Standard of Practice

Confidentiality and Privacy

Initial Approval: January 1, 2019 **Effective Date: January 1, 2019**

Standards of Practice of Medicine set out the requirements related to specific aspects for the quality of the practice of medicine. Standards of Practice of Medicine provide more detailed information than contained in the *Regulated Health Professions Act*, Regulations, and Bylaws. All registrants must comply with Standards of Practice of Medicine, per section 86 of the *Regulated Health Professions Act*.

This Standard of Practice of Medicine is made under the authority of section 82 of the *Regulated Health Professions Act* and section 15 of the CPSM Standards of Practice Regulation.

1. Transmission of Health Information

1.1. "Electronic transmission of prescription" includes all forms of prescription transmission for outpatients and persons receiving care in an ambulatory community practice.

1.2. A registrant who uses electronic transmission of prescriptions:

1.2.1. must ensure that:

1.2.1.i. the prescription is sent directly from the prescriber's office to a single licensed pharmacy of the patient's choice;

1.2.1.ii. the prescription is sent only to a pharmacist practicing in a Manitoba licensed pharmacy;

1.2.1.iii. the prescription is transmitted to the pharmacy in a clear, unambiguous manner;

1.2.1.iv. the mode of transmission is secure and maintains confidentiality;

1.2.1.iv.1. the prescription contains the information required by s. 55 of these standards of practice and prescriptions sent by facsimile also contain:

1.2.1.iv.2. the prescriber's name, address, fax number and telephone number;

1.2.1.iv.3. time and date of transmission;

1.2.1.iv.4. the name of the intended pharmacy;

1.2.1.iv.5. signed certification that:

1.2.1.iv.5.a. the prescription represents the original of the prescription drug order;

1.2.1.iv.5.b. the addressee is the only intended recipient and there are no others; and

1.2.1.iv.5.c. the original prescription will be invalidated, securely filed and not transmitted elsewhere at another time.

1.2.2. 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;

1.2.3. must adhere to the requirements of *The Personal Health Information Act* and regulations made pursuant to that legislation;

1.2.4. send facsimile prescriptions only from a machine authorized by the registrant.

1.3. Before leaving a message on voice mail or telephone answering machines, a registrant must be confident that the voice mail or answering machine is confidential to the patient.

1.4. 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 registrant must cooperate with the pharmacist to issue a signed "pen and paper" prescription or a verbal prescription communicated between the prescriber and pharmacist.

2. Medical Information to Third Parties and Sickness Certificates

2.1. When providing medical information to any third party, a registrant must:

2.1.1. ensure that there is consent from the patient to provide information to the third party unless otherwise required by law;

2.1.2. limit the information provided to that covered by the patient's consent;

2.1.3. limit information to that specifically required by the third party within the scope of the patient's consent;

2.1.4. ensure that all statements made are accurate and based upon current clinical information about the patient;

2.1.5. limit the statements to and identify the time period with respect to which the registrant has personal knowledge;

2.2. When providing a sickness certificate (i.e. a document provided by the registrant 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):

2.2.1. avoid diagnostic terms;

2.2.2. Information provided may indicate:

2.2.2.i. prognosis relative to the work situation;

2.2.2.ii. activity limits and ability limits;

2.2.2.iii. risk factors (to the patient and to others).

2.2.3. have accurate information about the requirements of the patient's job before giving an opinion on fitness to work;

2.2.4. be aware of and take into account the provisions of *The Personal Health Information Act*.

2.3. 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 registrant must not imply that the registrant has evidence of an actual diagnosis if the information is restricted to history or examination that is non-contributory.

3. Observers

3.1. Registrants who permit any other individuals such as, but not limited to, international medical graduates, to observe patient care in clinical practice must:

3.1.1. 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;

3.1.2. obtain express consent from each patient before permitting a third party to observe the registrant-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;

3.1.3. 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*.

4. Responding to Requests for Information or Opinion

This section is addressed by section 9 of the Regulation which provides as follows:

9(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.

9(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.