of the name of the non-institutional setting, the name(s) of all the physician(s) and medical corporations are clearly posted, either on the exterior of the non-institutional setting or in the reception area;
 - (c) ensure that the non-institutional setting complies with the Code of Ethics;
 - (d) ensure that all communication about the patient is through or on behalf of the appropriate attending member;
 - (e) be responsible for and have authority over all aspects of non-institutional setting operation which can affect the quality of patient care.

Duty to Assist in an Emergency

- 47(1) In this section:
- (a) "disaster" means a calamity, however caused, which has resulted in or may result in the loss of life, or serious harm or damage to the safety, health or welfare of people.
 - (b) "emergency" means a present or imminent situation or condition that requires prompt action to prevent or limit the loss of life or harm or damage to the safety, health or welfare of people.
 - (c) "medical emergency" means a sudden injury, illness or complication demanding immediate or early medical care to save life or to prevent serious disability, pain or distress or it may arise in the context of a more widespread disaster or emergency, whether or not a state of emergency is formally declared pursuant to provincial or federal legislation.
- 47(2) Requirements:
- (a) Subject to subsection 2(b), a member who is asked to attend a medical emergency must respond to render prompt and appropriate medical care to any person, whether or not the person is a current patient.

- (b) A member who does not attend a medical emergency when requested to do so must have a valid reason for the failure to attend. The following circumstances are recognized as potentially valid reasons for failure to attend:
 - (i) The member is already attending another medical emergency;
 - (ii) Attending the emergency places the personal safety of the member at an unreasonable risk;
 - (iii) Any situation where the member believes that his or her level of competence, health, or personal circumstances may compromise his or her ability to provide an appropriate level of care necessary to deal with the medical emergency.
- (c) The member's duty when called to an emergency is:
 - (i) to provide service within the scope of his or her proper professional competence and level of skill and, if he or she has no appropriate competence or skills, to present as a person with some knowledge of emergency first aid. The member is in the best position to know whether his or her area of competence and level of skill is sufficient to provide more than basic first aid.
 - (ii) to apply his or her knowledge and skill to save life, to relieve suffering and to establish the most favourable conditions for the patient's ultimate recovery.
- (d) In a medical emergency, a member has a duty to work cooperatively with:
 - (i) other health care providers and to recognize the competency or skills of other health care providers;
 - (ii) Regional Health Authorities and public health authorities within the federal and provincial health departments.

Conflict of Interest Involving Financial or Personal Gain in the Care of a Patient

A. Business Interests

- 48(1) A member must not, directly or indirectly, enter into any business arrangement that may create a real or perceived conflict of interest with the member's duty to the patient.
- 48(2) A member must not have a direct or indirect interest in a health care business to which the member refers a patient or to which a patient may be expected to attend due to geographic proximity or necessity, unless the member satisfies the following conditions:
- (a) the terms on which the interest is offered to the member must not be related to the past or expected volume of referrals of patients or other business from the member to that facility;
 - (b) there must be no requirement that the member make referrals to the facility or otherwise generate professional business as a condition for investment or remaining as an investor;

- (c) the financial return for the member must be directly attributable to the member's proportionate financial interest in the facility rather than to the volume of referrals made by that member.

B. Benefit for Service

- 49(1) A member must not seek or accept any payment or benefit, directly or indirectly, for any service rendered or product provided to a patient by any other member or person other than by a partner, associate, employee or locum of the member.
- 49(2) A benefit includes, but is not limited to:
 - (a) any financial advantage;
 - (b) any good or service sought or received by the member.

C. Inducements

- 50(1) A member must not offer or cause any inducement to be offered or received by any person, including a patient of the member, in return for:
 - (a) the referral of another person to the member or a clinic or group with which the member is associated, whether or not the referral is medically appropriate;
 - (b) the provision of any service or product, whether or not the provision of the service or product is medically appropriate.
- 50(2) Prohibited inducements within subsection 1 include, but are not limited to, offering or providing:
 - (a) discount coupons or gift certificates for a product or service unless available to all;
 - (b) prizes of a product or service;
 - (c) gifts of a product or service;
 - (d) promotional gifts or other benefits for attendance of informational sessions about medical services not insured by Manitoba Health.
- 50(3) Despite subsection (2), a member may:
 - (a) offer a reduced fee or charge to a specific patient for compassionate reasons;
 - (b) advertise that prices are subject to change without notice;
 - (c) provide free consultations for the purpose of informing and assessing the eligibility of a patient for an uninsured product or service.

D. Sale of Products

- 51(1) "Product" includes, but is not limited to, any product, device or appliance offered for the diagnosis, cure, alleviation or prevention of disease, disorders or injuries in a patient.

- 51(2) If a member offers products, other than prescription drugs, for sale to a patient, the member must not sell the product at a price in excess of the fair market price paid by the member plus a reasonable handling cost.
- 51(3) A member who offers medical services by a website must clearly disclose on the website the member's financial interest in any product recommended or sold by the member.
- 51(4) If a member offers products for sale to a patient, the member must, at a minimum, create and maintain records detailing the following:
- (a) the actual cost of the product to the member, including any rebate or price reduction provided to the member;
 - (b) the name of the manufacturer and the supplier of the product;
 - (c) the date the product was supplied to the member;
 - (d) the expiry date of the product, if any;
 - (e) any additional costs incurred by the member, including any formula or calculation used by the member to determine the additional cost added to the price of the product charged to the patient.

E. Job Action

- 52(1) A member must not withdraw services with the direct or indirect purpose of supporting job action for personal economic gain or in support of any political or economic principle if such actions could put the immediate health of patients at significant risk.
- 52(2) An entire group of members or an entire department must not withdraw services completely. A member must be available to provide for the care of seriously ill or emergency patients. Just as individual members cannot abandon their patients, groups of members cannot abandon their community.

F. Facilitating Adoptions

- 53(1) When discussing private adoption as an option for a patient, a member must refer the patient only to public or private agencies that deal with private adoption matters, such as Child & Family Services, Adoption Options, or others. A member must not engage in private referrals of his/her patients to prospective adoptive parents.
- 53(2) A member must not:
- (a) provide to a patient a profile or other documents indicating that a member of the member's family (including extended family) or a friend or colleague wishes to adopt.
 - (b) otherwise facilitate the adoption of a patient's child by a member of the member's family (including extended family) or a friend or colleague.

G. Disclosure

- 54 If a conflict of interest is unavoidable by a member, the member must:
- (a) make full, frank and timely disclosure of the conflict of interest to the patient;
 - (b) obtain the informed consent of the patient before providing any medical advice or treatment to the patient.

Relationship with the Industry:

A. Patient Care

- 55(1) A member must always maintain professional autonomy and independence in any relationship with industry.
- 55(2) A member must not enter into a relationship with industry if it weakens the fiduciary relationship with any patient of that member.
- 55(3) A member must disclose to a patient any relationship between the member and industry that reasonably could be perceived as having the potential to influence the member's clinical judgment.
- 55(4) A member must resolve any conflict of interest resulting from interaction with industry in favour of his or her patients.
- 55(5) When considering the use of clinical evaluation packages such as samples of medications or devices a member must:
- (a) recognize the influence on the 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;
 - (d) not receive any form of material gain based on the choice of the product.

B. Research Activities

- 56 When a member participates in industry sponsored research activities the 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 approved by Council;
 - (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 member will receive a fee for participation and the source and amount 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) not enter into agreements that limit the member's right to publish or disclose results of the study or report adverse events that occur during the course of the study;
- (i) only participate in industry sponsored surveillance studies that are scientifically valid and expected to contribute substantially to knowledge about the drug or device.

C. Continuing Professional Development Activities

- 57(1) A 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;
 - (c) not accept reimbursement for expenses or honoraria at a rate that could reasonably be perceived as having undue influence.
- 57(2) A member must not claim authorship or contribution to the production of educational materials unless the member has substantially contributed to the material.
- 57(3) A member must ensure that all industry contributions are declared on educational materials.
- 57(4) A 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.

D. Personal Benefit

- 58(1) A member must not accept any personal gift of any monetary or other value from industry, excepting only teaching aids provided by industry.
- 58(2) A member must not accept a fee or other consideration from industry in exchange for seeing an industry representative in a promotional or similar capacity.

Participation in Research

- 59(1) If asked, a member who provides treatment in any area of medicine with less well proven efficacy must participate in the collection of information that can be appraised qualitatively and quantitatively, so that new knowledge is created, to be shared with and critically appraised by the profession.
- 59(2) A procedure or therapy which has not been proven to be reliable, reproducible and with benefits that outweigh its risks, may be offered by a member as part of an approved research project, provided that:
- (a) participating patients must provide informed consent;
 - (b) no fee is assessed to the patient;
 - (c) the patient is not asked to contribute to the research costs;
 - (d) the research project has been approved by:
 - (i) a committee established by a Canadian University; or
 - (ii) a Canadian Medical Regulatory Authority,in compliance with the Code of Conduct for Research Involving Humans Final Report of the Tri-Council Working Group – Medical Research Council (MRC), Natural Sciences and Engineering Council (NSERC) and the Social Sciences and Humanities Research Council (SSHRC), 1997.

Practice Management: Patient Restriction or Selection

A. Accepting Patients

- 60(1) If a member restricts or selects patients for his or her practice, or has a practice that is closed to new patients, the restrictions or selection criteria for accepting patients must be relevant to the member's clinical competence and medical practice and to a patient's health care needs.
- 60(2) In special or exceptional circumstances, a member may accept as a patient a person who does not meet the criteria or falls outside the restrictions for accepting patients established under subsection (1).
- 60(3) If a member meets with a person seeking the member's medical services and does not accept the person as a patient, the member must explain the reason to the person, unless the disclosure of the reason could, in the opinion of the member, be reasonably expected to
- (a) threaten the person's mental or physical health or safety;
 - (b) threaten another person's mental health or physical health or safety;
 - (c) breach the privacy of another patient; or
 - (d) pose a threat to public safety.

- 60(4) A member who restricts or selects patients for his or her practice for any reason must establish a selection process which is clearly articulated to the prospective patient and which is not overwhelming for or demeaning to a prospective patient.

B. Prohibited Grounds for Refusing Patients

- 61 A member must not refuse to accept a person as a patient because:
- (a) the medical care required could or will be complex, unless the care the patient requires is beyond the clinical competence of the member;
 - (b) the medical care will or is likely to require the member to complete more documentation than is required for other patients;
 - (c) the medical care will or may take the member more time than required for other patients; or
 - (d) the patient is a pregnant woman seeking pre-natal care who intends to have a home birth, a new mother who had a home birth, or an infant born at home.

C. Billing for Meetings

- 62(1) If a meeting between a member and a person seeking his or her medical services is not a medical appointment, the member must notify the person of that fact.
- 62(2) A member must not submit a claim under *The Health Services Insurance Act*, or charge any person, for making an appointment to meet or for meeting with a person to determine if he or she will be accepted as a patient.
- 62(3) If medical care is provided by the member in the course of a meeting with the person, the member may submit a claim under *The Health Services Insurance Act* if authorized to do so by that Act.

Practice Management: Ending a Member-Patient Professional Relationship

- 63(1) A member who ends a professional relationship with a patient must give notice to the patient or his or her representative, have reasonable grounds for doing so and must document those reasons on the patient record.
- 63(2) A member must not end a professional relationship with a patient because:
- (a) the medical care required by the patient is or will become complex, unless the care the patient requires is beyond the clinical competence of the member;
 - (b) the medical care requires the member to complete documentation in addition to the patient record;
 - (c) the medical care takes the member more time than required for other patients;
 - (d) a patient makes unhealthy lifestyle choices (such as smoking);
 - (e) a patient fails to keep appointments or to pay outstanding fees, unless proper notice has been given to the patient. For an isolated incident of a missed

appointment, the member must afford the patient the privilege of scheduling a further appointment;

- (f) a patient does not follow the member's medical advice, unless the patient is repeatedly non-adherent despite reasonable attempts by the member to address the non-adherence; or
- (g) the member will be required to participate in legal proceedings.

63(3) Notwithstanding subsection (1), a member may terminate a professional relationship with a patient immediately if:

- (a) the patient poses a safety risk to office staff, other patients or the member;
- (b) the patient is abusive to the member, office staff or other patients;
- (c) the patient does not respect professional boundaries or acts in an inappropriate manner; or
- (d) the member is leaving medical practice because of personal illness or other urgent circumstances.

The member must document the reasons for terminating the relationship on the patient record.

63(4) Where notice is required under subsection (1), the notice provided to the patient must:

- (a) be in writing;
- (b) give the patient sufficient time to obtain an alternative physician, taking into account the continuing care needs of the patient, but the notice must be given no less than 30 days prior to the date of the termination;
- (c) include in the notice the reasons why the physician-patient relationship is being terminated 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 or physical health or safety of the member or another person, or pose a threat to public safety.

63(5) Despite notice of termination of the physician-patient relationship, the member must:

- (a) provide or arrange for follow-up on any outstanding investigations;
- (b) provide or arrange for care in relation to any serious medical conditions until the date of termination of the physician-patient relationship;
- (c) provide or arrange for any necessary emergency care until the date of termination of the physician-patient relationship;
- (d) provide or arrange for any ongoing medications for a reasonable period of time.

63(6) A member must establish a process for transfer of the patient's medical information if requested by the patient or an authorized third party.

Practice Management: Closing, Leaving or Moving a Medical Practice

A. Notice of Intention to Close, Leave or Move

- 64(1) A member must give notice of the member's intention to close his or her medical practice, to take a leave of absence, to relocate practice or otherwise cease to practice medicine in Manitoba to:
- (a) his or her patients or their representatives;
 - (b) the college;
 - (c) colleagues (referring and consulting);
 - (d) Manitoba Health;
 - (e) any Regional Health Authority in which the member has privileges;
 - (f) Canadian Medical Protective Association (if a member);
 - (g) Doctors Manitoba.
- 64(2) This section does not apply if the patient records are maintained by a trustee under *The Personal Health Information Act* who employed, engaged or granted privileges to the member.
- 64(3) The notice to the patients must include:
- (a) the date of closure, relocation, absence or cessation of practice;
 - (b) information about where the patient's records are to be located; and how the records can be transferred to another member or how copies can be obtained; and
 - (c) particulars of any arrangements for care that have been made for the patients.
- 64(4) The member must individually notify (i.e. not through a notice posted in the office) of the closure, relocation, leave of absence or cessation of practice each patient who:
- (a) has an appointment booked prior to the date of closure, absence or relocation;
 - (b) calls to arrange an appointment prior to the date of closure, absence or relocation.
- 64(5) The notice to the College must include:
- (a) the date of closure, relocation, absence or cessation of practice;
 - (b) a forwarding mailing address and contact information for the member; and
 - (c) if the member is ceasing medical practice in Manitoba, forward all unused Manitoba Prescribing Practices Program (M3P) prescription forms in the possession of the member to the Manitoba Pharmaceutical Association and notify the College when this has been done.
- 64(6) Unless a member is leaving a medical practice due to illness or other urgent circumstances, at least 90 days' notice must be provided to each of the persons described in subsection (1).

B. Alternate Care Arrangements

- 65(1) A primary care physician who intends to close or reduce his or her practice must make reasonable attempts to arrange suitable alternative care of patients, particularly those who are in the course of treatment at the time of the closure. The member must document those efforts.
- 65(2) Even if a member is unable to make suitable alternative arrangements for the care of patients, the member must make arrangements to ensure patients or their caregivers have appropriate access to information contained in the patient's record.
- 65(3) If the member is a specialist, the care of the patient may, by agreement of the specialist and the referring member, be returned to the referring member.

C. Information on New Location

- 66 A member practising in a location where another member previously practised must, on request, provide information to any person about the new location of the member who has moved, if that member is aware of it.

D. Storage and Disposition of Patient Records and Supplies

- 67(1) A member who closes his or her medical practice or takes a leave of absence must:
- (a) ensure the secure storage of any patient records for the remainder of the retention period required by subsection 29(1) and the retention of appointment records for the remainder of the period required by subsection 38(2) and the subsequent destruction of the information in accordance with *The Personal Health Information Act*; and
 - (b) give the college a copy of the notice sent to patients and information about to whom the notice was sent and the arrangements that have been made for the secure storage of the patient records and appointment records.
- 67(2) A member who ceases to engage in medical practice, temporarily or permanently, or who closes a medical practice, must safely dispose of medication, laboratory specimens, equipment and supplies.
- 67(3) The obligations under this section are in addition to any other requirements relating to patient records under the *Act*, *The Personal Health Information Act*, and any other enactment, by-law, standard of practice and code of ethics with which a member must comply.

Practice Management: Billing

A. Notice of Billing for Uninsured Services

- 68(1) A member may charge a reasonable fee when he or she performs a health service that is not insured by the provincial fee schedule.
- 68(2) Before medical care that is not an insured medical service under *The Health Services Insurance Act* is provided to or for a patient by a member, the member must notify the patient or third party of any fee or charge the patient will be required to pay, except in the case of emergency care where it is impossible or impractical to inform the patient.
- 68(3) A member's agent may give preliminary information to a patient about the billing policies in the member's medical practice, but the member remains responsible for the final decision and explanation to the patient if the patient disputes a fee or requests clarification.
- 68(4) A general notice to patients in a member's office is not sufficient by itself, to fulfill the requirements of subsections (2) and (3).

B. Block Billing

- 69(1) "Block billing" means a fixed fee for designated uninsured services provided during a specified time period.
- 69(2) "Uninsured services" includes all health services provided by members that are not insured by Manitoba Health. Examples include, but are not limited to:
- (a) advice by telephone;
 - (b) completion of non-insured forms and reports;
 - (c) transfer and/or photocopying of medical records;
 - (d) examinations for reason of employment or insurance.
- 69(3) A member may charge patients for uninsured services as the patient actually uses them individually or based on block billing.
- 69(4) A member who offers patients block billing must:
- (a) inform the patient that the patient has the choice to pay a block fee or to pay for uninsured services individually;
 - (b) ensure that the patient is given enough information to make an informed choice, including, but not limited to:
 - (i) a written statement of exactly what uninsured services are included in the block fee, and the cost of each uninsured service if paid for individually;
 - (ii) a copy of s. 71 of this By-Law;
 - (c) answer the patient's questions about charges for uninsured services;

- (d) offer the same block fee options to all patients in the same category, but the member may waive or reduce any fee according to the patient's ability to pay;
 - (e) not link the block fee arrangement to the provision of insured services, for example:
 - (i) the payment of a block fee must not be a condition of the member accepting a person as a patient;
 - (ii) the member must not offer to provide preferential services to a patient who agrees to pay a block fee.
- 69(5) A member must not include in a block fee any charge for:
- (a) a service for which the member is compensated through any other mode, including any charge for a service which is included as part of an insured service. An exception exists for the completion of forms for a patient's benefit where the payer limits its payment to a fixed fee and specifies additional charges may be collected from the patient;
 - (b) being available to render a medical service; or
 - (c) services not actually requested by the patient.
- 69(6) A member must not bill for a block fee before the patient:
- (a) has expressly elected to pay a block fee and agreed upon the amount of the block fee; and
 - (b) has actually received the services for the period agreed upon.
- 69(7) A member must not enter a block fee arrangement for a period of less than six months or of greater than 12 months.

C. Missed Appointments

- 70(1) A member who charges a patient for a missed appointment must adhere to the following requirements:
- (a) the patient must be informed in advance:
 - (i) that a charge will be made for a missed appointment and the amount of the charge; and
 - (ii) as to how much notice must be given to the member in order to avoid the charge for a missed appointment;
 - (b) the member must have been available to the patient for the period of time for which the fee is charged and must not have been engaged in other billable health care at that time;
 - (c) the fee charged for a missed appointment must reasonably reflect the actual costs of the missed appointment;
 - (d) the member must take into account the circumstances of the missed appointment and the ability of the patient to pay and must be prepared to discuss the fee with the patient.

- 70(2) It is the responsibility of the consulting physician to inform a patient of charges for missed appointments with that consultant.
- 70(3) A member may request a deposit to cover the costs of unavoidable expenses associated with the proposed visit which a missed appointment would make impossible to recover. However, the patient must be advised in advance of the circumstances that will result in a forfeiture of the deposit.

D. Required Services

- 71(1) A member must provide care that is clinically required and urgent in all cases that are not elective or when no other member is reasonably available, despite the fact that collection of a fee may not be possible.
- 71(2) A member may not demand payment in advance of urgently required health services that are not readily available elsewhere.

E. Accounting Records

- 72 A member must keep an accounting record showing the date every health service was rendered by the member to a patient, the type of service, and the charge made.

Advertising in Medical Practice

- 73(1) "Advertisement" means any communication made orally, in print or through electronic media, by or on behalf of a member, to the public generally or to one or more individuals, that has as its substantial purpose the promotion of the member or a non-institutional setting or a group with which the member is associated and includes:
- (a) signs;
 - (b) nameplates;
 - (c) professional cards;
 - (d) announcements;
 - (e) letterheads;
 - (f) listings;
 - (g) facility names;
 - (h) brochures;
 - (i) media appearances and announcements.
- 73(2) An advertisement must not:
- (a) misrepresent fact;
 - (b) compare directly, indirectly or by innuendo, the member's services, prices or ability with that of any other member, facility, clinic or group;
 - (c) promise or offer more effective services or better results than those available from another member;

- (d) deprecate another member, facility, clinic or group as to service, ability, result or fees;
- (e) create an unjustified or unreasonable expectation about the result the member can achieve;
- (f) be made under any false or misleading guise or take physical, emotional or financial advantage of a patient, or use coercion, duress or harassment;
- (g) be undignified, in bad taste, or otherwise offensive so as to be incompatible with the best interests of the public;
- (h) tend to harm the standing or reputation of the medical profession generally;
- (i) disclose the name or identifying features of a patient, unless the patient's prior consent has been obtained, and if any inducement or benefit is given or provided to the patient the nature of the inducement or benefit must be disclosed in the advertisement;
- (j) display "before and after" photographs except where the member has personally performed the procedure or provided the treatment to the patient depicted in the photograph.

Services Offered on Web Site

- 74 A member who offers medical services by a web site must:
- (a) clearly disclose on the web site the member's identifying information, including name, practice location, all jurisdictions in which licensure is held, the member's financial interest in any products recommended or sold, and the member's fees for providing the medical services.
 - (b) ensure that any transmission of information to or from the member's web site complies with confidentiality and privacy requirements.

Solicitation of Funds Using Patient Databases

- 75(1) Members must restrict the use of patient databases for solicitation of funds for charitable programs in accordance with the following conditions:
- (a) In an institutional setting, the only information about patients cared for at that institution which may be released for solicitation of funds is demographic, limited to name and address.
 - (b) No information about diagnosis may be released.
 - (c) The patient list must not be derived from a population which is usually regarded as sensitive, e.g. therapeutic abortion patients.
 - (d) Communication to individuals whose names have been extracted from databases:
 - (i) must not differ from the communication sent to other individuals who have not been patients in the relevant institution.
 - (ii) must not refer to the patient's use of the member's services.

75(2) A treating member must not solicit funds for charitable programs directly from a patient within the context of a doctor/patient relationship.

Requirements in Specific Subject Matters

76 The schedules attached to and forming part of this by-law set out standards with which members must comply as follows:

- A. Female Genital Cutting/Mutilation
- B. Home Births
- C. Seatbelt/Helmet Exceptions
- D. Withholding and Withdrawing Life-Sustaining Treatment
- E. Professional Responsibilities in Undergraduate and Postgraduate Medical Education
- F. Duty to Report Another Member
- G. Treating of Self and Family Members
- H. Self-Reporting to the College
- I. Volume of Service
- J. Bloodborne Pathogens
- K. Telemedicine
- L. Delegation
- M. Medical Assistance in Dying

Schedule A - Female Genital Cutting/Mutilation**Attached to and forming part of By-Law No. 11 of the College.**

1. Female genital cutting/mutilation (FGC/M) is the excision, infibulation or mutilation, in whole or in part, of the labia majora, labia minora or clitoris of a person, which may result in complications with voiding, sexual function, and psychological wellbeing. The *Criminal Code of Canada* categorizes FGC/M as aggravated assault with certain exceptions, and FGC/M on a minor is child abuse and must be reported to the appropriate child caring agency pursuant to *The Child and Family Services Act*.
2. Members must not perform FGC/M.
3. Members must not refer any patient to any other person for FGC/M.
4. If a member learns of another member performing FGC/M, the member must immediately report the matter to the College.
5. Members must be mindful of the legal obligation to report child abuse to the appropriate child caring agency pursuant to *The Child and Family Services Act*.

Schedule B – Home Births**Attached to and forming part of By-Law No. 11 of the College.**

1. Members must not have planned involvement in a home birth.
2. When a member is consulted by a pregnant woman who intends to give birth at home, the member must:
 - (a) Encourage appropriate prenatal and postnatal care for the mother and baby;
 - (b) Identify to the patient the risks of home delivery for both mother and infant, and issues of postnatal care (e.g. Vitamin K prophylaxis, eye care, metabolic screening);
 - (c) Familiarize the patient with emergency services available in the community; and
 - (d) Document discussions with the patient on the foregoing points.

Schedule C - Seatbelt/Helmet Exceptions**Attached to and forming part of By-Law No. 11 of the College.**

Since reconfiguration of the seatbelt, the use of padding, or other accommodations are available and acceptable alternatives to non-use of a seatbelt or helmet assembly, and since there are no medical conditions that justify exemptions from using a seatbelt or helmet assembly, a member must not write a seatbelt or helmet exemption.

Schedule D - Withholding and Withdrawing Life-Sustaining Treatment

Attached to and forming part of By-Law No. 11 of the College.

Persons who may be legally authorized to consent to or refuse medical treatment on behalf of a patient include persons:

- (a) authorized by statute, including:
 - (i) a health care proxy appointed by the patient in accordance with *The Health Care Directives Act*, C.C.S.M. c. H27 ;
 - (ii) a Committee appointed under *The Mental Health Act*, C.C.S.M c. M110 ;
 - (iii) a substituted decision maker appointed under *The Vulnerable Persons Living with a Mental Disability Act*, C.C.S.M c. V90;
 - (iv) The Public Trustee, in limited circumstances.
- (b) recognized by the common law, including:
 - (i) a parent or other legal guardian of a patient who is a minor;
 - (ii) a person with authority pursuant to a decision or order of a Court with jurisdiction.

The Vital Statistics Act, C.C.S.M. c. V60, s. 2. provides that the death of a person takes place at the time at which irreversible cessation of all that person's brain function occurs.

DEFINITIONS

The following terms are defined for the purpose of this Schedule. **The definitions do not necessarily reflect the meaning of the terms used in other contexts.**

Family

Persons recognized by the patient as being closely linked to the patient in knowledge, care and affection, including biological family, those linked by marriage or common-law (same or opposite sex) and any other person chosen by the patient as his/her family.

Health Care Team

This term includes all personnel who are actively involved in the health care of the patient and to whom the physician may turn for input in accordance with this Schedule.

Life-sustaining Treatment

Any treatment that is undertaken for the purpose of prolonging the patient's life and that is not intended to reverse the underlying medical condition.

Minimum Goal of Life-sustaining Treatment

This term is clinically defined as the maintenance of or recovery to a level of cerebral function that enables the patient to:

- achieve awareness of self; and
- achieve awareness of environment; and
- experience his/her own existence.

For pediatric patients, the potential for neurological development must be factored into the assessment.

Physician

A member of the College who is providing medical care to the patient. Where there is more than one physician involved in the patient's medical care, the physician who is the coordinator of the patient's medical care is responsible for ensuring that the requirements of this Schedule are met.

Patient

The patient is the recipient of medical care whose well-being is the physician's primary concern.

Proxy

The person who is legally authorized to make health care decisions on the patient's behalf in circumstances where the patient lacks capacity to make such decisions, including, but not limited to, a health care proxy appointed in a health care directive.

Representative

The person who represents the patient and/or the patient's family in discussions about the patient's health care where the patient lacks capacity to make health care decisions and there is no proxy or it is not possible to communicate with the patient or the proxy for any reason. This person is usually a member of the patient's family. If the patient is in a health care facility, the representative may be determined in accordance with that facility's internal policy. In the absence of an applicable policy, or if the patient is in the community, it will be up to the physician to use his/her best judgment to identify a member of the patient's family who has the support of interested parties to assume this role.

REQUIREMENTS

When a physician is confronted with a clinical scenario in which withholding or withdrawing life-sustaining treatment is being considered, the four main components of the process the physician must follow are the same in all cases:

1. Clinical Assessment;
2. Communication;
3. Implementation;
4. Documentation.

This Schedule establishes:

- **General Requirements**, which apply to each of the four components described above in all circumstances. These are the only requirements when there is consensus between the patient/proxy/representative and the physician.
- **Specific Requirements**, which supplement and/or modify the General Requirements when consensus cannot be achieved in the following circumstances:
 - A. No consensus - the physician offers life-sustaining treatment but the patient/proxy declines treatment or the representative advocates withholding or withdrawing treatment;
 - B. No consensus - the minimum goal is not realistically achievable and the physician concludes that life-sustaining treatment should be withheld or withdrawn but the patient/proxy/representative does not agree and/or demands life-sustaining treatment;
 - C. No consensus - the minimum goal is achievable but the physician concludes that life-sustaining treatment should be withheld or withdrawn and the patient/proxy/representative does not agree and/or demands life-sustaining treatment;
 - D. Emergency Situations where communication between physician and patient/proxy/representative cannot occur;
 - E. Cardiac arrest and resuscitation, including Cardiopulmonary resuscitation (CPR) and/or Advanced Cardiac Life Support (ACLS), and Do Not Attempt Resuscitation (DNAR) Orders.

GENERAL REQUIREMENTS

1. Clinical Assessment

- The physician must clinically assess the patient by gathering and evaluating information about the patient's physical condition, diagnosis, prognosis and treatment options, including palliation, balancing the risks and benefits associated with identified treatment options.
- The assessment must be based on the best available clinical evidence, including, where appropriate, consultation with another physician and must include consideration of the feasible life-sustaining treatment options in the context of the minimum goal of life-sustaining treatment, which is clinically defined as:

maintenance of or recovery to a level of cerebral function that enables the patient to:

- achieve awareness of self; and
- achieve awareness of environment; and
- experience his/her own existence.

For pediatric patients, the potential for neurological development must be factored into the assessment

- Where the physician is uncertain about any aspect of the assessment, including the range of treatment options, he/she must seek additional clinical input by consulting with at least one other physician before concluding that the minimum goal is not realistically achievable and/or that life-sustaining treatment should be withheld or withdrawn for any other reason.
- Based on the clinical assessment, the physician may conclude that:
 1. Life-sustaining treatment should be offered; OR
 2. Life-sustaining treatment should be withheld or withdrawn because the minimum goal is not realistically achievable.
- Where, based on the clinical assessment, the physician concludes that the minimum goal is realistically achievable, but is contemplating withholding or withdrawing life-sustaining treatment because of concerns that there are likely to be significant negative effects on the patient, including, but not limited to pain and suffering, the physician should explore the patient's values, needs, goals and expectations of treatment with the patient/proxy/representative before concluding that life-sustaining treatment should be withheld or withdrawn.

2. Communication

- The physician must identify the person(s) with whom he/she must communicate about withholding or withdrawing life-sustaining treatment and communicate with that person as early as possible and, where possible before life-sustaining treatment is withheld or withdrawn.
- Every effort must be made to communicate with the patient as early as possible, while the patient can identify his/her preferences for treatment and has the capacity to make his/her own health care decisions.
- Where there is a proxy, the physician must share personal health information and consult with the proxy in the same manner he/she would otherwise consult with the patient, unless he/she is made aware of limits on the proxy's authority.
- Where there is no proxy, the physician must share personal health information and consult with the representative in accordance with this Schedule to identify known preferences and/or interests of the patient and/or what treatment might be in the patient's best interests.
- The physician must comply with reasonable requests of the patient, proxy or representative to include other person(s) in the discussion described below.
- The physician must ensure that relevant information is exchanged and strive for understanding and consensus when discussing withholding or withdrawing life-sustaining treatment from the patient. The nature and content of discussion will depend on the physician's assessment of treatment options and the individual circumstances of the patient. The discussion should, at a minimum, include:
 - a description of the underlying condition or ailment and prognosis;

- an exploration of the patient's values, needs, goals and expectations of treatment;
- the options for treatment and their expected outcome, including potential benefit and harm;
- where the physician has concluded that treatment should be withheld or withdrawn, an explanation of the assessment and the basis for this conclusion;
- assurances that the patient will not be abandoned if treatment is either withheld or withdrawn, including an explanation and offer of palliative care;
- where there is a need or a request for additional assistance with psychosocial, cultural, spiritual, and/or informational needs by the patient or proxy or representative and/or family, an offer to seek support from institutional resources such as social work, chaplaincy, or clinical ethics;
- where welcomed by the patient, proxy or representative, the patient's personal, cultural, religious and family issues insofar as they are relevant to the decision;
- where appropriate, an exploration of potential guilt or regret associated with end of life decision-making.

3. Implementation

- Treatment may be withheld or withdrawn where there is consensus between the physician and:
 1. a patient who is capable of making his/her own health care decisions; or
 2. the proxy or representative, where the patient lacks capacity to make his/her own health care decisions.
- Provided that the physician has complied with the requirements of this Schedule, decisions may be implemented in as timely a manner as possible, while respecting the grieving process for patients and families.
- Once a decision to withhold or withdraw treatment is made, the need for someone to communicate this decision to other family members who were not involved in making the decision should be explored. In such circumstances, with proper consent, the physician should be prepared to assist by providing appropriate information to such family members.

4. Documentation

- Accurate and complete documentation of the pertinent details of the physician's assessment and his/her interaction with the patient and others involved in decisions whether to withhold or withdraw life-sustaining treatment is essential.
- At a minimum, the physician must clearly record in the patient's health care record:
 - sufficient details about the assessment of treatment options to identify the basis for the conclusion that treatment should be withheld or withdrawn;
 - pertinent details regarding consultations with others and second opinions;
 - if it is determined that the patient lacks capacity to make his/her own health care decisions, the basis for that determination and the identity of the proxy or representative designated in accordance with this Practice Direction;
 - particulars of the communications required by this Practice Direction, including:

- identity of the participants in the discussion;
- where there is a proxy or representative, any limits on that person's authority to make decisions on the patient's behalf;
- relevant information communicated by the physician;
- concerns raised by others and the information provided by the physician in response;
- whether or not consensus was reached;
- where consensus was not reached, the nature of the efforts made to reach consensus;
- the implementation plan.

SPECIFIC REQUIREMENTS

The specific requirements for the circumstances identified earlier are set out in separate sections below. Where no specific requirements are identified, the general requirements apply. Where specific requirements are identified, those requirements supplement or modify the general requirements.

A. NO CONSENSUS - THE PHYSICIAN OFFERS LIFE-SUSTAINING TREATMENT BUT THE PATIENT/PROXY DECLINES TREATMENT OR THE REPRESENTATIVE ADVOCATES WITHHOLDING OR WITHDRAWING TREATMENT

1. Clinical Assessment

- Where the physician is confronted with a patient who declines life-sustaining treatment that is offered, that physician should consider taking additional steps to assess the patient's capacity to make his/her own health care decisions.

2. Communication

- Where a patient with capacity to make his/her own health care decisions or a legally authorized proxy declines life-sustaining treatment for that patient, the physician must be satisfied that the decision to decline treatment is informed and voluntary in that the nature of treatment, including its benefits and risks and alternatives, are understood.
- Where the patient lacks capacity and the decision to decline treatment is made by a proxy on behalf of the patient, the physician must be satisfied that the proxy's legal authority includes declining treatment on the patient's behalf in such circumstances.
- Where the patient lacks capacity, there is no proxy, and a representative advocates withholding or withdrawing life-sustaining treatment:
 - the physician should review with the representative the physician's concerns regarding that person's lack of legal authority to make such a decision on the patient's behalf and the representative's reasons for advocating withholding or withdrawing life-sustaining treatment; and
 - should consider looking to other members of the health care team and/or another physician as a source of information.

- The physician must be mindful of the general communication requirements, but should be prepared to meet the unique needs of the patient, particularly in respect to the physician's communication with the patient's family

3. Implementation

- If the physician has satisfied him/herself of the matters referred to in the Communication section above, he/she **must** withhold or withdraw treatment in accordance with the patient/proxy's wishes.
- If a representative is advocating withholding or withdrawing treatment against the recommendation of the physician that the treatment be provided, the physician must make his/her treatment decisions in accordance with the accepted standard of care.

4. Documentation

- There are no specific requirements; the general requirements apply.

B. NO CONSENSUS - THE MINIMUM GOAL IS NOT REALISTICALLY ACHIEVABLE AND THE PHYSICIAN CONCLUDES THAT LIFE-SUSTAINING TREATMENT SHOULD BE WITHHELD OR WITHDRAWN BUT THE PATIENT/PROXY/REPRESENTATIVE DOES NOT AGREE AND/OR DEMANDS LIFE-SUSTAINING TREATMENT

1. Clinical Assessment

- There are no specific requirements; the general requirements apply.

2. Communication

- Where a physician concludes that the minimum goal is not realistically achievable and that life-sustaining treatment should be withheld or withdrawn and there is no consensus with the patient/proxy/representative, the physician is not obligated to continue to try to reach a consensus before withholding or withdrawing treatment, but must meet the implementation requirements set out below before treatment can be withheld or withdrawn.

3. Implementation

- WHERE THE PHYSICIAN CONCLUDES THAT THE MINIMUM GOAL IS NOT REALISTICALLY ACHIEVABLE AND THERE IS NO CONSENSUS, IF POSSIBLE, that physician must consult with another physician:
 1. Where the consultation supports the opposite conclusion, that the minimum goal is realistically achievable, the physician who sought the consultation must either provide the treatment or facilitate the transfer of care to another physician who will provide the treatment.
 2. Where the consultation supports the conclusion that the minimum goal is not realistically achievable, or it is not possible to consult with another physician, the

physician who sought the consultation is not obligated to continue to try to reach consensus before withholding or withdrawing treatment, but must first advise the patient/proxy/representative:

- a. that the consultation supports that physician's assessment that the minimum goal is not realistically achievable, or that it was not possible to consult with another physician and attempt to address any remaining concerns; and
- b. of the specified location, date and time at which treatment will be withheld or withdrawn.

4. Documentation

- The information regarding the communication between the physician and the patient/proxy/representative following the physician's consultation with the other physician, including the specified location, date and time at which treatment will be withheld or withdrawn, must be documented in the patient's chart.

C. NO CONSENSUS - THE MINIMUM GOAL IS ACHIEVABLE BUT THE PHYSICIAN CONCLUDES THAT LIFE-SUSTAINING TREATMENT SHOULD BE WITHHELD OR WITHDRAWN AND THE PATIENT/PROXY/REPRESENTATIVE DOES NOT AGREE AND/OR DEMANDS LIFE-SUSTAINING TREATMENT

1. Clinical Assessment

- There are no specific requirements; the general requirements apply.

2. Communication

- In this situation, communication is particularly challenging and important. The physician should be aware that careful discussion above and beyond what is generally required may be necessary;
- The concerns in these circumstances may not relate to clinical assessment or care and may involve subjective values and judgments regarding quality of life;
- When confronted with such concerns, the physician should consider seeking assistance from other members of the health care team and/or religious authorities and/or ethics and/or other consultants.

3. Implementation

- WHERE THE PHYSICIAN CONCLUDES THAT THE MINIMUM GOAL IS REALISTICALLY ACHIEVABLE BUT THAT TREATMENT SHOULD BE WITHHELD OR WITHDRAWN, that physician must consult with another physician.
 1. Where the consultation supports the opposite conclusion, that treatment should not be withheld or withdrawn, the physician who sought the consultation must either provide the treatment or facilitate transfer of care to another physician who will provide the treatment.

2. Where the consultation supports the conclusion that treatment should be withheld or withdrawn:
 - a. The physician who sought the consultation must advise the patient/proxy/representative that the consultation supports the initial assessment that treatment should be withheld or withdrawn
 - b. If there is still a demand or request for treatment, the physician must attempt to address the reasons directly and with a view to reaching consensus. The physician should consider resolving the conflict by:
 - i. offering a time-limited trial of treatment with a clearly defined outcome; and/or
 - ii. involving additional or alternative methods to facilitate a consensus, including, but not limited to, available resources such as a patient advocate, mediator or ethics or institutional review processes.
 - c. If consensus cannot be reached, the physician must give the patient/proxy/representative a reasonable opportunity to identify another physician who is willing to assume care of the patient and must facilitate the transfer of care and provide all relevant medical information to that physician.
 - d. Where, despite all reasonable efforts, consensus cannot be reached the physician may withhold or withdraw life-sustaining treatment, but:
 - i. in the case of a patient/proxy who is still not in agreement with the decision to withhold or withdraw treatment, the physician must provide at least 96 hours advance notice to the patient or proxy as described below.

Written Notice

The notice must be in writing, where possible, and must contain, at a minimum:

- name and location of the patient;
- name of the person to whom notice has been given;
- name, address and telephone number of the physician;
- diagnosis;
- description of the treatment(s) that will be withheld or withdrawn;
- date, time and location at which treatment will be withheld or withdrawn;
- date and time that notice was provided;
- name of the person who provided the notice.

Verbal Notice

Where it is not possible to provide notice in writing, notice to withhold or withdraw treatment may be given verbally, but must be witnessed and include:

- name and location of the patient;
- name, address and telephone number of the physician;
- diagnosis;

- description of the treatment(s) that will be withheld or withdrawn;
- date, time and location at which treatment will be withheld or withdrawn;
- name of the person who provided the notice.
 - i. in the case of a representative who is still not in agreement with the decision to withhold or withdraw treatment, the physician should exercise his/her discretion as to what, if any, notice should be provided to the representative before treatment is withheld or withdrawn.

4. Documentation

- In addition to the general requirements of documentation, the following must also be documented:
 - Where written notice has been given, a copy of the notice;
 - Where verbal notice has been given:
 - the reason that it was not possible to provide written notice;
 - all of the information required when verbal notice is given (see above);
 - the signature of the physician and a witness to the notice.

D. EMERGENCY SITUATIONS WHERE COMMUNICATION BETWEEN PHYSICIAN AND PATIENT/PROXY/REPRESENTATIVE CANNOT OCCUR

1. Clinical Assessment

- In emergent situations, where the patient lacks capacity to make his/her own health care decisions and it is not reasonably possible to identify and communicate with a proxy/representative, the physician must make a rapid assessment based on the patient's clinical status as well as information from others who have interacted with the patient, including other involved members of the health care team, before deciding whether to withhold or withdraw life-sustaining treatment.

2. Communication

- The physician should communicate with the proxy/representative as soon as possible after the decision has been implemented.

3. Implementation

- The physician must decide when to withhold or withdraw life-sustaining treatment.

4. Documentation

- There are no specific requirements; the general requirements apply.

E. CARDIAC ARREST AND RESUSCITATION, CARDIOPULMONARY RESUSCITATION (CPR) AND/OR ADVANCED CARDIAC LIFE SUPPORT (ACLS), AND DO NOT ATTEMPT RESUSCITATION (DNAR) ORDERS

Situations involving cardiac arrest are unique because, unlike some potentially life-sustaining treatments which can be provided over a prolonged period of time, CPR and/or ACLS are interim measures implemented to achieve a return of spontaneous circulation.

Actual or impending cardiac arrest is very different from a situation where a DNAR order is being considered as a proactive element of advanced care planning. The specific requirements of physicians in each of these situations are addressed separately in this Practice Direction.

The requirements for Clinical Assessment, Communication, Implementation and Documentation are combined in this section.

1. Actual or Impending Cardiac Arrest and Resuscitation

- Actual or impending cardiac arrest often occurs unexpectedly and it is not possible to communicate and/or achieve consensus before either initiating or withholding resuscitative efforts.
- A physician is not required to initiate or continue CPR and/or ACLS, if, based on his/her clinical assessment, the physician determines that:
 - CPR/ACLS will not achieve return of spontaneous circulation; OR
 - resuscitation will not result in the patient achieving the minimum goal.

If the physician is uncertain about his/her clinical assessment, he/she must consult with another physician, where possible.

- In the setting of an impending cardiac arrest, where a physician determines that he/she will not initiate cardiac resuscitation based on one of these criteria, and it is possible to communicate the decision prior to the cardiac arrest, the physician will make reasonable efforts to communicate the decision to the patient, proxy or representative, and will document the discussion in the patient's medical record and write an DNAR order.

2. DNR Orders

- Where a physician determines that a DNAR order is appropriate, but cardiac arrest is not imminent/impending, that physician must identify the appropriate section in this Practice Direction which corresponds to the surrounding circumstances and attempt to meet the requirements of that section prior to writing a DNAR Order. If while attempting to meet the requirements of the appropriate section(s), the patient suffers a cardiac arrest or the physician determines that a cardiac arrest is imminent/impending, the requirements automatically change to those for Actual or Impending Cardiac Arrest and Resuscitation as set out above.

LEGAL INTERVENTION

If at any time a physician becomes aware of anything such as a legal proceeding and/or a Court Order that may impact the legal right of a patient, proxy or representative to request or demand specific treatment(s), that physician must take steps to ensure that he/she complies with the law and should consider seeking legal advice.

Schedule E - Professional Responsibilities in Undergraduate and Postgraduate Medical Education

Attached to and forming part of By-Law No. 11 of the College.

Undergraduate medical students ("medical students") are students enrolled in an undergraduate medical education program in any jurisdiction who are registered on the educational register of the College.

Postgraduate Trainees ("trainees") are physicians who hold a degree in medicine and are continuing in postgraduate medical education or physician assistant students, who are registered on the educational register or the Manitoba Medical Register of the College. Regardless of the type of registration held, postgraduate trainees cannot practice independently within the confines of the training program.

Most responsible physician is the physician who has final accountability for the medical care of the patient, whether or not a medical student or a trainee is involved in the clinical encounter.

Supervisors are members who have taken on the responsibility to guide, observe, and assess the educational activities of medical students or trainees. The supervisor of a medical student or trainee involved in the care of a patient may or may not be the most responsible physician for that patient. Residents or fellows often serve in the role of supervisors but do not act as the most responsible physician for patient care.

PRINCIPLES

1. Safe, quality patient care must always take priority over the educational endeavour.
2. Proper education optimizes patient care, as well as the educational experience.
3. The autonomy and personal dignity of medical students, trainees and patients must be respected.
4. Allowing medical students to have insight into the decision-making process enables an optimal educational experience.
5. Joint decision-making and exchange of information between most responsible physician, supervisor, and trainee provides an optimal educational experience.
6. Professionalism, which includes demonstration of compassion, service, altruism, and trustworthiness, is essential in all interactions in the educational environment in order to provide the best quality care to patients.

REQUIREMENTS

1. Designation of Most Responsible Physician

Because there are multiple health care professionals involved in patient care, one physician must always be designated the most responsible physician for every patient to ensure continuity of care and appropriate monitoring. Every patient must be given the name of the most responsible physician along with an explanation that the most responsible physician is responsible for directing and managing their care.

2. Medical Students

(a) Identification of Medical Student

The supervisor and/or the most responsible physician is responsible for ensuring that the educational status of medical students and the nature of their role is made clear to the patient, the patient's family, and the members of the health care team as early as possible during the educational process. Medical students must be introduced as medical students and it must be made clear to patients that they are enrolled on the educational register at the College of Physicians and Surgeons of Manitoba. Where appropriate, medical students may introduce themselves to the patients instead of relying on a supervisor and/or the most responsible physician to make the formal introduction.

(b) Supervisor and Education of Medical Students

The supervisor and the most responsible physician must provide appropriate supervision which includes:

- i. determining the medical student's willingness and competency or capacity to participate in the clinical care of patients, as a learning experience;
- ii. closely observing interactions between the medical student and the patient to assess:
 1. the medical student's performance, capabilities and educational needs;
 2. whether the medical student has the requisite competence (knowledge, skill, behaviour and judgment) to safely participate in a patient's care without compromising that care; and
 3. whether the medical student demonstrates the necessary competencies and expertise to interact with patients without the supervisor being present in the room.
- iii. meeting at appropriate intervals with the medical student to discuss their assessments;
- iv. ensuring that the medical student only engages in acts based on previously agreed-upon arrangements with the most responsible physician;
- v. reviewing, providing feedback and countersigning documentation by a medical student of a patient's history, physical examination, diagnosis, and progress notes as soon as possible;
- vi. managing and documenting patient care, regardless of the level of

- involvement of medical students; and
- vii. counter-signing all orders concerning investigation or treatment of a patient, written under the supervision or direction of a physician. Prescriptions, telephone or other transmitted orders may be transcribed by the medical student, but must be countersigned by the most responsible physician or supervisor before being put into action.

In addition, appropriate supervision and education requires clear communication between the most responsible physician and supervisor in order to ensure the best possible care for the patient.

3. Trainees

The supervisor and/or most responsible physician must provide appropriate supervision to the trainee. This includes:

1. being familiar with program objectives;
2. making the patient or substitute decision-maker aware of the identity of the most responsible physician, and the fact that the most responsible physician is ultimately accountable for the patient's care;
3. making the patient or substitute decision-maker aware of the identity of trainee(s) who are members of the treatment team, their stage in the postgraduate program, as well as their degree of involvement in patient care;
4. being willing and available to see patients when required or when requested by the trainee;
5. regularly evaluating a trainee's clinical competence and learning needs, and assigning graduated responsibility accordingly;
6. making reasonable efforts to determine that the trainee has the necessary competence (knowledge, skill and judgment) to participate in a patient's care and does not compromise that care;
7. ensuring that all relevant clinical information is made available to the trainee, and directly assessing the patient as appropriate; and
8. communicating regularly with the trainee to discuss and review the trainee's patient assessments, management, and documentation of patient care in the medical record.

The trainee must:

1. participate in the care of patients as appropriate to his or her competencies, and specific circumstances, as well as to meet identified educational needs;
2. make the patient or substitute decision-maker aware of their name, role, stage in the postgraduate program, and degree of involvement in patient care;
3. make the patient or substitute decision-maker aware of the name and role of the most responsible physician, and the fact that the most responsible physician is ultimately accountable for the patient's care;
4. communicate with the supervisor and/or most responsible physician:
 - a. in accordance with guidelines of the postgraduate program and/or clinical placement setting;
 - b. about patient assessments performed by the trainee;

- c. when there is a significant change in a patient's condition;
 - d. when the trainee is considering a significant change in a patient's treatment plan or has a question about the proper treatment plan;
 - e. about a patient discharge;
 - f. when a patient or substitute decision-maker and family expresses significant concerns; and
 - g. in any emergency situation or when there is significant risk to the patient's wellbeing;
5. document his or her clinical findings and treatment plans and discuss these with the most responsible physician and/or the supervisor.

4. Professional Relationships

Members must demonstrate professional behaviour at all times during interactions with colleagues, students, patients, other trainees, other health care professionals and support staff.

The most responsible physician and supervisor must:

- (a) be mindful of the power differential in their relationship with all medical students and trainees.
- (b) not allow any personal relationships to interfere with the medical student's or the trainee's education, supervision, or evaluation.
- (c) disclose to the appropriate responsible member of the faculty (such as the department or section head or undergraduate program director) any relationship which pre-dates or develops during the educational phase between the most responsible physician or supervisor and a medical student or trainee (e.g., family, clinical care, dating, business, friendship, etc.) The appropriate faculty member must then decide whether alternate arrangements for supervision and evaluation of the medical student are warranted and, if necessary, make these arrangements.
- (d) support an environment which is safe, and free of harassment, discrimination and intimidation. Any form of behaviour that interferes with, or is likely to interfere with, quality health care delivery or quality medical education is considered "disruptive behaviour." This includes the use of inappropriate words, actions, or inactions that interfere with a member's ability to function well with others.
- (e) not enter into a sexual relationship with a medical student or trainee while responsible for teaching and/or evaluating that medical student or trainee.

Reporting Responsibilities

Members involved in the education of medical students or trainees must report to the University of Manitoba Faculty of Medicine, the College of Physicians and Surgeons of Manitoba and, if applicable, to the health-care institution when a medical student or trainee exhibits behaviours that would suggest incompetence, incapacity; or when the medical student or trainee fails to behave professionally and ethically in interactions with patients, supervisors or colleagues; or otherwise engages in inappropriate behaviour.

Members must support a safe, supportive environment that allows medical students and trainees to make a report if they believe their supervisor and/or the most responsible physician exhibit any behaviours that would suggest incompetence, incapacity, or abuse of a patient; or when the supervisor and/or most responsible physician fails to behave professionally and ethically in interactions with patients, supervisors, colleagues, medical students or trainees; or otherwise engages in inappropriate behaviour.

Consent and the Educational Environment

The most responsible physician and/or supervisor are responsible for communicating to patients that patient care in teaching hospitals and other affiliated sites where education occurs relies on a collaborative team-based approach, i.e., care is provided by multiple health-care professionals, including medical students, and that trainees are integral members of the health care team.

Medical student and trainee involvement in patient care requires patient consent including:

(a) Significant Component of Procedure Performed Independently by Medical Student

In the rare situation where a significant component, or all, of a medical procedure is to be performed by a medical student and the most responsible physician and/or supervisor is not physically present in the room, the patient must be made aware of this fact and, where possible, express consent must be obtained by the most responsible physician or supervisor. Express consent is directly given, either orally or in writing.

(b) Significant component of procedure performed independently by trainee

When a significant component, or all, of a medical procedure is to be performed by a trainee without direct supervision, the patient must be made aware of this fact and where possible, express consent must be obtained. Express consent is directly given, either orally or in writing.

(c) Investigations and Procedures Performed Solely for Educational Purposes

An investigation or procedure is defined as solely “educational” when it is unrelated to or unnecessary for patient care or treatment. An explanation of the educational purpose behind the proposed investigation or procedure must be provided to the patient and his or her express consent must be obtained. This must occur whether or not the patient will be conscious during the examination. If express consent cannot be obtained, for example if, the patient is unconscious, the examination cannot be performed. The most responsible physician and/or supervisor must be confident that the proposed examination or clinical demonstration will not be detrimental to the patient, either physically or psychologically.

(d) Examinations performed solely for educational purposes

An examination is defined as solely “educational” when it is unrelated to or unnecessary for patient care or treatment. An explanation of the educational purpose behind the proposed examination or clinical demonstration must be provided to the patient and their express consent must be obtained. This must occur whether or not the patient will be conscious during the examination. If express consent cannot be obtained, for example, if the patient is unconscious, then the examination cannot be performed. The most responsible physician and/or supervisor should be confident that the proposed examination or clinical demonstration will not be detrimental to the patient, either physically or psychologically.

Schedule F - Duty to Report Another Member

Attached to and forming part of By-Law No. 11 of the College.

1. Examples of situations when a member must report another member to the College pursuant to *The Medical Act* or the Code of Ethics include knowledge that another member:
 - (a) has made sexual advances to or has violated appropriate physician/patient boundaries, with a patient including having entered into a sexual relationship with a patient;
 - (b) has his or her ability to practice medicine safely impaired for any reason, including health conditions or concerns about the member's knowledge, skill and judgment in the practice of medicine;
 - (c) repeatedly or consistently behaves in a manner that interferes with the delivery of care to patients or the ability of other members or health care providers to provide care to patients.

2. When a patient discloses information leading a member to believe on reasonable grounds that another member has committed a sexual boundary violation with a patient, the member who receives the disclosure must:
 - (a) provide the patient with information about how to file a complaint with the College;
 - (b) if the patient does not wish to file a complaint personally, offer to file a third person complaint on behalf of the patient;
 - (c) in the absence of confirmation that the patient has filed a complaint, document the sexual boundary violation indicating that the patient does not wish to report to the College and report the member to the College.

3. The member must assess and record in the patient's record whether disclosure of the patient's personal information regarding the sexual boundary violation to the College as described in subsection 2 could cause serious imminent mental, physical or emotional harm to the patient.

Schedule G - Treating of Self and Family Members**Attached to and forming part of By-Law No. 11 of the College.**

1. "Immediate family" includes, but is not limited to, a member's spouse or domestic partner, parents, siblings, and children of the member or the member's partner within an interdependent family unit, whether or not that takes the form of a traditional family unit.
2. The limitation in Article 21 of the Code of Ethics prohibits a member from effectively assuming management through one or more of the following actions:
 - (a) initiating any pharmacologic management which is not consistent with the principle in Article 21.
 - (b) signing a prescription or authorization for himself or herself or someone in his or her immediate family even when pharmacologic management is being directed by another member when the pharmacologic product is a narcotic, a controlled drug, has psychotropic properties, or is otherwise habituating or addicting.
 - (c) adjusting the dosage or dosing frequency or prescribed or authorized medication for himself or herself or someone in his or her immediate family without the express approval of the member who is the independent treating physician.

Schedule H - Self-Reporting to the College**Attached to and forming part of By-Law No. 11 of the College.**

1. Members who have a diminished ability to provide safe, competent medical care have an ethical responsibility to appropriately restrict practice or withdraw from practice, and report to the College.
2. A member must report the following personal circumstances to the College at the time of registration or whenever the member becomes aware thereafter:
 - (a) a sexual or inappropriate personal relationship between the member and a patient;
 - (b) any voluntary or involuntary loss or restriction of diagnostic or treatment privileges granted by an administrative authority or any resignation in lieu of further administrative or disciplinary action.

Schedule I - Volume of Service**Attached to and forming part of By-Law No. 11 of the College.**

Members must not have excessive workload volumes, or be on call so frequently as to result in a risk that chronic fatigue may impair the judgment, decision or procedural skills of the member. Excessive workload volume may result from overly long work hours, insufficient time to provide an acceptable standard of care per unit of service, or being on call most or all of the time. Each of these risk factors may in turn result in chronic fatigue and place patients at unnecessary risk.

Schedule J - Bloodborne Pathogens

Attached to and forming part of By-Law No. 11 of the College.

1. Definitions

- (a) **Member(s)** – member(s) of the College providing medical care to patients.
- (b) **Exposure Prone Procedures (EPP)** - Interventions where there is a risk that injury to the member may result in the exposure of the patient's open tissues to blood and body fluids of the member (bleedback). These include procedures where the member's gloved hand may be in contact with sharp instruments, needle tips or sharp tissues (spicules of bone or teeth) inside a patient's open body cavity, wound, or confined anatomical space where the hands or finger tips may not be completely visible at times.
- (c) **Routine Practices** – A series of recommendations for the care of all patients incorporating the precautions necessary to prevent the transmission of microorganisms between patients and health care workers across the continuum of care, including previous precautions against bloodborne pathogens (Universal Precautions).

2. All Members:

- (a) have an ethical responsibility to be aware of their serological status with respect to blood borne communicable diseases, including HBV, HCV and HIV, if they are at personal or occupational risk and engaging in EPP;
- (b) must take all necessary steps to minimize the transmission of blood borne infections to patients, including conscientious and rigorous adherence to routine practices in their practice;
- (c) should be immunized for HBV before possible occupational exposure and should have their antibody status assessed and documented after immunization;
- (d) should seek re-testing of their serological status following a significant exposure to human blood or other body fluids.

3. A member who is known to have active infection with HBV and/or HCV and/or HIV must:

- (a) consult a physician to receive appropriate medical care and follow-up care;
- (b) directly or through a treating physician, report to the Deputy Registrar of the College;
- (c) cooperate with the College to facilitate a review by an expert panel to assess whether modifications to the member's practice are warranted based upon the test of public protection;
- (d) cooperate with the College in making modifications and/or adhering to restrictions to his/her clinical practice, pending and/or on completion of the expert panel review, including ceasing to practice EPP, if required, in order to protect the public;

- (e) notify the Deputy Registrar of the College of any significant change in his/her health status and/or practice circumstances to allow for a further expert panel review, if necessary to assess whether any further modifications and/or restrictions to his/her clinical practice are required.
- 4. A member who comes in contact with the blood or other body fluids of an individual who is known to carry a blood borne pathogen must consult a physician to receive appropriate medical care and follow-up care.
- 5. A member who is aware of another member being positive for HBV and/or HCV and/or HIV must report the matter to the Deputy Registrar of the College.

Schedule K – Telemedicine

Attached to and forming part of By-Law No. 11 of the College.

1. In this section “telemedicine” means the provision of medical care by means of electronic communication when the patient and the provider are separated by distance, and may include, but is not limited to, the provision of pathology, medical imaging and patient consultative services.
2. A member who advises or treats a patient through telemedicine must confirm the identity of the patient.
3. A member must observe the following when practising telemedicine:
 - (a) a member delivering treatment or gathering information through electronic means must take reasonable steps to ensure that:
 - (i) the hardware and software being relied upon is functioning properly and securely;
 - (ii) any support staff involved in operating the equipment are adequately trained and competent to use the equipment; and
 - (iii) the equipment is up to date and reliable;
 - (b) in the case of computer equipment, ensure that the possibility of computer hacking, computer viruses and malfunctions is kept to a minimum;
 - (c) in the case of an urgent medical or surgical procedure being conducted by a telemedicine process, ensure a backup system is in place to protect the patient in the event of an equipment malfunction;
 - (d) if the patient controls some component of the equipment used in the telemedicine intervention, for example, a computer or monitoring device, ensure that:
 - (i) the patient understands the importance of that equipment to the process;
 - (ii) the patient is competent to handle it properly and to advise the appropriate person or facility in the event of a malfunction or an inability to operate it.
4. Where a member participates in a telemedicine process as part of a team or for a specific health care facility, it is the member’s responsibility to determine who will be responsible for the technical aspects of the telemedicine intervention.
5. If telemedicine is being delivered to an out of province jurisdiction, the member must verify whether the licensing authorities in that jurisdiction require registration or licensure, and if so, comply with those requirements.

6. In every potential telemedicine situation, the member must carefully evaluate whether the patient can or should be treated via telemedicine. This must involve a careful consideration of the limitations of the available technology and the patient's circumstances.
7. A member treating remote or mobility-limited patients must be aware of the telemedicine treatment option and its potential application to his or her patients.
8. Any information that calls for action on the part of the patient, such as a laboratory result that indicates a potential or actual medical problem, must not be delivered through electronic mail unless the member incorporates a direction that the patient contact him or her by a certain deadline to acknowledge receipt of the information and follows up promptly should the patient fail to do so.
9. Members must not allow incentives offered by the providers of telemedicine technology to influence their decisions as to whether the telemedicine option is appropriate for a particular patient and if so what technology is to be used.
10. A member must take reasonable steps to ensure that the medical information will not be intercepted by a third party. Members are reminded that *The Personal Health Information Act* applies to electronically transmitted personal health information.
11. Members practising in Manitoba are required to carry professional liability insurance or have CMPA membership. Not all telemedicine activities are covered by CMPA. Members must confirm they are covered by appropriate liability insurance before engaging in telemedicine.

Schedule L - Delegation

Attached to and forming part of By-Law No. 11 of the College.

1. A physician may delegate a function which forms part of the practice of medicine only if he or she:
 - a. is legally permitted and competent to perform the function being delegated;
 - b. is satisfied on reasonable grounds that the person accepting the delegation is competent to perform the function;
 - c. is satisfied on reasonable grounds that it is safe and appropriate for the person accepting the delegation to perform the function; and
 - d. is readily available for consultation while the person accepting the delegation performs the function.
2. A person is considered to be competent to perform a function if he or she has the requisite knowledge, skill and judgment to perform the function.
3. A delegation may relate to a specific patient or to a group of patients who meet the clinical conditions specified in the delegation.
4. A delegation may be in writing or, in the case of a delegation relating to a specific patient, may be made verbally.
5. A written delegation must:
 - a. name the person or specify the class of persons to whom the delegation is made;
 - b. name the patient to whom the delegation relates or, in the case of a delegation that relates to a group of patients, a list of the specific clinical conditions, if any, that a patient must meet before the delegated function may be performed;
 - c. provide necessary instructions for performing the function;
 - d. state the duration of the delegation;
 - e. specify any conditions that the physician who makes the delegation considers appropriate; and
 - f. be signed by the physician who makes the delegation.
6. A physician who makes a verbal delegation must ensure that it is noted on the patient's chart as soon as practicable after the delegation is made.

Schedule M – Medical Assistance In Dying (MAID)

Attached to and forming part of By-Law No. 11 of the College

Background

Federal legislation now permits medical practitioners and nurse practitioners to provide medical assistance in dying (MAID)². Medical practitioners and nurse practitioners are the only people who can provide MAID. Pharmacists, health care providers and others can provide requested assistance.

Nothing in the federal legislation compels an individual to provide MAID.

Amendments to the Criminal Code set out the legislative framework for MAID by creating eligibility requirements, safeguards and specific requirements of the practitioners who provide MAID and those who assist them. Anyone who provides or assists a practitioner who provides MAID and follows the requirements of s. 241 of the Criminal Code and applicable provincial and territorial laws, rules and policies are exempt from criminal responsibility, including those who have a reasonable but mistaken belief about any fact that is an element of the exemption.

The federal legislation requires that MAID be provided with reasonable knowledge and skill in accordance with any applicable provincial laws, rules or standards.

This Schedule establishes the standards of practice and ethical requirements of physicians in Manitoba in relation to the legal requirements for MAID set out in the federal framework. It is subject to existing legislation and regulations governing any aspect of MAID which come into force and effect while this Schedule is in force and effect. Any such legislation and regulations take priority over the requirements of this Schedule where there is any inconsistency.

² *An Act to amend the Criminal Code and to make related amendments to other Acts (medical assistance in dying)* SC 2016, c. 3, http://cpsm.mb.ca/cjj39alckF30a/wp-content/uploads/MAID_federal_legislation.pdf

Definitions

Medical Assistance in Dying (MAID) is defined in s. 241.1 of the Criminal Code to mean:

- a) the administering by a medical practitioner or nurse practitioner of a substance to a person, at their request, that causes their death; or
- b) the prescribing or providing by a medical practitioner or nurse practitioner of a substance to a person, at their request, so that they may self-administer the substance and in doing so cause their own death.

Medical Practitioner - is defined in s. 241.1 of the Criminal Code to be a person who is entitled to practice medicine under the laws of a province.

Physician - a medical practitioner who is a member of the College and is both registered on the Manitoba Medical Register and licensed to practice medicine. This definition excludes a member who is only practicing within a residency training program.

Patient - the person requesting MAID and whose well-being must be the primary concern of any physician involved with responding to such a request.

Administering Physician – the physician who provides or administers the pharmaceutical agent(s) intended to cause the patient's death. The administering physician is responsible for confirming that all of the requirements of this Schedule have been met before the pharmaceutical agent(s) that intentionally cause the patient's death can be provided or administered. There can only be one administering physician for each patient.

Member – a member of the College who is registered on the Manitoba Medical Register, Educational Register, Physician Assistant Register or Clinical Assistant Register.

Requirements

I. Minimum Requirements of All Members and Physicians

- A. A member must not promote his or her own values or beliefs about MAID when interacting with a patient.
- B. On the grounds of a conscience-based objection³, a physician who receives a request about MAID may refuse to:
 - a. provide it; or
 - b. personally offer specific information about it; or
 - c. refer the patient to another physician who will provide it.
- C. A physician who refuses to refer a patient to another physician or to personally offer specific information about MAID on the grounds of a conscience-based objection must:
 - a. clearly and promptly inform the patient that the physician chooses not to provide MAID on the grounds of a conscience-based objection; and
 - b. provide the patient with timely access to a resource⁴ that will provide accurate information about MAID; and
 - c. continue to provide care unrelated to MAID to the patient until that physician's services are no longer required or wanted by the patient or until another suitable physician has assumed responsibility for the patient; and
 - d. make available the patient's chart and relevant information (i.e., diagnosis, pathology, treatment and consults) to the physician(s) providing MAID to the patient when authorized by the patient to do so; and
 - e. document the interactions and steps taken by the physician in the patient's medical record, including details of any refusal and any resource(s) to which the patient was provided access.
- D. A member who is not a physician and has a conscientious-based objection to MAID who receives a request for MAID, information about MAID or a referral to a physician who will provide MAID must advise the patient making the request that the member has a conscientious-based objection and must communicate the request to the member's supervising physician in a timely fashion.

³ See Section 17 of By-Law #11 - conscience-based objection is defined as an objection to participate in a legally available medical treatment or procedure based on a member's personal values or beliefs.

⁴Acceptable resources may include but are not limited to other members, health care providers, counsellors and publicly available resources which can be accessed without a referral and which provide reliable information about MAID.

II. Specific Requirements for Assessing Patient Eligibility for MAID

Federal legislation requires that to be eligible for MAID, the patient must meet all of the following criteria:

- a) be eligible for publicly funded health services in Canada
- b) be at least 18 years of age and capable of making decisions with respect to their health;
- c) have a grievous and irremediable medical condition (including an illness, disease or disability); and
- d) make a voluntary request for medical assistance in dying that is not the result of external pressure; and
- e) provide informed consent to receive MAID after having been informed of the means that are available to relieve the patient's suffering, including palliative care.

According to the federal legislation, a person has a grievous and irremediable medical condition only if **all** of the following criteria are met:

- a) they have a serious and incurable illness, disease or disability;
- b) they are in an advanced state of irreversible decline in capability;
- c) that illness, disease or disability or that state of decline causes them enduring physical or psychological suffering that is intolerable to them and that cannot be relieved under conditions that they consider acceptable; and
- d) their natural death has become reasonably foreseeable, taking into account all of their medical circumstances, without a prognosis necessarily having been made as to the specific length of time that they have remaining. (emphasis added)

The College requires that:

- A. Any physician who conducts an assessment for the purpose of determining if a patient is eligible for MAID pursuant to these requirements must:
 1. be satisfied that the patient seeking MAID has a grievous and irremediable medical condition which the physician has verified by:
 - a. a clinical diagnosis of the patient's medical condition; and
 - b. a thorough clinical assessment of the patient which includes consideration of all relevant, current and reliable information about the patient's symptoms and the available medical treatments to cure the condition or alleviate the associated symptoms which make the condition grievous, including, where appropriate, consultation with another qualified physician;

2. be fully informed of the current relevant clinical information about the patient and his/her condition;
 3. be qualified to render a diagnosis and opine on the patient's medical condition or be able to consult with another physician with relevant expertise for the limited purpose of confirming the diagnosis, prognosis or treatment options;
 4. use appropriate medical judgment and utilize a reasonable method of assessment;
 5. when assessing whether a patient's illness, disease or disability or state of decline causes the patient enduring physical or psychological suffering that is intolerable to the patient and cannot be relieved under conditions that the patient considers acceptable, ensure that:
 - a. the unique circumstances and perspective of the patient, including his/her personal experiences and religious or moral beliefs and values have been seriously considered;
 - b. the patient is properly informed of his/her diagnosis and prognosis in relation to the current or impending associated symptoms; and
 - c. treatment options described to the patient include all reasonable medical treatments to cure the condition or alleviate the associated symptoms which make it grievous or, if the patient is terminal, palliative care interventions; and the patient adequately understands the:
 1. current and anticipated course of physical symptoms, ability to function and pain and suffering specific to that patient; and
 2. effect that any progression of physical symptoms, further loss of function or increased pain may have on that specific patient; and
 3. available treatments to manage the patient's symptoms or loss of function or to alleviate his/her pain or suffering.
- B. Each physician must document in the patient's medical record all information that is relevant to his/her role and findings in respect to each of the specific requirements of any assessment related to the patient's eligibility for MAID.

III. Specific Requirements for Assessing Medical Decision Making Capacity

- A. Any physician who conducts an assessment of a patient for the purpose of determining if the patient is capable of making decisions with respect to their health pursuant to the federal requirements must be:
1. fully informed of the current relevant clinical information about the patient and his/her mental and physical condition; and

2. qualified to assess competence in the specific circumstances of the patient whose capacity is being assessed or be able to consult with another physician with relevant expertise for the limited purpose of assessing the patient's medical decision making capacity.
- B. In the event that a physician has a reasonable doubt as to the patient's competence, an additional independent assessment must be conducted by another physician who is enrolled on the Specialist Register as a psychiatrist.
 - C. Each physician must document in the patient's medical record all information that is relevant to his/her role and findings in respect to each of the specific requirements of any assessments of a patient's medical decision making capacity.

IV. Specific Requirements for Obtaining Informed Consent

The federal legislation requires that before a physician provides MAID, the physician must:

- (a) ensure that the request for MAID was:
 - i. made in writing and signed and dated by:
 - a. the patient; or
 - b. where the patient is unable to sign and date the request, by another person (proxy) at the express direction of and in the presence of the patient. The person who serves as the proxy must:
 1. be at least 18 years of age;
 2. understand the nature of the request for MAID;
 3. not know or believe that they are a beneficiary under the will of the patient or a recipient in any other way of a financial or other material benefit resulting from the patient's death; and
 - ii. signed and dated after the patient was informed by a physician or nurse practitioner that the patient has a grievous and irremediable medical condition.
- (b) be satisfied that the request was signed and dated by the patient or by the patient's proxy before two independent witnesses who then also signed and dated the request;
- (c) ensure that the person has been informed that they may, at any time and in any manner, withdraw their request;
- (d) ensure that another physician or nurse practitioner has provided a written opinion confirming that the person meets all of the eligibility criteria and be satisfied that they and the other physician or nurse practitioner providing the opinion are independent in that each of them :

- i. is not a mentor to the other practitioner or responsible for supervising their work;
 - ii. does not know or believe that they are a beneficiary under the will of the patient, or a recipient, in any other way, of a financial or other material benefit resulting from that patient's death, other than standard compensation for their services relating to the request; or
 - iii. does not know or believe that they are connected to the other practitioner or to the patient in any other way that would affect their objectivity;
- (e) ensure that there are **at least 10 clear days** between the day on which the request was signed by or on behalf of the patient and the day on which MAID is provided or — if they and the other physician or nurse practitioner are both of the opinion that the patient's death, or the loss of their capacity to provide informed consent, is imminent — any shorter period that the first physician or nurse practitioner considers appropriate in the circumstances;
- (f) immediately before providing MAID, give the patient an opportunity to withdraw their request and ensure that the patient gives express consent to receive MAID; and
- (g) if the patient has difficulty communicating, take all necessary measures to provide a reliable means by which the patient may understand the information that is provided to them and communicate their decision.

The federal legislation also provides that any person who is at least 18 years of age and who understands the nature of the request for MAID may act as an independent witness, except if that person:

- (a) knows or believe that they are a beneficiary under the will of the patient, or a recipient in any other way of a financial or other material benefit resulting from the patient's death;
- (b) are an owner or operator of any health care facility at which the patient is being treated or any facility in which patient resides;
- (c) are directly involved in providing health care services to the patient; or
- (d) directly provide personal care to the patient.

The College requires that:

- A. Physicians who obtain informed consent for MAID must have sufficient knowledge of the patient's condition and circumstances to ensure that:

1. the patient is properly informed of his/her diagnosis and prognosis in relation to the current or impending associated symptoms; and
 2. the treatment options described to the patient include all reasonable medical treatments to cure the condition or alleviate the associated symptoms which make it grievous and/or palliative care interventions where the patient is terminal; and
 3. the patient is offered appropriate counseling resources; and
 4. the patient fully understands that:
 - a. death is the intended result of the pharmaceutical agent(s); and
 - b. the potential risks and complications associated with taking the pharmaceutical agent(s).
- B. Each physician who obtains informed consent from the patient for MAID must:
1. have either conducted his/her own assessment or be fully informed of the assessments conducted by other physicians of the patient's medical condition and the patient's medical decision making capacity; and
 2. meet the legal requirements for informed consent, including informing the patient of:
 - a. material information which a reasonable person in the patient's position would want to have about MAID;
 - b. the material risks associated with the provision/administration of the pharmaceutical agent(s) that will intentionally cause the patient's death; and
 3. meet with the patient alone at least once to confirm that his/her decision to terminate his/her life by MAID is voluntary and that the patient has:
 - a. made the request him/herself thoughtfully; and
 - b. a clear and settled intention to end his/her own life by MAID after due consideration;
 - c. considered the extent to which the patient has involved or is willing to involve others such as family members, friends, other health care providers or spiritual advisors in making the decision or informing them of his/her decision; and
 - d. made the decision freely and without coercion or undue influence from family members, health care providers or others.
- C. Each physician must document in the patient's medical record all information that is relevant to his/her role and findings in respect to each of the specific requirements for obtaining informed consent.

V. Additional Requirements of the Federal Legislation

The federal legislation also:

- (a) requires physicians who receive a written request for MAID to provide information pursuant to regulations made by the Minister of Health;
- (b) requires that physicians who, in providing MAID, prescribe or obtain a substance for that purpose must, before any pharmacist dispenses the substance, inform the pharmacist that the substance is intended for that purpose;
- (c) requires physicians to comply with guidelines established for the completion of certificates of death for patients to whom MAID is provided;
- (d) creates criminal offences for knowingly failing to comply with the eligibility and safeguard requirements set out in Criminal Code and destroying documents with the intent to interfere with a patient's access to MAID, the assessment of a request for MAID or a person seeking an exemption related to MAID.

The College expects physicians to comply with the federal and provincial regulations and guidelines described above as they come into force and effect.

VI. Specific Requirements of the Administering Physician

A. The administering physician must:

1. have appropriate knowledge and technical competency to provide/administer the pharmaceutical agent(s) in the appropriate form and/or dosage that will terminate the patient's life in the manner in which the patient was informed that it would terminate his/her life at the time the patient provided his/her consent; and
2. be qualified to provide appropriate instructions to the patient as to how to administer the pharmaceutical agent(s) that will terminate the patient's life in the manner in which the patient was informed that it would terminate his/her life at the time the patient provided his/her consent in circumstances where the patient elects to administer the pharmaceutical agent(s) to him/herself; and
3. be readily available to care for the patient at the time the pharmaceutical agent(s) that intentionally brings about the patient's death is administered by the administering physician or taken by the patient until the patient is dead; and
4. provide reasonable notice to the Office of the Chief Medical Examiner that the patient is planning to die by means of MAID where the location is not a health care institution; and
5. certify, in writing, on the prescribed form (Appendix A) that he/she is satisfied on reasonable grounds that all of the following requirements have been met:

- a. The patient is at least 18 years of age;
 - b. The patient's medical decision making capacity to consent to receiving medication that will intentionally cause the patient's death has been established in accordance with the requirements of the Criminal Code and this Schedule;
 - c. All of the requirements of the Criminal Code and this Schedule in relation to assessing eligibility for MAID and obtaining and documenting informed consent have been met; and
6. ensure that the requirements of physicians set out in all relevant federal and provincial legislation, including the Criminal Code, The Fatality Inquiries Act, C.C.S.M. c. F52 and The Vital Statistics Act, C.C.S.M. c. V60 in respect to reporting and/or registering the cause and manner of the patient's death, including completing all required forms specified by the legislation or regulations, are met in a timely fashion.

Appendix A – Certification by the Administering Physician

I, _____, am the administering physician.
(print physician's name)

_____ is the patient.
(print patient's name)

I hereby certify that:

1. I am familiar with all of the requirements for providing MAID to a patient set out in the Criminal Code and Schedule M of By-Law 11 of The College of Physicians & Surgeons of Manitoba (“the Schedule”).
2. I am satisfied that:
 - a. The patient is at least 18 years of age;
 - b. The patient’s medical decision making capacity to consent to receiving pharmaceutical agent(s) that will intentionally cause the patient's death has been established in accordance with the requirements of the Criminal Code and this Schedule;
 - c. All of the requirements of the Criminal Code and this Schedule in relation to assessing eligibility for MAID and obtaining and documenting informed consent have been met. The following physicians were involved:

[Print first and last names of the physician(s)]
conducted the assessment(s) for patient eligibility

[Print first and last names of the physician(s)]
conducted the assessment(s) of the patient’s medical decision making capacity

[Print first and last names of the physician(s)]
obtained informed consent

Signed by me at _____, in the Province of Manitoba, this ____ day of _____, 20__.

WITNESS

Administering Physician

Print Name of Witness

Print Name of Administering Physician