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COLLEGE OF PHYSICIANS AND SURGEONS OF SASKATCHEWAN

REGULATORY BYLAWS

Effective date – May 10, 2013

PART I - DEFINITIONS

1.1 General

In these bylaws, unless there is something in the subject of the context inconsistent therewith, the definitions for words set out in the College's administrative bylaws shall apply to the words in the College's regulatory bylaws.

PART 2 – LICENSURE

2.1 Categories of Membership, licences and permits

- (a) Regular Member (Active);
- (b) Regular Member (Inactive);
- (c) Provisional Member (Active);
- (d) Provisional Member (Inactive);
- (e) Special Member;
- (f) Senior Life-Member (Active);
- (g) Senior Life-Member (Inactive).
- (h) Locum Tenens Permits;
- (i) Podiatric Surgery Permits;
- (j) Educational Licences

2.2 Regular Member (Active)

- (a) A regular member (active) is a member registered under Section 4 or 28 of the Act, other than a member who is a regular member (inactive).
- (b) A regular member (active) shall have the right to practise medicine in Saskatchewan, subject to any limitations imposed by the Council in accordance with the provisions of the bylaws and the Act, to hold office and to vote as may be provided for in the Act or the bylaws.
- (c) For the purpose of registration under Section 28 of the Act, the following shall constitute evidence of satisfactory postgraduate training.
 - (i) for applicants who will practise as a consultant specialist, certification by the Royal College of Physicians and Surgeons of Canada (R.C.P.S.C.);
 - (ii) For applicants who have not previously been licensed in Canada to engage in independent practice, and who have completed Canadian postgraduate training in family medicine, certification by the College of Family Physicians of Canada (CCFP);
 - (iii) For applicants other than those referred to in paragraph 2.2 (c)(ii) and who will practise family medicine, the applicant will be required to meet the requirements for a Provisional Licence for a family physician under section 2.4 of this bylaw.

2.3 Regular Member (Inactive)

- (a) A regular member (active) may apply for membership as an inactive member.
- (b) In order to be eligible for membership as an inactive member, a member shall withdraw from the active practice of medicine in Saskatchewan.
- (c) A regular member (inactive) shall pay the fee for inactive status established by the Council.
- (d) A regular member (inactive) shall not practise medicine in Saskatchewan, hold office, or vote.
- (e) In order for an inactive member to become an active member, an inactive member shall:
 - (i) produce a Certificate of Good Standing of recent origin from each jurisdiction in which the member has practised in since ceasing to be a regular member (active) in Saskatchewan; and,
 - (ii) produce evidence of good character to the satisfaction of the Council in a form and in a manner that may be prescribed by the Council; and,
 - (iii) if the member has not actively practised medicine for a period of 36 months, or intends to or has changed his/her field of practice, provide proof to the Council of successful completion of training as set out in bylaw 4.1; and,
 - (iv) pay the annual fee for an active member established by the Council.

2.4 Provisional Member (Active)

- (a) A provisional member is a member registered under Section 29 of The Act.
- (b) The Council may register and issue a Provisional Licence to a person who produces evidence in a form and manner that may be prescribed by Council that the person:
 - (i) is a graduate of an approved university medical school, and
 - (ii) has met the postgraduate training requirements established in paragraph 2.4(c) of these bylaws; and
 - (iii) has obtained the MCCEE, or MCCQE1 or USMLE qualification or has passed such other examination of general medical knowledge as the Council considers is equivalent to one of those examinations
 - (iv) is of good character; and
 - (v) has established good standing as a practitioner if at any time that person was entitled to practise medicine; and
 - (vi) has paid the fee prescribed by Council for licensure.
- (c) For the purpose of registration under Section 29 of the Act the following shall constitute evidence of satisfactory postgraduate training:
 - (i) Certification in Family Medicine by the College of Family Physicians of Canada (CCFP).
 - (ii) for applicants who shall practise as a consultant specialist, completion of a specialty training program and eligibility to sit the exam of the Royal College of Physicians and Surgeons of Canada; or
 - (iii) for physicians who will practise as family physicians, completion of postgraduate training in a training program accredited by the Accreditation Council for Graduate Medical Education, the College of Family Physicians of Canada, or other accreditation body that in the opinion of the Council, demonstrates similar standards for accreditation of postgraduate training; or

- (iv) for physicians who will practise as family physicians, and who apply for a licence on or before July 31, 2012, a period of successful practice in Saskatchewan, satisfactory to the Council, on a locum tenens permit, and an assessment through the Clinicians Assessment and Professional Enhancement (CAPE) program that, in the opinion of the Council, demonstrates satisfactory skills and knowledge in the practice of medicine; or
 - (v) proof that the applicant has demonstrated satisfactory skills and knowledge by an assessment, that, in the opinion of the Council, demonstrates satisfactory skills and knowledge in the practice of medicine. Such assessment shall be undertaken at the physician's own expense; and shall be in a form approved by the Council.
- (d) A provisional licence issued on the basis of a physician's successful completion of an assessment, that, in the opinion of the Council, demonstrates satisfactory skills and knowledge in the practice of medicine, or a provisional licence issued on the basis that the physician has obtained CCFP or been ruled eligible for CCFP on the basis that the physician's training and certification is equivalent to the training and certification required for Canadian-trained physicians granted CCFP may be issued subject to restrictions or conditions, which shall be stated in the licence. Such restrictions may include, but are not limited to:
- (i) a restriction that the physician practise only under the supervision of a named member or members approved by the Council;
 - (ii) a restriction that the supervising physician or physicians provide reports to the College with such frequency and in such form as may be required by the Registrar;
 - (iii) a condition that the licence is issued subject to a physician's participation in an assessment of the physician's skill, knowledge and suitability to practise in such form as may be required by the Registrar;
 - (iv) a condition that if, in the opinion of the Registrar, either of the restrictions in paragraphs (i) or (ii) above have been breached, or if, in the opinion of the Registrar, a physician has failed to participate in an assessment of the physician's skill, knowledge or suitability to practise, or the assessment has not demonstrated that the physician has appropriate skill, knowledge or suitability to practice, the Registrar may amend the physician's licence to restrict the physician's ability to practice medicine or may terminate the licence.
- (e) The Registrar may restrict or terminate a licence pursuant to paragraph (d)(iv)
- (f) A decision made by the Registrar pursuant to the paragraph (e) shall be subject to review by the Council in the same manner as provided in section 31.1 of the Act.
- (g) Provisional members, other than members to whom paragraph (d) of this bylaw applies, and who have been issued a licence subject to the condition in paragraph (d)(iii) and paragraph (d)(iv), must comply with the following conditions of registration:
- (i) the registrant must challenge the MCCEE at the first available opportunity after registration, if the physician has not passed the MCCEE or the MCCQE1; and
 - (ii) the registrant must obtain the LMCC within a period of 3 years of the date of registration if a family physician and the physician has passed MCCEE or MCCQE1; and
 - (iii) the registrant must obtain the LMCC within a period of 5 years from the date of registration if a specialist; and

- (iv) the registrant must pass the MCCEE within 2 years of the date of registration, if the physician has not passed the MCCEE; and
 - (v) the registrant must pass the MCCQE Part I within 4 years of the date of registration, if the physician has not passed the MCCEE at the date of registration; and
 - (vi) the registrant must obtain the LMCC within 5 years of the date of registration, if the physician has not passed the MCCEE at the date of registration; and,
 - (vii) the registrant will provide to the College full documentation respecting any examination results from the Medical Council of Canada or the Royal College of Physicians and Surgeons of Canada.
 - (viii) for registrants who have not previously been licensed in Canada to engage in independent practice without restrictions or conditions, and who have completed Canadian postgraduate training in family medicine, the registrant must obtain certification with the College of Family Physicians of Canada as set out in paragraph 2.4(l) and (m);
 - (ix) if an applicant has previously failed any examination of the Medical Council of Canada, the time periods set out in paragraphs 2.4(g)(i) to (vi) may be reduced;
 - (x) where in the opinion of the Council extraordinary circumstances exist relating to a registrant, the Council may extend the time for a registrant to challenge or complete any of the examinations of the Medical Council of Canada referred to above.
- (h) If the results achieved by a registrant in an examination from the Medical Council of Canada are, in the opinion of the Registrar, a substantial departure from what is to be expected of a physician practicing medicine in Saskatchewan, the Registrar may revoke a Provisional Licence granted to the registrant, or may impose additional conditions in respect of that registrant's medical practice;
 - (i) If the registrant fails to meet any of the conditions of registration contained in paragraph 2.4(g), the Registrar may revoke a Provisional Licence (active) granted to the registrant, or may impose additional conditions in respect of that registrant's medical practice;
 - (j) A decision made by the Registrar pursuant to paragraph 2.4 (h) or (i) shall be subject to review by the Council in the same manner as provided in section 31.1 of the Act;
 - (k) The Provisional Licence (active) issued under this Bylaw shall be automatically revoked and shall cease to be valid if the holder of a Provisional Licence, who is licensed on eligibility to sit the examinations of the Royal College of Physicians and Surgeons of Canada, fails to obtain certification from the Royal College of Physicians and Surgeons of Canada within the period of eligibility granted by the Royal College of Physicians and Surgeons of Canada.
 - (l) The Provisional Licence (active) issued under this Bylaw shall be automatically revoked and shall cease to be valid if the holder of a Provisional Licence who has not previously been licensed in Canada to engage in independent practice without restrictions or conditions, and who has completed Canadian postgraduate training in family medicine, fails to obtain certification from the College of Family Physicians of Canada within the earlier of:
 1. the initial period of eligibility granted by the College of Family Physicians of Canada;
 2. three years from completion of a residency in family medicine in a Canadian training program.

- (m) Notwithstanding paragraph (l), where in the opinion of the Council extraordinary circumstances exist relating to a registrant, the Council may extend the time for a registrant to obtain certification with the College of Family Physicians of Canada and may pose additional conditions in respect of the physician's medical practice and on the physician's licence.
- (n) a provisional licence may be issued subject to the condition that the physician participate in a program of orientation or review.

2.5 Provisional Member (Inactive)

- (a) A provisional member (active) who leaves the province may, upon payment of the fee for inactive status, remain a provisional member (inactive) for as long as the member meets the requirements to retain licensure of a provisional member (active).
- (b) A provisional member (active) who has left the province and has paid the fee for inactive status as set out in the previous subparagraph of this bylaw shall not be entitled to practise medicine in Saskatchewan, nor to have become a provisional member (active) until the member:
 - (i) produces a Certificate of Good Standing of recent origin from each jurisdiction the member has practised in since ceasing to be a regular member (active) in Saskatchewan; and,
 - (ii) produces evidence of good character to the satisfaction of the Council in a form and in a manner that may be prescribed by the Council; and,
 - (iii) pays the annual fee for a provisional member (active) established by the Council.

2.6 Special Member

- (a) A special member is a member registered under Section 30 of the Act.
- (b) The Council may register and issue a Special Licence under subsection 30(1) of the Act to a person who produces evidence in a form and manner that is acceptable to the Council that the person:
 - (i) is of good character; and,
 - (ii) possesses good standing as a medical practitioner; and
 - (iii) is a graduate in medicine of a University approved by the Council; and
 - (iv) holds certification from the Royal College of Physicians and Surgeons of Canada; and
 - (v) has been granted an exemption by the Council from the requirement that he/she pass the examinations of the Medical Council of Canada.
- (c) The Council may register and issue a Special Licence under subsection 30(1) of the Act to a person who is a physician of renowned reputation and will be receiving an academic appointment, and who:
 - (i) is of good character; and,
 - (ii) possesses good standing as a medical practitioner; and,
 - (iii) is a graduate in medicine of a University approved by the Council; and,
 - (iv) holds a specialty qualification acceptable to the Council.
- (d) The Council may register and issue a Special Licence under subsection 30(1) of the Act to a person who produces evidence in a form and manner that may be acceptable to the Council that the person:
 - (i) is of good character; and

- (ii) is of good standing as a medical practitioner; and
 - (iii) is a graduate in medicine of a University approved by the Council; and
 - (iv) has completed postgraduate training as evidenced by a specialty qualification acceptable to the Council; and
 - (v) possesses medical skills which are needed in the community in which the person will work which cannot reasonably be met by a person registered in accordance with Section 28 or 29 of the Act, or paragraph 2.6 (b) of this bylaw; and
 - (vi) has successfully completed a period of evaluation of the person's skill and knowledge in such form as may be approved by the Council; and
- (e) A physician who is granted a Special Licence under paragraph 2.6 (d) is required:
- (i) at the first opportunity to take an examination acceptable to the Council in that physician's specialty; and
 - (ii) to pass MCCQE II within a period of five years of the date of registration.
- (f) If the holder of a Special Licence granted under paragraph 2.6(d) does not pass MCCQE II within five years of the date of registration or does not successfully complete the examination in that physician's specialty acceptable to the Council at the first opportunity to take the examination, the Council may:
- (i) revoke that Special Licence; or
 - (ii) grant the person one or more opportunities, not to exceed three opportunities in total, to take that examination, subject to such terms and conditions as the Council may determine.
- (g) If the holder of a Special Licence granted under paragraph 2.6(d) is granted one or more additional opportunities by the Council to successfully complete the examination in that physician's specialty acceptable to the Council in accordance with paragraph 2.6(f)(ii), the Council may revoke that person's Special Licence if that person:
- (i) does not successfully complete that examination; or
 - (ii) does not comply with the terms and conditions imposed by the Council.
- (h) The Council shall register and issue a Special Licence under subsection 30(2) of the Act to a person who produces evidence in a form and manner that may be acceptable to the Council that the person:
- (i) is the person for whom a request for a Special Licence has been made by the Minister under subsection 30(2) of the Act; and
 - (ii) will practise Psychiatry in a branch of the public service of Saskatchewan, in a branch of the public service of Canada to provide services in Saskatchewan, or for a Regional Health Authority; and
 - (iii) has agreed that the Licence issued to that person may be revoked in the event that the person ceases to practise in the community for which the person has applied to work.
- (i) The Council shall register and issue a Special Licence under subsection 30(3) of the Act if the person produces evidence in a form and manner that may be acceptable to the Council that the person:
- (i) is of good character; and,
 - (ii) is of good standing as a practitioner; and,

- (iii) is the person who is the subject of the request of the Minister under subsection 30(3) of the Act; and,
 - (iv) is to be engaged in a branch of the public service of Saskatchewan, in a hospital or other institution, or as a designated public health officer for a Regional Health Authority; and
 - (v) has successful postgraduate training as evidenced by a minimum of two years post-graduate training approved by the Council, including eight weeks in each of internal medicine, general surgery, obstetrics and gynaecology, and paediatrics, where the physician is to carry out a general practice; or
 - (vi) has completed postgraduate training as evidenced by training in public health as may be approved by the Council, where the physician is to be engaged as a public health officer.
- (j) The Council shall register and issue a Special Licence under subsection 30(3) of the Act if the person produces evidence in a form and manner that may be acceptable to the Council that the person:
- (i) is of good character; and
 - (ii) is of good standing as a practitioner; and
 - (iii) is the person who is the subject of the request of the Minister under subsection 30(3) of the Act; and
 - (iv) is to be engaged in a branch of the public service of Saskatchewan, in a hospital or other institution, or a Regional Health Authority; and
 - (v) has completed post-graduate training as evidenced by a specialty qualification acceptable to the Council and is fully registered with the respective Medical Council; and
 - (vi) has successfully completed a period of evaluation of the person's skill and knowledge in such form as may be approved by the Council.
- (k) Until December 31, 2013, the Council shall register and issue a Special Licence under subsection 30(3) of the Act if the person produces evidence in a form and manner that may be acceptable to the Council that the person:
- (i) is of good character; and
 - (ii) is of good standing as a practitioner; and
 - (iii) is the person who is the subject of the request of the Minister under subsection 30(3) of the Act; and
 - (iv) is to be engaged with the Saskatchewan Cancer Agency; and,
 - (v) has completed postgraduate training as evidenced by a specialty qualification acceptable to the Council.
- (l) A physician who is granted a Special Licence under paragraph 2.6(j) is required:
- (i) at the first opportunity to take an examination acceptable to the Council in that physician's specialty; and
 - (ii) to pass the MCCQE II within a period of five years of the date of registration.
- (m) If the holder of a Special Licence granted under paragraph 2.6(j) does not successfully complete the examination in that physician's specialty acceptable to the Council at the first opportunity to take the examination, or does not pass the MCCQE II within five years of the date of registration, the Council may:
- (i) revoke that Special Licence; or

- (ii) grant the person one or more opportunities to take that examination, subject to such terms and conditions as the Council may determine;
 - (iii) grant the person one or more opportunities to pass the MCCQE II, subject to such terms and conditions as the Council may determine.
- (n) If the holder of a Special Licence granted under paragraph 2.6(j) is granted one or more additional opportunities by the Council to successfully complete the examination in that physician's specialty acceptable to the Council, or is granted one or more opportunities to pass the MCCQE II in accordance with paragraph 2.6(m), the Council may revoke that person's Special Licence if that person:
- (i) does not successfully complete that examination; or
 - (ii) does not comply with the terms and conditions imposed by the Council.
- (o) A Special Licence shall be automatically revoked and shall cease to be valid if:
- (i) the holder of the Special Licence granted under paragraph 2.6(h), (i), (j) or (k) ceases to be employed by or practise under contract with the employer for whom he/she applied to work, unless he/she has received the approval of the Council to work for another employer; or
 - (ii) the holder of the Special Licence granted under paragraph 2.6(h), (i), (j) or (k) ceases to be engaged in the branch of the public service of Saskatchewan, in a branch of the public service of Canada to provide services in Saskatchewan, in a hospital, a Regional Health Authority, or other institution; or
 - (iii) the holder of a Special Licence who has applied because of an academic appointment ceases to hold that academic appointment.
- (p) The Council may register and issue a special licence under subsection 30(1) of the Act to a person who produces evidence in a form and manner that is acceptable to the Council that the person:
- (i) is of good character; and,
 - (ii) possesses good standing as a medical practitioner; and
 - (iii) meets the requirements for registration under section 28 of the Act; and;
 - (iv) is fully licensed, without restrictions, in another province or territory of Canada; and,
 - (v) has signed a declaration that the person will limit his/her practice of medicine in Saskatchewan to the practice of telemedicine with the number of patients located in Saskatchewan that corresponds to the fee required under the College bylaws.
- (q) A licence issued pursuant to paragraph (s) will contain a restriction, limiting the physician named therein to practicing telemedicine while the physician is physically located outside the province of Saskatchewan.
- (r) A physician may, during the course of a year, sign a substitute declaration that the person will limit the physician's practice of medicine in Saskatchewan to a larger number of patients than specified in the original declaration, and pay the additional fee corresponding to the fee required under the College bylaws.

2.7 Senior Life Member

- (a) A physician shall become entitled to become a senior life member if the physician has been licensed on a form of postgraduate licensure in Saskatchewan for 40 years. Service with the Canadian and/or Allied forces and postgraduate training after registration shall be included in this period of time.
- (b) Designation as a senior life member is honorary only. It conveys no right to practise medicine in Saskatchewan, to hold office or to vote.



- (c) A physician may concurrently hold status as a senior life member and another form of licensure.
- (d) Physicians holding senior life membership shall not be required to pay a fee to obtain or retain that membership status.

2.9 Locum Tenens Permits

- (a) The Council may issue a locum tenens permit to a physician who meets the provisions of this paragraph 2.9.
- (b) Until July 31, 2014 the Council may issue a locum tenens permit to a physician who:
 - (i) produces documentation that he/she is a graduate in medicine from:
 - 1. a university approved by the Council, and has obtained the M.C.C.E.E., M.C.C.Q.E.1, F.L.E.X., N.B.M.E. or U.S.M.L.E. qualification or has passed such other examination of general medical knowledge as the Council considers is equivalent to one of those examinations; or
 - 2. until April 1, 2011, the College may grant a locum tenens permit to a physician who has not passed one of the examinations referred to in paragraph 1. above, but who meets the requirements for licensure as they existed on June 1, 2009.
 - 3. notwithstanding paragraph 1. the Council may grant a locum tenens permit to a physician who has not passed one of the examinations referred to in paragraph 1. above. In considering whether to grant such an exemption, the Council may consider:
 - (1) the physician's training and qualifications;
 - (2) the length of time during which the physician intends to practice in Saskatchewan;
 - (3) the nature of the physician's practice while in Saskatchewan;
 - (4) whether the physician possesses medical skills which are needed in the community in which the person will work which cannot reasonably be met by a physician who does not require the exemption.
 - 4. where a physician has been granted an exemption which permits the physician to obtain a locum tenens permit without having passed one of the examinations referred to in paragraph 1., the Council may impose conditions on that physician's licence, which may include one or more of the following:
 - (1) a condition that the physician pass one of the examinations referred to in paragraph 1. within a time specified in the permit;
 - (2) any one or more of the conditions referred to in paragraph (j) below.
 - (ii) produces evidence, in a form and manner that may be prescribed by the Council that he/she has:
 - 1. a minimum of one year postgraduate training approved by the Council including eight weeks in each of Medicine, General Surgery, Obstetrics & Gynaecology, and Paediatrics in order to carry out a general practice locum; or
 - 2. appropriate specialty training approved by the Council in order to carry out a locum in a specialty; or
 - 3. meets the requirements for postgraduate training contained in paragraph 2.4(e) of this bylaw; and
 - (iii) provides proof, to the satisfaction of the Council, that he/she is the person named in the documentation and is of good character.
- (c) The Council may require a physician seeking a locum tenens permit to undergo an interview by one or more persons, including at least one physician practicing in the same branch of medicine as the physician seeking the locum tenens permit, and may



refuse a permit to a physician who, in the opinion of the Council, is unsuited to the position that the physician seeks.

- (d) The Council may require a physician seeking a locum tenens permit to submit proof of competency in the English language and may refuse a permit to a physician who is unable to demonstrate English language competency to the satisfaction of the Council.
- (e) A physician who receives a locum tenens permit may be required to practise medicine under the sponsorship of a member.
- (f) The Council may, from time to time, define the responsibilities of a sponsoring physician.
- (g) A locum tenens permit issued to a physician to practise as a family physician, and who has not completed postgraduate training in a training program accredited by the Accreditation Council for Graduate Medical Education, the College of Family Physicians of Canada, or other accreditation body that, in the opinion of the Council, demonstrates similar standards for accreditation of postgraduate training, may be issued subject to the condition that the physician within the time specified in the permit, undertake an assessment through the Clinicians Assessment and Professional Enhancement (CAPE) program.
- (h) Where a physician fails to undergo an assessment in the CAPE program, or undertakes that assessment but the performance of the physician is not satisfactory to the Registrar, the Registrar may revoke a permit granted to the registrant, or may impose additional conditions in respect to that registrant's medical practice.
- (i) A decision made by the Registrar pursuant to paragraph 2.9(h) shall be subject to review by the Council in the same manner as provided in section 31.1 of the Act.
- (j) A locum tenens permit may be granted subject to restrictions or conditions, which shall be stated in the permit. Such restrictions may include, but are not limited to:
 - (i) a restriction that the physician practises only under the supervision of a named member approved by the Council;
 - (ii) a restriction that the physician practises only in a specified practice location;
 - (iii) a restriction that the physician practises only while employed by a named employer;
 - (iv) a restriction that the physician practises only a defined branch or form of medicine;
 - (v) a restriction that the physician shall not practise a branch or form of medicine;
 - (vi) a condition that the permit is issued subject to a physician's participation in a program of orientation, assessment or review;
 - (vii) a condition that the permit is issued subject to a review of the physician's practice.
- (k) The Registrar may rescind a locum tenens permit if the holder of the permit contravenes, fails to meet any restriction or condition in the permit, or if the performance of the physician in an assessment or review contained in the physician's permit is not satisfactory to the Registrar.
- (l) A decision made by the Registrar pursuant to the paragraph 2.9(k) shall be subject to review by the Council in the same manner as provided in section 31.1 of the Act.
- (m) Unless, in the opinion of the Council, extraordinary circumstances exist relating to a locum tenens permit, or unless a physician meets the requirements for licensure under section 28 of the Act, a physician granted a permit under paragraph 2.9(b) above shall not be entitled to hold a permit or permits for a total of more than 365 days.
- (n) The Council may issue a locum tenens permit to a physician who:
 - (i) is on the Education Register as a resident or by reason of other postgraduate training being undertaken by the physician; and,



- (ii) has filed a practice plan with the office of the Dean of Postgraduate Medical Education and has received the approval of the Program Director in the physician's program and the office of the Dean of Postgraduate Medical Education for that practice plan; and
- (iii) provides proof, to the satisfaction of Council that he/she is the person named in the documentation and is of good character.
- (o) A permit issued under paragraph (n) may be granted subject to restrictions or limitation.
- (p) A permit issued under paragraph (n) shall be revoked if the approval of the Associate Dean of Postgraduate Medical Education or the Program Director is withdrawn.
- (q) notwithstanding anything in paragraphs (a) to (p) above, a the Council may refuse to issue a locum tenens permit to a physician where there is an available program for the assessment of physicians to assess eligibility for licensure.

2.10 Podiatric Surgery Permits

- (a) The Council may issue a podiatric surgery permit to a person who:
 - (i) is a graduate of a Podiatric School of Medicine and Surgery approved by the American Podiatric Medical Association; and,
 - (ii) has successfully completed an American Podiatric Medical Association accredited surgical residency of a minimum of 2 years; and,
 - (iii) has successfully completed the National Board of Podiatric Medical Examination Parts I, II and III; and,
 - (iv) is certified by the American Board of Podiatric Surgery in foot surgery; and,
 - (v) provides proof of good character, and proof of good standing to the satisfaction of the Council; and,
 - (vi) completes the application form prepared by the College and provides the information requested in that form; and,
 - (vii) provides proof of insurance coverage that meets the requirements of insurance coverage prescribed in the bylaws for physicians; and,
 - (viii) pays the fee prescribed for a podiatric surgery permit.
- (b) The Council may issue a podiatric surgery permit to a person who:
 - (i) meets the requirements of paragraphs (i), (iii), (iv), (v), (vi), (vii) and (viii) of paragraph 2.10(a) above; and,
 - (ii) has successfully completed an American Podiatric Medical Association accredited surgical residency of a minimum of 1 year; and,
 - (iii) has practised podiatric surgery successfully for a minimum period of five years.
- (c) A podiatric surgeon who has practised podiatric medicine for fewer than 5 years, and who has Board qualification by the American Board of Podiatric Surgery rather than board certification by the American Board of Podiatric Surgery may be granted a podiatric surgery permit;
- (d) A podiatric surgery permit issued to a podiatric surgeon who has Board qualification by the American Board of Podiatric Surgery rather than Board certification by the American Board of Podiatric Surgery shall not be renewed after the fifth year of practice in podiatric medicine, unless the podiatric surgeon has achieved certification by the American Board of Podiatric Surgery in foot surgery;



- (e) A podiatric surgery permit may be renewed annually by a podiatric surgeon upon proof of insurance coverage and upon payment of the annual fee for a permit;
- (f) A podiatric surgeon may only perform procedures below the level of the skin in a facility that is operated by a Regional Health Authority;
- (g) A podiatric surgery permit may be issued subject to restrictions or conditions;
- (h) It is unbecoming, improper, unprofessional or discreditable conduct for a podiatric surgeon to practise podiatric surgery in contravention of any restriction or condition imposed in the permit or in this bylaw.

2.11 Grant or Renewal of Licence or Permit in Extraordinary Circumstances

- (a) If in the opinion of the council extraordinary circumstances exist relating to an application for a licence or permit, and if, in the opinion of the council there is a demonstrated resource need for a physician who does not meet all of the criteria for the issuance of a licence or permit, a licence or permit may be issued to a physician who does not meet one or more of the criteria specified in paragraphs 2.2 to 2.9 above, provided that the physician:
 - (i) has all of the qualification specified by the Act for a licence or permit requested; and,
 - (ii) is a graduate in medicine from a university approved by the Council; and,
 - (iii) has, in the opinion of the council, training to perform the services that are appropriate to the type of licence or permit being sought;
- (b) Notwithstanding paragraph 2.11(a), where a physician's licence or permit has been terminated due to that physician's failure to pass an examination or obtain a qualification within the time limited by that physician's licence or permit, a licence or permit granted under the authority of paragraph 2.11(a) may only be granted for a limited time, not to exceed one year, to allow for continuity of care for that physician's patients.
- (c) Notwithstanding paragraphs 2.11(a) and (b), where a physician's licence or permit has been terminated due to that physician's failure to pass an examination or obtain a qualification within the time limited by that physician's licence or permit, a licence or permit granted under the authority of paragraph 2.11(a) may be granted for a further limited time, beyond one year, but before doing so, the Council shall:
 - (i) determine that there are extraordinary circumstances which demonstrate that it is in the public interest to continue the physician's licensure after the 12 month period provided in paragraph 2.11(b); and,
 - (ii) consider information from the physician's peers respecting the physician's performance; and,
 - (iii) review the physician's information in the possession of the College, including information pertaining to any complaints filed with the College; and,
 - (iv) consult with the Regional Health Authority in which the physician works and consider any information or recommendations from the Regional Health Authority.

2.12 Delegation of Licensure Decisions to the Registrar

- (a) A licence under sections 28, 29, and 30 of the Act or a permit under Sections 31 or 42.1 of the Act, may be issued by the Registrar or a member of the Registrar's staff. Notwithstanding paragraphs 2.2 to 2.11 above, the issuance of a licence or permit by the Registrar or member of the Registrar's staff is subject to approval by the Council at the next meeting of the Council. If, at the next meeting of the Council, the Council



refuses to approve the issuance of the licence or permit, the licence or permit shall be immediately void.

- (b) Any action or decision that, pursuant to paragraphs 2.2 to 2.11 of these bylaws, may be taken or made by the Council may be taken or made by the Registrar, or a member of the Registrar's staff;
- (c) The Council delegates to the Registrar and the members of the Registrar's staff its authority to issue licences and permits to the extent required to give effect to paragraphs 2.12(a) and (b) above.

2.13 Exemption from Medical Council of Canada Examinations

- (a) Notwithstanding the other provisions of this bylaw, the Council of the College may exempt a physician who has obtained, or has applied for, a Provisional, Educational, or Special Licence from one or more of the requirements that the physician challenge or pass the MCCEE, MCCQE Part 1 or MCCQE Part 2. Such exemption may be given on such terms, and subject to such conditions, as the Council may specify.
- (b) A decision pursuant to section 2.13(a) may be made by the Registrar, or a member of the Registrar's staff, or may be referred by the Registrar, or a member of Registrar's staff, to the Council for decision.

2.14 Educational Licences

- (a) The Council may register and issue an Educational Licence to a person who produces evidence in a form and manner that may be prescribed by Council that the person:
 - (i) is an undergraduate student enrolled in the College of Medicine, University of Saskatchewan and has been recommended by the Dean of that College; or
 - (ii) is an undergraduate student enrolled in any other College of Medicine approved by Council and has been recommended by the Dean of that College; or
 - (iii) is a postgraduate student who has been appointed as a resident or fellow in a training program through the College of Medicine, University of Saskatchewan; or
 - (iv) is a postgraduate student enrolled as a resident in a residency training program other than a training program through the College of Medicine, University of Saskatchewan, but who is enrolled in a temporary elective through the College of Medicine;
 - (v) is involved in a assessment or training program approved by the Council; and
 - (vi) if the physician is a graduate of an approved medical schools other than an L.C.M.E./C.A.C.M.E. approved school the physician has passed Medical Council of Canada Evaluating Exam; and
 - (vii) if the physician's medical school training was conducted in a language other than English, a score of 100 on the iBT (internet-based) Test of English as a Foreign Language (TOEFL) or other proof of English proficiency acceptable to the Council; and,
 - (viii) is of good character.
- (b) A person who is granted an Educational Licence under paragraph 2.14 (a) (i),(ii), (iii), or (iv) above may only practise medicine within the scope of the authority granted by the educational program of the College of Medicine or residency or fellowship training program, as the case may be.
- (c) A person who is granted an Educational Licence under paragraph 2.14 (a) (iv) may practise medicine within the scope of the assessment or training program approved by the Council.
- (d) An Educational Licence may be granted subject to restrictions or conditions, which shall be stated in the Licence.
- (e) A person's name shall be removed from the education register



- (i) Upon completion of the training or assessment program;
- (ii) Upon removal of the person's status with the assessment or training program.
- (iii) By Council for cause.

2.15 Telemedicine for follow-up care

(a) A person who:

- (i) holds a full licence to practise medicine granted by a medical regulatory body in Canada; and;
- (ii) resides in another province or territory of Canada, and practises medicine in that province or territory; and,
- (iii) has received a referral from a Saskatchewan physician to provide medical care to a Saskatchewan patient; and,
- (iv) has provided medical care to that patient in the province or territory where the physician resides; and,
- (v) intends to provide follow-up care to that patient with respect to the condition for which the patient was referred by the Saskatchewan physician, from the physician's province or territory of residence, while that patient is located in Saskatchewan

is authorized to provide such follow-up care without being licensed to practise medicine in Saskatchewan.

2.16 Licensure of physicians in another province

(a) A physician who applies for licensure in Saskatchewan on the basis that the physician currently holds a licence to practise medicine pursuant to the legislation of another jurisdiction in Canada shall be required to:

- (i) Provide the information and documentation required of other applicants for licensure in Saskatchewan;
- (ii) Pay the fees required of other applicants for licensure in Saskatchewan;
- (iii) Disclose all complaints or disciplinary or criminal proceedings in any other jurisdiction;
- (iv) Demonstrate that the physician meets the requirements of bylaw 4.1 pertaining to active practice; and,
- (v) Disclose all practice limitations, restrictions or conditions imposed by the regulatory body or bodies where the physician holds a licence to practise medicine.

(b) Notwithstanding anything else in these regulatory bylaws pertaining to the licensure of physicians, a physician who applies for licensure in Saskatchewan as set out in paragraph (a), and whose licence is subject to practice limitations, restrictions or conditions may be issued a licence subject to equivalent limitations, restrictions or conditions.

(c) Notwithstanding anything else in these regulatory bylaws pertaining to licensure of physicians, a physician who applies for licensure in Saskatchewan as set out in paragraph (a), and whose licence is subject to one or more practice limitations, restrictions or conditions may be refused a licence if, in the opinion of the Council, the College is unable to apply equivalent practice limitations, restrictions or conditions.

(d) Notwithstanding anything else in these regulatory bylaws pertaining to licensure of physicians, a physician who applies for licensure in Saskatchewan as set out in paragraph (a) may be refused a licence if the physician:



- (i) Fails to provide the information or documentation required by the Act or the bylaws;
- (ii) Fails to demonstrate to the satisfaction of the Council that the physician is of good character; or,
- (iii) Fails to demonstrate to the satisfaction of the Council that the physician is in good standing in the jurisdiction or jurisdictions of Canada in which the physician is currently licensed.

3.1 Renewal and Expiration of Licences

- (a) All licences and permits, other than locum tenens permits issued under section 31 of the Act, and Educational Licences issued under section 34 of the Act, expire on November 30, next following the date of issuance of the licence or permit;
- (b) In order to renew a licence or permit, other than an Educational Licence issued under section 34 of the Act, a physician shall be required to:

- (i) pay the fee for the licence or permit established under College bylaws;
- (ii) provide confirmation of insurance or a waiver of the insurance requirement pursuant to College bylaws;
- (iii) provide a signed declaration, providing the information and documents required by the following declaration:

1. During the past two calendar years, has a medical regulatory authority suspended or revoked your medical licence, registration or certificate?

Yes _____ No _____

2. For this question, the College does not inquire about investigations that have resulted in a decision that an allegation is not proved. It also does not inquire about complaints that are dealt with through the Complaints Resolution Advisory Committee of the College of Physicians and Surgeons of Saskatchewan or the alternate dispute resolution processes used by regional health authorities. The College requires information about all other enquiries or investigations by medical licensing authorities or hospitals.

During the past two calendar years, have you been notified that you are the subject of an enquiry or investigation by a medical licensing authority or hospital, not referenced above?

Yes _____ No _____

3. The College does not inquire about criminal investigations that have resulted in a decision to withdraw a criminal charge, or a decision that the physician is not guilty. The College requires disclosure of information about all other arrests or criminal charges. Criminal offences do not include traffic violations or parking infractions but do include drinking and driving violations and possession of illegal drugs.

During the past two calendar years, have you been arrested or charged with any criminal offence, in Canada or elsewhere, other than charges that have been withdrawn or which resulted in your acquittal?

Yes _____ No _____

If you answered yes to this question, provide a copy of the legal decision.

4. During the past two calendar years, have you pleaded guilty to, or been convicted of, any criminal offence in Canada or elsewhere? (Criminal offences do not include traffic violations or parking infractions but do include



drinking and driving violations and possession of illegal drugs). Yes _____
No _____

If you answered yes to this question, provide a copy of the legal decision.

5. During the past two calendar years, have your privileges been restricted, suspended or removed by a hospital, health authority or other health care organization? Yes _____ No _____

6. During the past two calendar years, have you agreed to a limitation, restriction, suspension or removal of your privileges after having been notified of an investigation by a hospital, health authority or other health care organization? All such limitations, restrictions, suspensions or removals must be reported, whether arising from alternate dispute resolution processes or any other process.

Yes _____ No _____

7. During the past two calendar years, have you been diagnosed or been treated for drug or alcohol addiction? Yes _____ No _____

If you answered "yes" to this question - have you referred yourself or been referred to the Physician Support Program of the Saskatchewan Medical Association? Yes _____ No _____

8. Have you been diagnosed with a blood borne communicable disease (including but not limited to Hepatitis B, Hepatitis C, HIV and AIDS) which, by its nature, could place your patients at risk if there were an inadvertent exposure?

Yes _____ No _____

If you answered "yes" to this question - have you referred yourself or been referred to the Expert Advisory Committee on blood borne diseases of the College of Physicians and Surgeons of Saskatchewan? Yes _____ No _____

9. During the past two calendar years, have you suffered from any mental health condition that may limit your ability to practise or pose a risk of harm to patients? Yes _____ No _____

If you answered "yes" to this question - have you referred yourself or been referred to the Physician Support Program of the Saskatchewan Medical Association? Yes _____ No _____

10. During the past two calendar years, have you suffered from any physical health condition that may limit your ability to practise or pose a risk of harm to patients? Yes _____ No _____

11. During the past two calendar years, have you been sued in a civil suit related to your medical practice? Yes _____ No _____

If the answer is "YES" provide a copy of the statement of claim or legal decision as the case may be.

12. During the past two calendar years, has there been a settlement or court judgment that awarded damages against you in a civil suit related to your medical practice? Yes _____ No _____

If the answer is "YES" provide a copy of the statement of claim or legal decision as the case may be.

13. List all licensing authorities, (Canadian or otherwise) not including the College of Physicians and Surgeons of Saskatchewan, with whom you currently hold a licence to practise medicine.



14. During the past 2 years, have you made a significant change in your scope of practice? Yes _____ No _____

If you answered yes to this question, provide a statement with complete details of the change in the scope of practice.

15. Do you intend to make a significant change in your scope of practice during the next year? Yes _____ No _____

If you answered yes to this question, provide a statement with complete details of the change in the scope of practice.

16. Do you practise in a practice location where you have custody and control of patient health information? Yes _____ No _____

If you practise in a location where someone else - a physician, a Regional Health Authority or some other third party - controls all of the patient health information, then you are not a "trustee" as defined by Saskatchewan privacy legislation, **The Health Information Protection Act**

17. Does each of the practice locations where you regularly practise have a written privacy policy? Yes _____ No _____

If you have answered "No" to this question, identify the practice location and the individual primarily responsible for management of that practice location.

College bylaws require all facilities that are controlled by physicians to have a written privacy policy that is available to the individuals working in that location.

18. For each practice locations where you regularly practise that has a written privacy policy – Have you read and are you familiar with that privacy policy? Yes _____ No _____ Not Applicable _____

College bylaws require if there is a privacy policy available at a practice location, the physicians who work at that practice location should read and be familiar with that privacy policy.

- (c) For the purpose of questions 14 and 15 above, 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.
- (d) In addition to complying with paragraph (b) above, a physician who seeks to renew a special licence issued under bylaw 2.6(s) and (t) shall be required to sign a declaration that during the preceding year, the physician has limited his/her practice of medicine in Saskatchewan to the practice of telemedicine with the number of patients located in Saskatchewan that corresponds to the fee paid to the College prescribed by the bylaws;
- (e) The Registrar shall not renew a licence unless all of the requirements of paragraphs 3.1(b) and 3.1(d) have been met;
- (f) The Registrar may ask for clarification of any information provided by an applicant for a licence and may withhold the grant of a licence until that information has been provided.

3.2 The Register

- (a) The Registrar shall keep a Register, in which shall be entered the name of every person entitled to be registered according to the provisions of the Act;



- (b) For the purpose of section 27 of the Act, the contents of the Register which shall be available to the public shall consist of the following information:
 - (i) the physician's name;
 - (ii) the physician's gender;
 - (iii) the physician's office address;
 - (iv) the physician's office telephone number;
 - (v) the physician's medically related degrees, including where and when conferred;
 - (vi) the physician's certifications granted by the RCPSC, CFPC, or equivalent organization granting certification in a discipline of medicine;
 - (vii) the physician's area of practice;
 - (viii) final decisions in which a physician was found guilty of unbecoming, improper, unprofessional or discreditable conduct under section 47 of the Act, or to have lacked skill and knowledge under section 45 of the Act.
- (c) Nothing in paragraph (b) shall require the College to gather the information described in that paragraph.

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.

5.1 Standards for Continuing Education and Maintenance of Membership

- (a) In this bylaw:
 - (i) the term “Mainpro” means the program of Continuing Medical Education which the College of Family Physicians of Canada may require from time to time of its members as a condition of maintaining certification with the College of Family Physicians of Canada. The program, at the date of implementation of this bylaw, is called “Mainpro”. If the name or requirements of that program shall change, the requirements of this bylaw will continue to apply to physicians licensed in Saskatchewan, despite a change in the name or requirements;
 - (ii) the term “Maintenance of Certification” means the program of Continuing Medical Education which the Royal College of Physicians and Surgeons of Canada may require from time to time of its members as a condition of maintaining fellowship with the Royal College of Physicians and Surgeons of Canada. The program, at the date of this bylaw, is called “Maintenance of Certification”. If the name or requirements of that program shall change, the requirements of this bylaw will continue to apply to physicians licensed in Saskatchewan, despite a change in the name or requirements.
- (b) All licences to practise as a regular member - active, as a provisional member - active, as a special member, or a senior life member - active expire on November 30, next following the date of issuance of the licence.
- (c) This bylaw shall apply to all physicians who have been granted a licence to practise as a regular member – active, as a provisional member – active, as a special member, or a senior life member-active, whether such physician is, or is not, a certificant, member or fellow of either CFPC or RCPSC.
- (d) In order to renew a licence to practise as a regular member – active, as a provisional member – active, as a special member, or a senior life member – active, a physician shall:
 - (i) provide a statement to the College of Physicians and Surgeons that the physician is enrolled in either Mainpro or Maintenance of Certification;
 - (ii) if the physician is enrolled in Mainpro, provide a statement of the date established by CFPC for the physician to meet the requirements of Mainpro;
 - (iii) if a physician has reached the date established by CFPC for the physician to meet the requirements of Mainpro, or the date established by RCPSC for the physician to meet the requirements of Maintenance of Certification, provide proof to the satisfaction of the Registrar that the physician has met the requirements of Mainpro or Maintenance of Certification, as the case may be;
 - (iv) if CFPC has established a date for a physician to meet the requirements of Mainpro, or the RCPSC has established a date for a physician to meet the requirements of Maintenance of Certification, and a new date is subsequently set by CFPC or RCPSC, the physician shall provide proof to the satisfaction of the Registrar that the physician, at the originally established date, met the requirements of Mainpro or Maintenance of Certification, as the case may be;
 - (v) an original certificate from CFPC or RCPSC, as the case may be, that the physician has met the requirements of Mainpro or Maintenance of Certification shall be acceptable proof that the physician has met the requirements.



- (e) A physician may apply to the Registrar for:
 - (i) an exemption from the requirements of this bylaw; or
 - (ii) a direction that the physician's licence be renewed, notwithstanding the failure of the physician to meet the requirements of this bylaw.
- (f) The Registrar may require a physician making such a request to provide such information or documentation as the Registrar may specify, and may refuse to consider the application until such information or documentation is provided.
- (g) The Registrar may, in the exercise of the Registrar's discretion, grant or refuse a physician's request under this bylaw, or may grant the request subject to such terms and conditions as the Registrar may specify. In making a decision to grant, refuse, or grant subject to terms and conditions such a request, the Registrar may consider matters such as the following:
 - (i) the efforts of the physician to comply with the terms of the bylaw;
 - (ii) whether the physician is in substantial compliance with the terms of the bylaw;
 - (iii) the extent to which a physician is engaged in clinical practice;
 - (iv) whether the physician has applied to the CFPC or RCPSC for an extension of time to meet the Mainpro or Maintenance of Certification requirements, or for other relief with respect to the Mainpro or Maintenance of Certification requirements;
 - (v) if the physician has made such an application, the position of CFPC or RCPSC in response to the request;
 - (vi) any other matter that the Registrar may consider relevant to the request.
- (h) The Registrar may, in granting such a request, include any or all of the following conditions:
 - (i) the physician will provide an undertaking in writing that the physician will meet such terms and conditions as may be required by the Registrar;
 - (ii) the physician will take such form of education or remediation as the Registrar may specify;
 - (iii) the physician will meet the requirements of Mainpro or Maintenance of Certification within such time as the Registrar may specify;
 - (iv) any other term or condition as the Registrar believes is consistent with the goals and objectives of this bylaw.
- (i) If the Registrar imposes terms or conditions pursuant to paragraph 5.1(h), and a physician fails to meet those conditions, the Registrar may refuse to renew a physician's licence when the physician next requests a licence renewal.
- (j) The Registrar shall not renew a physician's licence unless the physician meets the requirements of this bylaw.
- (k) A decision made by the Registrar pursuant to paragraph 5.1 shall be subject to review by the Council in the same manner as provided in section 31.1 of the Act.
- (l) Where a physician has been refused renewal of a licence pursuant to this bylaw, and where the physician thereafter meets the requirements of this bylaw, the physician may apply within one year to be re-registered and, upon payment of the fee and meeting the other requirements for renewal of licensure prescribed in the College bylaws, the physician's licence shall be restored.



PART 3 – PRACTICE ENHANCEMENT

6.1 The Practice Enhancement Committee

(a) Composition

- (i) There shall be a standing committee appointed pursuant to Section 6(2)(p) and 6(2)(q) of the Act for the purpose of peer assessment of medical office practices which shall be known as the Practice Enhancement Committee.
- (ii) The Practice Enhancement Committee shall be composed of six persons appointed by the Council, three of whom shall be nominated by the Saskatchewan Medical Association.
- (iii) The members of the Practice Enhancement Committee shall be appointed by the Council annually. The Council may fill a vacancy in the Committee by appointing such person or persons as the Council thinks appropriate.
- (iv) From time to time, the chair, or one of the co-chairs, may appoint from the assessors one or more temporary members of the Practice Enhancement Committee as a temporary replacement for a member of the Committee who is unable to attend a meeting of the Committee, or as a temporary replacement for a member who has resigned. Such an appointment shall be made only for a single meeting of the committee.
- (v) A member of the committee appointed pursuant to subsection (iv) is entitled, with respect to the meeting for which the person is appointed, to all the rights and privileges of a member appointed pursuant to subsection (iii).

(b) Objectives

- (i) The purpose of the Practice Enhancement Committee is to establish, develop and administer an ongoing program of peer assessment of the office practice of members of the College in the member's chosen field to the end that the public may be served by helping members of the College to maintain proper standards of practice in the care of patients and the keeping of records.

(c) Methods

- (i) Subject always to the direction of the Council, the Practice Enhancement Committee shall conduct its business in such manner and may adopt, use and vary such programs and forms as it sees fit.
- (ii) The Practice Enhancement Committee may from time to time appoint any one or more of its members or other persons as assessors and delegate to persons so appointed the authority to conduct an assessment and to report thereon to the Practice Enhancement Committee.
- (ii) The Practice Enhancement Committee will select the members of the College to be assessed and in doing so will endeavour to have due regard for the distribution of medical practitioners in the province and the differences in practices and specialties to the end that the benefits of the activities of the Practice Enhancement Committee may be fairly extended to the public and the members of the College throughout the province.
- (iv) Every member of the College whose standards of practice are the subject of an assessment as part of a peer assessment program shall co-operate fully with the Practice Enhancement Committee and with its assessors. The co-operation required of a member includes:
 - 1. permitting assessors appointed by the Practice Enhancement Committee to enter and inspect the premises where the member engages in the practice of medicine;



2. permitting assessors appointed by the Practice Enhancement Committee to inspect the member's records of the care of patients;
3. providing to the Practice Enhancement Committee or its assessors information requested by the Practice Enhancement Committee or the assessors in respect of the care of patients by the member, the member's records of the care of patients or such other information that may be requested that is relevant to office practice of the member;
4. providing the information mentioned in paragraph 6.1(c)(iv)3 in the form requested by the Practice Enhancement Committee or its assessors; and
5. conferring with the Practice Enhancement Committee or its assessors when requested to do so by the Practice Enhancement Committee or its assessors.

(d) Reporting

- (i) Where the Practice Enhancement Committee forms the opinion that the information it has gathered respecting a physician indicates that:
 1. the public is at an immediate risk of harm; or
 2. the physician has failed, after due notice, to comply with provisions of these bylaws pertaining to the Practice Enhancement Program, or has otherwise failed or refused to co-operate with the Practice Enhancement Committee in its assessment; or
 3. the physician has refused to undertake remedial measures recommended by the Committee and the Committee considers that such refusal is unreasonable; or
 4. the physician has done or failed to do something that is a serious breach of ethics;

it shall report the matter to the Council in accordance with paragraphs 6.1(d)(ii) and (iii).

- (ii) Where the Practice Enhancement Committee concludes that one or more of the conditions in paragraph 6.1(d)(i) have been satisfied, the Practice Enhancement Committee shall report the matter to the College. When reporting such matter to the College, the Practice Enhancement Committee shall, at first instance, provide only sufficient information to permit the College to fulfill its responsibilities pursuant to the Act. Such information shall, at first instance, be limited to:
 1. where the Committee has formed the opinion that the public is at immediate risk of harm, the name of the physician, the conclusion of the Committee and general information pertaining to the harm perceived by the Committee;
 2. where the Committee has formed the opinion that the physician has failed, after due notice, to comply with the provisions of these bylaws pertaining to the Practice Enhancement Program, or has otherwise failed or refused to cooperate with the Practice Enhancement Committee in its assessment, the name of the physician and sufficient particulars of the physician's failure or refusal to permit the College to appoint a Preliminary Inquiry Committee to investigate such failure or refusal, or to permit the Council to lay a charge of unbecoming, improper, unprofessional or discreditable conduct against the physician;
 3. where the Committee has formed the opinion that the physician has refused to undertake remedial measure recommended by the Committee and the Committee considers that such refusal is unreasonable, the name of the physician, information respecting the remedial measures recommended by the Committee and information pertaining to the physician's refusal;



4. where the Committee has formed the opinion that the physician has done or failed to do something which is a serious breach of ethics, the name of the physician and sufficient particulars of the physician's action or failure to permit the College to appoint a Preliminary Inquiry Committee to investigate such action or failure, or to permit the College to lay a charge of unbecoming, improper, unprofessional or discreditable conduct against the physician.
- (iii) Notwithstanding paragraph 6.1(d)(ii), if the physician with respect to whom the report is made applies to a court to prevent action being taken by the College, or if the physician seeks to quash an action taken by the College, or to appeal from a decision made by the College, or if the physician should oppose the appointment of a Preliminary Inquiry Committee or a Competency Committee by the College, the Practice Enhancement Committee shall provide to the College such additional information as may be necessary to provide the Court or the College with full information pertaining to the factual basis for the Committee's opinion.
 - (iv) Notwithstanding paragraphs 6.1(d)(ii) and 6.1(d)(iii) above, the Committee may, in its absolute discretion, provide additional information to the College relating to the matters in paragraph 6.1(d)(i) above, if the Committee concludes that the information is required by the College to protect the public interest.
 - (v) The Practice Enhancement Committee shall keep confidential all information gathered in the course of an assessment of an individual, and shall disclose such information only in accordance with the provisions of paragraphs 6.1(d) (i), (ii), (iii) and (iv). The Practice Enhancement Committee may provide information to the Council of a general nature, which does not identify the physicians involved, to permit the Council to assess the Practice Enhancement Program and to prepare reports of a general nature to the members of the College. The Council shall maintain confidential all information which it obtains from the Practice Enhancement Committee and shall not utilize such information unless:
 1. If the Practice Enhancement Committee has provided this information to the Council pursuant to paragraphs 6.1(d) (i), (ii), (iii) and (iv), the information may be used solely for the purpose of determining whether to lay a charge of unbecoming, improper, unprofessional or discreditable conduct, or to appoint a Preliminary Inquiry Committee or a Competency Committee, or for the purpose of an interview conducted by the Council or a Committee appointed by the Council, and for no other purpose; or
 2. For the purpose of preparing a report of a general nature by the Council to the members of the College. Such information shall not identify the physicians involved.
 - (vi) The Practice Enhancement Committee shall report to the Council and the Saskatchewan Medical Association on its activities and programs of assessment at such times and in such manner as the Council may from time to time direct.

(e) Meetings

- (i) The Committee will meet at the call of the Chair.

(f) Other provisions

- (i) A witness before a Discipline Hearing Committee or a Competency Hearing Committee may not be asked and is not permitted to answer any question or make any statement with respect to any proceeding before a Practice Enhancement Committee, and may not be asked to produce and is not permitted to produce any report, statement, memorandum, recommendation, document, information, data or record that is:
 1. prepared exclusively for the use of or made by; or



2. used exclusively in the course of, or arising out of, any investigation by a Practice Enhancement Committee.
- (ii) No report, statement, memorandum, recommendation, document, information, data or record mentioned in paragraph 6.1(f)(i) is admissible as evidence before a Discipline Hearing Committee or a Competency Committee.
 - (iii) Paragraphs 6.1(d)(v), 6.1(f)(i) and 6.1(f)(ii) do not apply to hearings before a Discipline Hearing Committee on a charge that a physician is guilty of unbecoming, improper, unprofessional or discreditable conduct for failing or refusing to co-operate with the Practice Enhancement Committee or for failing to comply with the provisions of these bylaws pertaining to the Practice Enhancement Program.
 - (iv) If, during the course of an assessment or assessments, the Practice Enhancement Committee identifies concerns of a systemic nature that, in the opinion of the Committee:
 1. should be remedied; and
 2. are not limited to the practice of the physician being assessedthe Committee may report their concerns to the individuals or organizations that, in the Committee's opinion, have the responsibility to remedy such concerns.
 - (v) If a report pursuant to paragraph 6.1(f)(iv) is made to a physician, or to more than one physician, the Practice Enhancement Committee may:
 1. meet with the physician(s);
 2. prepare recommendations to the physician(s) to address the concerns identified by the Practice Enhancement Committee;
 3. arrange for a review, at some future time, to determine if the concerns of a systemic nature identified by the Committee have been rectified.
 - (vi) Where the Committee has formed the opinion that the physician(s) has refused or neglected to remedy the concerns of a systemic nature identified by the Committee pursuant to paragraph 6.1(f)(iv) the Committee may refer that matter to the College and the provisions of paragraph 6.1(d) apply, with such changes as may be necessary.
 - (vii) If a report pursuant to paragraph 6.1(f)(iv) is made to a person who is not a physician, or to an organization, the Practice Enhancement Committee may:
 1. meet with such person or persons as the Committee think advisable;
 2. prepare recommendations to the person or persons to address the concerns identified by the Practice Enhancement Committee;
 3. arrange for a review, at some future time, to determine if the concerns of a systemic nature identified by the Committee have been rectified.
 - (viii) The Committee may also report the matter to the Minister of Health if the report pertains to:
 1. a regional health authority or a health care organization within the meaning of The Regional Health Services Act, the Saskatchewan Cancer Foundation, or a person or organization that provides health services pursuant to an agreement with the Minister of Health, or
 2. any other persons or organization, on an informational basis.



PART 4 – CODE OF ETHICS, UNPROFESSIONAL CONDUCT, DISCIPLINE, AND COMPETENCY ASSESSMENTS

7.1 The Code of Ethics

- (a) Subscription to and observance of the Code of Ethics is a condition of registration under the Act.
- (b) No person who is registered under the Act shall contravene or fail to comply with the Code of Ethics.
- (c) Contravention of or failure to comply with the Code of Ethics is unbecoming, improper, unprofessional or discreditable conduct for the purpose of the Act.
- (d) Every person who applies for registration under the Act shall subscribe to The Code of Ethics, as adopted by the College of Physicians and Surgeons from time to time, as a condition of registration.
- (e) Every person who is registered under the Act shall observe The Code of Ethics, as adopted by the College of Physicians and Surgeons from time to time, as a condition of maintaining his or her registration.
- (f) The Code of Ethics as adopted by the College of Physicians and Surgeons is the 2004 Canadian Medical Association Code of Ethics, with a change to paragraph 48 of the CMA Code of Ethics.
- (g) The Code of Ethics adopted by the College of Physicians and Surgeons is as follows:

CODE OF ETHICS

This Code has been prepared by the Canadian Medical Association as an ethical guide for Canadian physicians, including residents, and medical students. Its focus is the core activities of medicine – such as health promotion, advocacy, disease prevention, diagnosis, treatment, rehabilitation, palliation, education and research. It is based on the fundamental principles and values of medical ethics, especially compassion, beneficence, non-maleficence, respect for persons, justice and accountability. The Code, together with CMA policies on specific topics, constitutes a compilation of guidelines that can provide a common ethical framework for Canadian physicians. Physicians should be aware of the legal and regulatory requirements that govern medical practice in their jurisdictions. Physicians may experience tension between different ethical principles, between ethical and legal or regulatory requirements, or between their own ethical convictions and the demands of other parties. Training in ethical analysis and decision-making during undergraduate, postgraduate and continuing medical education is recommended for physicians to develop their knowledge, skills and attitudes needed to deal with these conflicts. Consultation with colleagues, regulatory authorities, ethicists, ethics committees or others who have relevant expertise is also recommended.

Fundamental Responsibilities

1. Consider first the well-being of the patient.
2. Treat all patients with respect; do not exploit them for personal advantage.
3. Provide for appropriate care for your patient, including physical comfort and spiritual and psychosocial support, even when cure is no longer possible.
4. Practise the art and science of medicine competently and without impairment.



5. Engage in lifelong learning to maintain and improve your professional knowledge, skills and attitudes.
6. Recognize your limitations and the competence of others and when indicated, recommend that additional opinions and services be sought.
7. Resist any influence or interference that could undermine your professional integrity.
8. Contribute to the development of the medical profession, whether through clinical practice, research, teaching, administration or advocating on behalf of the profession or the public.
9. Refuse to participate in or support practices that violate basic human rights.
10. Promote and maintain your own health and wellbeing.

Responsibilities to the Patient

General Responsibilities

11. Recognize and disclose conflicts of interest that arise in the course of your professional duties and activities, and resolve them in the best interest of patients.
12. Inform your patient when your personal values would influence the recommendation or practice of any medical procedure that the patient needs or wants.
13. Do not exploit patients for personal advantage.
14. Take all reasonable steps to prevent harm to patients; should harm occur, disclose it to the patient.
15. Recognize your limitations and, when indicated, recommend or seek additional opinions and services.
16. In determining professional fees to patients for non-insured services, consider both the nature of the service provided and the ability of the patient to pay, and be prepared to discuss the fee with the patient.

Initiating and Dissolving a Patient-Physician Relationship

17. In providing medical service, do not discriminate against any patient on such grounds as age, gender, marital 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 a patient 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.



20. Limit treatment of yourself or members of your immediate family to minor or emergency services and only when another physician is not readily available; there should be no fee for such treatment.

Communication, Decision Making and Consent

21. Provide your patients with the information they need to make informed decisions about their medical care, and answer their questions to the best of your ability.
22. Make every reasonable effort to communicate with your patients in such a way that information exchanged is understood.
23. Recommend only those diagnostic and therapeutic procedures that you consider to be beneficial to your patient or to others. If a service is recommended for the benefit of others, as for example in matters of public health, inform your patient of this fact and proceed only with explicit informed consent or where required by law.
24. Respect the right of a competent patient to accept or reject any medical care recommended.
25. Recognize the need to balance the developing competency of minors and the role of families in medical decision-making. Respect the autonomy of those minors who are authorized to consent to treatment.
26. Respect your patient's reasonable request for a second opinion from a physician of the patient's choice.
27. Ascertain wherever possible and recognize your patient's wishes about the initiation, continuation or cessation of life-sustaining treatment.
28. Respect the intentions of an incompetent patient as they were expressed (e.g., through a valid advance directive or proxy designation) before the patient became incompetent.
29. When the intentions of an incompetent patient are unknown and when no formal mechanism for making treatment decisions is in place, render such treatment as you believe to be in accordance with the patient's values or, if these are unknown, the patient's best interests.
30. Be considerate of the patient's family and significant others and cooperate with them in the patient's interest.

Privacy and Confidentiality

31. Protect the personal health information of your patients.
32. Provide information reasonable in the circumstances to patients about the reasons for the collection, use and disclosure of their personal health information.
33. Be aware of your patient's rights with respect to the collection, use, disclosure and access to their personal health information; ensure that such information is recorded accurately.
34. Avoid public discussions or comments about patients that could reasonably be seen as revealing confidential or identifying information.



35. Disclose your patients' personal health information to third parties only with their consent, or as provided for by law, such as when the maintenance of confidentiality would result in a significant risk of substantial harm to others or, in the case of incompetent patients, to the patients themselves. In such cases take all reasonable steps to inform the patients that the usual requirements for confidentiality will be breached.
36. When acting on behalf of a third party, take reasonable steps to ensure that the patient understands the nature and extent of your responsibility to the third party.
37. 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.

Research

38. Ensure that any research in which you participate is evaluated both scientifically and ethically and is approved by a research ethics board that meets current standards of practice.
39. Inform the potential research subject, or proxy, about the purpose of the study, its source of funding, the nature and relative probability of harms and benefits, and the nature of your participation including any compensation.
40. Before proceeding with the study, obtain the informed consent of the subject, or proxy, and advise prospective subjects that they have the right to decline or withdraw from the study at any time, without prejudice to their ongoing care.

Responsibilities to Society

41. Recognize that community, society and the environment are important factors in the health of individual patients.
42. Recognize the profession's responsibility to society in matters relating to public health, health education, environmental protection, legislation affecting the health or well-being of the community and the need for testimony at judicial proceedings.
43. Recognize the responsibility of physicians to promote equitable access to health care resources.
44. Use health care resources prudently.
45. Recognize a responsibility to give the generally held opinions of the profession when interpreting scientific knowledge to the public; when presenting an opinion that is contrary to the generally held opinion of the profession, so indicate.

Responsibilities to the Profession

46. Recognize that the self-regulation of the profession is a privilege and that each physician has a continuing responsibility to merit this privilege and to support its institutions.
47. Be willing to teach and learn from medical students, residents, other colleagues and other health professionals.
48. Avoid impugning the reputation of colleagues for personal motives; however, report to the appropriate authority any unprofessional



conduct by a colleague or concerns, based upon reasonable grounds, that a colleague is practicing medicine at a level below an acceptable medical standard, or that a colleague's ability to practice medicine competently is affected by a chemical dependency or medical disability.

49. Be willing to participate in peer review of other physicians and to undergo review by your peers. Enter into associations, contracts and agreements only if you can maintain your professional integrity and safeguard the interests of your patients.
50. Avoid promoting, as a member of the medical profession, any service (except your own) or product for personal gain.
51. Do not keep secret from colleagues the diagnostic or therapeutic agents and procedures that you employ.
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.

Responsibilities to Oneself

53. Seek help from colleagues and appropriately qualified professionals for personal problems that might adversely affect your service to patients, society or the profession.
54. Protect and enhance your own health and wellbeing by identifying those stress factors in your professional and personal lives that can be managed by developing and practicing appropriate coping strategies.

8.1 Bylaws Defining Unbecoming, Improper, Unprofessional or Discreditable Conduct

(a) In this section:

- (i) "standard of practice of the profession" means the usually and generally accepted standards of practice expected in the branches of medicine in which the physician is practicing.
- (ii) "Sexual impropriety" and "sexual violation" include, but are not limited to:
 1. Acts or behaviours which are seductive or sexually-demeaning to a patient or which reflect a lack of respect for the patient's privacy, such as examining a patient in the presence of third parties without the patient's consent or sexual comments about a patient's body or underclothing;
 2. Making sexualized or sexually-demeaning comments to a patient;
 3. Requesting details of sexual history or sexual likes or dislikes when not clinically indicated;
 4. Making a request to date a patient or dating a patient;
 5. Initiation by the physician of conversation regarding the sexual problems, preferences or fantasies of the physician;
 6. Kissing of a sexual nature with a patient;
 7. Physician-patient sex whether initiated by the patient or not;
 8. Conduct with a patient which is sexual or may reasonably be interpreted as sexual such as touching any sexualized body part of a patient except for the purpose of an appropriate examination or treatment;



9. Touching any sexualized body part of the patient where the patient has refused or withdrawn consent;
 10. Sexual acts by the physician in the presence of the patient.
- (iii) "Prescribing to a patient without establishing an appropriate physician-patient relationship" includes any situation in which a physician issues a prescription, via electronic or other means, unless the physician has obtained a history and has performed an appropriate physical evaluation of the patient adequate to establish diagnoses and identify underlying conditions and/or contra-indications to the treatment recommended/provided.
- "Prescribing to a patient without establishing an appropriate physician-patient relationship" does not include a situation where the prescription is issued:
1. In an emergency situation to protect the health or well-being of the patient;
 2. In consultation with another Saskatchewan physician who has an ongoing relationship with the patient, and who has agreed to supervise the patient's treatment, including use of any prescribed medications;
 3. In an on-call or cross-coverage situation in which the physician has access to the record of the patient for whom the prescription is issued;
 4. In an on-call or cross-coverage situation, or in a situation of dealing with a physician's own patient where a doctor-patient relationship has been established, in which the physician is able, on the basis of a telephone discussion with the patient or a representative of the patient, to reach an appropriate diagnosis that is consistent with good medical practice.
- (iv) "Offering an inducement for medical treatment" includes any situation in which:
1. a physician, or any person or organization with the knowledge of a physician, offers or provides any inducement to a patient, a prospective patient, or any other person, for the referral of a person to the physician for the provision of any service or product, whether that service or product is, or is not, medically necessary;
 2. a physician, or any person or organization with the knowledge of a physician, offers any inducement, or causes any inducement to be received directly or indirectly by a patient of the physician, or any other person for the benefit of the patient of the physician, in return for the provision of any service or product to that patient, whether that product or service is, or is not, medically necessary;
- but does not include a reduction of a fee or charge that is made by a physician to a patient where that reduction is not related to products or services that may be provided to persons other than the patient.
- (b) The following acts or failures are defined to be unbecoming, improper, unprofessional or discreditable conduct for the purpose of Section 46(p) of the Act. The enumeration of this conduct does not limit the ability of Discipline Hearing Committees to determine that conduct of a physician is unbecoming, improper, unprofessional or discreditable pursuant to Section 46(o):
- (i) Failure by a physician to abide by the terms, conditions or limitations of a licence or permit issued to the physician.
 - (ii) Permitting, counseling or assisting any person who is not the holder of a licence or permit issued under the Act to engage in the practice of medicine, except as provided for in the Act or the bylaws.
 - (iii) Charging a fee that is excessive in relation to the services performed.
 - (iv) Failing, without just cause, to carry out the terms of an agreement with a patient.



- (v) Refusing to render a medically necessary service unless payment of the whole or part of the fee is paid in advance of the service being rendered.
- (vi) Falsifying a record in respect of the examination or treatment of a patient.
- (vii) Engaging in the practice of medicine while impaired by alcohol or a drug.
- (viii) Contravening any federal, provincial, or municipal law, regulation or rule or any bylaw of a hospital designed to protect public health while engaged in the practice of medicine.
- (ix) Failing to maintain the standard of practice of the profession.
- (x) Giving information concerning a patient's condition or any professional services performed for a patient to any person other than the patient without the patient's consent unless required or authorized by law to do so.
- (xi) Failing to continue to provide professional services to a patient until the services are no longer required or until the patient has had a reasonable opportunity to arrange for the services of another physician.
- (xii) Failing to provide within a reasonable time any report or certificate requested by a patient or a patient's authorized agent in respect of an examination or treatment provided by a physician.
- (xiii) Sharing fees with any person who has referred a patient or receiving fees from any person to whom a physician has referred a patient, or accepting or requesting a rebate or commission for the referral of a patient.
- (xiv) Making a deliberate misrepresentation regarding a remedy, treatment or device.
- (xv) Utilizing any remedy, treatment or device in connection with the physician's medical practice which is not generally accepted as having therapeutic value by the medical community unless:
 1. The remedy or device is utilized in connection with a bonafide clinical trial authorized by a reputable medical organization; or
 2. The physician demonstrates to the satisfaction of the Discipline Hearing Committee that there was a reasonable scientific basis to utilize the remedy or device, or:
 3. The Council has given permission to the physician to utilize the remedy or device on such terms as the Council may believe are in the interest of the public.
- (xvi) Committing an act of sexual impropriety with a patient or an act of sexual violation of a patient.
- (xvii) Committing an act of sexual harassment in the physician's professional capacity.
- (xviii) Being found guilty of an action or failure by a body responsible for licensing or regulating physicians outside Saskatchewan, where the Discipline Committee considers that the action or failure of which the member has been found guilty is unbecoming, improper, unprofessional or discreditable.
- (xix) Prescribing to a patient without establishing an appropriate physician-patient relationship.
- (xx) Offering an inducement for medical treatment.
- (xxi) Offering or undertaking by any means or method to diagnose, treat, operate or prescribe for any human disease, pain, injury, disability or physical or mental condition while the physician is subject to an order of suspension under **The Medical Profession Act, 1981.**



9.1 Conflict of Interest

- (a) In this section “benefit” means any benefit, gift, advantage or emolument of any kind whatsoever, whether direct or indirect, and includes:
- (i) the receipt of any benefit from the services of any person or reimbursement of the cost thereof;
 - (ii) the benefit or receipt of the payment or reduction of any amount of any debt or financial obligation;
 - (iii) the receipt of any consultation fee or other fee for services rendered, except pursuant to a written contract for each such service where:
 - 1. a copy of the contract is available and produced to the College on demand;
 - 2. each contracted service is within the normal scope of the physician’s specialty; and
 - 3. each service is supported by records adequate to satisfy the College that it was in fact performed.
 - (iv) the acceptance of any loan except pursuant to a written evidence of indebtedness,
 - 1. executed at the time of transfer of funds;
 - 2. witnessed at the time of actual execution by an individual whose name is legibly recorded on the document;
 - 3. available and produced to the College on demand; and,
 - 4. that provides for a fixed term of loan and fixes a set interest rate, both of which are reasonable having a view to prevailing market rates at the time of the loan.
 - (v) the acceptance of a loan that is interest free or related in any way to any referral made by the physician;
 - (vi) the acceptance of credit unless the credit is unrelated in any way to any referral of patients to the creditor and the credit is extended pursuant to an agreement in writing,
 - 1. executed at the time of the transaction;
 - 2. witnessed at the time of actual execution by an individual whose name is legibly recorded on the agreement;
 - 3. available and produced to the College on demand; and,
 - 4. which provides for a fixed term of credit and fixes a set interest rate, both of which are reasonable having a view to prevailing market rates at the time of the transaction.
- (b) In this section “medical goods or services” includes medical goods, appliances, materials, services and equipment, and drugs and laboratory services.
- (c) In this section “member of the physician’s family” means any person connected with the physician by blood relationship, marriage or adoption, and:
- (i) persons are connected by blood relationship if one is the child or other descendent of the other or one is the brother or sister of the other;
 - (ii) persons are connected by marriage if one is married to the other or to a person who is connected by blood relationship to the other; and
 - (iii) persons are connected by adoption if one has been adopted, either legally or in fact, as the child of the other or as the child or a person who is connected by blood relationship (otherwise than as a brother or sister) to the other.



- (d) In this section “supplier” means a person who:
- (i) sells or otherwise supplies medical goods or services; or
 - (ii) is registered or licensed under any Act regulating a health profession.
- (e) In this section “conflict of interest” includes a situation whereby a physician, or a member of the physician’s family, or a corporation, wholly, substantially or actually owned or controlled by the physician or a member of the physician’s family:
- (i) receives any benefit, directly or indirectly from:
 - 1. a supplier to whom the physician refers his patients or their specimens; or,
 - 2. a supplier who sells or otherwise supplies any medical goods or services to the patients of the physician.
 - (ii) rents premises to,
 - 1. a supplier to whom the physician refers his patients or their specimens; or
 - 2. a supplier who sells or otherwise supplies any medical goods or services to the patients of the physician,except where,
 - 3. the rent is normal for the area in which the premises are located; and,
 - 4. the amount of the rent is not related to the volume of business carried out in the premises by the tenant.
 - (iii) rents premises from:
 - 1. a supplier to whom the physician refers his patients or their specimens; or
 - 2. a supplier who sells or otherwise supplies any medical goods or services to the patients of the physician,except where,
 - 3. the rent is normal for the area in which the premises are located; and,
 - 4. the amount of the rent is not related to the referral of patients to the landlord.
 - (iv) Sells or otherwise supplies any drug, medical appliance, medical product or biological preparation to a patient at a profit, unless the physician can demonstrate that the product sold or supplied was reasonably necessary for the medical care of the patient.
- (f) It is a conflict of interest for a physician to order diagnostic tests other than medically necessary tests to be performed by a diagnostic facility in which the physician or a member of the physician’s family has any proprietary interest.
- (g) It is unbecoming, improper, unprofessional or discreditable conduct for a physician to have a conflict of interest in relation to the physician’s professional practice.

10.1 The Discipline Committee

(a) Definition:

(i) In this section, "committee member" means a member of the Discipline Committee.

(b) Composition:

(i) The Council may, from time to time, appoint persons to the Discipline Committee pursuant to section 43 of the Act.

(ii) The Council shall, from time to time, appoint one committee member as the chairperson and one or more committee members as acting chairpersons. An acting chairperson may perform any of the functions of the chairperson and may perform such functions whether or not the chairperson is absent and whether or not the chairperson is, or is not, able to act.

(iii) A committee member shall remain a member of the Discipline Committee until he or she resigns or is removed by the Council.

(iv) Notwithstanding paragraph 10.1(b)(iii) of this bylaw, where a committee member who has participated in a hearing resigns or is removed by the Council, the committee member shall continue to be a member of the Discipline Committee for the purpose of disposing of the matter under consideration at the hearing until:

1. the hearing has been concluded and the Committee's report to the Council has been made;
2. the Council has considered the report and, in the case of a person who is found to be guilty of unbecoming, improper, unprofessional or discreditable conduct, has made a decision pursuant to Section 54 of the Act; and
3. all appeals under the Act have been decided and, where the matter has been remitted back to the Discipline Committee, the matter is concluded and all things that are required to be done by the Discipline Committee or the Council or in relation to all appeals have been completed.



- (c) Objectives and Methods:
 - (i) The Committee shall be available for its members to be selected to Discipline Hearing Committees pursuant to the Act and these bylaws.

11.1 The Discipline Hearing Committee

- (a) Composition:
 - (i) Discipline Hearing Committees shall be selected from the Discipline Committee in accordance with the Act and bylaws.
- (b) Objectives:
 - (i) To conduct hearings into charges laid against a physician pursuant to section 47.5 or 47.6 of the Act, and to carry out the other responsibilities of a Discipline Hearing Committee under the Act and bylaws.
- (c) Methods:
 - (i) To conduct hearings pursuant to the provisions of the Act and the bylaws.
- (d) Reporting:
 - (i) The Committee shall provide reports to the Council in accordance with section 52 of the Act.

11.2 Hearings before the Discipline Hearing Committee

- (a) It is the intention of the Council that all discipline hearings before the Discipline Hearing Committee be conducted in a manner that is fair to the physician who is charged and in a manner that permits both the physician who is subject to discipline and the College to know the nature of the evidence which will lead at the hearing. In order to accomplish this, it is necessary for full and complete disclosure to be made by both parties relating to the witnesses to be called and the nature of the evidence which will be introduced at the hearing. It is also the intention of the Council to allow for matters of a preliminary nature to be determined by the Discipline Hearing Committee in advance of the hearing wherever possible. The Council therefore enacts the following bylaw.
- (b) Not less than two weeks prior to the date set for the commencement of a hearing before the Discipline Hearing Committee, the physician who has been charged and the College will provide to each other the following information and documents:
 - (i) the names of each of the witnesses which that party intends to call to give evidence at the hearing;
 - (ii) A summary of the evidence which that party expects will be given by that witness;
 - (iii) If a witness will be called to give expert evidence, a summary of the qualifications of that witness;
 - (iv) A list of all documents which the party intends to introduce into evidence at the hearing. Such party shall permit the other party to examine such documents and to obtain copies of all such documents, at the cost of the party requesting the documents.
- (c) If, as a result of the information disclosed by the other party under paragraph 11.2(b) above, a party intends to introduce evidence at the hearing in addition to the evidence which it has disclosed, that party shall provide the information referred to in paragraph 11.2(b) with respect to that additional evidence.
- (d) The Discipline Hearing Committee shall not permit a witness to testify unless the name of that witness, a summary of that witness' evidence, and, if the witness is called to give expert evidence, a summary of that witness' qualifications has been

disclosed in accordance with paragraph 11.2(b) or 11.2(c) of this bylaw. The Discipline Hearing Committee shall not permit a document to be entered into evidence unless the information respecting that document has been disclosed in accordance with paragraph 11.2(b) or 11.2(c) of this bylaw.

- (e) Notwithstanding paragraph 11.2(d) of this bylaw, if the Discipline Hearing Committee is satisfied that the failure to disclose the required information arose through inadvertence, or that the information was not in the possession of the party at the time that disclosure was required, or that for any other compelling reason it would be manifestly unfair to exclude evidence or documents not disclosed as required, the Discipline Hearing Committee may permit such evidence to be given, or such documents to be introduced into evidence. This may be done on such terms or conditions as the Discipline Hearing Committee may determine, including the following:
 - (i) the Committee may adjourn the hearing for such time as the Committee considers reasonable to permit the other party the opportunity to respond to such evidence;
 - (ii) the Committee may require the party who requests the introduction of such evidence to agree to pay an amount of costs, as estimated by the Committee, which may be incurred by the physician or the College as a result of the failure to disclose such evidence in accordance with paragraph 11.2(b) or 11.2(c) of this bylaw.
- (f) If either party intends to object to the jurisdiction of the Committee, or intends to raise any preliminary objection or preliminary issue of law before the Committee, such party shall prepare a written summary of the nature of the objection, the points of law to be argued, the authorities relied upon and the evidence to be lead in support of such objection or issue of law. Such summary shall be provided to the other party and, if an assessor has been named for the hearing, the assessor, not less than 14 days before the date set for the commencement of the hearing.
- (g) A party who fails to provide the written summary contemplated by paragraph 11.2(f) shall be deemed to have waived the objection or issue of law and the Committee shall not entertain such objection or argument on such issue of law. If the Committee is satisfied that the failure to provide the written summary arose through inadvertence, or that the party was not in possession of all of the relevant facts to determine whether the objection should be made or the point of law raised, or that for any other compelling reason it would be manifestly unfair that the party not be permitted to make such objection, or raise such point of law, it may permit the objection to be made or the point of law to be raised on such terms or conditions as the Discipline Hearing Committee may determine, including the following:
 - (i) the Committee may adjourn the hearing for such time as the Committee considers reasonable to permit the other party the opportunity to respond to such objection or point of law;
 - (ii) the Committee may require the party who wished to raise such objection or point of law to agree to pay an amount of costs, as estimated by the Committee, which may be incurred by the other physician or the College as a result of the failure to provide the written summary in accordance with paragraph 11.2(f) of this bylaw.
- (h) The Discipline Hearing Committee may meet by telephone conference call or similar communications equipment, whereby all Committee members participating in the meeting can hear each other at the same time to deal with any matters which may arise at any time that are relevant to a hearing, objections to the jurisdiction of the Committee, questions of law and requests for adjournments, and may for that purpose establish a date and time for such meetings which may be in advance of the date established for the commencement of the hearing.



- (i) A Discipline Hearing Committee may consider in one hearing one or more charges against a member and a charge may contain one or more allegations.
- (j) If one or more members of a Discipline Hearing Committee withdraw from acting at the hearing, or are unable or unwilling to hear and determine the charge, the hearing may continue with the remaining members of the Discipline Hearing Committee provided that there shall at all times be a quorum, as required by section 49(7) of the Act.
- (k) The chairperson or acting chairperson may appoint an assessor to assist the Discipline Hearing Committee for all, or any part, of a hearing before the Discipline Hearing Committee. Such assessor may advise the Discipline Hearing Committee on any issues of fact, law or procedure which arise before the Committee in advance of or during the hearing, or in connection with the decision of the Committee. For that purpose the assessor may assist the Discipline Hearing Committee during its deliberations and may review drafts of the decision of the Committee and provide advice to the Committee respecting such decisions.

12.1 The Competency Committee

- (a) Composition
 - (i) The Chair and members of the Committee shall be appointed by Council.
 - (ii) A Competency Committee shall be composed of one or more members whose training and experience lie within the same field of medicine as the member being evaluated.
- (b) Objective
 - (i) To determine whether a member has adequate skill and knowledge to practise in Saskatchewan.
- (c) Method - The methods of evaluation to determine skill and knowledge may include one or more of the following:
 - (i) case discussion;
 - (ii) observation of the performance of the physician in an office setting;
 - (iii) observation of the performance of the physician in hospital;
 - (iv) written examination;
 - (v) the use of Family Medicine, or Royal College evaluation forms;
 - (vi) a medical examination to determine the physician's health;
 - (vii) any other method deemed appropriate by the Committee;
- (d) Reporting - Upon completion of its assigned task the Committee shall prepare for Council a written report of its activities, findings and conclusions, to be signed by each member of the Committee concurring. A minority report may be submitted. Council may require the presence of the Chair or his/her designate at a meeting of Council to present the report and answer questions. The report should state one of the following:
 - (i) that the physician had adequate skill and knowledge to practise; or
 - (ii) that the physician lacks adequate skill and knowledge in a particular discipline or disciplines; or
 - (iii) that the physician lacks adequate skill and knowledge to practise.

13.1 The Competency Hearing Committee

- (a) Composition:



- (i) Competency Hearing Committees shall be selected from the Council in accordance with the Act and bylaws.
- (b) Objectives:
 - (i) To conduct hearings following a report from a Competency Committee to determine whether a member has adequate skill and knowledge in the practice of medicine in accordance with the Act and the bylaws.
- (c) Methods:
 - (i) To conduct hearings pursuant to the provisions of the Act and the bylaws.
- (d) Reporting:
 - (i) The Committee shall provide reports to the Council in accordance with section 45(9) of the Act.

13.2 Hearings before the Competency Hearing Committee

- (a) The Council, the Executive Committee, or the Competency Hearing Committee shall name from the Competency Hearing Committee a person to be the Chair of the Competency Hearing Committee. The Council, the Executive Committee or the Competency Hearing Committee may replace the Chair and name a different person from the Competency Hearing Committee as Chair.
- (b) The Chair of the Competency Hearing Committee shall fix the time and place for the hearing by the Competency Hearing Committee.
- (c) The Competency Hearing Committee may, from time to time, adjourn the hearing.
- (d) Where:
 - (i) The time and place for a hearing has been scheduled; or
 - (ii) a hearing has been adjourned to a specific time and place;
 and, before the scheduled or adjourned date, the Chair forms the opinion that the hearing should be adjourned to a different time or place, he or she may adjourn the hearing.
- (e) The person who is the subject of the hearing may be present at the hearing and may be represented by counsel at his own expense.
- (f) The report of the Competency Committee is admissible in evidence before the Competency Hearing Committee as evidence of the matters set out in the report. The members of the Competency Committee shall not be required to give *viva voce* evidence at the hearing or to be cross-examined at the hearing. A representative of the College of Physicians and Surgeons or the physician whose competency is under investigation may ask the Competency Hearing Committee to request one or more members of the Competency Committee to attend at the hearing and to give evidence at the hearing. Upon such a request, or on its own motion, the Competency Hearing Committee may, in its discretion, and if it considers it necessary, request one or more members of the Competency Committee to attend at the hearing to give evidence at the hearing.
- (g) The Competency Hearing Committee may, in addition to the report of the Competency Committee, consider such additional information as it considers reliable.
- (h) For the purpose of advising the Competency Hearing Committee on questions of law arising in proceedings before it, the Competency Hearing Committee may appoint a person entitled to practise as a member of the Law Society of Saskatchewan, and who has at least 10 years standing as a barrister or solicitor, to be an assessor at the hearing.

- (i) The Competency Hearing Committee may, subject to the Act and this bylaw, determine the practice and procedure to be followed at the hearing.
- (j) A majority of the members of the Competency Hearing Committee shall constitute a quorum, provided however that the quorum cannot be fewer than three members of the Competency Hearing Committee.
- (k) If a member of the Competency Hearing Committee withdraws, or is unable or unwilling to hear and determine whether the person whose competence is under investigation has adequate skill and knowledge in the practice of medicine, the Executive Committee or the Council may select from the members of the Council a person to replace such individual. This section does not apply once a hearing has been commenced and evidence has been considered by the Competency Hearing Committee in the presence of the person whose competency is under investigation.
- (l) If one or more members of the Competency Hearing Committee shall at any time withdraw, or shall be unable or unwilling to hear and determine whether the person whose competence is under investigation has adequate skill and knowledge in the practice of medicine, the hearing may continue with the remaining members of the Competency Hearing Committee, provided that there is at all times a quorum of the Competency Hearing Committee present.
- (m) If the hearing by a Competency Hearing Committee has been adjourned, the Executive Committee or the Council may appoint a differently constituted Competency Hearing Committee to determine whether the person whose competence is under investigation has adequate skill and knowledge in the practice of medicine. This section does not apply once a hearing has been commenced and evidence has been considered by the Competency Hearing Committee in the presence of the person whose competency is under investigation.
- (n) A member or person appointed to a Competency Hearing Committee shall remain a member of that Competency Hearing Committee until:
 - (i) the hearing has been concluded and the Committee's report to the Council has been made;
 - (ii) if the physician is determined not to have adequate skill and knowledge in the practice of medicine the Council has made a decision under Section 45(12) of the Act; and
 - (iii) all appeals under the Act have been decided and, where the matter has been remitted back to the Competency Hearing Committee, the matter is concluded and all things that are required to be done by the Competency Hearing Committee or the Council or in relation to all appeals have been completed.

14.1 Notifying Former Members of Disciplinary Investigations

- (a) When the Council or the Executive Committee acts pursuant to section 42.5 or 42.6 of the Act with respect to a person no longer registered with the College of Physicians and Surgeons of Saskatchewan, the Council or the Executive Committee shall cause a notice to be sent within 30 days to the person by registered mail to the person's last known address as shown by the records of the College.

15.1 Cost of Discipline Proceedings

- (a) For the purpose of clause 54(1)(i) of the Act, the following are defined to be costs of and incidental to the investigation and hearing:
 - (b) the travel, accommodation and meal expenses of the members of the Discipline Hearing Committee for the hearing, as well as the per diem allowances payable by the College to such members for such hearing;



- (c) the fees and expenses, including travel, accommodation and meal expenses of the assessor retained by the College in connection with the hearing;
- (d) the travel, accommodation and meal expenses of the members of the Preliminary Inquiry Committee in connection with its investigation, as well as the per diem allowances payable by the College to such persons for such investigation;
- (e) the cost of reporting services and expenses;
- (f) expert fees both for the preparation of written opinions and attending to give evidence with travel, accommodation and meal expenses incurred by such expert witnesses for the purpose of giving evidence;
- (g) payments made to witnesses in connection with a hearing before the Discipline Hearing Committee or before the Preliminary Inquiry Committee, including witness fees, travel and meal expenses;
- (h) the fees and expenses of the lawyer or lawyers retained by the College in connection with the investigation and/or hearing;
- (i) the sum of \$200.00 per hour for each hour spent by a lawyer employed by the College of Physicians and Surgeons in connection with the investigation and/or hearing;
- (j) costs of photocopying done by the College of Physicians and Surgeons in connection with the investigation and/or hearing calculated at a rate of \$.25 per page;
- (k) any other expenses incurred by the College incidental to the investigation and hearing.

PART 5 –COMMUNICATION WITH THE COLLEGE

16.1 College requests for information

- (a) The Registrar, the Deputy Registrar, the Executive Committee, the Council and the Standing Committees referred to in the bylaws of the College frequently request information and explanations from physicians. Prompt response to such requests is required if the College is to expeditiously and effectively regulate the practice of medicine and comply with the objects of the Act.

16.2 Response to College Requests for Information

- (a) Upon receipt of a written request from the Registrar, the Deputy Registrar, the Executive Committee, the Council or a standing committee for information a physician shall:
 - (i) respond substantially to the request;
 - (ii) provide the information or explanation requested to the best of the physician's ability to do so;
 - (iii) provide originals of documents requested, if originals are requested, or legible copies of documents if copies are requested;
 - (iv) provide a printed record if the requested information or documents are stored in an electronic computer storage form or similar form.
- (b) A physician shall provide the requested information, as referred to in the paragraph (a) within 14 days of receipt of the request, or such additional time as may be granted by the Registrar or Deputy Registrar for the response.
- (c) A physician who is requested to provide information to the College of Physicians and Surgeons or to any individual or committees associated with the College of Physicians and Surgeons under paragraph (a), or under any other provision of the Act or these bylaws relating to the provision of information and documents including,



without limiting the generality of the foregoing, the Administrative bylaws establishing the standing committees, 4.1, 16.1, 18.1, 19.1, 21.1, 22.1, or 25.1 of the bylaws and Section 55.3 of the Act, shall provide the information, explanation or documents contemplated by the request whether the consent of any person with an interest in the information, explanation or documents has, or has not, been sought or obtained.

- (d) Information obtained pursuant to this paragraph or under any other provision of the Act or these bylaws relating to the provision of information and documents shall be treated confidentially and, unless otherwise directed by the Executive Committee, or the Council, shall not be used except for the purpose of complying with the objects of the Act or the duties of the committee or individual which obtains such information or documents.
- (e) It is unbecoming, improper, unprofessional or discreditable conduct for a physician to fail to comply with paragraph 16.1 or 16.2.

PART 6 –PRACTICE STANDARDS

17.1 Minimum Standards for Written and Verbal Medication Prescriptions Issued by Physicians

- (a) Safe patient care requires clear written or verbal communication between physicians and pharmacists to minimize the risk of medication dispensing errors. To that end, the following bylaw defines minimum standards for written and verbal prescriptions issued by physicians.
- (b) For the purpose of this bylaw, “written prescription” includes an electronic prescription that meets the requirements for electronic prescribing under the Pharmaceutical Information Program.
- (c) For the purpose of this bylaw, “signature” includes a method of physician identification that meets the requirements for electronic prescribing under the Pharmaceutical Information Program.
- (d) A physician who issues a written prescription must include all of the following information on the prescription in a manner that is fully legible:
 - (i) his/her name and signature;
 - (ii) the patient’s name;
 - (iii) the full name of the medication;
 - (iv) the medication concentration where appropriate;
 - (v) the medication strength where appropriate;
 - (vi) the dosage;
 - (vii) the amount prescribed or the duration of treatment;
 - (viii) the administration route if other than oral;
 - (ix) explicit instructions for patient usage of the medication;
 - (x) the number of refills where refills are authorized.
- (e) All of this information shall be contained on one side of the prescription form.
- (f) Notations such as “use as directed” or similar remarks do not meet the requirements of d(ix) except where usage instructions are uniformly included on the manufacturer’s medication packaging label.
- (g) A physician who issues a prescription which prohibits drug substitution by the pharmacist must hand write those instructions or initial any pre-printed instructions to that effect.



- (h) A physician who issues a prescription for the purpose of obtaining drugs from a pharmacist for professional office use must explicitly make a notation on the prescription that the drugs in question are for professional office use.
- (i) Physicians in training who are enrolled on the educational register of the College of Physicians and Surgeons and who may be authorized to issue prescriptions must clearly identify on the prescription the name of the fully registered physician who is their supervisor in respect to that specific physician/patient interaction.
- (j) Physicians may transmit written prescriptions to pharmacists by fax, e-mail or other electronic means in accordance with policies that may be adopted by the Saskatchewan Pharmaceutical Association from time to time. All of the provisions of paragraphs (b) through (g) above apply to prescriptions transmitted by fax or e-mail.
- (k) Other than prescriptions transmitted in accordance with the policies and protocols of the Pharmaceutical Information Program, a physician shall only transmit written prescriptions to pharmacists by fax, email or other electronic means based upon patient instructions to transmit the prescription to a specific pharmacy.
- (l) A physician who issues a verbal prescription to a pharmacist must provide to the pharmacist all of the information described in paragraphs (d)(i) through (d)(x).
- (m) All verbal prescriptions must be communicated directly between a physician and a pharmacist as opposed to agents for either licensed professional.

18.1 The Prescription Review Program

- (a) Panel of Monitored Drugs – The Prescription Review Program shall apply to all dosage forms of the following drugs, except where indicated otherwise:
 - ACETAMINOPHEN WITH CODEINE - in all dosage forms except those containing 8 mg or less of codeine
 - ACETYLSALICYLIC ACID (ASA) WITH CODEINE - in all dosage forms except those containing 8 mg or less of codeine
 - AMPHETAMINES - in all dosage forms
 - ANABOLIC STEROIDS
 - ANILERIDINE - in all dosage forms
 - BARBITUATES
 - BENZODIAZEPINES – in all dosages and forms
 - BUPRENORPHINE – in all dosages and forms
 - BUTALBITAL - in all dosage forms
 - BUTALBITAL WITH CODEINE - in all dosage forms
 - BUTORPHANOL
 - CHLORAL HYDRATE
 - COCAINE - in all dosage forms
 - CODEINE - as the single active ingredient, or in combination with other active ingredients, in all dosage forms except those containing 20 mg per 30 ml or less of codeine in liquid for oral administration
 - DIETHYLPROPION - in all dosage forms
 - FENTANYL - in all dosage forms
 - GABAPENTIN



HYDROCODONE - DIHYDROCODEINONE - in all dosage forms
HYDROMORPHONE - DIPHRYDROMORPHONE - in all dosage forms
LEVORPHANOL - in all dosage forms
MEPERIDINE - PETHIDINE - in all dosage forms
METHADONE - in all dosage forms
METHYLPHENIDATE - in all dosage forms
MORPHINE - in all dosage forms
NORMETHANDONE-P-HYDROXYEPHEDRINE - in all dosage forms
OXYCODONE - as the single active ingredient or in combination with other active ingredients in all dosage forms
OXYMORPHONE
PANTOPON - in all dosage forms
PENTAZOCINE - in all dosage forms
PHENTERMINE - in all dosage forms
PROPOXYPHENE - in all dosage forms

- (b) Prescriptions for drugs covered by the Prescription Review Program shall be issued by physicians according to the policies and procedures agreed to and amended from time to time by the College of Dental Surgeons of Saskatchewan, the College of Physicians and Surgeons of Saskatchewan, the Saskatchewan Registered Nurses Association and the Saskatchewan College of Pharmacists.
- (c) In order to prescribe a drug to which the Prescription Review Program applies, physicians shall complete a written prescription which meets federal and provincial legal requirements and includes the following:
- (i) The patient's date of birth;
 - (ii) The patient's address;
 - (iii) The total quantity of medication prescribed, both numerically and in written form;
 - (iv) The patient's health services number; and,
 - (v) The prescriber's name and address.
- (d) For the purpose of this bylaw, "written prescription" includes an electronic prescription that meets the requirements for electronic prescribing under the Pharmaceutical Information Program.
- (e) A physician who prescribes a drug to which the Prescription Review Program applies, and who provides the prescription directly to a pharmacy by electronic prescribing, by email or by FAX, or who transmits a prescription in accordance with the policies and protocols of the Pharmaceutical Information Program, need not include both the quantity numerically and in written form.
- (f) If a physician is registered on the Educational Register, the physician shall, in addition to the information in paragraph (c) above, include the following in a prescription for a drug to which the Prescription Review Program applies:
- (i) The training level of the physician writing the prescription;
 - (ii) The legibly printed name of the Most Responsible Physician (the physician to whom queries regarding the prescription should be addressed);



- (iii) The legibly printed name of the physician writing the prescription.
- (g) Physicians shall only prescribe part-fills of medications to which the Prescription Review Program applies if the following information is specified in the prescription:
 - (i) The total quantity;
 - (ii) The amount to be dispensed each time; and
 - (iii) The time interval between fills.
- (h) The office of the Registrar may gather and analyze information pertaining to the prescribing of medications to which the Prescription Review Program applies in Saskatchewan for the purpose of limiting the inappropriate prescribing and inappropriate use of such drugs. In order to fulfill that role, the office of the Registrar may, among other activities:
 - (i) Generally, provide education to physicians in order to encourage appropriate prescribing practices by physicians registered by the College;
 - (ii) Alert physicians to possible inappropriate use of medications to which the Prescription Review Program applies by patients to whom they have prescribed such drugs;
 - (iii) Alert physicians to possible inappropriate prescribing of medications to which the Prescription Review Program applies;
 - (iv) Make recommendations to a physician with respect to the physician's prescribing of medications to which the Prescription Review Program applies;
 - (v) Require physicians to provide explanations for their prescribing of medications to which the Prescription Review Program applies. In making requests for explanations, the office of the Registrar may require the physician to provide information about the patient, the reasons for prescribing to the patient, and any knowledge which the physician may have about other narcotics or controlled drugs received by the patient;
 - (vi) Cause information, concerns or opinions of general application to the profession to be communicated to the physicians registered by the College without identifying the particular physician to whom such information relates;
 - (vii) Provide information gathered in connection with the Prescription Review Program to another health professional body including the College of Dental Surgeons of Saskatchewan, the Saskatchewan College of Pharmacists or the Saskatchewan Registered Nurses Association, provided the information gathered is required by that body to perform and carry out the duties of that health professional body pursuant to an Act with respect to regulating the profession. Where the personal health information relates to a member of the health professional body seeking disclosure, disclosure by the Registrar of that information may only be made in accordance with The *Health Information Protection Act*, and in particular section 27(5) or that Act.
- (i) Physicians shall respond to such requests for explanation, as described in paragraph (h)(v) above, from the office of the Registrar within 14 days of receipt of such a request for information.
- (j) The Registrar, Deputy Registrar, or Prescription Review Program Supervisor may extend the deadline for reply at their discretion, upon receipt of a written request for extension from the physician.
- (k) All physicians who receive such a request for information will comply, to the best of their ability, fully and accurately with such requests for information.



- (l) Failure to comply with paragraphs (h)(v), (i) and (k) above is unbecoming, improper, unprofessional or discreditable conduct.
- (m) Members shall keep a record of all drugs to which the Prescription Review Program applies that are purchased or obtained for the member's practice and a record of all such drugs administered or furnished to a patient in or out of the physician's office, showing:
 - (i) the name, strength and quantity of the drug purchased or obtained;
 - (ii) the name, strength, dose and quantity of the drug administered or furnished;
 - (iii) the name and address of the person to whom it was administered or furnished, and, if applicable, the name and address of the person who took delivery of the drug; and
 - (iv) the date on which the drug was obtained and the date(s) on which the drug was administered, furnished or otherwise disposed of.
- (n) The record referred to in paragraph (m) shall be kept separate from the patient's medical record.

19.1 Standards for prescribing of buprenorphine

- (a) For the purposes of this bylaw, "buprenorphine" shall include all products containing buprenorphine, but shall not include buprenorphine in its transdermal form and shall not include buprenorphine that is prescribed solely for the purpose of pain control.
- (b) No physician shall prescribe buprenorphine unless:
 - (i) The physician has taken an educational program on prescribing of buprenorphine approved by the Council; and,
 - (ii) The physician has a relationship with one or more addiction counselors and one or more pharmacists to offer opioid addicted patients the full range of treatment options; and,
 - (iii) The physician has established a program for the regular testing of patients receiving buprenorphine for drugs of possible abuse; and,
 - (iv) The physician has access to the Pharmaceutical Information Program to permit monitoring of drugs prescribed to those patients for whom the physician has prescribed buprenorphine.
- (c) No physician shall prescribe buprenorphine unless:
 - (i) The physician has received an exemption from Health Canada to allow that physician to prescribe methadone for the purpose of treating addiction; or
 - (ii) The physician has spent a minimum of one day with another physician who has received an exemption from Health Canada to allow that physician to prescribe methadone for the purpose of treating addiction, who has met the requirements of this bylaw to prescribe buprenorphine and who prescribes buprenorphine as part of his/her regular practice.
- (d) Physicians who prescribe buprenorphine shall, as a condition of prescribing buprenorphine, participate in a program of continuing medical education which includes a minimum of six hours every two years in addiction medicine.
- (e) Physicians who wish to prescribe buprenorphine shall, as a condition of doing so, sign an undertaking in which they agree that:
 - (i) Their prescribing of buprenorphine may be audited on such terms and at such times as may be required by the College of Physicians and Surgeons; and,



- (ii) They will co-operate with any such audit or audits; and
 - (iii) They will follow the requirements of this bylaw pertaining to the prescribing of buprenorphine.
- (f) Failure to follow this bylaw shall be unbecoming, improper, unprofessional or discreditable conduct under the Act.

20.1 Acupuncture

- (a) The College recognizes acupuncture as a medical act.
- (b) Physicians wishing to practise acupuncture shall submit to the Registrar their qualifications and experience.
- (c) The minimum qualification is the Diploma from the Acupuncture Foundation of Canada or other approved course of training.

21.1 Performance Enhancing Substances

- (a) A physician shall not prescribe or administer anabolic steroids, growth hormones, testosterone or its analogs, human chorionic gonadotropin (HCG), other hormones or other performance enhancing substances that are banned by sports governing councils for the purpose of enhancing athletic ability.
- (b) A physician shall complete and maintain patient medical records which accurately reflect the utilization of any substance or drug described in (a) above. Patient medical records shall indicate the diagnosis and purpose for which the substance or drug is utilized, and any additional information upon which the diagnosis is based. Records on these patients must be produced for inspection by the College.
- (c) It is unbecoming, improper, unprofessional or discreditable conduct for a physician to fail to follow this bylaw.

22.2 Performance Standards for Performance of Chelation Therapy

- (a) While the College of Physicians and Surgeons is not convinced of the efficacy of chelation therapy, and does not endorse its use for any purpose other than heavy metal poisoning, it recognises that there is public demand for safe access to this treatment.
- (b) The provisions of this bylaw apply only to the use of chelation therapy for purposes other than treatment of heavy metal poisoning as defined by the reference values set by the Provincial Lab of Saskatchewan.
- (c) For the purpose of this bylaw:
 - (i) Chelation therapy means the intravenous or intramuscular administration of ethylene diamine tetra acetate (EDTA) or magnesium disodium-ethylene diamine tetra acetate or similar substances;
 - (ii) Physician or physicians shall mean persons registered under section 4, 28, 29, 30 or 31 of the Act.
- (d) No physician shall practice chelation therapy unless:
 - (i) That physician is certified by the American Board of Chelation Therapy or any other body acceptable to Council; or
 - (ii) That physician has passed the written examination of the American Board of Chelation Therapy, the International Board of Chelation Therapy or other body acceptable to the Council, and less than two years have passed since passing the written examination.
- (e) All patient charts will include (at a minimum) written or typed records of:



- (i) Precounseling information, consent, history including health questionnaire, and physical examination;
 - (ii) Pretreatment tests;
 - (iii) Evidence of Cockcroft-Gault calculation;
 - (iv) Flow chart of treatments including number of treatment, date, weight, creatinine, blood pressure (pre and post), pulse rate, lab results (glucose, magnesium, creatinine etc.), urine and notes;
 - (v) Medication / fluid record;
 - (vi) Progress notes.
- (f) Prior to beginning chelation therapy on a patient, a physician shall:
- (i) Obtain a consent form signed by the patient indicating:
 1. Pretreatment counseling in regard to possible adverse effects including pain at the injection site, thrombophlebitis, hypocalcemia, hypoglycemia, and renal failure (that may not be reversible);
 2. A signed copy must be given to the patient and a copy kept on the chart.
 - (ii) Obtain a complete medical history, including a complete list of current medications and a list of all known allergies;
 - (iii) Perform a complete physical examination including vascular examination;
 - (iv) Perform vascular studies if indicated;
 - (v) Obtain a CBC, serum electrolytes, urea and creatinine, fasting blood sugar, calcium, phosphorous, total protein, albumin, ALT, bilirubin, ALP, PT, total cholesterol/HDL cholesterol, TSH, Serum digoxin level (if the patient is receiving digoxin), INR (if the patient is receiving anti-coagulants);
 - (vi) Obtain a complete urine analysis and a 24 hour urine collection for urea, creatinine and protein;
 - (vii) Record the patient's weight and blood pressure (standing and lying);
 - (viii) Obtain a recent (within three months) electrocardiogram with written interpretation and chest x-ray with written interpretation;
 - (ix) Perform pregnancy test on women of child-bearing years.
- (g) Patient Exclusion Criteria:
- (i) Renal insufficiency defined as creatinine clearance calculated by Cockcroft-Gault Formula of less than 30 mls/min. (N.B. serum creatinine is not an accurate reflection of renal function in many situations. Therapy should be based on calculation of creatinine clearance.);
 - (ii) Presence of uncontrolled heart failure;
 - (iii) Hypocalcemia (serum calcium less than 2.10, corrected for hypoalbuminemia);
 - (iv) Significant hepatic dysfunction;
 - (v) Active tuberculosis or tuberculosis treated within the last year;
 - (vi) Allergy to EDTA or the chelating agent(s) to be used;
 - (vii) Pregnancy;
 - (viii) Children
- (h) Treatment Procedures:



- (i) The EDTA shall be mixed as per protocol (as given by American College of Advancement in Medicine [ACAM]) in a specified area of clinic, mixed by one person, and properly labeled;
 - (ii) The dosage of EDTA given to a patient shall not exceed 50 mg per kg of lean body weight (not exceeding a total of 3 gm of EDTA on any single treatment) and shall be administered at a rate not exceeding 16.7 mg per kg of lean body weight per hour. ½ dose shall be given on first treatment and allergic reactions monitored;
 - (iii) The EDTA shall be given by infusion pump with a heating pad beneath the arm with the injection site;
 - (iv) Blood pressure shall be monitored at time 0, 1 hour, 3 hours, and at the end of treatment. The patient's weight shall be taken pre-therapy each time. Patients with limited cardiac reserve shall be weighed pre and post treatment to detect fluid retention;
 - (v) Spot blood sugars shall be done if the patient is diabetic;
 - (vi) Physicians providing chelation to patients who are receiving anticoagulation shall frequently monitor INR times during the course of chelation therapy, or append a report from another physician to the record.
- (i) Physicians performing chelation therapy shall have available on site:
- (i) An area suitable for resuscitation;
 - (ii) Treatment chairs with the ability to lay flat for resuscitation;
 - (iii) At least one registered nurse or physician with current ACLS certification present during all phases of treatment; and
 - (iv) An emergency kit of the "crash cart" type containing the usual medical supplies and equipment required for cardiopulmonary resuscitation. This equipment shall include, as a minimum, the following:
 1. Laryngoscope with an adequate light source and fresh batteries;
 2. Airways of various sizes;
 3. An Ambu bag or its equivalent;
 4. Injectable calcium gluconate or other form of calcium suitable for intravenous use;
 5. Epinephrine, atropine and other usual resuscitative drugs;
 6. A fifty per cent solution of glucose for intravenous use and oral glucose solution;
 7. Appropriate syringes with needles;
 8. An oxygen supply with regulator equipped for emergency administration by mask or nasal catheter together with tubing for emergency connection to an Ambu bag;
 9. Airway suction equipment.
- (j) Physicians performing chelation therapy shall perform appropriate follow up tests:
- (i) The patient's renal function shall be closely monitored;
 - (ii) In patients with mild / moderate renal insufficiency (creatinine clearance as calculated by the Cockcroft-Gault Formula 80 ml/min or less), serum electrolytes, urea, creatinine shall be performed:



1. Prior to second treatment and;
 2. Weekly for 4 weeks; and
 3. If the patient's renal status remains stable, then every two weeks until completion of therapy;
 4. 24 hour urine collection for urea, protein and creatinine shall be repeated at one month;
- (iii) In patients who have developed hypocalcemia serum calcium shall be performed after each treatment.
- (k) The standards of practice for physicians performing chelation therapy shall include any protocols relating to the safe administration of chelation therapy as may be established by the Council from time to time.
- (l) No physician shall, by any method, state or imply that chelation therapy has been approved by the College of Physicians and Surgeons or that any particular physician has been endorsed by the College to perform chelation therapy.
- (m) All physicians who wish to practise chelation therapy shall, as a condition of doing so, sign an undertaking in which they agree that:
- (i) They will practice chelation therapy in accordance with the bylaws and protocols of the College as they exist from time to time;
 - (ii) Their practice may be subject to audit or review in accordance with the bylaws and the protocols of the College as they exist from time to time;
 - (iii) They will co-operate with any such audits or reviews;
 - (iv) They will comply with any directions of the Council made pursuant to the paragraph (o) of this bylaw; and
 - (v) The Council retains the right to revoke its authorization to practice chelation therapy if the Council concludes that chelation therapy is ineffective and/or produces unacceptable risks to patients or for any other reason should not be practiced by physicians in Saskatchewan.
- (n) The Council may at any time appoint a physician to conduct an audit of a physician's chelation practice to report whether in that physician's opinion the physician practicing chelation therapy is complying with the standards of this bylaw and any protocols which may be established by the Council from time to time.
- (o) The Council may from time to time in its sole discretion direct that the practice of a physician practicing in whole or in part chelation therapy be subject to peer review by a committee appointed for that purpose by the Council to assess the continued safety of the therapy and the ethical and competent provision of such therapy by the physician.
- (i) This Committee will be composed of at least three people, one of whom must be a physician and one of whom must be a practitioner of chelation therapy under this bylaw or a person who is licensed to practice medicine in another jurisdiction who practices chelation therapy under the authorization of that person's local medical licensing body.
 - (ii) The physician and the practitioner of chelation therapy may be the same individual.
 - (iii) If the Committee reports to the Council that the therapy conducted by the physician does not meet appropriate standards of safety, and/or that the physician has failed to provide the therapy in an ethical and/or competent

manner, the Council shall consider the report and may do one or more of the following:

1. Require that physician to cease practicing chelation therapy;
 2. Impose restrictions on the ability of the physician to practice chelation therapy;
 3. Order that the physician cease conducting chelation therapy until the Council is satisfied that any deficiency found by the Council in safety of the practice and/or the ethical and competent provision of the therapy has been rectified.
- (p) The costs of an inspection pursuant to paragraphs (n) and (o) above will be borne by the physician or physicians who were subject to inspection. In determining the amount of costs that may be chargeable to a physician in connection with such an inspection the Council may establish a formula to allocate travel costs associated with such inspections in an equitable manner among chelation facilities in Saskatchewan.
- (q) A physician who fails to pay the costs of an inspection within a period of 60 days from the date of invoice to the physician shall have the right to practice chelation revoked.
- (r) This bylaw applies, with any necessary changes to the practice of chelation therapy by the administration of substances other than EDTA.
- (s) It is unbecoming, improper, unprofessional or discreditable conduct for a physician to:
- (i) Practice chelation therapy, otherwise than in accordance with the terms of this bylaw and the protocols which may be established from time to time by the College of Physicians and Surgeons;
 - (ii) Fail to fully co-operate with an audit or review referred to in paragraph (n) or (o) of this bylaw;
 - (iii) Practice chelation therapy in a manner inconsistent with a restriction or order made by the Council pursuant to paragraph (o)(iii) of this bylaw.
- (t) Chelation therapy is an unproven therapy with an unproven record of safety and efficacy. The Council may review the available information from time to time and may change the standards and protocols which apply to the practice of chelation therapy and may prohibit the practice of chelation therapy if the available information indicates to the Council that this would be a prudent action.

23.1 Medical Records

- (a) All members of the College of Physicians and Surgeons of Saskatchewan shall keep, as a minimum requirement, the following records in connection with their practice:
- (i) In respect of each patient a legibly written or typewritten record setting out the name, address, birthdate and Provincial Health Care Number of the patient;
 - (ii) In respect of each patient contact, a legibly written or typewritten record setting out:
 1. the date that the member sees the patient;
 2. a record of the assessment of the patient which includes the history obtained, particulars of the physical examination, the investigations ordered and where possible, the diagnosis; and
 3. a record of the disposition of the patient including the treatment provided or prescriptions written by the member, professional advice given and particulars of any referral that may have been made. Prescribing information should include the name of medication, strength, dosage and any other directions for use.



- (b) The patient record should include every report received respecting a patient from another member or other health professional.
- (c) The records are to be kept in a systematic manner.
- (d) The records must be completed in a timely manner.
- (e) The records may be made and maintained in an electronic computer system providing:
 - (i) the system provides a visual display of the recorded information;
 - (ii) the system provides a means of access to the record of each patient by the patient's name and if the person has a Provincial Health Care Number, by the health number;
 - (iii) the system is capable of printing the recorded information promptly;
 - (iv) the system is capable of visually displaying the recorded information for each patient in chronological order;
 - (v) the system maintains an audit trail that:
 - 1. records the date and time of each entry of information for each patient;
 - 2. indicates any changes in the recorded information;
 - 3. preserves the original content of the recorded information when changed or updated; and,
 - 4. is capable of being printed separately from the recorded information of each patient
 - 5. the system includes a password or otherwise provides reasonable protection against unauthorized access, and
 - 6. the system backs up files and allows the recovery of backed up files or otherwise provides reasonable protection against loss of, damage to and inaccessibility of information.
- (f) A member shall retain the records required by this regulation for six years after the date of the last entry in the record. Records of pediatric patients shall be retained until 2 years past the age of majority or 6 years after the date last seen, whichever may be the later date.
- (g) A member who ceases to practise shall:
 - (i) transfer the records to a member with the same address and telephone number; or
 - (ii) transfer the records to:
 - 1. another member practicing in the locality; or
 - 2. a medical records department of a health care facility; or
 - 3. a secure storage area with a person designated to allow physicians and patients reasonable access to the records,after publication of a newspaper advertisement indicating when the transfer will take place.
- (h) A member who attends a patient at a hospital shall complete the medical records for which that member is responsible in accordance with the requirements of Saskatchewan legislation and regulations and the bylaws of the Regional Health Authority.



23.2 Privacy Policy

- (a) All physicians who regularly practise in a location where there is a privacy policy have an obligation to read and be aware of the contents of that privacy policy.
- (b) All physicians who are trustees as defined by **The Health Information Protection Act** shall ensure that:
 - (i) The practice locations in which they practise have established a written privacy policy that complies with **The Health Information Protection Act**;
 - (ii) The privacy policy is reviewed on a regular basis and is amended if required; and,
 - (iii) The privacy policy is provided to all persons who have access to personal health information as defined in **The Health Information Protection Act**.
- (c) the written privacy policy referred to in paragraph (a) shall, at a minimum, address the following topics:
 - (i) Who the designated privacy officer in the practice location is;
 - (ii) The obligations of physicians and staff to protect the confidentiality and security of patient health information;
 - (iii) Policies and procedures to obtain signed confidentiality agreements from individuals who have access to patient health information;
 - (iv) Policies and procedures to restrict access to personal health information unless access is required for a purpose authorized by **The Health Information Protection Act**;
 - (v) Policies and procedures for patients to access and obtain copies of their records;
 - (vi) Policies and procedures for third parties to access and obtain copies of patient records to which they have access pursuant to **The Health Information Protection Act**;
 - (vii) Policies and procedures for the collection of personal health information;
 - (viii) Policies and procedures respecting the use of personal health information;
 - (ix) Policies and procedures respecting the disclosure of personal health information;
 - (x) Policies and procedures to protect the integrity, accuracy and confidentiality of patient health information;
 - (xi) Policies and procedures to protect against reasonably anticipated threats to the security, integrity or loss of personal health information;
 - (xii) Policies and procedures to protect against unauthorized access to or use, disclosure or modification of personal health information.

24.1 Reporting of Blood Borne Infections

- (a) A member who knows that he or she is positive for a transmissible blood borne infection shall notify the registrar immediately of that information.
- (b) Applicants for a licence who have tested positive for a transmissible blood borne infection shall report that information on their application form.
- (c) Members referred to in (a) or (b) above shall comply with the registrar's directions pertaining to the monitoring of their medical condition and restrictions on their practice.

25.1 Operation of Diagnostic Imaging Facilities in the Province of Saskatchewan

- (a) Preamble

The following bylaw has been developed to ensure the provision of an acceptable quality patient care in diagnostic imaging. This document indicates conditions that must exist in any diagnostic imaging facility, whether fixed or portable to allow a physician to:

- perform diagnostic imaging procedures in that facility; or
- interpret diagnostic images rendered or obtained in that facility; or
- refer patients to that facility.

Diagnostic imaging facilities themselves are acknowledged to be outside the jurisdiction of the College. The standards must, however, be met by a diagnostic imaging facility for a health care professional to have a professional relationship with the facility.

The medical acts to be covered by these provisions would include all procedures involving diagnostic imaging and all interpretation of images including, but not limited to radiography, CT scanning, nuclear medicine, magnetic resonance imaging, all imaging applications of ultrasound including echocardiography, and other medical imaging procedures which may be developed in the future.

Imaging facilities may perform, as long as there is no other legal exclusion, imaging acts at the request of a physician, dentist, chiropractor, enhanced skill nurse or registered midwife duly licensed to practise in the province of Saskatchewan.

All physicians working in these facilities shall conform to the CMA Code of Ethics and other ethical standards adopted by the College of Physicians & Surgeons of Saskatchewan.

Nothing in this bylaw requires a physician to perform medical imaging services when, in the opinion of that physician, it would be medically inappropriate to do so.

No physician shall perform or report radiological examinations unless the physician is licensed by the College of Physicians and Surgeons of Saskatchewan and restricts their practice to radiology, or a specialty discipline in which they have the appropriate qualifications to perform or report selective diagnostic imaging examinations.

All physicians shall, as a condition of performing diagnostic imaging procedures in an imaging facility or interpreting diagnostic images rendered or obtained in an imaging facility, fulfill the credits for the Maintenance of Certification and Continuing Professional Development programs for specialists of the Royal College of Physicians and Surgeons of Canada as required by the Royal College.

(b) Definitions

- (i) "Diagnostic Imaging Facility" – any facility that performs diagnostic imaging of any type; including radiography, fluoroscopy, ultrasound, CT, MRI, mammography, and other imaging modalities that may be developed in the future.
- (ii) "Invasive Cardiologist" – a specialist physician who is trained in performing and interpreting cardiac angiography as required by the Canadian Cardiovascular Society.
- (iii) "Nuclear Medicine Facility" – any facility that performs diagnostic and/or therapeutic nuclear medicine procedures.
- (iv) "Nuclear Medicine Physician" – a physician who is certified in nuclear medicine by the Royal College of Physicians and Surgeons of Canada.



- (v) “Ophthalmic Ultrasonographer” – a qualified technologist who has completed a recognized sub-specialty course and is trained to perform ophthalmic ‘A’ and ‘B’ mode scans.
 - (vi) “Physician with Practice Restricted to Radiology (Physician PRR)” – a physician who:
 1. is certification eligible with the Royal College of Physicians and Surgeons of Canada in diagnostic radiology; or
 2. is a physician practicing Radiology at the time this bylaw comes into effect; or
 3. has specialty qualifications as recognized by the Council of the College of Physicians and Surgeons of Saskatchewan; and is licensed under subsection 30(1) or section 31 of The Act; or
 4. is a physician who has been granted a Special Licence to practise radiology under subsection 30(3) of the Act.
 - (vii) “Radiologist” – a physician who is certified in diagnostic radiology by the Royal College of Physicians and Surgeons of Canada.
 - (viii) “Radiology Facility” – those facilities that employ ionizing radiation.
 - (ix) “Specialist Ultrasonographer” – a qualified technologist who has completed a recognized sub-specialty course.
 - (x) “Ultrasonologist” – a physician who is certified by the Royal College of Physicians and Surgeons of Canada in the specialty pertaining to the imaging being performed, or is certification eligible in that specialty; or has been granted a Special or Temporary Licence by the College of Physicians and Surgeons of Saskatchewan and has completed an approved period of training in an ultrasound centre.
 - (xi) “Ultrasound” – an acoustic energy at frequencies above the range of human hearing used for medical diagnosis. Simple Doppler units that are used solely for purpose of detection of fetal cardiac activity or volume of urine in the bladder are excluded from these standards.
 - (xii) “Ultrasonographer” – a technologist trained in performing ultrasonography who is either:
 1. registered with the American Registry of Diagnostic Medical Sonographers (ARDMS); or
 2. is eligible for registration with ARDMS; or
 3. holds an equivalent Canadian qualification.
 - (xiii) “Ultrasonography or Sonography” – a method of investigation using ultrasound to produce a graphic or other display of the part of the body being examined.
- (c) **The Director of a Diagnostic Imaging Facility**
- (i) The owner(s) of a private diagnostic imaging facility or the Regional Health Authority that operates a public facility, or any other imaging facility shall cause the appointment of a Director who shall be a Radiologist, a physician PRR, or a specialist who has completed an approved period of training pertaining to the imaging modality being performed.
 - (ii) The Director shall be responsible for:
 1. the day to day operation of the facility;
 2. ensuring that:



- (1) the facility maintains the standards in this bylaw of the College of Physicians and Surgeons of Saskatchewan and the standards of any other applicable Provincial and Federal authority;
 - (2) adequate consideration is given to the design and operation of the facility to protect personnel of the facility, patients and the public from unnecessary radiation. *The Radiation Health and Safety Act, 1985*, requires that all ionizing radiation facilities obtain prior plan approval from the Radiation Safety Unit, Saskatchewan Ministry of Labour Relations and Workplace Safety;
 - (3) all radiation equipment installed in the facility meets the requirements of Health Canada's Radiation Emitting Devices Act and Regulations;
 - (4) all personnel who routinely participate in radiological procedures are issued with personal dosimeters for monitoring their radiation exposure and these are used in accordance with Provincial and Federal guidelines;
 - (5) all ionizing radiation equipment in the facility is operated by qualified individuals;
 - (6) all ionizing radiation equipment in the facility is adequately maintained and has the required number of Safety Preventive Maintenance inspections as per section 14 of *The Radiation Health and Safety Regulations, 2005*;
 - (7) all provisions in the on-going quality assurance procedures manual are carried out and proper documentation kept;
 - (8) all personnel of the facility are familiar with **The Radiation Health and Safety Act, 1985** and Regulations and that adequate resources are provided so that all requirements of the Act and Regulations will be complied with;
 - (9) the personnel of the facility are familiar with **The Health Information Protection Act** and that the facility will comply with the obligations of a trustee under that Act.
3. informing the College of Physicians & Surgeons of ownership, directorship or technical supervision of the facility, qualifications of technical staff, or any change thereof;
 4. providing notification of any major addition, replacement or modification of any equipment at the facility to the College of Physicians and Surgeons of Saskatchewan.
- (iii) The Physician Director shall ensure that the imaging facility does not:
1. establish criteria for referral of patients to the facility other than those required by clinical considerations; in accordance with Bylaw 9.1(f);
 2. function to increase its profitability at the expense of sound medical practice;
 3. perform imaging investigations which contravene the standards;
 4. use unqualified personnel;
 5. use substandard equipment or obsolete equipment as defined for each modality.

(d) General Requirements

(i) Ultrasound Facilities:



1. Types of Ultrasound Facilities:
 - (1) Restricted: Perform examinations pertaining to a particular recognized medical specialty.
 - (2) Comprehensive: Perform general ultrasound within limitations related to the training of the operator.

2. Records of Examination:
 - (1) Reporting: All ultrasound examinations shall be reported promptly to the referring physician by the Ultrasonologist performing or interpreting the ultrasound examination. Where a physician other than a radiologist performs or interprets ultrasound examinations on his/her own patients, a complete record of the results of this examination must be included in the patient record.

The Ultrasonologist shall ensure that Ultrasonographers do not provide interpretations of ultrasound results to physicians or patients.

- (2) Records: Written reports and archival image records sufficient to support the report must be retained in accordance with the College bylaw regarding records.
3. Training Standards:

The Director of a diagnostic imaging facility shall ensure that:

- (1) An Ultrasonographer shall have completed the required course of study in ultrasonography and have passed the American Registry of Diagnostic Medical Sonographer (ARDMS) examinations or an equivalent Canadian certification;
- (2) An Ophthalmic ultrasonographer shall have completed a recognized training program and must perform all scans under on-site supervision of an ophthalmologist;
- (3) Technologists performing ultrasonography must fulfill the requirements of the ARDMS or an equivalent Canadian certification;
- (4) A Specialist Ultrasonographer shall have completed a recognized course and continue to meet the requirements of that subspecialty;
- (5) Technologists performing echocardiography must fulfill the requirements of the ARDMS or an equivalent Canadian certification;
- (6) The physician performing and/or interpreting ultrasound studies must be:
 - A. For a restricted facility: an ultrasonologist as defined under the Interpretation section of the bylaws. The required period of training shall be as set for each discipline by the Council of the College of Physicians and Surgeons as:

Obstetrician/Gynecologists – 3 months

Ophthalmologists – ‘A’ mode - no special training

 ‘B’ mode - 3 months

Cardiologists – 6 months (1 year for directors of a cardiology laboratory)

Vascular Sonologists – 3 months

Neurosonologists (Transcranial) – 3 months

Urologists – 3 months

Any specialist physician wishing to perform a specialized area of ultrasound that is not included under the criteria of these bylaws, must apply to the Advisory Committee on Medical Imaging of the College of Physicians and Surgeons of Saskatchewan for training standards.

- B. For a comprehensive facility: a Radiologist or Physician PRR who has completed an approved period of training in ultrasound.

4. Equipment:

The Director of the facility shall ensure that:

- (1) The equipment used for ultrasound examinations is appropriate for the specific type of examination performed. This stipulation includes the required use of appropriate high frequency transducers for "small parts" ultrasound examinations;
- (2) Every six months all active ultrasound equipment is inspected by a duly qualified service technician trained in the application, performance characteristics and repair of the specific equipment software and the archival imaging systems;
- (3) 'A' mode ophthalmic ultrasound units are calibrated daily, while 'B' mode units are inspected annually by a qualified service technician trained in the application, performance characteristics and repair of the specific equipment software and the archival imaging systems.

5. Procedures:

The Director of the facility shall ensure that:

- (1) A policy and procedure manual shall outline the minimum ultrasound examination techniques required, and shall follow section 34 of *The Radiation Health and Safety Regulations, 2005* in accordance with Canadian Association of Radiologists (CAR) or College guidelines, where applicable;
- (2) In communities which have a resident ultrasonologist, he or she shall be on-site at the facility for consultation, supervision and interpretation for all of the ultrasound examinations. Real time video linkage is deemed to be the same as having on-site supervision. If the sonologist must be away from the department, scans should not be performed or arrangements should be made for an alternate sonologist. An acceptable alternative to being on-site is the capacity to generate and transmit dynamic diagnostic images and to have direct communication between the ultrasonologist and the technologist at the time of the examination;
- (3) In communities which do not have a resident ultrasonologist on-site to be fully responsible for the supervision and interpretation of all ultrasound examinations done in the facility, the ultrasonologist shall be immediately available for consultation, supervision and interpretation of at least 50% of examinations where annual volume is less than 1000 and for all examinations where the annual volume exceeds 1000 cases. Real time video linkage is deemed to be the same as having on-site supervision.

(ii) **Radiology Facilities:**

1. Records of Examination:

- (1) Reporting: The Director of the facility shall ensure that all examinations are reported promptly by a radiologist or Physician PRR, except in the following situation:

Where radiologic examinations are performed by a specialist other than a radiologist as part of the accepted function of that specialty and where traditionally a report from a radiologist has not been made (e.g. cardiac catheterization performed and reported by cardiologists).

- (2) Records: Archival image records sufficient to support the report for each examination should be kept for 6 years and the written reports of each examination must be kept in accordance with College bylaws regarding records.

2. Training Standards:

The Director of a diagnostic imaging facility shall ensure that:

- (1) Where CLXTs are employed, the radiological examinations they perform (except DEXA) shall be restricted to those examinations for which they have been formally trained as outlined in the syllabus of training for the Certified Combined Laboratory & X-ray Technician Program;
- (2) Facilities comply with the policy of the Radiation Safety Unit of Saskatchewan Ministry of Labour Relations and Workplace Safety regarding staffing of facilities with fluoroscopic equipment;
- (3) The physician performing and/or interpreting radiology examinations is a physician who is certified in radiology by the Royal College of Physicians and Surgeons of Canada or a Physician PRR or on a Special or Temporary Licence issued by the College of Physicians and Surgeons of Saskatchewan;
- (4) Non-radiologists who perform and/or interpret investigations that require diagnostic imaging are certified in their specialty by the Royal College of Physicians and Surgeons of Canada and have completed the required training in that particular area of diagnostic imaging or have been granted a Special or Temporary Licence by the College of Physicians and Surgeons of Saskatchewan;

3. Equipment:

The Director of the facility shall ensure that:

- (1) A demonstrable Continuous Quality Improvement program is developed and maintained and that policies and procedures are in place that allow for problem resolution. This would include, but is not limited to:
 - A. processing;
 - B. equipment repair/review mechanism;
 - C. densitometry/sensitometry.
- (2) Image quality (including image generation and viewing monitors/screens) is up to the current acceptable standards;
- (3) Ionizing radiation equipment used in the facility are of the quality and type appropriate to imaging procedures performed at the facility;
- (4) Equipment and associated apparatus meet the standards required by *The Radiation Health and Safety Act, 1985* and Regulations under that Act as well as the requirements of the *Radiation Emitting Devices Act* and regulations.

4. Procedures:



The Director of the facility shall ensure that:

- (1) A policy and procedure manual shall outline minimum examination techniques required; and shall follow section 16 of *The Radiation Health and Safety Regulations, 2005* in accordance with Canadian Association of Radiologists (CAR) or College guidelines, where applicable;
- (2) Where radiological examinations/procedures require the direct involvement of a physician, these should be performed by a Radiologist or Physician PRR, except where performed by other specialists as part of the accepted practice of the speciality.

(iii) **MRI Facilities:**

1. Director of an MRI facility:

- (1) In addition to meeting the general requirements for directors of Diagnostic Imaging Facilities a director of an MRI facility or department shall be:
 - A. a radiologist who is fully approved by the Advisory Committee on Medical Imaging in MRI; and
 - B. on-site at the MRI facility or department for a minimum of 25% of the studies performed each month in that institution.
- (2) In addition to meeting the general responsibilities for directors of Diagnostic Imaging Facilities a director of an MRI facility or department shall:
 - A. ensure that a radiologist with full or limited accreditation in MRI is on-site for at least 80% of the studies performed each day in the facility; and
 - B. ensure that a physician is on-site for any injected medications or contrast media; and
 - C. approve all MRI imaging protocols that are performed in the department; and
 - D. ensure that all physicians who practise in an MRI facility have received either full or limited accreditation; and
 - E. ensure that all technologists practicing in that unit are fully accredited.

2. Physician accreditation:

- (1) In this section, all training, in order to meet the requirements, must occur in a minimum of two-week blocks within a span of not more than 2 years.
- (2) The Advisory Committee on Medical Imaging may provide full approval of a physician who:
 - A. is a radiologist certified by the Royal College of Physicians and Surgeons of Canada; or
 - B. is certification eligible in radiology with the Royal College of Physicians and Surgeons of Canada; or
 - C. is fully qualified as a radiologist by a certification authority whose certification standards are, in the opinion of the Advisory Committee on Medical Imaging, similar to the certification standards of the Royal College of Physicians and Surgeons of Canada; and



- D. is licensed to practise in Saskatchewan; and
 - E. has completed 6 months of MRI training in an accredited teaching facility approved by the Royal College of Physicians and Surgeons of Canada, or by the Advisory Committee for Medical Imaging, under the supervision of a radiologist fully accredited in MRI; or
 - F. has completed 3 months of MRI training in an accredited facility approved by the Royal College of Physicians and Surgeons of Canada, or by the Advisory Committee for Medical Imaging, under the supervision of a radiologist fully accredited in MRI, and has spent twelve months of active practice in an accredited facility; and
 - G. has provided a letter from the program director or the director of the MRI facility that attests to the physician's competence in the performance of MRI.
- (3) The Advisory Committee on Medical Imaging may provide limited approval of a physician who:
- A. is a radiologist certified by the Royal College of Physicians and Surgeons of Canada; or
 - B. is certification eligible in radiology with the Royal College of Physicians and Surgeons of Canada; or
 - C. is fully qualified as a radiologist by a certification authority whose certification standards are, in the opinion of the Advisory Committee on Medical Imaging, similar to the certification standards of the Royal College of Physicians and Surgeons of Canada; and
 - D. is licensed to practise in Saskatchewan; and
 - E. has completed 3 months of MRI training in an accredited teaching facility approved by the Royal College of Physicians and Surgeons of Canada, or by the Advisory Committee on Medical Imaging, under the supervision of a radiologist fully accredited in MRI; and
 - F. has provided a letter from the program director or the director of the MRI facility that attests to the physician's competence in the performance of MRI.
- (4) The Advisory Committee on Medical Imaging shall not provide full or limited approval to a physician who:
- A. has not been in active practice for three years unless the physician has previously qualified for full or limited accreditation, the physician has completed a minimum of 4 weeks (20 days) of retraining in an accredited MRI facility under the supervision of a radiologist fully accredited in MRI and the physician has provided a letter from the program director and/or MRI director attesting to the physician's competence in MRI; or
 - B. has not been in active practice for five years unless the physician has previously qualified for full or limited approval, the physician has completed a minimum of 8 weeks (40 days) of retraining in an accredited MRI facility under the supervision of a radiologist fully accredited in MRI and the physician has provided a letter from the program director and/or MRI director attesting to the physician's competence in MRI.
3. Technologist accreditation:



- (1) The Director of an MRI facility shall ensure accreditation of a technologist practicing in the facility who:
 - A. is a member in good standing with both the Saskatchewan and Canadian Association of Medical Radiation Technologists (CAMRT), and has successfully completed an MRI training program recognized by the CAMRT, and has successfully passed, or is eligible to write, the CAMRT National Certificate Examination for MRI.

(iv) Nuclear Medicine Facilities:

1. Director of a Nuclear Medicine Facility:

- (1) The director of a Nuclear Medicine facility or department shall be:
 - A. a Nuclear Medicine physician who is fully approved by the Advisory Committee on Medical Imaging in Nuclear Medicine; and
 - B. on-site at the Nuclear Medicine facility or department for a minimum of 25% of the studies performed each month in that facility.
- (2) The director of a Nuclear Medicine facility or department shall:
 - A. ensure that a Nuclear Medicine physician with full or limited accreditation in Nuclear Medicine is on-site or available to view images of the studies performed each day in the facility, and
 - B. ensure that a physician or other licensed health professional who the director has determined has appropriate skills and knowledge is on-site for any injected medications; and
 - C. approve all Nuclear Medicine imaging protocols that are performed in the department; and
 - D. ensure that all physicians who practise in a Nuclear Medicine facility have received either full or limited accreditation; and
 - E. ensure that all Nuclear Medicine technologists practising in that unit are fully accredited.

2. Nuclear Medicine Physician accreditation:

- (1) The Advisory Committee on Medical Imaging may provide full approval of a physician who:
 - A. is a Nuclear Medicine Physician certified by the Royal College of Physicians and Surgeons of Canada; or
 - B. is certification eligible in Nuclear Medicine with the Royal College of Physicians and Surgeons of Canada. The candidate must obtain certification in Nuclear Medicine with the Royal College of Physicians and Surgeons of Canada within 3 years of eligibility and,
 - C. is licensed to practise in Saskatchewan.
- (2) The Advisory Committee on Medical Imaging may provide limited approval of a physician who:
 - A. is certified by the Royal College of Physicians and Surgeons of Canada in a discipline in which Nuclear Medicine training is relevant to the practice of that discipline; and,
 - B. has completed a minimum of one-year training in Nuclear Medicine, and



- C. will limit the physician's practice of Nuclear Medicine to within the scope of the discipline in which the physician was trained.
- (3) The Advisory Committee on Medical Imaging shall not provide full or limited approval of a physician who:
- A. has not been in active practice for three years unless the physician has previously qualified for full accreditation, the physician has completed a minimum of 4 weeks (20 days) of retraining in an accredited Nuclear Medicine facility under the supervision of a physician fully accredited in Nuclear Medicine and the physician has provided a letter from the program director and/or Nuclear Medicine director attesting to the physician's competence in Nuclear Medicine, or
 - B. has not been in active practice for five years unless the physician has previously qualified for full or limited accreditation, the physician has completed a minimum of 8 weeks (40 days) of retraining in an accredited Nuclear Medicine facility under the supervision of a Nuclear Medicine physician fully accredited in Nuclear Medicine and the physician has provided a letter from the program director and/or Nuclear Medicine director attesting to the physician's competence in Nuclear Medicine.
3. Technologist accreditation:
- (1) The Director of a Nuclear Medicine facility shall ensure accreditation of a technologist practising in the facility who:
 - A. is a member in good standing with both the Saskatchewan and Canadian Association of Medical Radiation Technologists (CAMRT); and,
 - B. has successfully completed a Nuclear Medicine training program.

(e) Specific Examinations

(i) Contrast Studies:

- 1. Studies involving the use of intravenous contrast agents shall be done under the following conditions:
 - (1) IVPs should be performed by RTs and may be performed by CLXTs only in an emergency situation, as defined by the CLXT syllabus of study;
 - (2) If the facility has no tomographic capabilities, IVPs should only be performed in the diagnosis of acute renal colic;
 - (3) Contrast studies for IVP other than in emergency situations will be carried out under the direct supervision of a radiologist or Physician PRR;
 - (4) Facilities performing studies requiring intravenous contrast administration when a radiologist is not present to supervise the study, shall have a written protocol for:
 - A. the amount/type of contrast media administered;
 - B. the number of radiographs that should be taken.
 - (5) When intravascular contrast is administered, emergency resuscitation equipment and drugs must be available for treatment of contrast reactions and a radiologist or other physician trained in emergency



resuscitation must be immediately available on-site for not less than 30 minutes following the injection;

- (6) Contrast studies using intravascular iodinated contrast agents shall **not** be performed using ionic or high osmolality agents except where clinically indicated.

(ii) Fluoroscopic Procedures:

1. All use of fluoroscopic equipment shall be by:
 - (1) a radiologist or Physician PRR; or
 - (2) other specialist performing procedures particular to their specialty under the supervision of a radiologist; or
 - (3) a technologist where designated appropriate by a supervising radiologist; or
 - (4) those specialists in cardiology who have received the requisite training and credentialing in invasive cardiology.
2. Fluoroscopy must not be used as a substitute for radiography nor solely for positioning a patient for radiographic examination, except where this has been authorized for a specific patient by a radiologist or Physician PRR prior to the examination.
3. For fluoroscopic procedures, a record of fluorotime shall be kept for each patient.

(iii) Mammographic Facilities:

1. Mammography centres must have CAR (ACR) accreditation.
2. Mammographic practice guidelines are as outlined in the current CAR document entitled, NATIONAL STANDARDS and GUIDELINES for MAMMOGRAPHY.
3. The following clarifications to the CAR guidelines are made:
 - (1) Screening Mammography in the 50-69 year age group is provided by the Screening Program for Breast Cancer;
 - (2) Current mammographers practicing outside the CAR guidelines, with respect to qualifications (see MAMMOGRAPHY, Section 4a. of the CAR document) must apply to the Advisory Committee on Medical Imaging for special approval.

(iv) Obstetrical Ultrasound and Examination of the Female Pelvis:

1. These investigations shall be performed under the supervision of and interpreted by:
 - (1) a Diagnostic Radiologist;
 - (2) a Physician PRR;
 - (3) an Obstetrician/Gynecologist who has been certified by the Royal College of Physicians and Surgeons and has acquired three months of training in obstetrical and gynecological ultrasound. The SOGC recommends a minimum of 170 obstetrical and gynecological ultrasound scans must be performed annually to maintain competency.

(v) General Ultrasound:

1. Must be interpreted by a radiologist or a Physician PRR in a comprehensive facility. See (d)(i)1(2).

(vi) **Bone Densitometry:**

1. Bone Densitometry investigations shall be performed under the supervision of and interpreted by physicians who:
 - (1) Are certified by the Royal College of Physicians and Surgeons of Canada in Nuclear Medicine or are certified by the Royal College of Physicians and Surgeons of Canada in Radiology and whose training programs have included the following elements:
 - A. knowledge and understanding of bone structure, metabolism, and osteoporosis;
 - B. the physics of X-ray absorption and radiation protection, including the potential hazards of radiation exposure to both patients and personnel;
 - C. processing DEXA data and image acquisition, including proper patient positioning and placement of regions of interest, and artifacts and anatomic abnormalities which may falsely increase or decrease bone mineral density values;
 - D. reporting parameters including, but not limited to, bone density measurements, percentage of mean, T-score, Z-score, fracture risk and World Health Organization classification systems;
 - E. the criteria for accurate and precise comparison of serial measurements, including limitations of comparing measurements made by different techniques and different devices;
 - F. the entire spectrum of bone density techniques, such as pDEXA, DEXA, SXA, QCT, RA and QUS; and
 - (2) Are familiar with the methods of statistical analysis necessary for the determination of site and machine-specific precision; and,
 - (3) Have two weeks documented training in bone densitometry in a teaching center recognized by the Royal College of Physicians and Surgeons of Canada.
2. The Director of the facility shall ensure that:
 - (1) There is a physician responsible for the densitometry program who, in addition to meeting the other criteria to supervise and interpret bone density testing, is certified by the International Society for Clinical Densitometry; and
 - (2) The physician responsible for the densitometry program is available for consultation and quality control during the performance of bone densitometry procedures.
3. The Director of the facility shall ensure that a technologist who performs the technical component of bone densitometry:
 - (1) Is certified in radiographic or nuclear medicine technology by the Canadian Association of Medical Radiation Technology and complies with that Association's continuing education requirements;
 - (2) Has obtained two weeks of formal training in the use of bone densitometry in a dedicated bone densitometry unit;



- (3) Performs all manufacturers' specified quality assurance procedures;
- (4) Accepts responsibility to provide patient comfort and safety, to prepare and properly position the patient, to place regions of interest for assessment of bone densitometry measures, to monitor the patient during measurements and to obtain the measurements performed by the supervising physician;
- (5) Has read, is familiar with, and has access to the manufacturer's operation manual for the scanner being used.

4. Quality Control:

- (1) The Director of the facility shall ensure that there are documented policies for monitoring and evaluating the effective management, safety and operation of equipment.
- (2) The Director of the facility shall ensure that at least once per year a qualified medical physicist monitors equipment performance and performs a quantitative dose determination.
- (3) Only testing modalities that have been clinically validated and endorsed by the Canadian Association of Radiologists and/or the Canadian Association of Nuclear Medicine shall be utilized in a clinical setting.

(vii) **Interventional Radiology:**

- 1. For the purposes of this bylaw, the following interventional radiology procedures are type "A" procedures:
 - Central Venous Access
 - Percutaneous Drainage of fluid collections
 - Percutaneous Biopsy
- 2. For the purpose of this bylaw, all other interventional radiology procedures including, but not limited to, the following procedures are type "B" procedures:
 - Angiography
 - Biliary Interventions
 - Fallopian Tube Catheterization
 - IVC Filter Placement
 - Intravascular Stents
 - Percutaneous Atherectomy
 - Percutaneous Biliary Endoprosthesis
 - Percutaneous Fluoroscopic Fallopian Tube Catheterization
 - Percutaneous GI Intervention
 - Percutaneous Nephrostomy
 - Percutaneous Transluminal Angioplasty
 - Regional Thrombolysis
 - Therapeutic Embolization

- Ureteral Stents
- Transjugular Intrahepatic Portosystemic Shunts (TIPS)
- Endoluminal Stent Grafting

3. *Type “A” interventional radiology procedures may be performed by a Diagnostic Radiologist, or a Physician PPR who has received a minimum of three months of training in interventional radiology.*

4. *Type “B” procedures may be performed by a Diagnostic Radiologist or a Physician PPR who has received a minimum of six months of training in interventional radiology.*

5. *Diagnostic and therapeutic coronary angiography may be performed by an Invasive Cardiologist who has received residency and fellowship training as recommended by the Canadian Cardiovascular Society.*

6. *Physicians who limit their practice to a recognized specialty may perform interventional radiology procedures consistent with the accepted standards of practice of the discipline in which they practise.*

7. *No physician shall perform interventional radiology except in accordance with paragraphs 25.1(e)(vii) 1. through 6. above.*

(f) Professional Conduct

- (i) It is unbecoming, improper, unprofessional or discreditable conduct for a member, except in the case of an emergency, to perform imaging procedures in an imaging facility or interpret diagnostic images rendered or obtained in an imaging facility, or to refer patients to an imaging facility, unless the diagnostic imaging facility meets the standards of this bylaw.
- (ii) Notwithstanding paragraph (i) above, it is not unbecoming, improper, unprofessional or discreditable conduct for a member, other than a director of a diagnostic imaging facility, to do any of the acts enumerated in paragraph (i) above if, at the time of such conduct, the member was unaware of the breach by the medical imaging facility and had exercised reasonable diligence to ensure that the facility met the standards of the bylaw.

(g) Quality Assessment Program

- (i) All physicians who work in a diagnostic imaging facility, including physicians who practice teleradiology, will co-operate in the ACMI quality assessment program.
- (ii) Where the Imaging Committee has formed the opinion that a physician has refused to co-operate in the quality assessment program, the name of the physician and information pertaining to the perceived lack of co-operation shall be forwarded to the Council of the College.

(h) Other Provisions

- (i) Notwithstanding anything in paragraphs (a) to (g) above, nothing in paragraphs (a) to (g) above applies to a diagnostic imaging facility that is operated by a Regional Health Authority or the Saskatchewan Cancer Agency.
- (ii) Notwithstanding anything in paragraphs (a) through (g) above, a physician who, prior to the coming into force of this bylaw, performed diagnostic imaging procedures in a diagnostic imaging facility or interpreted diagnostic images rendered or obtained in an imaging facility, may continue to perform the diagnostic procedures that the physician performed, or interpret the diagnostic images that the physician interpreted on the date that this bylaw came into effect even if that physician does not meet the qualifications that are outlined in paragraphs (a) through (g) above. However, nothing in this paragraph shall

entitle a physician who does not meet the qualifications in paragraphs (a) through (g) above to:

1. Perform any form of imaging procedure or interpret types of diagnostic images that the physician did not perform or interpret on the date that this bylaw came into effect;
2. Perform any form of imaging procedure in or interpret a diagnostic image from an imaging facility that does not meet the requirements of this bylaw, other than requirements relating to the qualification of the physician; or
3. Perform any form of imaging procedure or interpret types of diagnostic images if the physician does not meet the ongoing education and training requirements of this bylaw.

26.1 Operation of Non-Hospital Treatment Facilities in the Province of Saskatchewan

(a) The following bylaw has been developed to ensure the provision of quality patient care in non-hospital treatment facilities. This bylaw sets out conditions that must exist in a non-hospital treatment facility which is subject to the terms of this bylaw to allow a physician to:

- (i) perform procedures in that facility; or
- (ii) provide anaesthesia procedures in that facility; or
- (iii) refer patients to that facility.

(b) Treatment facilities themselves are acknowledged to be outside the jurisdiction of the College. The standards established in this bylaw must, however, be met by a non-hospital treatment facility for a physician to have a professional relationship with the facility.

(c) In this bylaw:

- (i) the terms "deep", "major", and "complicated" refer to procedures that may require more resources than are commonly available in a medical office. Surgeons should make decisions as to the appropriate location for these surgical procedures in accordance with the resources necessary for unexpected complications and with generally accepted standards of care in Saskatchewan;
- (ii) "Certificate of approval" means a certificate granted by the council indicating that the facility meets the standards for procedures set forth herein, and which specifies a time period and any conditions of such approval;
- (iii) "Committee" means the Health Care Facility Credentials Committee of the College of Physicians and Surgeons of Saskatchewan;
- (iv) "Critical incident" means an incident that occurs in a facility and is listed or described as a critical incident in the **Saskatchewan Critical Incident Reporting Guideline**, 2004 published by the department of health, as amended from time to time, or any subsequent edition of the Saskatchewan Critical Incident Reporting Guideline
- (v) "Director" means the member who is appointed pursuant to Sections (i), (j) and (k) of this bylaw;
- (vi) "Facility" means a non-hospital facility for the performance of medical/surgical procedures;
- (vii) "Physician" means a person licensed to practise medicine in Saskatchewan;
- (viii) "Procedure" means the medical/surgical procedures carried out in the facility.



- (ix) "Assisted Reproduction Technology Procedures" mean the following:
1. controlled ovarian hyperstimulation, other than through the use of clomiphene
 2. intrauterine insemination
 3. therapeutic donor insemination
 4. oocyte retrieval
 5. in vitro fertilization and embryo transfer
 6. intracytoplasmic sperm injection
 7. embryo cryopreservation
 8. oocyte donation
 9. gestational surrogacy
 10. procedures which are necessary for preimplantation genetic diagnosis or screening, including blastomere and trophoctoderm biopsy.
- (x) "Assisted Reproduction Technology Facility" means a facility in which one or more Assisted Reproduction Technology Procedures are performed.
- (d) A physician shall not perform the following procedures in a non-hospital treatment facility:
- (i) management of major complications such as haemorrhage, organ or organ system failure or metabolic derangement;
 - (ii) post-operative circulatory or respiratory support;
 - (iii) continuous monitoring of vital signs beyond the period of recovery from anaesthetic;
 - (iv) procedures under general anaesthetic on patients less than eighteen months of age;
 - (v) procedures on the contents of the retroperitoneal space;
 - (vi) procedures on the contents of the cranium;
 - (vii) procedures on the contents of the thorax;
 - (viii) any procedure lacking the approval of the Council for that facility.
- (e) a non-hospital treatment facility is one in which any of the following are performed:
- (i) the use of drugs which are intended or which may induce general anaesthesia or sedation requiring the monitoring of vital signs, including all uses of intravenously administered sedatives or narcotics, except in emergency circumstances;
 - (ii) the use of drugs by injection which are intended or may induce a major nerve block, or spinal, epidural, or intravenous regional block;
 - (iii) surgical and diagnostic procedures with risk of bleeding from major vessels, gas embolism, perforation of internal organs and other life-threatening complications or requiring sterile precautions to prevent blood-borne, deep, closed cavity or implant-related infections;
 - (iv) Hyperbaric oxygen therapy;
 - (v) Cardiac exercise stress testing;
 - (vi) Hemodialysis;

- (vii) one or more Assisted Reproduction Technology Procedures.
- (f) without limiting the generality of the foregoing, a non-hospital treatment facility is one in which any of the following surgical or endoscopic procedures are performed:
- (i) DERMATOLOGY
1. Liposuction to a maximum of five (5) litres total aspirate
 2. Lipolysis by percutaneous application of any form of energy
 3. Mohs micrographic surgery
- (ii) GENERAL SURGERY
1. Upper gastrointestinal endoscopy with or without biopsy
 2. Colonoscopy with or without biopsy or minor polypectomy
 3. Simple mastectomy
 4. Segmental resection of breast and sentinel node biopsy
 5. Resection of large or deep soft tissue lesions
 6. Deep lymph node biopsies – up to but not including full axillary dissection
 7. Inguinal hernia repair, including femoral
 8. Minor abdominal wall hernia repair, including umbilical hernia repair
 9. Varicose vein ligation and stripping
 10. Hemorrhoidectomy beyond simple single excision
 11. Trans-anal excision of rectal polyps
 12. Laparoscopic procedures
 - Diagnostic
 - Biopsies – peritoneal
 - Laparoscopic Adjustable Gastric Band procedures
 13. Endovenous laser sclerotherapy
- (iii) GYNAECOLOGY
1. Perineoplasty not requiring extensive dissection
 2. Marsupialization of Bartholin cysts
 3. Cervical, vaginal and vulvar polypectomy and biopsy with risk of bleeding requiring surgical control
 4. Dilatation and curettage of uterus
 5. Trans-cervical global endometrial ablation procedures except those performed by resection or by electrocautery that does not have impedance regulation
 6. Cystoscopy
 7. Minimally invasive incontinence procedures: injectables, percutaneous slings
 8. Laparoscopy with minor surgical interventions:
 - Diagnostic
 - Tubal sterilization

- Aspiration of cysts
- Minor adhesiolysis
- Diathermy for endometriosis (AFS Stages I and II)
- Abortions

9. Tumescant anterior and posterior vaginal repair

(iv) OPHTHALMOLOGY

1. Intra-ocular surgery requiring dissection of the tissues of the globe including procedures on:
 - the cornea (including ring segment implants, keratomies, LASIK and corneal transplant)
 - the lens and implants
 - the iris
 - the sclera
 - the vitreous
2. Eyelid procedures requiring implants or dissection of the orbital septum or beyond.
3. Lacrimal procedures requiring incision into the nasal passages.
4. Orbital and socket procedures not associated with risk of intracranial or neurovascular complications, including:
 - orbital tumor excision
 - insertion of an implant
 - enucleation/evisceration with or without implant
 - socket reconstruction requiring implant, transplant or exposure of bone, other than Minor anterior orbital procedures
5. Strabismus procedures
6. Rheopheresis

(v) ORTHOPEDIC SURGERY

1. ARTHROSCOPY
 - diagnostic
 - repair and reconstruction of ligaments
 - meniscectomy, meniscal repair and arthroplasty
 - excision meniscal cysts, loose bodies and foreign bodies
2. AMPUTATION
 - finger through MCP or IP joints, hand
 - toe – through TP or IP joints foot
 - single ray amputation hand or foot
3. ARTHRODESIS
 - hand and wrist



- foot and ankle
4. ARTHROPLASTIES
 - acromio-clavicular and sterno-clavicular joints
 - radial head arthroplasty
 - wrist and hand joints
 - foot
 5. OSTEOTOMIES
 - hand/wrist/foot/ankle
 6. REPAIR RECURRENT DISLOCATION/LIGAMENT RECONSTRUCTION
 - shoulder
 - elbow
 - wrist
 - hand
 - knee
 - ankle and foot
 7. TENDONS OR MUSCLES – REPAIR/TRANSPLANT/TRANSFER
 - transfers repairs and transplants at or distal to elbow or knee
 - decompression/repair rotator cuff at shoulder
 8. FASCIA/TENDON SHEATH
 - plantar fasciotomy/fasciectomy of hand or foot
 - release or excision Dupuytren's contracture
 - excision of minor hand tumors including ganglions
 - carpal tunnel release
 - excision tendon sheaths: wrist, forearm or hand
 9. ARTHROTOMY/SYNOVECTOMY
 - shoulder
 - elbow
 - wrist and hand
 - knee
 - ankle and foot
 - excision Baker's cyst
 10. EXCISION BURSAE & GANGLION
 11. MUSCULO-SKELETAL TUMORS
 - biopsy of peripheral tumors
 - needle biopsy only of tumors of the spine
 - excision of minor tumors



12. DISLOCATIONS

- open reduction acromio-clavicular joint
- closed or open reduction of joints of upper extremity
- closed reduction of dislocated total hip
- closed or open reduction of patello-femoral joint
- closed or open reduction of ankle, hindfoot, midfoot or forefoot

13. FRACTURES: UPPER EXTREMITIES

- closed and open reduction clavicle, humerus, radius/ulna, wrist and hand
- closed reduction of scapula

14. FRACTURES: LOWER EXTREMITIES

- closed and open reduction of patella, fibula, ankle and foot
- closed reduction of tibia

15. OTHER

- single level lumbar discectomy and/or decompression – uncomplicated
- procedures listed under podiatric surgery
- removal of hardware including plates, pins, screws, nails and wires
- peripheral nerve surgery – repairs, decompression or grafts
- saucerization
- sequestrectomy
- joint manipulation under general anesthesia or intravenous sedation
- harvesting of bone graft

16. EXTENDED STAY PROCEDURES

- Hip arthrotomy and primary arthroplasty (including total joint replacement)
- Knee arthrotomy and primary arthroplasty – (including total joint replacement)
- Tibial osteotomy
- Shoulder arthrotomy and primary arthroplasty – (including total joint replacement)
- Lumbar posterior spinal fusion – not exceeding two disc-space levels
- Lumbar spinal laminectomy – not exceeding two disc-space levels
- Ankle arthrotomy and primary arthroplasty (including total joint replacement)

(vi) OTOLARYNGOLOGY

1. Deep biopsy of the nasopharynx
2. Deep excision of intraoral papilloma
3. Major excision of lip, nasal, ear or neck lesions



4. Lip shave procedures
5. Major partial glossectomy limited to anterior 2/3 of tongue
6. Adenoidectomy
7. Rigid laryngoscopy
8. Rigid trans-oral nasopharyngoscopy
9. Complete esophagoscopy – flexible only
10. Complete bronchoscopy – flexible only
11. Caldwell Luc procedure
12. Intranasal antrostomy
13. Intranasal complete ethmoidectomy
14. Turbinate resection
15. Sphenoidotomy
16. Nasal septum reconstruction
17. Nasal septum submucous resection
18. Nasal polypectomy in conjunction with complete ethmoidectomy
19. Rhinoplasty
20. Complicated nasal fractures
21. Biopsies of the parotid beyond needle aspiration or sampling the tail of the gland
22. Excision of submandibular gland
23. Excision of sublingual gland
24. Otoplasty
25. Complicated myringoplasty
26. Dissection of neck beyond the platysma muscle
27. Deep cervical node biopsy
28. Endoscopic soft-tissue surgery

(vii) PLASTIC SURGERY

1. SKIN AND SUBCUTANEOUS TISSUE

- Excision of deep tumors outside a body cavity requiring exposure of bone or isolation of vascular or nerve supply.
- Grafts, flaps, and tissue expansion where there is a minimal risk of major bleeding or third space fluid loss that may require replacement fluids.
- Liposuction to a maximum of 5 litres total aspirate.
- Lipolysis by percutaneous application of any form of energy

2. HEAD AND NECK

- Grafts and flaps as above except where there is a significant risk of airway compromise requiring post-operative or overnight monitoring.



- Eyelids (blepharoplasty, ptosis repair, tarsorrhaphy, canthopexy, canthoplasty)
 - Browlift, facelift (rhytidectomy), necklift
 - Nose (SMR, rhinoplasty, turbinectomy, reduction of fractures)
 - Ears (otoplasty)
 - Genioplasty
3. BREAST
- Reduction mammoplasty
 - Augmentation mammoplasty
 - Mastopexy
 - Mastectomy without chest wall, muscle or axillary node dissection
 - Capsulotomy and capsulectomy
 - Gynecomastia surgery
 - Reconstruction of breast or nipple
4. ABDOMEN
- Repair of abdominal wall hernia
 - Abdominoplasty not requiring overnight monitoring of blood or third space fluid loss.
5. OTHERS
- Tendon – repairs, transfers or grafts
 - Peripheral nerve – repairs, decompression or grafts
 - Muscle – flaps or repairs.
 - Fascia – flaps, decompression or excision
 - Bone – biopsies, fusions, removal of hardware, excision of exostoses, amputations of digits or rays, open and closed reduction of hand fractures
 - Joints – arthrotomy, arthroscopy, arthrodesis, and reductions of hands, wrists, feet and TMJ
 - Minor treatment of surgical complications such as hematoma or wound separation

(viii) UROLOGY

1. Inguinal canal surgery
2. Open procedures on scrotal contents
3. Penile procedures up to but not including implants
4. Minor urethral reconstruction, urethral fistula repair and distal hypospadias repair
5. Minimally invasive incontinence procedures, including injectables and percutaneous slings



6. Cystoscopy and ureteroscopy with or without biopsy or minor manipulation of stones or obstruction
- (g) A physician shall not perform a procedure in a non-hospital surgical facility unless the procedure is one that will safely allow the discharge of a patient from medical care in the facility within 12 hours of completion of the surgical procedure.
- (h) Notwithstanding paragraph (g), the Council may approve the provision of specified surgical procedures at a facility which is approved for that purpose by the Council where patients undergoing such procedures require medically supervised post-operative care exceeding twelve (12) hours.

Medical Director of a Non-Hospital Treatment Facility

- (i) The owner(s) of a non-hospital treatment facility shall cause the appointment of a Director who shall be a member.
- (j) The Director shall be responsible for:
 - (i) the day to day operation of the facility;
 - (ii) instituting and maintaining an adequate quality assurance program;
 - (iii) providing continuous adequate and effective direction and supervision of personnel and the medical service performed;
 - (iv) providing evidence of a satisfactory initial inspection and any subsequent inspection(s) as required by the Council;
 - (v) ensuring that:
 1. the facility maintains the standards in this bylaw of the College of Physicians and Surgeons of Saskatchewan and the standards of any other applicable Provincial and Federal authority;
 2. the procedures employed in the facility are selected and performed in accordance with current accepted medical practice;
 3. a quality assurance procedure manual is developed and maintained for guidance of the medical staff and inspection by the College;
 4. all provisions in the on-going quality assurance procedures manual are carried out and proper documentation kept;
 5. the facility complies with legal and ethical requirements for medical records, including access, confidentiality, retention and storage of medical records;
 6. the facility complies with the bylaws and ethical requirements with respect to the propriety and accuracy of advertising, promotion and other marketing activities for medical services provided in the facility;
 7. the owner of the facility does not enter into an agreement whereby the payment of rental consideration for the lease of office space, management services, or for equipment required for the practice of medicine is calculated or based on a percentage of the professional income derived from the practice of medicine;
 8. the fees and expenses to be paid to the College pursuant to this bylaw are paid within the time required, including all fees for any registration, initial or annual, and inspections of the facility;
 9. No procedures are conducted in the facility unless the facility has been granted a subsisting accreditation by the Council;



10. The facility is eligible for assistance from the Canadian Medical Protective Association with respect to all medical care provided at the facility or the facility maintains insurance coverage with an insurance company registered to do business in Saskatchewan that provides a minimum coverage of two million dollars for each occurrence against liability from professional negligence in patient care.
 11. The personnel of the facility are familiar with **The Health Information Protection Act** and that the facility will comply with the obligations of a trustee under that Act.
 12. If the facility is an Assisted Reproduction Technology Facility, the facility complies with the standards established by the College for such facilities.
 - (vi) informing the College of Physicians & Surgeons of any change or proposed change of Medical Director, ownership, directorship or technical supervision of the facility or qualifications of technical staff;
 - (vii) providing notification of any major addition, replacement or modification of any equipment at the facility to the College of Physicians and Surgeons of Saskatchewan.
 - (viii) promptly notifying the College of Physicians and Surgeons of Saskatchewan of any critical incident that occurs at the facility, and cooperating with any College investigation of the incident.
- (k) The Physician Director shall ensure that the facility does not:
- (i) establish criteria for referral of patients to the facility other than those required by clinical considerations;
 - (ii) contravene the conflict of interest provisions of the College bylaws;
 - (iii) function to increase its profitability at the expense of sound medical practice;
 - (iv) perform procedures which contravene this bylaw;
 - (v) use unqualified personnel.

Certificates of Approval

- (l) The Director shall apply to the College for a Certificate of Approval, on a form approved by the College, and shall provide the information requested by the College.
- (m) The Director shall, with the application for a Certificate of Approval, pay the fees established by the Council and, in addition, an amount which the College estimates will be sufficient to pay the expenses incurred by the College for inspections, honoraria to assessors or Committee members, and all other expenses.
- (n) The Committee or its designate may inspect a facility to determine if a Certificate of Approval should be granted to the facility.
- (o) Each Certificate of Approval shall contain an expiry date for the approval.
- (p) At least 60 days prior to the expiry date of the approval, the Director shall apply to the College for renewal of the Certificate of Approval, on a form approved by the College, and shall provide the information requested by the College.
- (q) The Director shall, with the application for renewal of the Certificate of Approval, pay the fees established by the Council and, in addition, an amount which the College estimates will be sufficient to pay the expenses incurred by the College for inspections, honoraria to assessors or committee members, and all other expenses.
- (r) The Committee or its designate may inspect a facility to determine if a renewal of the Certificate of Approval should be granted to the facility.



- (s) Each renewal of the Certificate of Approval shall contain an expiry date for the approval.
- (t) Each Certificate of Approval or renewal of a Certificate of Approval shall state the procedures that may be performed in the facility.
- (u) In deciding whether to grant or refuse a Certificate of Approval, the Council may consider any matter that it considers relevant and, in particular, whether the facility meets the standards expected of a public hospital for the types of procedures intended to be performed at the facility, and whether the facility has provided proof of coverage against liability from professional negligence in patient care
- (u.1) In deciding whether to grant or refuse a Certificate of Approval, if the facility is an Assisted Reproduction Technology Facility, the Council may consider whether the facility complies with the standards established by the College for such facilities.

Granting Physician Privileges

- (v) Physicians desiring privileges to perform procedures in a facility, or to provide care in a facility, or to provide anaesthesia in a facility shall apply in writing to the Director of the facility indicating the specific procedural privileges being applied for.
- (w) The application of the physician seeking privileges shall be on a form approved by the College and shall include details of the privileges currently held in facilities in Saskatchewan together with details of the number of similar procedures performed during the past year and/or related past experience.
- (x) The application shall include the names of two references who can be consulted as to the skills, knowledge and suitability of the physician to perform such procedures.
- (y) The Director shall forward a copy of the application to the College together with an assessment of the suitability of the facility to support such procedures and the suitability of the physician to perform such procedures in the facility.
- (z) The Committee shall consider the application and make recommendations to the Council.
- (aa) The decision of the Council shall be forwarded to the physician applying for privileges and the Director.
- (bb) Temporary approval may be made by the Registrar of the College.
- (cc) Reapplication for privileges shall be made annually to the Director and shall be dealt with in the same manner as the initial application for privileges.
- (dd) In deciding whether to grant or refuse such privileges, the Council may consider any matter that would be relevant in an application for privileges in a facility operated by a Regional Health Authority in Saskatchewan.
- (ee) Where a physician's privileges in a Regional Health Authority have been removed, restricted or suspended by a Regional Health Authority, or where a physician has agreed to resign or restrict his or her privileges in a Regional Health Authority, the Registrar may remove, restrict or suspend the privileges granted to that physician to work in a facility in a similar manner.
- (ff) Where, after providing the physician with a reasonable opportunity to present relevant information on his or her behalf, the Registrar has formed the opinion that a physician's conduct, performance or competence exposes or is likely to expose a patient to harm or injury or is reasonably likely to be detrimental to the delivery of quality patient care, the Registrar may remove, restrict or suspend the privileges granted to that physician to work in a facility.
- (gg) A physician who does not have privileges approved by Council for a particular procedure shall not perform that procedure in a facility.



Inspection and Audits

- (hh) Where the Council or the Executive Committee receives information indicating that the conditions at a facility pose a risk to patient safety, it may direct an inspection of a facility to determine whether a facility's Certificate of Approval should be amended, suspended or revoked;
- (ii) Any such inspection may include any or all of the following:
 - (i) Inspection of the premises and all equipment located therein;
 - (ii) Inspection of all records pertaining to the provision of medical services and providing copies of the same if so requested;
 - (iii) Providing information requested by persons conducting the assessment in respect of the provision of medical services in the facility in such form requested by persons conducting the assessment;
 - (iv) Providing on request samples or copies of any material, specimen, or product originating from the medical service provided by the facility;
 - (v) Answering questions posed by the persons conducting the assessment as to procedures or standards of performance and if requested providing copies of records relating to procedures followed and standards of performance applied in the facility;
 - (vi) Providing to the persons conducting the assessment copies of all documents and information relating to business arrangements involving the practice of medicine conducted in the facility. The production of documents and information may include lease arrangements, management agreements, records of advertising and agreements for the provision of medical services.
- (jj) The costs of such an inspection will be borne by the facility or the member in question.
- (kk) The Director shall permit the Council, the Committee, or its designate right of access to the facility at all reasonable times for the purpose of conducting an audit or review of the procedure undertaken in that facility.

Revocation or Amendment of Certificates of Approval

- (ll) Where access to the facility for an inspection or audit is refused, or where the information or documents requested in such an assessment is not provided, the Council may amend, suspend or revoke the Certificate of Approval.
- (mm) Where the Council concludes that there has been a material adverse change in the facility since the last grant of a Certificate of Approval, or renewal of a Certificate of Approval, the Council may amend, suspend or revoke the Certificate of Approval.
- (nn) Where the Council concludes that there has been a material breach of the provisions of this bylaw, it may amend, suspend or revoke the Certificate of Approval.

Unbecoming, Improper, Unprofessional or Discreditable conduct

- (oo) It is unbecoming, improper, unprofessional or discreditable conduct for a physician, except in the case of an emergency, to perform a procedure in a facility, or to provide care in a facility, or to provide anaesthesia in a facility, if the physician does not have the privileges to do so.
- (pp) It is unbecoming, improper, unprofessional or discreditable conduct for a physician to perform a procedure in a facility, or to provide care in a facility, or to provide anaesthesia in a facility if that does not have a valid and subsisting Certificate of Approval;



- (qq) It is unbecoming, improper, unprofessional or discreditable conduct for a Director to fail to meet the obligations of a Director as outlined in this bylaw;
- (rr) It is unbecoming, improper, unprofessional or discreditable conduct for a physician to refuse to allow Council, the Committee or its designate access to a facility.
- (ss) Paragraphs (oo), (pp), (qq) and (rr) do not apply if the discipline hearing committee concludes that the physician exercised due diligence to ensure compliance with the requirements of this bylaw.
- (tt) Notwithstanding anything in paragraphs (a) to (ss) above, nothing in paragraphs (a) to (ss) above applies to a non-hospital treatment facility that is operated by a Regional Health Authority or the Saskatchewan Cancer Agency.

Publication of Information Pertaining to Non-Hospital Treatment Facilities

- (uu) The College will make information about Non-Hospital Surgical Facilities publicly available. The information will include the following information:
 - (i) The name of the facility and address of the facility in the College records;
 - (ii) The date of inspections of the facility;
 - (iii) The outcome of inspections of the facility;
 - (iv) The procedures which the facility has been approved to perform;
 - (v) Any limitations or conditions contained in the certificate of approval

PART 7 –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 with the relevant provisions of the Code of Ethics adopted by the Council of the College of Physicians and Surgeons of Saskatchewan.

PART 8 – PROFESSIONAL LIABILITY COVERAGE

33.1 Maintenance of Insurance

- (a) In order to be granted a licence, or renew a licence, to practise as a regular member – active, as a provisional member – active, as a special member, a senior life member – active or in order to be granted a *locum tenens* permit a physician shall:
 - (i) provide a written authorization to the College of Physicians and Surgeons in which the physician authorizes the Canadian Medical Protective Association, or any insurer with whom the physician maintains professional liability insurance, to release to the College of Physicians and Surgeons any information respecting the



status of that physician's membership or insurance coverage that may be required by the College of Physicians and Surgeons;

(ii) if the physician has been registered with the College immediately prior to the application for a licence or permit, or, although not registered with the College, has membership in the Canadian Medical Protective Association or is insured under a contract of malpractice insurance, provide proof that the physician either:

1. is registered with the Canadian Medical Protective Association as a member of that organization; or
2. is insured under a contract of malpractice insurance with an insurance company registered to do business in Saskatchewan that provides a minimum coverage of two million dollars for each occurrence.

(iii) if the physician has not been registered with the College of Physicians and Surgeons of Saskatchewan immediately prior to the application for a licence or permit, or has been registered under an inactive licence, enter into an undertaking with the College of Physicians and Surgeons that:

1. the physician will obtain membership with the Canadian Medical Protective Association or maintain malpractice insurance with an insurance company registered to do business in Saskatchewan that provides a minimum coverage of two million dollars for each occurrence before beginning medical practice; and
2. the physician will provide proof of membership or insurance to the College of Physicians and Surgeons within a period of 30 days.

(iv) enter into an undertaking with the College of Physicians and Surgeons that the physician will continuously maintain membership with the Canadian Medical Protective Association or maintain malpractice insurance with an insurance company registered to do business in Saskatchewan that provides a minimum coverage of two million dollars for each occurrence while the physician remains licensed or authorized to practise under a permit.

(b) A physician who:

- (i) does not provide medical care to patients in Saskatchewan; or
- (ii) practises exclusively with the Armed Forces of Canada; or
- (iii) practises exclusively as an employee of an employer who maintains insurance coverage that includes insurance coverage that insures the physician against professional malpractice with an insurance company registered to do business in Saskatchewan that provides a minimum of two million dollars for each occurrence; or
- (iv) provides information to the Registrar that satisfies the Registrar that the Saskatchewan public would not be placed unduly at risk if the physician were not required to maintain insurance coverage or membership in the Canadian Medical Protective Association;

may apply to the College of Physicians and Surgeons for exemption from the requirement that the physician be a member of the Canadian Medical Protective Association or be covered by a policy of insurance. The application for an exemption shall be accompanied by an undertaking that the physician will immediately obtain membership with the Canadian Medical Protective Association or obtain malpractice insurance with an insurance company registered to do business in Saskatchewan that provides a minimum coverage of two million dollars for each occurrence if the physician should cease to meet the conditions of paragraph (i), (ii) or (iii), or if any of



the information provided in an application under paragraph (iv) should cease to be accurate.

- (c) It is unbecoming, improper, unprofessional, or discreditable conduct for a physician to breach an undertaking provided to the College pursuant to this paragraph.

PART 9 – PAYMENT FOR PROFESSIONAL SERVICES

34.1 Pain Clinics

- (a) The Registrar shall keep a list of physicians eligible to bill under the pain clinic codes in the Medical Services Branch, Saskatchewan Health payment schedule.
- (b) Physicians eligible must have proof of a rotation through a pain management service in a L.C.M.E./C.A.C.M.E. accredited training program in Canada, Continental United States, or an approved pain management program in the United Kingdom.

35.1 Payment at Specialist Rates

- (a) The College recognizes only Certification from the Royal College of Physicians and Surgeons of Canada as the qualification to be held by a member in order to place their name on the specialist list of the College.
- (b) The paying agencies will be appraised of the member's specialty status on the date that an original document from the Royal College is received in the Registrar's office.

PART 10 – PROFESSIONAL CORPORATIONS

36.1 Professional Corporations

- (a) An applicant for registration by a Professional Corporation, or an applicant for renewal of a permit by a Professional Corporation shall file with the College shall complete an application in the form determined by the Registrar that:
 - (i) is legible;
 - (ii) contains all of the information required by the form;
 - (iii) attaches all documents that are required by the form; and
 - (iv) is signed by all persons required to sign the form.
- (b) The Registrar may refuse registration, or refuse to renew a permit where the form is not completed in accordance with paragraph (a).
- (c) The Registrar may request additional information relating to an application for registration or an application for renewal of a permit by a professional corporation, and may refuse registration or renewal of a permit until that information is provided.
- (d) All advertising by Professional Corporations shall comply with the provisions of these bylaws pertaining to advertising by members.
- (e) Each member who practises medicine by, through or in the name of a Professional Corporation is responsible to ensure that all advertising by the Professional Corporation complies with the bylaws.

37.1 Disclosure of Information in Certificates of Status

The Registrar or designate is authorized to provide certificates of status at the request of a member to another regulatory body with an interest in the member. In deciding what information to provide in a certificate of status, the Registrar or designate shall consider the following guidelines:

- (a) The certificate of status should provide the physician's credentials that are relevant to the grant of the member's licence as recorded with the College of Physicians and Surgeons;
- (b) The certificate of status should provide the dates for which licences were granted to the member, and the types of licences that were granted;
- (c) The certificate of status should disclose all formal investigations of lack of competence or unprofessional conduct, whatever the outcome of the investigation, and should disclose investigations that are currently underway and investigations that concluded no further action was warranted;
- (d) The certificate of status should disclose all formal charges of unprofessional conduct against the physician;
- (e) The certificate of status should disclose information about any sanctions imposed against the physician as a consequence of a finding of unprofessional conduct;
- (f) The certificate of status should disclose information about any findings of lack of competence, and any remedies imposed as a result of such a finding;
- (g) The certificate of status should disclose any restrictions upon the physician's practice imposed by the College or agreed to by the member;
- (h) The certificate of status should not disclose information about matters dealt with by the Complaints Resolution Advisory Committee, except as permitted by section 60 of The Act;
- (i) The certificate of status may, in the discretion of the Registrar, include the outcome of a complaint that has been successfully mediated;
- (j) The certificate of status may, if the member has a health condition that may limit the member's ability to practice or pose a risk of harm to patients, disclose that fact;
- (k) The certificate of status may, in the discretion of the Registrar, include additional information that may be relevant to the licensure of a physician;
- (l) Nothing in this bylaw requires the Registrar or designate to disclose information if, in the opinion of the Registrar, it is not in the public interest to do so.

