Standard of Practice

Good Medical Care

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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.

Additional Requirements of Good Medical Care

This Part sets out the requirements of good medical care in addition to those described in Section 3 of the Regulation which is as follows:

3(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 consideration 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.*

3(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.

1. Multiple Concerns in a Medical Visit

1.1. Registrants 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.

1.2. Registrants 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 registrant:

- 1.2.1. to gather sufficient information from the patient to triage patient concerns;
- 1.2.2. to decide which concerns must be dealt with at that visit and which concerns can safely wait; and
- 1.2.3. to schedule appointment(s) to address concerns not dealt with, within a time frame appropriate for the condition.

1.3. Registrants 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 registrant's responsibility to triage when multiple concerns are presented.

2. Follow-up to Diagnosis and Test Results

2.2. A registrant 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.

2.3. A registrant who orders a diagnostic test and directs a copy of the results to another registrant remains responsible for any follow-up care required, unless the registrant to whom a copy of the results is directed has agreed to accept responsibility for the patient's follow-up care.

3. Practice Coverage - Critical Test Results

3.1. "Critical test results" are test results that are significantly out of the normal range and which need to be communicated to the registrant urgently.

3.2. Each registrant, including registrants who provide episodic care, is responsible to ensure that specific arrangements are in place for the registrant to receive communication respecting critical test results.

3.3. The registrant 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.

3.4. When ordering tests, registrants must:

3.4.1. provide the diagnostic facility with a telephone number at which the registrant or the registrant's designate may be reached and which may be used by the diagnostic facility to communicate critical test results to the registrant or the registrant's designate;

3.4.2. provide pertinent information about the patient for use by the diagnostic facility to help determine whether a test result is critical.

3.5. If a registrant is unable to be personally available to receive the critical test results, the registrant must make arrangements with another registrant to be available to receive the critical test results and to provide the appropriate follow-up communication and care to the patient promptly.

3.6. Each registrant must establish a reasonable system for communicating test results to his or her patients.

4. Assessing Competence or Mental Capacity

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

5. Informed Consent

5.1. Consent to examination or treatment may be implied or may be expressed orally or in writing.

5.2. Before performing an examination or providing treatment a registrant must ensure that the patient or a substitute decision maker has provided consent except where the registrant is permitted by law to act without consent. A registrant must:

- 5.2.1. 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;
- 5.2.2. 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;
- 5.2.3. if relying on implied consent, be certain that the actions of the patient would be interpreted by others as having implied permission for the registrant's actions;
- 5.2.4. 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;
- 5.2.5. consider the knowledge and expertise of trainees and staff if delegating the consent procedure.

5.3. A registrant must determine a patient's capacity and competence to give consent.

5.4. A registrant must respect the right of a patient to withdraw consent at any time.

5.5. In obtaining full and informed consent for procedures of higher risk of harm for the patient, a registrant must discuss, at a minimum:
- 5.5.1. the exact nature and the anticipated benefits of the proposed examination or treatment;
- 5.5.2. reasonable and accepted alternative examinations or treatments that are generally available;
- 5.5.3. the natural history of the medical condition at issue;
- 5.5.4. consequences of not undertaking the examination or treatment;

5.5.5. the common and significant risks of the examination or treatment alternatives;
5.5.6. serious risks, even if unlikely;
5.5.7. special risks, that although uncommon, may have particular relevance to the patient;
5.5.8. any questions the patient may have.

5.6. A registrant who obtains consent from a patient for participation in research must also comply with direction and advice from the applicable research ethics board.

5.7. In advancing knowledge in any area of medicine, registrants 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.

6. Maintaining Boundaries: Current Patients - See with new Standard of Practice

7. Maintaining Boundaries: Former Patients – See new Standard of Practice

8. Maintaining Boundaries: Psychotherapeutic Relationship – See new Standard of Practice

9. Disclosure of Harm to a Patient

9.1. A registrant 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:
9.1.1. 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.
9.1.2. If the registrant is the only health care professional treating the patient, it is the registrant's responsibility to disclose harm to the patient.
9.1.3. In a team setting, the registrant must cooperate with other registrants 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.
9.1.4. Where a registrant believes another health care professional has caused harm to a patient and has not yet disclosed that harm to the patient, the registrant must discuss the issue with that health care professional and must encourage that health care professional to disclose the harm. If the other health care professional does not disclose the harm, the registrant must do so.
9.1.5. 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.

9.2. When a patient suffers harm and wishes to see another registrant, the registrant must ensure that the patient is transferred to another registrant able to provide the required care.

10. Conscience-Based Objection

10.1. A conscience-based objection is an objection to participate in a legally available medical treatment or procedure based on a registrant's personal values or beliefs.

10.2. A registrant must not promote his or her own values or beliefs when interacting with a patient.

10.3. On the grounds of a conscience-based objection, a registrant who receives a request about a medical treatment or procedure that a patient needs or wants may refuse to:
- 10.3.1. Provide it;
- 10.3.2. personally offer specific information about it; or
- 10.3.3. refer the patient to another registrant who will provide it.

10.4. A registrant who refuses to refer a patient to another registrant or to personally offer specific information about a medical treatment or procedure on the grounds of a conscience-based objection must:
- 10.4.1. clearly and promptly inform the patient that the registrant chooses not to provide a medical treatment or procedure on the grounds of a conscience-based objection;
- 10.4.2. provide the patient with timely access to a resource[1] that will provide accurate information about a medical treatment or procedure;
- 10.4.3. 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 registrant has assumed responsibility for the patient;
- 10.4.4. make available the patient's chart and relevant information (i.e., diagnosis, pathology, treatment and consults) to the registrant(s) providing a medical treatment or procedure to the patient when authorized by the patient to do so; and
- 10.4.5. document the interactions and steps taken by the registrant in the patient's medical record, including details of any refusal and any resource(s) to which the patient was provided access.

11. Non-Traditional Therapies

11.1. Before a registrant proposes a non-traditional therapy to a patient, the registrant must:
- 11.1.1. make a conventional diagnosis using good medical care described in section 2 of the regulation;
- 11.1.2. inform the patient about prevailing medical practice as it relates to the health care needs of the patient;
- 11.1.3. 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,
  - 11.1.3.i. the cost of the non-traditional therapy,

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

11.1.3.ii. the number of appointments or treatment required for the non-traditional therapy, and

11.1.3.iii. the period of time over which the non-traditional therapy would be required; and

11.1.4. document the information provided to the patient in the patient record.

11.2. A registrant 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 of the regulation.

11.3. A registrant 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 CPSM.

12. Non-Treating Medical Examinations

12.1. When accepting a request to perform a non-treating medical examination (a "NTME"), the registrant undertaking the examination must:

12.1.1. examine the person under the same ethical obligations that apply to any patient;

12.1.2. provide an objective and scientifically sound report; and

12.1.3. 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.

12.2. Before undertaking a NTME, a registrant must disclose to all parties:

12.2.1. his or her involvement at any time in the medical care of the person who will undergo the examination;

12.2.2. any relationship with the third party outside of a fee for service for the NTME.

12.3. In advance of the examination, a registrant and the party requesting the examination must agree on the fee for the NTME.

12.4. A registrant undertaking a NTME must obtain from the person concerned informed consent for the examination, diagnostic intervention and release of the registrant's report, unless the informed consent is not required as a result of a court order or legislation.

12.5. A registrant undertaking a NTME must not access records about the patient which are not provided by the third party requesting the NTME or the patient.

12.6. A registrant is not required to:

12.6.1. enforce the terms of a court order or legislative requirement;

12.6.2. proceed with a NTME if the person refuses to cooperate with the registrant performing the NTME.

12.7. A registrant who conducts a NTME must not establish a therapeutic relationship with the person who is the subject of the NTME unless:

12.7.1. there is no other registrant available to provide those services, or the treatment is authorized by legislation; and
12.7.2. the relationship starts after the registrant concludes the NTME.

12.8. If a patient who is the subject of a NTME requires urgent intervention, the registrant must make arrangements for follow-up through another registrant who can treat the patient, but if no other registrant is available or there is no known treating registrant, the registrant must:
12.8.1. promptly advise the patient of the particulars of the medical issue that requires urgent attention, and
12.8.2. provide necessary care if the situation is emergent or urgent and no alternative is available.

12.9. A registrant 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:
12.9.1. the final report and any interim reports issued to the third party by the registrant;
12.9.2. informed consent document;
12.9.3. the contract (if it exists in written form) outlining scope, purpose, timeliness, and fee arrangements;
12.9.4. notes of the medical history of the person being examined;
12.9.5. notes of the physical examination;
12.9.6. audio and video recording if made by the registrant;
12.9.7. a list of sources of ancillary information, including medical reports, records, and any audio or visual information recorded by another person;
12.9.8. the name of any person who accompanied the person being examined during the examination.