



ESTABLISHING PRACTICE



A guide for physicians and surgeons

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NOTE: As this is a general information package, some of the information contained in this package may not pertain to your specific practice specialty.

Disclaimer: This information is intended to serve as a user-friendly information guide only. It is not intended to replace the bylaws, policies and guidelines of the College of Physicians and Surgeons of Saskatchewan. Please visit the College's website at www.cps.sk.ca for complete, up-to-date copies of the bylaws, policies and guidelines.

Introduction

There are many things to plan for when establishing a new practice, joining an existing one, or returning to practice after an absence or disability, inactive practice, or change in scope of practice. There are licences to acquire, facilities to be chosen, agreements to be signed, announcements to be made, and a multitude of other associated tasks to complete.

In addition to this, a physician must also consider how he or she will **transfer records** safely, establish healthy **patient-physician relationships**, and **advertise available services** in a professional and ethical manner. A physician should also consider what arrangements would be made to ensure **continuity of care** should the practice cease to be active or in the case of irresolvable patient-physician and/or physician-physician differences.

This guide will provide you with a general framework to help ensure a smooth transition towards your new practice.

Advertising Physician or Specialist Services

When setting up a new practice, you will likely want to advertise your new location and the services you wish to offer. Be aware that the College has regulations concerning the content that is allowed, where you may advertise, the type of signage that is allowed, and other provisions as well.

The College has established *Bylaw 25 – Advertising* (see **Appendix C**) to help you ensure this is done in such a way as to respect the profession's Code of Ethics.

Speaking with the Media

While physicians may respond to requests for interviews of a general nature to educate the public, it is not permitted to do so to advertise your services. See **Appendix C** for more details.

Establishing Patient-Physician Relationships

The patient-physician relationship is a unique relationship based on trust, honesty, respect and a mutual desire to improve health outcomes. There must be a mutual and collaborative understanding of the patient's needs and expectations, and the physician's capacity to respond. Relationships based on openness, trust and good communication will enable the physician, in partnership with the patient, to address the patient's individual needs. It is necessary for the physician in the patient-physician

relationship to be honest, considerate and polite, and treat patients with dignity and as individuals. It is also important to respect patient's privacy and right to confidentiality, to support patients in caring for themselves to improve and maintain their health, and to encourage patients who have knowledge about their condition to use this when making decisions about their care. It is equally necessary for the patient to be honest and open in providing pertinent communication to enhance the value of the interaction.

The patient should be mindful of the advice or treatment recommendations provided by the physician. The patient/guardian is ultimately responsible for selection of the preferred option for medical care and follow-through. If possible, they should strive to incorporate physician advice and recommendations into the patients' health and lifestyle situations.

Meeting a Patient for the First Time

When the physician is meeting a patient for the first time, the physician should identify the patient's needs and expectations, disclose to the patient information about their area of knowledge, skills, limitations of practice and mode of after-hours operation, and determine whether the terms of the relationship (partnership) are mutually acceptable. The physician must be mindful of human rights issues. The Canadian Medical Association Code of Ethics says:

17. *In providing medical service, do not discriminate against any patient on such grounds as age, gender, married status, medical condition, national or ethnic origin, physical or mental disability, political affiliation, race, religion, sexual orientation, or socioeconomic status. This does not abrogate the physician's right to refuse to accept patients for legitimate reasons.*
18. *Provide whatever appropriate assistance you can to any person with an urgent need for medical care.*
19. *Having accepted professional responsibility for a patient, continue to provide services until they are no longer required or wanted, until another suitable physician has assumed responsibility for the patient, or until the patient has been given adequate notice that you intend to terminate the relationship.*

The first contact with a new patient may occur at a visit which some refer to as a **meet-and-greet visit**. **The meet-and-greet is not an insured service and** the physician may use this visit to identify the patient's needs and expectations, and disclose information about their knowledge, skills, and limitations of practice, along with the organization of their practice, such as the mode of after-hours operation. ***The visit should not be used to review the medical history of the patient or otherwise provide medical services and*** it is essential that physicians pay attention to the Code of Ethics, especially Section 17, in order not to be challenged on the basis of human rights if they decline to accept a patient to their practice.

The Office Visit

Effective communication between patients (or their patient advocate) and physicians is essential to the ideal delivery of care. The goals of communication are to exchange information, to develop a common understanding and build trust, and to reach a mutually satisfying decision.

The physician's obligation with respect to communication with a patient is to:

1. Commit full attention to the patient;
2. Create an environment that preserves the patient's dignity;
3. Foster candor in the disclosure of confidential, intimate information;
4. Convey genuine concerns for the patient's wellbeing; and
5. Respect the role of the patient advocate and/or caregiver.

The patient's obligation with respect to communication with the physician is to ensure that they are open and provide pertinent information. In advance, it is sometimes helpful if the patient:

1. Prepares a list of questions and concerns they wish the physician to address;
2. Makes the physician aware of these questions and concerns at the beginning of the visit;
3. Shares their medical histories as completely and accurately as possible;
4. Clearly designates a patient advocate or caregiver and defines their role in the care process; and
5. Establishes a single point of contact for providing information to family members.

Improving patient-physician communication should improve patient adherence to recommended therapies, improved patient self-care, and improved comprehension of the information given by the physician, increased patient satisfaction, and increased physician satisfaction.

It is important for physicians to retain control over their scheduling and timeliness in offering appointments to patients. Physicians should continually evaluate their scheduling systems for effectiveness. Office visits should be used as an opportunity to assess illnesses/ medical conditions, review care plans, pharmacological therapies, potential drug-to-drug interactions, or review any new medications added by additional caregivers. It is appropriate for a patient to be able to provide the list of problems for which they are seeking assistance, and for the physician and patient to go through the list and determine what requires urgent attention and what can be deferred to another appointment.

Ending a Patient-Physician Relationship

Occasionally there will be some patient-physician relationships that for one reason or another do not work. Either party may decide to terminate the relationship. A physician may ethically decide not to continue to see a patient, as long as there are valid reasons and the patient is not in immediate need of medical care. Regardless of the reasons for discontinuing a patient-physician relationship, it is important for physicians to understand that in an emergency situation the physician must provide

emergency care if no other suitable physician is available unless there is real and imminent threat of harm or violence to the physician, clinic staff or others present.

The patient-physician relationship encountered most frequently will be that of a patient to their primary care provider. When the care provider is a specialist, consulted to provide specific care, the guideline remains pertinent until such time as the specialist has appropriately discharged the patient in writing back to the care of the primary care provider. In circumstances where a specialist decides to terminate a patient-physician relationship prior to the condition specific discharge criteria being met, then the specialist remains responsible for the management until he/she transfers care to an accepting specialist of the same specialty or back to the care of the primary provider for referral to another specialist.

When **ending a patient-physician relationship**, the College recommends the following:

1. The decision to end the relationship should be clearly communicated to the patient. The initial decision may be communicated verbally if appropriate. A follow-up letter sent by registered mail is recommended. Be as compassionate and supportive as possible. State the reason(s) for the decision. Document any discussion and place a copy of the letter in the patient's file.
2. Give the patient a "reasonable" period (minimum of one month, unless there is a real and imminent threat of harm or violence to the physician, clinic staff or others present) of time to find another physician. This will obviously vary according to location and circumstances.
3. State that you will give or arrange for care until that date, and that you will respond to a request for care in an emergency situation. If ongoing care is needed, ensure that the patient is aware of this.
4. Be helpful to the patient in finding a new physician and transferring records (see guideline on *Transfer of Patient Records*) and ensure that there are appropriate arrangements in place to ensure that there is follow up of outstanding investigations and consultations.

A physician must not discharge a patient:

1. Based on a prohibited ground of discrimination including age, gender, marital status, medical condition, national or ethnic origin, physical or mental disability, political affiliation, race, religion, sexual orientation, or economic status.
2. Because a patient makes poor lifestyle choices (such as smoking).
3. Because a patient fails to keep appointments or pay outstanding fees unless advance notice has been given to the patient and the patient has been provided with the opportunity to address the concerns.
4. Because the patient refuses to follow medical advice unless the patient is repeatedly non-adherent despite reasonable attempts by the physician to address the non-adherence.

5. Because the physician relocates his/her practice to a new location/setting to which current patients could be reasonable expected to follow.
6. Because the patient requests access to services that the physician has a conscientious objection to.
7. If discharge significantly hampers access to a physician due to remoteness or lack of local physician resources in the community. For example, only one physician or one clinic in the community.

For a sample patient dismissal letter, with suggested wording, see **Appendix B**.

Ownership, Transfer and Storage of Patient Medical Records

When establishing a practice, you will need to gain access to your new patients' records. In some cases, you may also have records from a previous practice that you will want to bring with you to your new location should these patients choose to follow you.

A guideline has been developed jointly by the SMA and the College to guide physicians in dealing with the transfer of copies of patient records from a physician to their patients. See **Appendix A** for a complete set of guidelines for the *Transfer of Patient Medical Records*.

When leaving or suspending practice, arrangements must be made for the physician/patient records to be stored safely and for patients to have reasonable access to copies of their records.

Health Information Protection Act (HIPA)

The Health Information Protection Act provides protection for privacy of personal health information by legislating the right to access and the care of personal health information. Persons or organizations who have custody or control of personal health information must abide by these rules. HIPA applies to both paper and electronic records.

For more information: <http://www.health.gov.sk.ca/hipa>

Ownership of Patient Records

When establishing a practice, it is the physician's responsibility to ensure that provisions are made to determine the ownership of the paper and electronic

The College of Physicians and Surgeons of Saskatchewan MUST be notified of the location of the records and how they can be accessed by patients and/or other healthcare professionals with the patient's consent.

medical records that will be created or have been acquired. This can be done through a signed mutual agreement.

For more information on who can have ownership of records, consult the *Guidelines on Transferring Patient Records* (See Appendix A).

Out-Sourcing Storage of Patient Records

Physicians wishing to out-source the storage of patient records to a storage facility need to be aware of the following advisory from the [Saskatchewan Information and Privacy Commission](#) :

Advisory to Saskatchewan Physicians and Patients regarding outsourcing storage of patient records, March 10, 2010

<http://www.oipc.sk.ca/What's%20New/Advisory%20to%20Saskatchewan%20Physicians%20and%20Patients%20regarding%20%20outsourcing%20storage%20of%20patient%20records,%20March%2010,%202010.pdf>

Leaving Practice & Continuity of Care

The College of Physicians and Surgeons of Saskatchewan has developed a guide entitled *Leaving Practice: A guide for physicians and surgeons* to assist physicians in ensuring continuity of care and arranging for appropriate transfer of medical files when leaving practice. This guide is available on the College website at www.cps.sk.ca, by contacting the College at (306) 244-7355 or by e-mail at cpssinfo@cps.sk.ca.

Checklist for Establishing a Practice in Saskatchewan

TASK	Action	Complete By	✓
Licensing			
<i>Read Bylaw 4.1(Appendix D)</i>			
Advertising			
<i>Read Bylaw 25 (Appendix C)</i>			
Transfer of Patient Records			
<i>Read Guideline for Transfer of Patient Records (Appendix A)</i>			
Continuity of Care			
Ownership of Records			
<i>Read Guideline for Transfer of Patient Records (Appendix A)</i>			

Appendix A – Guideline for Transfer of Patient Records

GUIDELINE: PROVISION OF PATIENT RECORDS TO PATIENTS

PREAMBLE

This guideline has been developed jointly by the Saskatchewan Medical Association (the SMA) and the College of Physicians and Surgeons (The College) to guide physicians in dealing with the transfer of copies of patient records from a physician to their patients.

Patient medical records belong to the physician and not to the patient. Physicians have a responsibility to ensure that the record is secured and maintained accurately, and that information is not altered. The patient has a right to access the medical information in the record, and to obtain a copy of documents in the record, but not to obtain the record itself.

Saskatchewan legislation, [The Health Information Protection Act](#) confirms that that patients have a right of access to all of the information in their record unless there is a specific reason which justifies withholding a portion of the information in the record. This right of access includes all information in the record, including reports of consultants and other records.

The obligation to provide information to patients is also an ethical obligation. Paragraph 37 of the [Code of Ethics](#) of the Canadian Medical Association provides as follows:

Upon a patient's request, provide the patient or a third party with a copy of his or her medical record, unless there is a compelling reason to believe that information contained in the record will result in substantial harm to the patient or others.

THE GUIDELINE

1. Patients should never be given original medical records. This could result in loss of the file, removal of relevant portions of the patient file, and an inability for the physician to deal with future complaints, litigation or enquiries;
2. A copy of a requested record should be provided without undue delay;
3. A physician has a right to charge a reasonable fee in relation to photocopying a patient record. If a fee is to be charged, that fee should be fair and represent cost recovery including staff time and overhead costs. The Saskatchewan Medical Association publishes the *SMA Fee Guide (for uninsured services)*, which on pages 4 and 5 of the Introduction and Codes 511A, 512A and 810A on page A2, suggests what the Saskatchewan Medical Association considers to be a fair fee where paper records are to be photocopied;

4. If the patient seeks a copy of an electronic medical record, the physician should assess what will be a reasonable fee for providing the record. In some circumstances it may be possible to provide an electronic copy of the record to a patient at little cost to the physician;
5. It has been customary not to charge a patient for a copy of relevant portions of a patient record if the physician who has control of the record has moved or otherwise required the patient to transfer their care to another physician;
6. The physician should consider the patient's ability to pay when considering whether a fee will be charged and, if a fee will be charged, the amount of that fee;
7. Charging a fee for a copy of a record should never impede the orderly and timely transfer of required information;
8. If a fee is to be charged, and if the record is not immediately required for patient care or for some other pressing reason, it is reasonable for a physician to ask for some assurance of payment before a copy of the requested record is made;
9. [The Health Information Protection Act](#), section 38 sets out circumstances in which a patient may be denied access to all or part of the patient's medical records. The most common situations are:
 - (a) in the physician's opinion the information could reasonably be expected to endanger the mental or physical health or the safety of the patient or another person;
 - (b) disclosing the information would reveal personal health information about another person who has not expressly consented to the disclosure;
 - (c) disclosure of the information could identify a third party who supplied the information in confidence.
10. If a physician withholds all or part of a patient record, the physician must advise the patient that has been done and advise the patient of the patient's right to have the decision reviewed by the Privacy Commissioner ([The Health Information Protection Act](#), section 36).

GUIDELINE: TRANSFER OF PATIENT RECORDS TO THIRD PARTIES

PREAMBLE

This guideline has been developed jointly by the SMA and the College to guide physicians in dealing with the transfer of copies of patient records from a physician to third parties.

Patient medical records belong to the physician, and not to the patient. Physicians have a responsibility to ensure that the record is secured and maintained accurately, and that information is not altered. The

patient has a right to access the medical information in the record, and to obtain a copy of documents in the record, but not to obtain the record itself. That includes a right to authorize other persons to obtain copies of their medical information.

Saskatchewan legislation, [The Health Information Protection Act](#), confirms that patients have a right of access to all of the information in their record, unless there is a specific reason which justifies withholding a portion of the information in the record. This right of access includes all information in the record, including reports of consultants and other records.

The obligation to provide information to patients, or to a third party at the patient's request, is also an ethical obligation. Paragraph 24 of the [Code of Ethics](#) of the Canadian Medical Association provides as follows:

Upon a patient's request, provide the patient or a third party with a copy of his or her medical record, unless there is a compelling reason to believe that information contained in the record will result in substantial harm to the patient or others.

It is critical to ensure that either informed patient consent is obtained to transfer a record to a third party, or that the transfer is authorized by law (see paragraph 22 of the [Code of Ethics](#) of the Canadian Medical Association and section 27 of [The Health Information Protection Act](#)).

THE GUIDELINE

1. Physicians have an obligation to provide copies of patient records to third parties if properly authorized by the patient;
2. Physicians should take appropriate steps to satisfy themselves that, if the request for a copy of a patient record is based upon the patient's request, the patient has given informed consent to the transfer;
3. If the authorization is in writing, and the authorization is dated a substantial time previous to the request, this may include an obligation to ensure that the patient still agrees to the transfer of the copy of the record;
4. If providing the requested information would disclose information that is particularly sensitive to the patient, or information that appears not to be required for the purpose for which the information is to be provided to the third party, the physician may be ethically required to ensure that the patient agrees to the transfer of the record;
5. If the request is made based upon a legal requirement, it is reasonable to expect that the person requesting the information will provide the authorization for the request, (court order, a copy of the legislation, etc.) before the documents are provided;
6. A copy of a requested record should be provided without undue delay;

7. A physician has a right to charge a fee in relation to photocopying or reproducing a patient record. If a fee is to be charged, that fee should be fair and represent cost recovery including staff time and overhead costs. The Saskatchewan Medical Association publishes the *SMA Fee Guide (for uninsured services)*, which on pages 4 and 5 of the Introduction and Codes 511A, 512A and 810A on page A2 suggests what the Saskatchewan Medical Association considers to be a fair fee where paper records are to be photocopied;
8. If the record is not immediately required for patient care or for some other pressing reason, it is reasonable for a physician to ask for some assurance of payment before a copy of the requested record is made;
9. If, in addition to requesting a copy of a patient record, the third party requests an opinion, or wishes to speak to the physician pertaining to the care of the patient, it is reasonable for the physician to charge a reasonable fee for the time involved in discussing care provided to the patient, or in providing an opinion to the third party.

GUIDELINE: TRANSFER OF PATIENT RECORDS BETWEEN PHYSICIANS

PREAMBLE

The College and the SMA are regularly consulted with respect to disputes that arise when a physician leaves a medical practice and establishes a new practice. This guideline has been developed jointly by the SMA and the College to guide physicians in dealing with the transfer of patient records from one physician to another physician.

Saskatchewan legislation, [The Health Information Protection Act](#) confirms that patient medical records belong to the physician and not to the patient. The physician has a responsibility to ensure that the record is secured and maintained accurately and that information is not altered. The patient has a right to access the medical information in the record, and to obtain a copy of documents in the record, but not to obtain the record itself.

There are a number of situations in which a physician may need to access an old medical record. Examples include a billing review by the Joint Medical Professional Review Committee, complaints to the College of Physicians and Surgeons and legal proceedings. It is therefore essential that physicians maintain an ability to access medical records that they have created and assure their security.

While it can be difficult to address some of the situations in which a physician is asked to transfer patient records to another physician, physicians must bear in mind that a primary ethical obligation is to cooperate with other physicians to optimize patient care. Paragraph 52 of the [Code of Ethics](#) of the Canadian Medical Association states:

52. Collaborate with other physicians and health professionals in the care of patients and the functioning and improvement of health services. Treat your colleagues with dignity and as persons worthy of respect.

TRANSFERRING PAPER RECORDS BETWEEN PHYSICIANS

The SMA, the College and CMPA all recommend that the clinic that owns the record should generally keep the original record, only providing a photocopy if requested. This is so for a variety of reasons:

1. The file could be lost in transit;
2. The patient may wish to return to the clinic for care, either on an episodic or permanent basis. The clinic will then need to obtain access to the medical file from the departing physician;
3. If the clinic needs access to the file at some later date, but the patient refuses permission to allow access, the person having control of the file may not be able to allow access;
4. The clinic has no control over the file after it leaves its possession and will have no proof of treatment given to the patient while at the clinic. This could make it very difficult to respond to complaints or court actions.

The SMA and College have concluded that the following principles apply to ownership of paper medical records:

1. Unless there is a specific agreement to the contrary, patient records belong to the owner of the practice where the patient is seen;
2. The same principles of ownership apply if the clinic is not owned by physicians. In the absence of an agreement to the contrary, the patient records associated with such clinics will be owned by the entity that owns the clinic (e.g. district health boards, corporations, etc.);
3. If a departing physician was an employee of the clinic, the physician is usually not entitled to take the records for the patients that he/she will continue to see, unless the clinic agrees to transfer the patient records;
4. A departing physician who was a partner in a medical practice is not generally entitled to take any of the assets of the partnership, including patient records. Usually, the physician leaving will not continue as a partner in the practice. Usually, the partnership will continue as a legal entity with the remaining partners. Usually, the assets of the partnership (including the patient records) will continue to be owned by the partnership. The partners

may agree to allow the departing partner to remove original patient records for patients that he/she will continue to see;

5. Many physicians practice in association. This means that the physicians in the practice will share expenses but will not join together to own the assets of the practice. Not all of these agreements are well-documented and it can be difficult in some circumstances to determine who owns what assets in the absence of a written agreement. When a physician leaves such an association, it can be difficult to determine exactly who is entitled to the patient records. As a general rule, if the patients in the practice are seen by more than one physician, it is likely that those patient records will continue to be owned by the clinic. This would mean that a departing physician does not have a right to take patient records to a new location. If the patients were seen by only one physician, the right of that physician to take the patient records pertaining to those patients will be dependent upon the nature of the relationships within that association. In some circumstances, the right to remove patient records may be determined by prior agreement between the physicians in the clinic.

OUR RECOMMENDATIONS - PAPER RECORDS

The College and the SMA suggest that all medical practices should establish a written policy dealing with ownership of, and control over, medical records of patients who are seen at the clinic. Such a policy will help to avoid disputes and should address the following issues:

1. Who owns patient medical records if a patient is seen by more than one physician in the medical practice;
2. Who owns patient medical records if a patient is seen by only one physician in the medical practice;
3. If a physician who leaves the medical practice seeks a transfer of medical records pertaining to patients of the medical practice what charge, if any, will be made by the medical practice;
4. If copies of some records will be provided at no cost, what records will be so provided.

THE GUIDELINE – PAPER RECORDS

The following principles apply to a request for a transfer from one physician to another physician. There may be unusual circumstances that make the application of these principles impractical, but generally physicians should follow these principles:

1. A medical practice should retain the original records in accordance with the requirements of the College bylaws;

2. Patient files should only be transferred to another physician with the express or implied consent of the patient. It is reasonable to assume that there is implied consent to transfer a patient record to a physician who is leaving a clinic if that physician has been the patient's primary physician, unless there is information that indicates that the patient will not continue to receive treatment from the departing physician. The departing physician who requests information or copies of patient records has an ethical obligation to only request information for patients for whom the physician expects to provide ongoing care. If there is doubt whether there is express or implied consent to the transfer of the patient record, the clinic can require authorization from the patient;
3. A copy of a requested record should be provided without undue delay;
4. It has been customary not to charge a colleague for a copy of relevant portions of a patient record. This is especially so if the physician who has control of the record has moved or otherwise required a patient to transfer their care to another physician;
5. A request for payment from another physician may be justified if there have been repeated requests for transfer of information relating to that patient, if the patient has transferred voluntarily to another physician in the locality, if the request is for a copy of a large portion of a patient file, or if the request requires considerable expenditure of physician or staff time.
6. If a fee is to be charged, that fee should be fair and represent cost recovery including staff time and overhead costs. The Saskatchewan Medical Association publishes the [SMA Guide \(for uninsured services\)](#), which on pages 4 and 5 of the Introduction and Codes 511A, 512A and 810A on page A2 suggests what the Saskatchewan Medical Association considers to be a fair fee;
7. Charging a fee for a copy of a record should never impede the orderly and timely transfer of required information.
8. If a fee is to be charged, and if the record is not immediately required for patient care, it is reasonable for a physician to ask for some assurance of payment before a copy of the requested record is made.

ADDITIONAL COMMON CONSIDERATIONS RELATING TO THIS GUIDELINE

There are some circumstances in which it may be more practical to transfer original patient files, rather than to transfer a copy of patient files to a physician.

If a physician with an established practice moves to another clinic and the departing physician has provided all, or nearly all, of the care to a patient, it may be more practical to transfer the entire file than to leave the file at the existing clinic. If patient care has been shared between the physicians in the clinic, but the patient will be transferring their care to the departing physician, the clinic may want to

provide the patient file to the departing physician to allow that physician to photocopy relevant portions of the record, and return the original.

There are some circumstances where a file will be sent to a hospital or other agency to assist in providing care for the patient at that location, with the file then returned to the clinic. In such circumstances the clinic should:

1. Consider whether patient authorization is required (see above);
2. List the patient files that have been so transferred and make a record when those files are returned;
3. Ensure that the files are transferred by a secure method to prevent loss in transit;
4. If the files are to be transferred temporarily to allow for them to be copied, the medical practice and the departing physician should agree on a date when those files will be returned;
5. If the clinic transfers the files permanently, the medical practice and the departing physician should enter into an agreement that the departing physician will, upon the request of the medical practice, allow the medical practice access to the patient files that were transferred if needed by the medical practice (this could be required to deal with litigation, a fee review by the Joint Medical Professional Review Committee, etc.).

TRANSFERRING ELECTRONIC PATIENT RECORDS BETWEEN PHYSICIANS

Electronic patient records can, in some circumstances, be easily transferred between physicians with little cost or disruption to either the clinic providing the record, or the physician receiving the record.

Physicians should consider whether a request by another physician for copies of patient records can be met by arranging for the transfer of an electronic copy of the patient records.

The following principles apply to a request for a transfer of electronic patient records from one physician to another physician. There may be unusual circumstances that make the application of these principles impractical, but generally physicians should follow these principles:

1. A medical practice that arranges to provide a copy of an electronic patient record to another physician should retain the original records in accordance with the requirements of the College bylaws;
2. Patient files should only be transferred to another physician with the express or implied consent of the patient. It is reasonable to assume that there is implied consent to transfer a patient record to a physician who is leaving a clinic if that physician has been the patient's primary physician, unless there is information that indicates that the patient will not continue to receive treatment from the departing physician. The departing physician who

requests information or copies of patient records has an ethical obligation to only request information for patients for whom the physician expects to provide ongoing care. If there is doubt whether there is express or implied consent to the transfer of the patient record, the clinic can require authorization from the patient;

3. The College interprets section 27(2) of [The Health Information Protection Act](#) to mean that patient consent is not required for a clinic to transfer a copy of electronic patient records to a physician who leaves a clinic and who reasonably expects to provide ongoing care to patients of the clinic. Section 27(2) states:

Disclosure

27(2) A subject individual is deemed to consent to the disclosure of personal health information:

(a) for the purpose for which the information was collected by the trustee or for a purpose that is consistent with that purpose;

(b) for the purpose of arranging, assessing the need for, providing, continuing, or supporting the provision of, a service requested or required by the subject individual;

4. A physician who, upon leaving a clinic, requests that the clinic make available an electronic copy of patient records, has an ethical obligation to only request a copy of records for patients who the physician reasonably expects to continue to provide care;
5. A copy of a requested record should be provided without undue delay;
6. A physician who, upon leaving a clinic, requests that the clinic make available an electronic copy of patient records, should pay the reasonable costs associated with the copying of the patient records;
7. It has been customary not to charge a colleague for a copy of relevant portions of a patient record. This is especially so if the physician who has control of the record has moved or otherwise required a patient to transfer their care to another physician;
8. If a fee is to be charged for a copy of a record, that fee should be fair and represent cost recovery including staff time and overhead costs;
9. Charging a fee for a copy of a record should never impede the orderly and timely transfer of required information.
10. If a fee is to be charged, and if the record is not immediately required for patient care, it is reasonable for a physician to ask for some assurance of payment before a copy of the requested record is made.

Appendix B – Patient Dismissal

Sample letter – Patient dismissal

Dear (patient's name):

The patient-physician relationship is fundamental in providing and receiving excellent care. The patient-physician relationship must be based on trust, honesty, respect and a mutual desire to improve health outcomes. This can only be done in the context of a satisfactory patient-physician relationship in which both partners participate willingly.

{Use the next paragraph to describe your valid reasons for withdrawing from the patient-physician relationship, such as unacceptable behavior, loss of trust and breakdown in interpersonal relationship, repeated non-compliance with medical advice or a monitored drug contract, etc.}

In these circumstances, I do not believe it is in your best interest for me to continue to serve as your physician. I therefore regret to inform you that I will not be in a position to provide further medical services after {date? This time will vary, but you should give at least one month's notice.}.

Until that date, I will provide services to you or provide an alternate arrangement. After that date, I will not provide elective services to you, only emergency services in a life-threatening situation, when there are no other physicians to provide the required care.

I urge you to obtain the services of another physician as soon as possible. I will be pleased to provide a summary of my care while you have been my patient and with your consent will arrange to have a copy of your file transferred.

Sincerely,

APPENDIX C – Bylaw 25, Advertising



27.1 Advertising – General Provisions

- (a) A member or clinic may make information about the member and services provided or the clinic and the services it provides available to any patient, potential patient or the public generally, subject to the limitations contained herein.
- (b) The word "advertising" in relation to the medical profession must be taken in its broadest sense. It includes all those methods by which a practicing physician is made known to the public either by himself or by others without his objections, in a manner which can be fairly regarded as having for its purpose the obtaining of patients or the promotion in other ways of the physicians individual professional advantage. The word "advertising" includes information made available on websites or in other electronic media.
- (c) A member or clinic may participate in or donate services to charitable endeavors.
- (d) It is unbecoming, improper, unprofessional or discreditable conduct for a physician to advertise in a manner contrary to this bylaw, or to permit such advertising to be done on the physician's behalf or to permit any clinic with which the physician is associated to advertise contrary to this bylaw.

28.1 Ethical, Professional, Advertising Criteria

- (a) Advertising, promotion, and other marketing activities must be in good taste, accurate, and not capable of misleading the public. Any conduct, either directly or indirectly or through any medium or agent that:
 - (i) misrepresents facts;
 - (ii) compares either directly, indirectly or by innuendo, the member's services or ability with that of any other practitioner or clinic, or promises or offers more effective service or better results than those available elsewhere;
 - (iii) deprecates another member or clinic as to service, ability or fees;
 - (iv) creates an unjustified expectation about the results the member can achieve;
 - (v) is made under any false or misleading guise, or takes advantage, either physical, emotional, or financial of any patient or uses coercion, duress or harassment;
 - (vi) is undignified, in bad taste or otherwise offensive so as to be incompatible with the best interests of the public or members under the Act or tends to harm the standing of the medical profession generally;
 - (vii) discloses the names of patients; or,
 - (viii) makes statements which are not statements of fact or makes statements that cannot be proven to be accurate by the member or clinic is to be strictly

avoided as such conduct is contrary to the interest of the public and the profession.

29.1 Telephone Directories

- (a) A physician may place his name, address and telephone number in two areas of a telephone directory, the white and the yellow pages.
- (b) The white pages may indicate, in alphabetical order in bold print, the physician's name and address and telephone number of, if he so wishes, his home and his office.
- (c) The yellow pages may indicate in bold print the physician's name, office address and office telephone number.
- (d) The name of the physician in the yellow pages may be followed, in regular print, by a brief reference to the physician's field of practice i.e., Family Practice, etc.

30.1 Clinic and Office Signs

- (a) A free standing Clinic with direct patient access from the street may erect a sign on the hoarding usually provided for advertising purposes. The sign shall be restricted to two contrasting colours, may be illuminated and shall indicate:
 - (i) the name of the Clinic
 - (ii) office hours
- (b) Printing on or in a door or window may indicate the names and medical degrees of physicians practicing in the Clinic and specialists certificates if any.
- (c) Clinics located in separate non-commercial structures in residential areas may erect a tasteful sign on or adjacent to the building indicating:
 - (i) the name of the Clinic;
 - (ii) office hours; and
 - (iii) the names and medical degrees of physicians practicing in the Clinic.
- (d) Physicians practicing within the confines of establishments housing several medical services in rented or leased space shall confine the advertisement on their individual office entrance to their name, medical degrees and room number. The same information and an indication of specialty may be included in the directory usually found in the public entrance to these establishments.
- (e) All permitted advertisements referred to above shall be in good taste and acceptably proportional to the size of the structure adjacent or on which they are located.
- (f) The facility, clinic or office name shall not have the connotation of particular excellence or superiority, but may reflect the physician's certifications or registrations, as recognized by the Council.
- (g) Physician's may list on office letterhead and business cards:
 - (i) only those qualifications they hold; and

- (ii) any restrictions they place on their practice.

31.1 Use of the description “specialist”

- (a) A physician shall not use the words “specialist” or similar term in any advertising or description of the physician’s qualifications unless the physician:
 - (i) has received certification from the Royal College of Physicians and Surgeons of Canada; or,
 - (ii) has received permission from the Council to use that term, under any conditions that the Council may determine.
- (b) In considering an application by a physician to use the term “specialist” or a similar term, the council shall determine whether the physician has demonstrated to the satisfaction of the Council that:
 - (i) the physician has spent a minimum of 4 years in a postgraduate training program approved by the Council in the specialty of medicine for which the person has received a recognized foreign credential; and,
 - (ii) the physician has achieved a certification in a specialty in the country where the training was taken that is indicative of the ability to practise as a consultant in that specialty.

32.1 Statements to and Interviews with the media

- (a) Media and Public interest in medicine is growing and there is increasing pressure on physicians to participate in radio, television and newspaper interviews.
 - (i) Physicians may initiate a press release or media interview to disseminate information of an educational nature designed to warn of a current, proven health hazard or inform of a technique of preventive medicine.
 - (ii) Physicians shall not initiate but may respond to request for interviews exploring new research breakthroughs, proven effective innovations in treatment, and philosophical examination of medical history and changing trends.
 - (iii) Physicians shall not participate in interviews extolling their personal professional accomplishments or the availability through the physician of a facility, medical device, or mode of treatment.
 - (iv) In all statements and interviews the physician will exercise caution that he be seen as speaking for the profession rather than promoting his own qualifications and professional services.
 - (v) The conduct of interviews with the media concerning medical matters should be carried out so as to conform to the relevant provisions of the Code of Ethics adopted by the Council of the College of Physicians and Surgeons of Saskatchewan.

APPENDIX D – Bylaw 4.1, Returning to Practice



4.1 Returning to Practice in Saskatchewan after an absence or disability, inactive practise, or change in scope of practice

- (a) For the purpose of paragraph 4.1, a significant change in a physician's scope of practice is one in which the nature of the patient population cared for by the physician, the treatments provided by the physician or the environment in which the physician sees patients has changed in a significant way. A significant change in a physician's scope of practice is also where a physician begins to practise outside of what would be considered the usual scope of practice for the physician's discipline, training and experience.
- (b) Upon the written request of the Registrar or the Deputy Registrar, a physician who has practised in another jurisdiction, or who has not actively practised in Saskatchewan for a period exceeding six months, shall:
 - (i) provide a list of other jurisdictions in which the physician has practised medicine;
 - (ii) provide a description of the type of medical practice which the physician has carried on;
 - (iii) provide details of continuing medical education which has been taken by the physician;
 - (iv) advise whether any investigations have been undertaken by any other medical licensing or regulatory authority and, if such investigations have occurred, provide authority to the Registrar or the Deputy Registrar to make inquiries of the medical licensing or regulatory authority which has undertaken any such investigations;
 - (v) provide any other information or documents in the possession or control of the physician which, in the opinion of the Registrar or Deputy Registrar, are relevant to the conduct of the physician in another jurisdiction or the fitness of the physician to practise in Saskatchewan;
 - (vi) provide a Certificate of Standing from any jurisdiction in which the physician has practised;
 - (vii) provide such consents as may be requested by the Registrar or the Deputy Registrar for the release of information or documents which are not in the possession or control of the physician, if in the opinion of the Registrar or the Deputy Registrar, the information or documents are relevant to the conduct of the physician in another jurisdiction or the fitness of the physician to practise in Saskatchewan; and
 - (viii) provide the information, documents or consents referred to in paragraphs (i) through (vii) within fourteen days of the receipt of the request, or such additional time as may be granted by the Registrar or Deputy Registrar for the response.
- (c) It is unbecoming, improper, unprofessional or discreditable conduct to fail to comply with paragraph 4.1(b).
- (d) For the purpose of paragraph 4.1(f) to (i), a physician who has not engaged in 5 months of clinical practice within the past 5 years must comply with the same requirements as physicians who have been absent from clinical medical practice for three years or more.
- (e) For the purpose of paragraph 4.1(f) to (m), a physician who has been inactive due to illness or disability will be evaluated on an individual basis, as to the need for a formal assessment, irrespective of the length of time they have been absent from practice, and may be required

- to comply with the same requirements as physicians who have been absent from clinical medical practice for three years or more.
- (f) Physicians who plan to return to clinical medical practice after an absence of three years or more, or who plan to make a significant change in scope of practice, must first notify the College and complete an assessment and retraining satisfactory to the Registrar before doing so.
 - (g) The Registrar shall consider the following when considering a need for assessment and retraining:
 - (i) The physician's previous training and experience;
 - (ii) The physician's previous performance in practice;
 - (iii) The physician's related activity during absence from practice, including participation in continuing professional learning;
 - (iv) The reasons for the physician's absence from practice;
 - (v) The physician's intended scope of practice.
 - (h) Assessments may include but are not restricted to one or more of the following:
 - (i) Observed performance in practice-settings;
 - (ii) Structured clinical encounters;
 - (iii) Structured oral interviews;
 - (iv) Simulators;
 - (v) Written examinations.
 - (i) Retraining may include but is not limited to the following:
 - (i) Directed self-study;
 - (ii) Traineeships with identified preceptors;
 - (iii) Formal residency training programs;
 - (iv) Supervised practice.
 - (j) Physicians shall be responsible for the costs of their assessments and retraining.
 - (k) Restrictions may be attached to a physician's registration based on the results of an assessment.
 - (l) It is unbecoming, improper, unprofessional or discreditable conduct to fail to comply with paragraph 4.1(d) to (f).
 - (m) A decision made by the Registrar pursuant to paragraph 4.1 shall be subject to review by the Council in the same manner as provided in section 31.1 of the Act.