



College of
Physicians
& Surgeons
of Alberta

Health Professions Act Standards of Practice

DRAFT

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Table of Contents

Table of Contents	2
Introduction.....	3
Maintenance of Competency	4
1 Re-Entering Practice or Changing Scope of Practice.....	4
Collaboration.....	4
2 Collaboration with Health Professionals	4
3 Supervision of Restricted Activities.....	5
4 Responding to Third Party Requests	6
5 Referrals and Consultation Process	6
Patient Physician Relationship.....	9
6 Establishing the Physician Patient Relationship	9
7 Terminating the Physician-Patient Relationship	10
Standards of Medical Care.....	11
8 Termination of Pregnancy and Birth Control.....	11
9 Assessing the Mental Capacity (Competence) of a Patient.....	12
10 Complementary and Alternative Medicine	12
11 Medical Services Requiring Accreditation.....	14
12 Faxing Prescriptions	14
13 Dispensing of Schedule 1 or 2 Drugs by a Physician for a Fee	15
14 Non-Treating Medical Examinations	17
15 Managing Patients with Chronic Non-Malignant Pain	19
Practice Management.....	20
16 Advertising by Physicians	20
17 Reprocessing of Medical Equipment	22
18 Charging for Uninsured Services	23
19 Practice in Association	23
20 Direction and Control of a Medical Practice.....	24
21 Closing, Leaving, or Moving a Medical Practice.....	25
22 Telemedicine	26
23 Patient Records.....	27
24 Preventing Follow-up Failures	30
Ethics, Integrity and Professionalism	30
25 Informed Consent	31
26 Withdrawal or Withholding of Services.....	32
27 Conflict of Interest.....	32
28 Sale of Products by Physicians.....	33
29 Disclosure of Harm	34
30 After-Hours Access to Care	34
31 Self Reporting to the College	35
32 Duty to Report a Colleague	36
33 Sexual Boundary Violations.....	37
34 Completing Discharge Summaries	38
35 Relationships with Industry	38

Introduction

These Standards of Practice are a non-exhaustive, minimum standard of professional behaviour and ethical conduct expected of all physicians registered in Alberta. This first draft largely reflects existing by-laws and policies covering the obligations and responsibilities of physicians in Alberta. Standards of Practice will be enforceable under the *Health Professions Act* and will be referenced in complaints resolution and discipline hearings.

These standards complement the *CMA Code of Ethics*, which is the particular code adopted by the College of Physicians and Surgeons of Alberta on behalf of its members.

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

Standards of Practice are purposely concise. Some topics will seem rather “black-and-white” or incomplete. When assessing an alleged breach of these Standards of Practice, the College considers the context of the matter on a case-by-case basis. Additional advice and elaboration on specific topics can be found in the *Messenger* (the newsletter of the College) and on the College’s web site at www.cpsa.ab.ca.

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

Maintenance of Competency

1 Re-Entering Practice or Changing Scope of Practice

- (1) A physician must notify the College when the physician intends to return to clinical medical practice after an absence of three (3) years or more.
- (2) A physician, who is returning to clinical medical practice after an absence of three (3) years or more, must complete an assessment and retraining satisfactory to the Registrar prior to returning to practice
- (3) A physician, who intends to change or increase the scope of medical services to include a service which the physician has not provided on a frequent or continuous basis over the previous three (3) years,
 - 3..1 must notify the Registrar, and
 - 3..2 must complete an assessment and retraining satisfactory to the Registrar prior to a change or increase in scope of practice.

Collaboration

2 Collaboration with Health Professionals

- (1) A physician must collaborate with other physicians and health professionals to care for patients and to ensure the functioning and improvement of health services.
- (2) A physician must treat other health professionals with dignity and respect.
- (3) A physician must communicate effectively with other members of the healthcare team, and with the patient.
- (4) When working in a team setting, a physician must document clearly his or her contribution to the patient's care.
- (5) When collaborating in the care of a patient, a physician must explain the physician's role and responsibilities to the patient.

3 Supervision of Restricted Activities

- (1) A physician may supervise another person performing a restricted activity, as defined by Schedule 7.1 of the *Government Organization Act*, if the physician:
 - (a) is satisfied with the knowledge, skill and judgment of the supervised person performing the particular activity, or
 - (b) has confirmed that the supervised person is a student enrolled in a program that, in the opinion of the Registrar, is a legitimate program to train persons to provide professional health services.
- (2) Notwithstanding the above, a physician must not supervise a person in performing a restricted activity if that person:
 - (a) is eligible for registration in a healthcare profession in Alberta but is not registered with that profession's regulatory authority in Alberta, or
 - (b) is registered with a healthcare profession in Alberta but is not permitted by that profession's regulatory authority to perform that restricted activity.
- (3) A physician may supervise a regulated health care professional, an unregulated worker or a student performing a restricted activity only if the physician is satisfied that:
 - (a) it is safe and appropriate for the supervised person to perform the restricted activity on the particular patient;
 - (b) the risk to the patient is not substantially greater than if the restricted activity was performed by the physician;
 - (c) the equipment and resources available to perform the restricted activity are safe and appropriate; and
 - (d) the patient consents to the restricted activity by the supervised person, unless consent is not possible due to circumstances of a medical emergency.
- (4) A physician who supervises a person performing a restricted activity must remain readily available during the performance of the restricted activity for:
 - (a) consultation with the person who is supervised; and

- (b) direct contact with the patient when the risks of the activity and the training of the supervised person are not appropriate for indirect or remote supervision.

4 Responding to Third Party Requests

- (1) A physician must provide details of his or her findings, assessment, advice and treatment given to a patient, when requested by the patient or an authorized agent or required to do so by law.
- (2) When responding to requests in section (1) for information about a patient, a physician must respond to such a request within thirty (30) days in one of the following ways:
 - (a) providing the information requested,
 - (b) acknowledging the request and giving an estimated date for providing the information requested, or
 - (c) explaining why all or part of the information will not be provided.
- (3) Notwithstanding section (1), a physician is not obligated to:
 - (a) provide a report containing a medical-legal opinion,
 - (b) provide an expert opinion, or
 - (c) become an expert witness in a legal proceeding.

5 Referrals and Consultation Process

- (1) A physician must recognize his or her limitations and the special skills of others in the delivery of patient care.
- (2) When a physician believes that referral to another healthcare professional is appropriate but the patient does not, the physician must discuss and document difference of opinion and the implications for care in the patient's record.
- (3) A physician must continue to provide care as best as possible within any limits imposed by the patient's decision in section (2).

- (4) A physician must honor a patient's reasonable request to be referred to other health care professionals and to receive a second opinion about treatment or the physician's methods.
- (5) Notwithstanding section (4), a physician is entitled to refuse to make a referral that, in his or her opinion, is unlikely to provide a clinical benefit and which would be an imprudent use of healthcare resources
- (6) A physician must ensure that the patient agrees with the choice of consultant to whom a referral is made.
- (7) A physician must discuss the purpose of the consultation with the patient.
- (8) A physician must tell the patient about any fees that may not be covered by the Alberta Health Care Insurance Plan if the referring physician knows that such fees are likely to be charged.
- (9) A physician must make or confirm the request for a consultation in writing to the consultant unless the circumstances are urgent and the consultant agrees to accept care of the patient after discussion between the referring physician and the consultant.
- (10) In the case of a referral for emergency care, the physician must discuss the referral with the consultant or otherwise ensure acceptance of care by the consultant.
- (11) A referring physician must perform a preliminary work-up of the patient within his or her scope of practice and provide those results to the consultant.
- (12) A referring physician must, at the time of the request for consultation, clearly identify that the consultation is requested for the purpose of providing a third party with information.
- (13) Referral letters must include, at a minimum:
 - (a) the identity of the referring physician,
 - (b) the identity of the patient, including contact information,
 - (c) the identity of the consultant,
 - (d) the date of the referral,
 - (e) the purpose of the referral as intended by the referring physician, including whether an opinion only or transfer of care is requested, and

- (f) all pertinent clinical information, including, but not limited to, results of clinical investigations.
- (14) A consultant must respond in writing to a request for a non-urgent consultation from a referring physician within two (2) weeks of receipt of a request.
 - (15) If a request for a consultation is denied, the consultant must provide reasons and suggestions for alternative consultants to the referring physician.
 - (16) A consultant must not insist on a repeat referral from the referring physician solely for the purpose of gaining a higher fee.
 - (17) If a consultant agrees to see a patient, then 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 physician.
 - (18) A consultant must, as soon as possible but generally within two (2) weeks of having seen the patient, report in detail all pertinent findings and recommendations to the referring physician
 - (19) If the consultant's conclusions require further investigation or treatment, the consultant must provide an interim written report to the referring physician in addition to a final written report at the conclusion of the consultant's involvement.
 - (20) If the consultant requires further investigations before reaching a definitive diagnosis, the consultant must not delegate arrangement of those investigations to the referring physician without prior agreement.
 - (21) A consultant's report must include, when applicable:
 - (g) the identity of the consultant,
 - (h) the identity of the patient,
 - (i) the identity of the referring physician,
 - (j) the date of the consultation,
 - (k) the purpose of the referral as understood by the consultant,
 - (l) information considered, including history, physical findings, and investigations,
 - (m) diagnostic conclusions,

- (n) the treatments initiated, including medications prescribed,
 - (o) recommendations for monitoring,
 - (p) recommendations for continuing care by the consultant,
 - (q) recommendations for referral to other consultants, and
 - (r) the advice given to the patient.
- (22) A consultant must respect the patient's right to privacy, autonomy and reasonable explanations about the patient's care.
- (23) A consultant must convey all pertinent medical information to the referring physician unless the patient explicitly requests otherwise.
- (24) A consultant should advise the referring physician if a patient withholds consent for release of information to the referring physician.
- (25) A consultant must obtain informed consent for any procedure planned from the patient directly and not defer the consent process to the referring physician.
- (26) A consultant must explain the consultant's role, if any, in the continuing care of the patient and the advisability of follow-up care by the consultant.
- (27) A consultant must contact the referring physician at the time the patient is returned to the referring physician for ongoing care and provide written information as soon as possible thereafter to assist with the continuity of care.

Patient Physician Relationship

6 Establishing the Physician Patient Relationship

- (1) A physician who is accepting patients on anything other than a "first come first served basis" must establish criteria for patient selection, based on matters relevant to the physician's scope of practice
- (2) A physician's criteria for selection must not include any ground of discrimination under human rights legislation.

- (3) A physician must inform a potential patient of his or her practice limitations, restrictions and selection criteria prior to accepting that person as a patient, preferably before the introductory visit.
- (4) A physician must advise a potential patient in advance when an introductory appointment is not a medical appointment.
- (5) When a person is not accepted as a patient in a physician's practice, a physician must advise the person of the reasons.
- (6) A physician who treats injuries in the usual course of the physician's medical practice must not refuse to treat a patient with injuries caused under circumstances that may require the physician to prepare and provide additional documentation or reports.
- (7) A physician must not refuse to accept a patient into his or her practice because that patient's care may require more time than others with fewer medical needs.
- (8) Notwithstanding sections (6) & (7), it is acceptable for a physician to arrange for another healthcare provider to treat such a patient if the arrangement is acceptable to the patient and the other healthcare provider.
- (9) Notwithstanding section (8), a physician must provide care to a patient in an urgent medical situation when no other physician is immediately available.
- (10) Information that is collected for the purposes of screening prospective patients must be collected, disclosed and retained in accordance with relevant privacy legislation and the College's requirements.

7 Terminating the Physician-Patient Relationship

- (1) A physician who terminates a relationship with a patient must have reasonable grounds for discharging the patient from the practice and document those reasons in the patient's record.
- (2) A physician must not discharge a patient;
 - (a) based on a ground of discrimination under human rights legislation,
 - (b) because a patient refuses to follow medical advice, unless that refusal contravenes a treatment contract,

- (c) because the patient refuses to follow medical advice, unless the patient is repeatedly non-compliant despite reasonable attempts by the physician to address the non-compliance.
 - (d) because a patient fails to keep appointments or pay outstanding fees, unless advance notice has been given to the patient.
- (3) When discharging a patient, a physician must;
- (a) give advance written notice of intention to terminate care and a timeline that is commensurate with the continuing care needs of the patient,
 - (b) advise the patient of the reason(s) for termination of the doctor-patient relationship,
 - (c) ensure continuity of follow-up for outstanding investigations and serious medical conditions prior to the termination date or arrange transfer of care to another physician,
 - (d) provide or arrange for care until the termination of care,
 - (e) establish a process for transfer of the patient's medical information in response to future requests by the patient or an authorized third party, and
 - (f) notify other treating physicians that the physician's services are being terminated.
- (4) Notwithstanding section (3), a physician may immediately discharge a patient:
- (a) if the patient poses a serious safety risk to office staff, other patients or the physician.
 - (b) if the reason is the physician is leaving practice because of personal illness or other urgent circumstances.

Standards of Medical Care

8 Termination of Pregnancy and Birth Control

- (1) Even if a physician's religious or personal convictions prevent the physician from advising or offering care regarding birth control or termination of a pregnancy, the physician must ensure that the patient who seeks such advice or

medical care is offered access to information and assistance in making an informed decision and access to available medical options.

- (2) A physician must not only perform a procedure or provide a prescription for the purpose of terminating a pregnancy, with the exception of the emergency contraceptive, unless the physician holds privileges in a hospital or in an accredited non-hospital surgical facility for that procedure.

9 Assessing the Mental Capacity (Competence) of a Patient

- (1) A physician conducting an assessment of a patient's mental capacity must:
 - (a) attempt to obtain informed consent from the patient;
 - (b) seek valid consent from the appropriate authorized person if the patient is not deemed competent to give consent for the assessment;
 - (c) assess the patient's capacity to understand information relevant to the topic at hand;
 - (d) assess the patient's capacity to understand the decision(s) to be made;
 - (e) assess the patient's capacity to understand the risks and benefits of actions that may be undertaken;
 - (f) assess the patient's ability to justify his or her choices; and
 - (g) use accepted clinical means to determine mental capacity.

10 Complementary and Alternative Medicine

- (1) In this section, Complementary and Alternative Medicine (hereafter referred to as "CAM") means a group of diverse medical and healthcare systems, practices, and products that are not presently considered to be part of conventional medicine.
 - (a) While some scientific evidence exists regarding some CAM therapies, for most there are key questions that are yet to be answered through well-designed scientific studies--questions such as whether these therapies are safe and whether they work for the diseases or medical conditions for which they are used.
 - (b) The list of what is considered to be CAM changes continually, as those therapies that are proven to be safe and effective become adopted into conventional healthcare and as new approaches to health care emerge.

- (2) A physician must not provide a CAM therapy to a patient until the physician has been approved by the Registrar to provide such therapy.
- (3) Application for approval to provide CAM therapy must provide information about the therapy and the physician's training and experience with the therapy, acceptable to the Registrar.
- (4) Providing medical information to support a patient's application to possess dried marijuana pursuant to the *Marihuana Medical Access Regulations* does not require application for approval from the Registrar.
- (5) Notwithstanding section (2), a physician who does not hold approval to administer a CAM therapy may provide the CAM therapy without approval from the Registrar to a patient who suffers from an imminently fatal, incurable disease provided that the steps set out in section (6) are followed.
- (6) A physician who provides a CAM therapy to a patient must ensure that the following steps have been fulfilled:
 - (a) an orthodox medical evaluation of the patient,
 - (b) an orthodox medical diagnosis has been established,
 - (c) orthodox medical treatment options have been discussed with the patient,
 - (d) the unproven status, the safety and the potential toxicity of the CAM therapy have been discussed with the patient,
 - (e) the physician's professional experience with use of the CAM therapy and conventional therapy has been declared to the patient; and
 - (i) the number of treatments, time frame and costs to the patient for the CAM therapy are discussed with the patient.
- (7) A physician must keep a medical record that meets or exceeds the College's standard of practice for medical records and contains sufficient detail to document completion of the above steps.
- (8) A physician conducting clinical research into the use of a CAM therapy must have approval for the research from an ethics review board approved by Council.

11 Medical Services Requiring Accreditation

- (1) A physician must not perform diagnostic or treatment procedures in a medical office that are restricted by the College to accredited facilities and hospitals.

12 Faxing Prescriptions

- (1) When faxing a prescription, a physician must ensure that the prescription is sent directly from the physician's office to a single pharmacy acceptable to the patient.
- (2) The physician must be able to verify the source of the faxed prescription for the pharmacist.
- (3) The prescription must be sent only to a pharmacist practising in a licensed pharmacy or hospital dispensary.
- (4) The prescription must be legible and include all the legal requirements of a prescription as outlined in federal legislation plus:
 - (a) the physician's address, fax number and phone number,
 - (b) the time and date of the fax transmission,
 - (c) the name and fax number of the pharmacy intended to receive the transmission, and
 - (d) the signature of the sender verifying that:
 - (i) the prescription represents the original of the prescription drug order,
 - (ii) the addressee is the only intended recipient and there are no others, and
 - (iii) the original prescription will be invalidated, securely filed and not transmitted elsewhere at another time.
- (5) For triplicate prescription medications, the physician must fax the top copy of the TPP prescription so that the TPP prescription's unique number and the physician's TPP registration number are included with the transmission.
- (6) After confirmation of successful transmission, the original written prescription must be invalidated and retained with the patient record.

- (7) A physician must not use pre-printed fax forms that reference a pharmacy, pharmacist, pharmaceutical manufacturer, distributor, agent or broker.
- (8) Computer-generated prescriptions must contain the handwritten signature of the physician until the federal and provincial governments and professional regulatory bodies approve guidelines to ensure the security of electronically-generated signatures.

13 Dispensing of Schedule 1 or 2 Drugs by a Physician for a Fee

- (1) A physician may only dispense a Schedule 1 or 2 drug, as defined by the Pharmacy and Drug Act, to a patient for a fee when the drug is relevant to the medical consultation or surgical procedure provided to that patient.
- (2) A physician must limit fees for the provision of drugs to the cost of the drugs to the physician and reasonable handling costs.
 - (a) handling costs may include shipping, containers and containment systems, refrigeration and inventory maintenance costs associated with replacement of expired drugs.
 - (b) a physician must maintain a detailed description of the calculation of handling costs for inspection by the College.
- (3) A physician must not charge a fee for dispensing a drug or for maintaining required documentation in respect of the inventory control or dispensing of drugs.
- (4) A physician must not compound drugs unless specifically approved by the College.
- (5) A physician must personally discuss instructions for use of the drug with the patient.
- (6) Any drug dispensed to a patient for a fee must have a label affixed to the drug container or packaging that is legible and identifies the following:
 - (a) the name, address and telephone number of the clinic from which the drug is dispensed,
 - (b) the name of the patient,
 - (c) the name of the prescriber,
 - (d) the name of all active ingredients, the strength and the manufacturer,

- (e) instructions for use,
 - (f) the date the drug was dispensed,
 - (g) the quantity dispensed, and
 - (h) the expiry date, when appropriate.
- (7) Any drug dispensed to a patient for a fee must be dispensed in child-proof containers except where inappropriate for a particular patient.
- (8) Each time a drug is dispensed, the transaction must be recorded in the clinical record or in a separate log that identifies the following:
- (a) the name of the patient for whom the drug was dispensed,
 - (b) the name of the prescriber,
 - (c) the date the drug was dispensed,
 - (d) the name, strength and dosage form of the drug dispensed, and
 - (e) the quantity of the drug dispensed.
- (9) Drugs in a physician's office must be stored to ensure security and integrity.
- (10) Drugs received by the physician for dispensing to patients must be visually inspected to ensure there has been no damage or contamination.
- (11) Drugs in a physician's office must be stored at appropriate temperatures to ensure stability.
- (12) Narcotic and controlled drugs must be stored in accordance with federal regulations.
- (13) A physician who dispenses a drug must have an established policy and procedures for the safe and proper disposal of drugs that are unfit to be dispensed, including outdated or damaged products.
- (14) A physician must not accept the return of any dispensed drug for the purpose of re-use.

14 Non-Treating Medical Examinations

- (1) When accepting a request to perform a Non-Treating Medical Examination (hereafter referred to as “NTME”) request, physicians must be aware of the terms of authority set out in the contract, statute or Rules of Court.
- (2) When agreeing to undertake a NTME, a physician must disclose to all parties:
 - (a) His or her involvement at any time in the medical care of the person undergoing the examination.
 - (b) any relationship with the third party outside of a fee for service arrangement.
- (3) In advance of the examination, a physician must discuss the fee for the NTME with the party requesting the examination.
- (4) A physician must maintain an independent and objective perspective when undertaking a NTME.
- (5) A physician must not be an advocate for either the person undergoing the NTME or the third party requesting the NTME
- (6) The physician undertaking the NTME must obtain fully informed consent from the person for the examination, diagnostic interventions and release of the physician’s report. The consent process must:
 - (a) inform the person that consent may be withdrawn at any time prior to completion of the examination and reporting.
 - (b) explain the physician’s responsibility to report to the third party and that the report may contain information that is not in the person’s best interests.
 - (c) declare the physician’s qualifications, including training and credentials.
 - (d) explain that the NTME is occurring at the request of a third party and identify that person or agency.
 - (e) advise the person undergoing the examination that the report is the property of the third party, from which the person may request a copy of the report.
- (7) A physician is not required to obtain informed consent if a person has been ordered by a court order or statutory direction to undergo a NTME; however, the physician must not:

- (a) enforce the terms of a court order or statutory direction, or
 - (b) proceed with an NTME if the person refuses to cooperate with the physician undertaking the NTME.
- (8) A physician must not establish a therapeutic relationship with the person being examined unless:
- (a) there is no other physician readily available to provide those services, and
 - (b) then, only after concluding the process with the third party.
- (9) If a patient requires urgent intervention, the physician must make arrangements for follow-up through another physician who can treat the patient. If no other physician is available or there is no known treating physician, the physician must:
- (a) promptly advise the patient of the particulars of the medical issue that requires urgent attention.
 - (b) provide necessary care if the situation is emergent or urgent and no alternative is available.
- (10) The physician must retain the following records obtained or created for the NTME for a period of ten (10) years:
- (a) the final report and any interim reports issued to the third party,
 - (b) informed consent document,
 - (c) contract (if it exists in written form) outlining scope, purpose, timeliness, and fee arrangements,
 - (d) notes of history,
 - (e) notes of physical examination,
 - (f) audio and video recording if made by the physician,
 - (g) a list of sources of ancillary information, including medical reports, records, and any audio or visual information recorded by another person, and
 - (h) the name of any person who attended with the person being examined.

15 Managing Patients with Chronic Non-Malignant Pain

- (1) In managing a patient with chronic non-malignant pain (hereafter referred to as “CNMP”), a physician must take a complete pain history and conduct a physical examination, including assessment of physical function and evaluation of disability. In evaluating a patient with CNMP, the physician must:
 - (a) assess the patient for the possibility of:
 - (i) co-existent depression,
 - (ii) sleep disorder,
 - (iii) personality disorder,
 - (iv) poorly developed coping skills,
 - (v) substance abuse potential, and
 - (vi) level of social function.
 - (b) obtain all relevant documentation concerning prior investigations and consultations.
 - (c) establish the underlying medical diagnosis causing the pain and determine if the pain symptoms are commensurate with the diagnosis.
- (2) If a physician determines that a patient may benefit from opioid medication to manage CNMP pain, the physician must consider any new start of an opioid as a trial of medication.
- (3) If a physician determines that a patient with CNMP derives therapeutic benefit from opioid medication, the physician must:
 - (a) discuss mutual expectations for continuing a course of treatment involving opioids;
 - (b) discuss a plan with the patient for handling disagreements in regard to prescribing;
 - (c) take all possible precautions to prevent loss or alteration or other misuse of prescriptions;
 - (d) titrate the dose of opioids in small increments;
 - (e) require frequent follow-up and monitoring of the effects of the drugs;
 - (f) establish which physician or physicians will prescribe opioids to the patient;

- (g) use long-acting (every eight hour or every twelve hour dosing) opioid preparations in preference to short-acting preparations upon establishing a stable dosage of opioid;
 - (h) inquire and monitor for evidence of apparent drug abuse-related behaviors;
 - (i) avoid the daily use of intramuscular injections of opioids unless there are clear contraindications to the use of oral or transdermal routes for administration;
 - (j) establish an agreement between the patient and the physician that clearly delineates that there is to be:
 - (i) no unsanctioned dose escalation,
 - (ii) no selling or sharing of opioids,
 - (iii) no injecting of opioids,
 - (iv) no seeking of opioids from another physician, and
 - (v) no hoarding of opioids, and
 - (vi) willingness to consent to urine and blood testing to confirm compliance with treatment instructions; and
 - (k) ensure that the therapeutic agreement defines consequences of violation, such as a non-negotiable end to the prescribing relationship between the physician and the patient.
- (4) A physician who prescribes opioids to a patient for CNMP must assess the patient at least every eight (8) weeks once treatment has been stabilized.
- (5) A physician who prescribes opioids must ensure that the opioid is dispensed in quantities and at intervals that are appropriate for the safety of the patient in the particular circumstances.

Practice Management

16 Advertising by Physicians

- (1) In this section “advertisement” means any communication made orally, in print or through electronic media by or on behalf of a physician, to the public in general or to one or more individuals, that has as its substantial purpose the promotion of the physician or a clinic or group with which the physician is associated.
- (2) Any advertisement must conform to the relevant provisions of the Canadian Medical Association *Code of Ethics*.

- (3) An advertisement must not:
 - (a) misrepresent fact;
 - (b) compare directly, indirectly or by innuendo, the physician's services or ability with that of any other physician, facility, clinic or group or promise or offer more effective services or better results than those available from another physician.
 - (c) deprecate another physician, facility, clinic or group as to service, ability, result or fees;
 - (d) create an unjustified or unreasonable expectation about the result the physician can achieve;
 - (e) be made under any false or misleading guise or take physical, emotional or financial advantage of any patient, or use coercion, duress or harassment;
 - (f) be undignified, in bad taste or otherwise offensive so as to be incompatible with the best interests of the public or tend to harm the standing or reputation of the medical profession generally; or
 - (g) disclose the name or identifying features of a patient unless the patient's prior consent has been obtained; but any inducement or benefit given to the patient must be disclosed in the advertisement.
- (4) A physician must not use the term "surgeon" alone or in combination with other descriptors, unless the physician:
 - (a) is recognized as a surgical specialist or equivalent by the Council; or
 - (b) is entitled by the Department of National Defense to use the term surgeon; or
 - (c) uses the term in a manner that, in the opinion of the Registrar, does not falsely suggest to the public that the physician is a surgical specialist.
- (5) A physician must only use a term, title, or designation indicating or implying specialization in an area or branch of medicine if that practitioner is recognized by the Council as a specialist in that area or branch of medicine.
- (6) A physician may indicate an area of "special interest" only if approved by the Registrar after application and submitting documentation regarding training,

experience and interest, and submit a formal request for approval of the “special interest”.

- (7) A physician must not seek referral of a person to a service or product offered by the physician, whether or not it is medically necessary, by offering an inducement to a patient or any other person.
- (8) A physician must not provide any service or product to a patient, whether or not it is medically necessary, by offering, directly or indirectly, an inducement to the patient.
- (9) Prohibited inducements within section (8) include, but are not limited to, offering or providing:
 - (a) time-limited prices for a product or service,
 - (b) discount coupons or gift certificates for a product or service,
 - (c) prizes of a product or service,
 - (d) gifts of a product or service, or
 - (e) promotional gifts or other benefits for attendance of informational sessions about medical services not insured by the Alberta Health Care Insurance Plan.
- (10) Notwithstanding the section (9), a physician 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, or
 - (c) provide free consultations for the purpose of informing and assessing the eligibility of a patient for an uninsured product or service.

17 Reprocessing of Medical Equipment

- (1) A physician who uses reprocessed medical instruments in a non-hospital setting must ensure that procedures for the cleaning, disinfecting and sterilizing of those instruments comply with the manufacturers’ recommendations and with such standards as approved by the College.

18 Charging for Uninsured Services

- (1) A physician must provide care as clinically required in all cases that are not purely elective or where no other physician is reasonably available, despite the fact that collection of a fee may never be possible.
- (2) A physician must inform a patient or third party of any fee to be charged before the provision of an uninsured medical service.
- (3) A physician's agent may give preliminary information to a patient about the billing policies in that practice, but the physician remains responsible for the final decision and explanation to the patient when the patient disputes a fee or requests clarification.
- (4) A general notice to patients in a physician's office is not sufficient by itself to fulfill the requirements in sections (2) and (3).
- (5) A physician may not demand payment in advance of urgently required uninsured services that are not readily available elsewhere.
- (6) A physician must not make acceptance or continuation of care of a patient conditional on the patient agreeing to pay an annual administrative fee.
- (7) A physician must not charge a fee in advance for "being available" to render services.

19 Practice in Association

- (1) In this section "practice in association" means a professional relationship between a physician and a non-physician health professional who is not an employee of the physician in which any of the following applies:
 - (a) joint advertising,
 - (b) joint office phone number,
 - (c) joint billing for professional services, or
 - (d) joint office reception area.
- (2) Practice in association does not include:
 - (a) the release of copies of medical records to any person at the request and with the consent of the patient, or

- (b) consultation between a physician and another health professional.
- (3) A physician must not enter into a practice in association with any person who is not a health professional regulated under the Health Professions Act.
- (4) A physician must, before entering into and while engaged in practice in association, be certain that the qualifications, professional standing, and scope of practice of the associated health professional are acceptable to the health professional's own college.
- (5) A physician must ensure that the qualifications or professional designation of each health professional practicing in association with the physician are clearly set out for any patient or member of the public coming to the clinic or office.
- (6) All records maintained for professional services provided to a patient by a physician must be identifiable and separable from the entries of other health professionals that practice in association with the physician.
- (7) Any referral by a physician to an associated health professional and any resulting opinion or provision of health care must be:
 - (a) in written form, and
 - (b) maintained on the patient's medical record by the physician.
- (8) A referral by a physician to an associated health professional must only occur when there is a reasonable expectation of a health benefit to the patient arising from such referral.
- (9) A physician must not enter into a legal partnership arrangement with a health professional although it is permissible to enter into a contractual arrangement for cost-sharing of office or clinic expenses.

20 Direction and Control of a Medical Practice

- (1) In this section, the "practice of medicine" includes, but is not limited to:
 - (a) the care provided for or to a patient, including advice on the use of any substance or treatment, and assessment, diagnosis, treatment, and referral of the patient,
 - (b) the safety and quality of equipment used,

- (c) the creation, access to and security of medical records, including charting of medical care to a patient, patient appointment schedules, patient billing and payment records prepared for the medical care of a patient,
 - (d) compliance with all applicable laws regarding personal information,
 - (e) advertising for the practice of medicine,
 - (f) billing for the practice of medicine, and
 - (g) responsibility for the qualifications and performance of staff supervised by the physician.
- (2) The practice of medicine does not include ownership of any supplies, equipment or premises used by the physician for the practice of medicine.
 - (3) At least one physician must maintain full direction and control over the practice of medicine in any location outside of a hospital or facility operated by a health authority or a provincial or federal government.
 - (4) A physician must not practise medicine in a location or facility in which a non-physician holds any legal or beneficial interest, directly or indirectly, in that practice of medicine.

21 Closing, Leaving, or Moving a Medical Practice

- (1) A physician must notify the College in advance when the physician plans to close, leave or move a clinical medical practice in Alberta.
- (2) A physician must provide the College with:
 - (h) information describing how the transfer of patient care is being managed,
 - (i) information on the location and disposition of patient records and how the patient records may be accessed.
 - (j) a forwarding mailing address and contact information for the physician, and
 - (k) all unused triplicate prescription forms in the possession of the physician if ceasing clinical medical practice in Alberta.
- (3) A physician who closes or leaves a clinical medical practice is responsible for the secure storage and disposition of the patient records from that practice.

- (4) A physician must provide a minimum of ninety (90) days notice of the practice closure or move to patients with whom there is an expectation on ongoing care.
- (5) Section (4) does not apply to a physician if the reason for leaving practice is illness or other urgent circumstances.
- (6) A physician, who is practicing in the location where another physician had previously practiced, must provide information to any member of the public about the new location of the physician who has moved, if it is known.

22 Telemedicine

- (1) In this section, “telemedicine” means the provision of medical diagnosis and patient care by means of electronic communication where 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 physician must not practise telemedicine in Alberta from a location outside of Alberta unless he or she is currently registered with the College.
- (3) Notwithstanding (2), a physician is not required to register with the College if:
 - (a) the consultation is for emergency assessment or treatment of a patient, or
 - (b) the physician provides telemedicine consultations in Alberta less than six times per year, or
 - (c) the physician is consulting with a physician registered in Alberta who is working on behalf of the patient.
- (4) A physician registered in Alberta who provides a medical opinion or treatment by electronic or other means to a patient located outside of Alberta must conform to any licensing or registration requirements of the jurisdiction where the patient is located.
- (5) A physician must not issue a prescription, by way of electronic or other means, unless the physician has:
 - (a) obtained a history and conducted a physical examination of the patient adequate to establish a diagnosis and identify underlying conditions, and
 - (b) there are no contraindications to the treatment recommended or provided.

- (6) Section (2) does not apply in the following situations;
 - (a) treatment in an emergency;
 - (b) treatment provided in consultation with another physician who has an ongoing relationship with the patient and who has agreed to supervise the patient's treatment, including use of any prescribed medication; or
 - (c) on-call or cross-coverage situations in which the physician has access to patient records.

23 Patient Records

- (1) In the course of providing medical advice or treatment to a patient, a physician must document and retain a record of such advice and treatment in a unified record for the patient.
- (2) A patient record must be legible, in ink or in electronic format, must be accessible, and must be in English.
- (3) In this section, "patient record" includes the record of information described in section (4) and (5).
- (4) A patient record must contain enough information for another physician to be sufficiently informed of the care being provided, and must include at a minimum:
 - (a) clinical notes,
 - (b) laboratory and imaging reports,
 - (c) pathology reports,
 - (d) consultation reports,
 - (e) hospital summaries, and
 - (f) surgical notes.
- (5) In addition to section (4), a patient record in a primary care practice must contain or provide reference to the following information, at a minimum:
 - (a) the patient's name and address,

- (b) dates seen and the identity of the physician attending the patient on those dates,
- (c) documentation of presenting complaints and functional inquiry,
- (d) significant prior history,
- (e) current medications, allergies and drug sensitivity,
- (f) relevant social history including alcohol or drug use or abuse,
- (g) relevant family history,
- (h) findings on physical examination, including relevant abnormalities or their absence,
- (i) diagnoses (tentative, differential or established),
- (j) treatment advised and provided, including medication prescribed,
- (k) when a prescription is issued:
 - (i) the name of the medication,
 - (ii) the dose of medication to be taken at each administration,
 - (iii) the frequency of administration,
 - (iv) the duration of the period for which the patient is to take the medication, and
 - (v) whether or not refills have been issued.
- (l) investigations ordered and results obtained,
- (m) instructions, precautions and advice to the patient, including for follow-up,
- (n) responses of the patient to the advice given, if refused,
- (o) letters of referral,
- (p) reports received or sent in regard to the patient's medical care.

- (6) In the case of telephone consultation between two physicians with respect to a specific patient, the referring physician must document a summary of the consultation on the patient record, and the consultant must document such information as is necessary to validate that the consultation occurred.
- (7) A physician must keep an accounting record showing the date the service was rendered, the type of service, and the charge made.
- (8) A physician must keep a diary of appointments showing for each day the names of patients who received professional services.
- (9) A physician must ensure that a patient's record is kept in a manner so as to ensure security against loss or destruction and to prevent unauthorized disclosure.
- (10) A physician must ensure that a patient record is accessible for a minimum of ten (10) years following the date of last service or, in the case of minors – for ten (10) years, or until two (2) years past the age of majority – whichever is longer.
- (11) A physician must not store identifiable patient information on a mobile electronic device without ensuring patient records are secure and cannot be accessed by an unauthorized person.
- (12) While physicians own patients' records, the patients own the information in their records; on the request of a patient, the physician must
 - (a) allow the patient to inspect the patient record, and
 - (b) provide the patient a copy of the patient record
- (13) A physician may charge a fee as permitted in legislation for a patient's request for access to or a copy of his or her record.
- (14) Physicians in group practice must determine the ownership of patient records within that practice so that:
 - (a) if a physician or physicians leave the practice, ownership of the patients' records will be clear to all parties and to the patients of the departing and remaining physicians, and
 - (b) departing physicians and their patients have reasonable access to the patient records.

- (15) Where a physician works as an occupational health physician for a company or a facility owned by the federal or provincial government, the physician is not required to be the owner of the patient record.
- (16) A physician who works in a practice described in section (15) is expected to fulfill all obligations respecting the completion of patient records, the maintenance of security of patient records and the confidentiality of the information contained in the patient records even though the physician does not own the patient record.
- (17) When a patient record is altered after the fact to correct an error, the original entry must be identifiable and the identity of the altering person and the date of the alteration must be identifiable.

24 Preventing Follow-up Failures

- (1) A physician who orders a diagnostic test or makes a referral to another health professional must:
 - (c) have a system in place for review of test results or consultations and arrangements for follow-up when necessary,
 - (d) have a system in place to contact the patient when follow-up is necessary,
 - (e) document all contacts and attempts to contact the patient, and
 - (f) make arrangements for responding to “critical” diagnostic test results reported by a laboratory or imaging facility for urgent attention after regular working hours or in the absence of the ordering physician.
- (2) A physician must not copy the results of a diagnostic test to another physician for follow-up unless that physician has been notified and has agreed to accept the responsibility for follow-up of the patient.

Ethics, Integrity and Professionalism

25 Informed Consent

- (1) A physician must obtain informed consent for the examination or treatment of a patient or disclosure of a patient's personal health information, except where permitted by law to act without consent.
- (2) A physician must determine a patient's capacity to give informed consent in accordance with the standards of the College.
- (3) A physician who obtains consent from a substitute decision maker on behalf of a patient must comply with applicable laws.
- (4) A physician must respect the right of a patient to withdraw consent at any time.
- (5) In obtaining informed consent, a physician shall discuss, at a minimum:
 - (a) The exact nature and the anticipated benefits of the proposed examination, treatment or release of personal health information;
 - (b) Alternative examinations or treatments available;
 - (c) The natural history of the medical condition at issue;
 - (d) Consequences of not undertaking the examination or treatment or disclosing personal health information;
 - (e) The common and significant risks of the examination or treatment or disclosure and alternatives;
 - (f) Serious risks, even if unlikely;
 - (g) Special risks which although uncommon may have particular relevance to the patient; and
 - (h) Any questions the patient or the substitute decision-maker may have.
- (6) A physician who obtains consent from a patient for participation in research must also comply with direction and advice from a research ethics board acceptable to the College.

26 Withdrawal or Withholding of Services

- (1) A physician must not withdraw services with the direct or indirect purpose of supporting job action for personal economic gain if such actions could put patients at risk.

27 Conflict of Interest

- (1) A physician must not offer or cause any inducement to be offered or received by any person, including a patient of the physician, in return for:
 - (a) the referral of another person to the physician or a clinic or group with which the physician is associated, whether or not the referral is medically appropriate, or
 - (b) the provision of any service or product, whether or not the provision of the service or product is medically appropriate.
- (2) A physician must not refer a patient to a facility or healthcare business operated separate and apart from the physician's office practice if the physician has a direct or indirect interest in that facility or health care business, unless:
 - (a) the physician directly provides the care or service, or Council has approved an exemption to the physician and the physician is acting within the terms and conditions established by the Council,
 - (b) the care or service has been approved by Council to be provided at that facility, and
 - (c) the facility has the appropriate accreditation from the College.
- (3) A physician must not have a direct or indirect interest in a health care business to which the physician refers a patient or to which a patient may be expected to attend due to geographic proximity or necessity, unless permitted by Council.
- (4) If Council has granted permission to a physician in section (3), the physician must satisfy the following conditions:
 - (a) the terms on which the interest is offered to the physician must not be related to the past or expected volume of referrals of patients or other business from the physician to that facility,

- (b) there must be no requirement that the physician make referrals to the facility or otherwise generate professional business as a condition for investment or remaining as an investor, and
 - (c) the financial return for the physician must be directly attributable to the physician's proportionate financial interest in the facility rather than to the volume of referrals made by that physician.
- (5) A physician 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 physician or person other than for services provided by a partner, associate, employee or locum of the physician.
- (6) For the purposes of section (5), a benefit includes, but is not limited to:
- (a) any financial advantage, and
 - (b) any good or service sought or received by the physician.
- (7) If a conflict of interest is unavoidable by a physician, or if Council has given permission for the physician to remain in a conflict of interest, the physician must:
- (a) make full, frank and timely disclosure of the conflict of interest to the patient, and
 - (b) obtain the informed consent of the patient before providing any medical advice or treatment to the patient.
- (8) The consent of a patient to permit the physician to remain in a conflict of interest does not allow the physician to act in any manner other than in the best interests of the patient.

28 Sale of Products by Physicians

- (1) For the purpose of sections (2) and (3), products include, but are not limited to, any product, device or appliance offered for the diagnosis, cure, alleviation or prevention of disease, disorders or injuries in a patient.
- (2) If a physician offers products, other than prescription drugs, for sale to a patient, the physician must not sell the product at a price in excess of the fair market price paid by the physician plus a reasonable handling cost.
- (3) If a physician offers products for sale to a patient, the physician must, at a minimum, create and maintain records detailing the following:

- (a) the actual cost of the product to the physician, including any rebate or price reduction provided to the physician,
- (b) the name of the manufacturer and the supplier of the product,
- (c) the date the product was supplied to the physician,
- (d) the expiry date of the product, if any, and
- (e) any additional costs incurred by the physician, including any formula or calculation used by the physician to determine the additional cost added to the price of the product charged to the patient.

29 Disclosure of Harm

- (1) When a patient suffers harm, the responsible physician must disclose that information to the patient.
- (2) If the responsible physician is unable to inform the patient, the physician may instruct another physician or regulated health professional to provide the information to the patient.
- (3) Disclosure must occur whether or not the harm is a result of progression of disease, a complication of care or an adverse event and whether or not the harm was preventable.

30 After-Hours Access to Care

- (1) A physician must ensure that care is continuously available to the patients in his or her practice.
- (2) When a physician is unavailable, the physician must make specific arrangements with another physician or physicians or with an appropriate coverage service with which the physician has an agreement.
- (3) A physician must make information available to the physician's patients about the arrangements in place for after-hours coverage of the physician's practice.
- (4) If requested by the College, a physician must demonstrate the existence of an agreement described in section (2).
- (5) It is not acceptable for a physician's answering service to direct patients to attend an emergency room or other episodic care facility unless the physician

has a formal agreement with the specific facility or with a physician working in that facility.

- (6) Notwithstanding section (5), a patient with an emergent or life-threatening condition must be immediately referred to an emergency department if a physician is unable to render care.

31 Self Reporting to the College

- (1) A physician must report the following personal circumstances to the College at the time of registration or whenever the physician becomes aware thereafter:
 - (a) any transmissible blood-borne infection
 - (b) serious health issues that could impair the physician's ability to care safely for a patient including, but not limited to:
 - (i) chemical abuse or dependency, and
 - (ii) medical conditions that could impair the physician's judgment or cognition.
 - (c) a sexual or inappropriate personal relationship between the physician and a patient.
 - (d) any loss or restriction of diagnostic or treatment privileges granted by an administrative authority or any resignation in lieu of further administrative action.
- (2) A physician who has a diminished ability to provide safe and competent medical care must adhere to practice restrictions imposed by the College, to the satisfaction of the College, or withdraw from practice.

32 Duty to Report a Colleague

- (1) A physician must report another physician to the College, when the first physician believes, on reasonable grounds, that the conduct of the other physician could place patients at risk or could generally be considered unprofessional conduct.
- (2) Knowledge of physician conduct that should be reported in Section (1) includes, but is not limited to, situations in which a physician:
 - (a) makes sexual advances to or enters into a sexual relationship with a patient.
 - (b) suffers from a chemical dependency or abuse that may be evident in the workplace;
 - (c) suffers from a medical condition that may affect the physician's ability to care for patients;
 - (d) repeatedly or consistently behaves in a manner that interferes with the delivery of care to patients or the ability of other physicians or health care professionals to provide care to patients; and
 - (e) is not competent in the care of patients.
- (3) When a patient discloses information leading the first physician to believe that another physician may have committed a sexual boundary violation with the patient:
 - (a) the first physician must provide the patient with information about how to file a complaint to the College,
 - (b) if the patient does not wish to file a complaint, the physician must offer to file a third person complaint with the patient's permission,
 - (c) if the patient does not give permission to proceed, then the physician must, at a minimum, document the event indicating that the patient does not wish to report to the College and the physician may report the name of the physician, but not the patient to the College, and
 - (d) the physician 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 could cause serious and imminent mental, physical or emotional harm to the patient.

33 Sexual Boundary Violations

- (1) A physician must maintain professional boundaries in any interaction with a patient and must not sexualize any interaction with a patient through conduct including, but not limited to, the following:
 - (a) providing inadequate draping or privacy while the patient is undressing or dressing,
 - (b) criticism of a patient's sexual orientation or activities,
 - (c) sexualized comments, gestures or tones of voice,
 - (d) requesting details of a sexual history when not clinically appropriate,
 - (e) failing to obtain informed consent for intimate or sensitive examinations,
 - (f) examination of the breasts, genitalia, or anus using unorthodox examination techniques,
 - (g) sexualized body contact including frotteurism, kissing, hugging or fondling,
 - (h) socializing with a patient in the context of developing an intimate relationship, or
 - (i) physician patient sexual contact.
- (2) A physician must not:
 - (a) initiate any form of sexual advance toward a patient or a person with whom the patient has an interdependent relationship.
 - (b) respond sexually to advances made by a patient.
 - (c) terminate a physician-patient relationship in order to pursue a sexual or personal relationship.
 - (d) initiate any form of sexual advance toward a previous patient where there is a risk of "power imbalance" from the previous physician-patient relationship.
- (3) In the absence of risk of a continuing power imbalance, a physician must not have any sexual or intimate involvement with the former patient for six months after the physician and patient encounter.

34 Completing Discharge Summaries

- (1) A physician who discharges a patient from an acute care hospital with the expectation of follow-up care by another physician must:
 - (a) prepare a legible summary of active medical problems and treatment plans at discharge for the other physician before the follow-up appointment is expected to occur, and
 - (b) notify the other physician directly if follow-up care is required within one (1) week.
- (2) Notwithstanding section (1), the physician is not responsible for delays in the transcription and delivery of the discharge summary that are not under his or her control.

35 Relationships with Industry

- (1) For the purposes of this section, “industry” means any manufacturer or distributor of healthcare products, including pharmaceuticals and medical devices.
- (2) A physician must not enter into a relationship with industry if it weakens the fiduciary nature of any physician-patient relationship of that physician..
- (3) A physician must resolve any conflict of interest resulting from interaction with industry in favour of his or her patients.
- (4) A physician must always maintain professional autonomy and independence in any relationship with industry.
- (5) A physician must disclose to a patient any relationship between the physician and industry that reasonably could be perceived as having the potential to influence the physician’s clinical judgment.
- (6) When a physician participates in industry sponsored research activities the physician must:
 - (a) only participate in research activities that are ethically defensible, socially responsible and scientifically valid,
 - (b) only participate in research activities that have been formally reviewed and approved by an appropriate ethics review body,

- (c) enroll patients in research activities only after full, informed, competent and voluntary consent of the patient,
 - (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 physician will receive a fee for participation and the source of that fee,
 - (g) when submitting and/or publishing information in any media, disclose any relationships with industry providing funding or other consideration for the research performed or the publication submitted,
 - (h) avoid entering into agreements that limit the physician's right to publish or disclose results of the study or report adverse events which occur during the course of the study, and
 - (i) only participate in industry sponsored surveillance studies that are scientifically valid and expected to contribute substantially to knowledge about the drug or device.
- (7) A physician involved in organizing or presenting at a continuing professional development event must:
- (a) disclose to participants any financial relationship with industry for products mentioned at the event or with manufacturers of competing products.
 - (b) not conduct a seminar or similar event directly or indirectly for industry that promotes a product for the purpose of enhancing the sale of that product, and
 - (c) not accept reimbursement for expenses or honoraria at a rate that could reasonably be perceived as having undue influence.
- (8) A physician must not claim authorship or contribution to the production of educational materials unless the physician has substantially contributed to the material.
- (9) A physician must ensure that all industry contributions are declared on educational materials.

- (10) A physician attending a continuing professional development event must not accept reimbursement for expenses from industry.
- (11) When considering the use of clinical evaluation packages, such as samples of medications or devices, a physician must:
 - (a) recognize the influence on the physician'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.
- (12) A physician must not accept any personal gift of any monetary or other value from industry.
- (13) Notwithstanding section 12.0, a physician may accept teaching aids provided by industry.
- (14) A physician must not accept a fee or other consideration from industry in exchange for seeing an industry representative in a promotional or similar capacity.