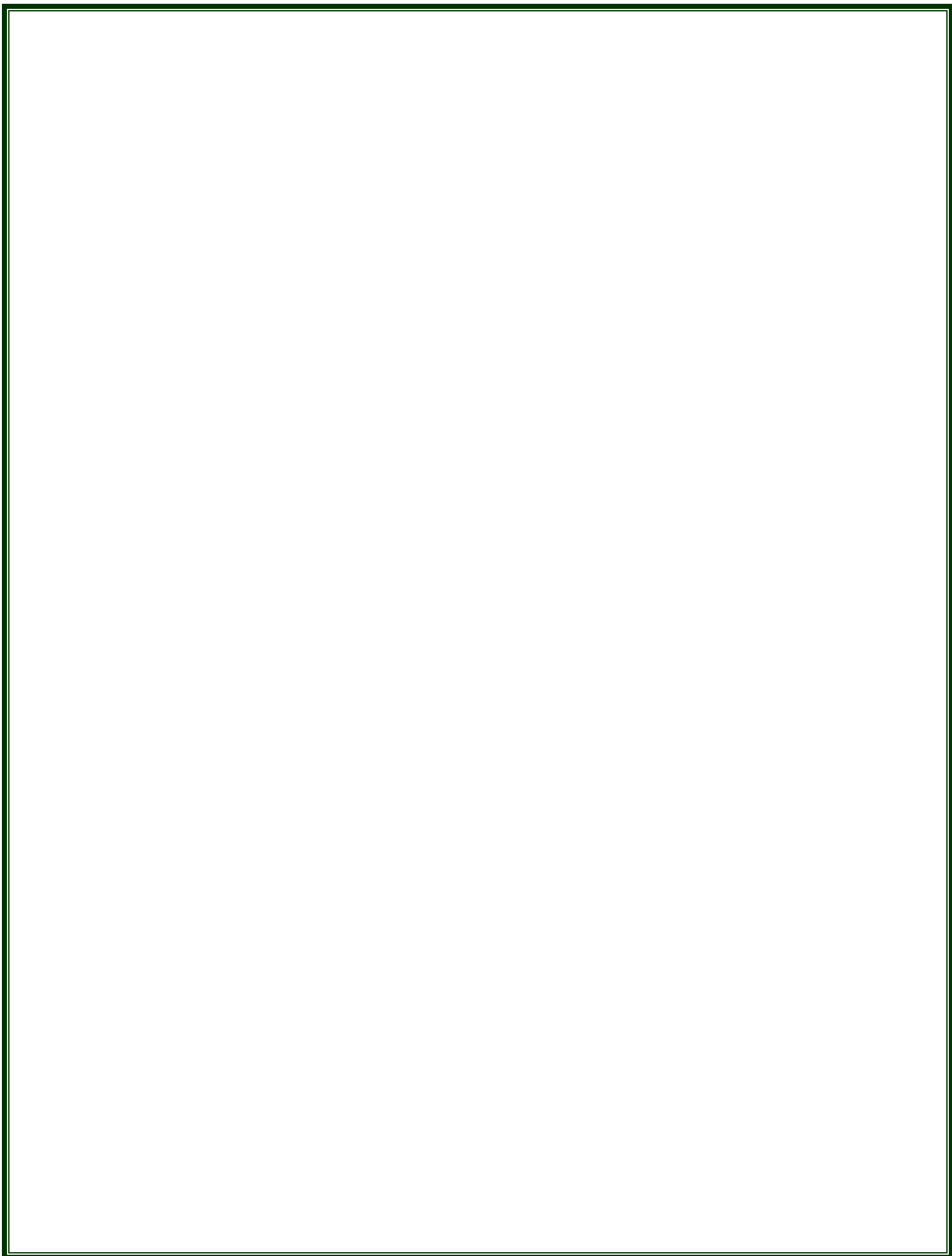


Rural Physician's Orientation Guide  
For Medical Practice in Manitoba



University of Manitoba  
Department of Continuing Medical Education





**Revisions:**

- 11APR05 Pg. 37 ADD: Eden Mental Health Centre Winkler 325-4325
- 11APR05 Pg. 16 CHANGE: [www.mcfp.mb.ca](http://www.mcfp.mb.ca) to <http://www.ocfp.on.ca/english/regional/Manitoba/default.asp?s=1>
- 11MAY05 Pgs. 6 – 9 UPDATE: The College of Physicians and Surgeons of Manitoba
- 26JUL06 Pg. 26 CHANGE: Brandon Emergency Room Phone number to 578-4166 (J. Beaver)

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# **1 Welcome to Medical Practice in Manitoba**

Setting up medical practice in a new area can be a challenging experience. We hope the information in this guide will make your experience in Manitoba positive and rewarding.

Within every organization described in this book, there are people who genuinely want to be of service to you, and efforts are being made to coordinate policies and make your experience in Manitoba a good one.

This guide is designed to ease your adaptation into life and practice in Manitoba. Welcome to Manitoba: Information for Newcomers has been written for all newcomers to the province and deals with the generic issues of adjusting to life in Manitoba. The Rural Physician's Orientation Guide is addressed more specifically to medical practice issues. While some sections will be most useful during your first few weeks, other sections contain references you will use regularly.

You will probably be quite busy as you begin the process of settling into your practice and will not have time to read all the materials in this package cover to cover. Familiarize yourself with the general contents, and then refer to the pertinent sections as questions arise. This booklet contains telephone numbers and internet addresses through which you can obtain information directly from the sources, and the people you work with should also be able to address many of your questions.

**Welcome and we wish you all the best!**

# The System

## 2 The Canadian Health System - An Introduction

Canada's health care system (Medicare) provides universal and comprehensive access to medically necessary physician services and medical coverage to Canadians, anywhere in Canada. Having evolved in a step-wise fashion since being established in Saskatchewan in 1947, Medicare has become culturally and politically important to Canadians as a reflection of, and as a defining influence on our national identity. Shared principles of equity, fairness, and compassion are embodied in the health care system, and the services it provides are now regarded as a basic right.

In order to receive medical attention, Canadians need only go to the physician or clinic of their choice and present the health insurance card<sup>1</sup> issued to all eligible residents of a province or territory<sup>2</sup>. There are no charges, deductibles, or dollar limits for insured medical services (physician, hospital, and surgical-dental), and there are no forms for patients to fill out.

### The Federal Government

The role of the federal government is to assist in financing provincial health care services via fiscal transfers, and to set standards and principles upon which transfers to the provinces and territories are contingent. The principles are, briefly:

**Public Administration:** The health insurance plan of a province/territory must be administered and operated on a non-profit basis by a public authority accountable to the provincial/territorial government.

**Comprehensiveness:** The plan must insure all medically necessary services provided by physicians and hospitals as well as all necessary drugs, supplies, diagnostic tests and a broad range of out-patient services.

**Universality:** The plan must entitle 100 % of eligible residents to insured health services on uniform terms and conditions.

**Portability:** The plan must provide coverage to residents even when they travel or move to another province/territory until they meet criteria for coverage by the new province or territory.

**Accessibility:** The plan must provide reasonable access to insured hospital and physician services without barriers or additional charges.

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<sup>1</sup> In Manitoba, other provincial and territorial health cards are also accepted by medical facilities. This averts the necessity of out of province patients having to pay for services in Manitoba and then apply to their own province for reimbursement.

<sup>2</sup> Canada's territories are Yukon, Northwest Territories and Nunavut.

Compliance to these standards assures relative equivalence of health services in different provinces and territories.

*(Please see the more detailed overview in Appendix I on page 49.)*

## **Provincial and Territorial Governments**

The ten provinces and three territories are ultimately responsible for administration of the system, and ensuring that the principles of the *Canada Health Act* are met. Provinces and territories plan, finance, and evaluate the provision of hospital care, physician and allied health care services, some aspects of prescription care and public health. Public coverage for some supplementary health benefits for certain groups of the population (e.g., elderly, children, and welfare recipients) are also provided by the provinces and territories. These benefits often include prescription drugs, dental and vision care, and prosthetics. More information is available at [www.gov.mb.ca/health/mhsip](http://www.gov.mb.ca/health/mhsip). Manitoba Health produces a wide variety of free health-related documents for release to health researchers, schools, public health professionals, and the general public available they are available on the web at: [www.gov.mb.ca/health/documents](http://www.gov.mb.ca/health/documents).

## **Regional Health Authorities**

The twelve Regional Health Authorities (RHAs) in Manitoba were created in 1996 as part of a larger effort to decentralize and improve provincial health care services. Following the amalgamation of two RHAs in 2002, there are now 11 RHAs in Manitoba. Through regionalization, resources may be more efficiently distributed and communities should have greater input into the functioning of their local systems.

The eleven RHA's are:

- *Brandon Regional Health Authority*
- *Burntwood Regional Health Authority*
- *Central Regional Health Authority - Central Manitoba Inc.*
- *Churchill Regional Health Authority Inc.*
- *Interlake Regional Health Authority*
- *Assiniboine Regional Health Authority*
- *NOR-MAN Regional Health Authority*
- *North Eastman Health Association*
- *Parkland Regional Health Authority*
- *South Eastman Health/Sante Sud-Est Inc.*
- *Winnipeg Regional Health Authority*

A map of each RHA is available on the Manitoba government website <http://www.gov.mb.ca/health/rha/rhamap.html>

The mandate of the RHAs is to assess community health needs, set policy and distribute regional resources, deliver service and maintain a qualified regional health staff as well as ensure that the consumer remains the priority in the provision of health care according to the principles of the *Canada Health Act*.

## Hospitals

In most regions, hospitals and personal care homes have devolved to the RHA. Annual operating budgets are administered by the RHA but, for the most part, day to day administration and allocation of resources is managed by the hospital administration. Proposals for the expansion of programs and facilities, as well as the acquisition of equipment, must be approved by regional health authorities and the province through the annual business plan. In Manitoba, all hospitals are private non-profit entities. The for-profit sector is composed mostly of long-term care facilities or specialized services such as addiction centres. For a listing of all hospitals, please see: <http://www.gov.mb.ca/health/hospitals.html>

## Physicians

Physicians are licensed to practice by, and are responsible to the provincial medical regulatory body. In Manitoba the College of Physicians and Surgeons of Manitoba (CPSM) serves this role, which includes the evaluation of competence and maintenance of standards and the establishment of rules of conduct. As a self-governing body, the College is responsible for taking action when its members fail to comply with its guidelines. (*See "Legal Responsibilities: The College of Physicians and Surgeons of Manitoba." Section 3 - (p.6).*)

Primary care physicians (general / family practitioners) account for about 2/3 of active doctors in Canada and, for most patients, are the points of first contact with the formal health care system. They control access to diagnostic services, prescription drugs, and many specialists and allied health care providers. The majority of physicians in Manitoba work in private group practices of 3 or more physicians. For the most part physicians in this province are paid on a fee-for-service basis where they bill for services provided through a provincial insurance plan. However, a growing number are entering into service contracts with their health authority where they receive a set income in return for providing services as outlined in their contract. Some services, such as Emergency Room coverage are supernumerary and physicians, whether they are paid through fee- for-service or by contract, may bill the provincial insurance system for the provision of these services separately.

Although membership is voluntary, a significant number of the physicians providing primary care in Manitoba are members of the College of Family Physicians of Canada (CFPC – <http://www.cfpc.ca>) and its Manitoba chapter, the Manitoba College of Family Physicians (MCFP – (<http://www.mcfp.mb.ca>)) This national organization mandates ongoing accredited medical education of its members. The CFPC sets the standards for the Family Medicine residency training programs across the country, as well as setting and administering the certification exam. Physicians who have not participated in the post-graduate residency training may write the exam provided all requirements for eligibility are met. Successful completion of the exam, and ongoing membership in the CFPC allow physicians to identify themselves as a Certificant of the College of Family Physicians of Canada (CCFP).

## **Allied Health Professionals**

Not all health care is insured by Medicare. Dental and optometry services are usually the responsibility of the user. There are, however, several exceptions to this. Dental surgery requiring hospitalization for its proper performance is insured, as are biennial eye examinations by optometrists for patients under 19 or over 65 years of age. Pharmacists are employed in the private sector and dispense prescribed medicines, as well as provide clients with information concerning their prescription and non-prescription medications. In Manitoba, patients are not required to pay for routine laboratory or x-ray tests.

Manitoba Health will insure a maximum of 12 visits per Manitoba resident 18 years or older per calendar year to chiropractors. The adjustment of the spinal column, pelvis and extremities are insured chiropractic services.

## **Funding**

Health care in Manitoba accounts for about a third of provincial expenditures. About 70% of health care costs are paid for by public sector spending, mostly by way of the Canada Health and Social Transfer, which comprises the federal government's contribution to provincial health care, post secondary education, and social programs. The remaining 30% is financed by way of supplementary insurance, employer sponsored benefits, or directly by the consumer.

## **Evolving Trends**

Per capita health care spending in Canada is second only to the United States. Despite this, it is recognized that we are no healthier for it than many countries who spend less per capita, such as Sweden and Japan. With the growing realization that health is not merely the absence of disease, and that health care is only one of the determinants of health, there is a transition away from traditional institution centered health care to a more community centered view of health. Today all provinces in Canada are exploring primary care options including the creation of care teams of healthcare professionals, increased focus on prevention and better coordination of services.

### **3 Legal Responsibilities: The College of Physicians and Surgeons of Manitoba (CPSM)**

Physicians are licensed to practice by, and are responsible to, provincial medical regulatory bodies. In Manitoba the College of Physicians and Surgeons (CPSM) serves this role, which includes setting qualifications for registration and licensure, reviewing competence, establishing and maintaining standards, and determining rules of ethical conduct. As a self-governing body, the College is responsible for taking action when its members fail to comply with its guidelines.

The College's Code of Conduct and Statements (mandatory practice) can be downloaded from the College website – <http://www.cpsm.mb.ca>

Upon becoming licensed with the College, you will receive a *Physician Information Packet*, including:

1. The Manitoba Medical Act (Summary)
2. Statutory Responsibilities of Physicians - Reporting of Diseases
3. Death Certification and the Fatality Inquiries Act
4. Narcotic Control Act (Canada) and Food and Drug Act (Canada) (Summary)
5. Physician Disclosure of Harm that Occurs in the Course of Patient Care
6. At Risk Colleagues
7. Manitoba Quality Assurance Program Registration Form
8. Prescribing Practices: Doctor/Pharmacist Relationships
9. Article 25 (location) and 26 (termination)
10. Advertising Statement
11. Canadian Medical Protective Association (CMPA) - Information Application Booklet and Undertaking
12. College Newsletter
13. Sexual Misconduct in the Physician/Patient Relationship
14. Code of Conduct of the CPSM
15. Medical Standards for Driving -Manitoba Highways and Transportation
16. Physician and Medical Examiners Handbook for Medical Certification of Death and Stillbirth for MB - Referred as reference in #2
17. Diabetes Information
18. Fetal Alcohol Syndrome Information Handout and CD
19. Medical Records Self-Evaluation (from the College of Physicians and Surgeons of Ontario)
20. Prescribing and Treatment: Self and Family
21. Child Protection and Child Abuse Booklets, Parts I and II
22. Physicians Manual of Substance Abuse and Dependence
23. Counselling Guide for Clients with Accidental Exposure to Bloody or Body Fluids
24. Information Package – College of Family Physicians of Manitoba

The packet will be a valuable resource in familiarizing yourself with the jurisdiction and function of the College. It will be important to review the contents of these materials so that you may refer to them when questions arise. Pay careful attention to the section labeled **Statutory Responsibilities of Physicians**. It outlines cases in which the law overrules your patient's right to confidentiality.

These include:

**Disease episodes of public health significance**

(including invasive group A streptococcal infections (IGAS))

- report to the Director of Communicable Disease Control at 1-204-945-5141

**Sexually transmitted diseases (including AIDS)**

- report to the Director of Communicable Disease Control at 1-204-945-5141

**Cancer and malignant neoplasms**

- report to the Central Cancer Registry at 1-204-787-2103

**Suspicion of child abuse**

- report to your regional Family Services office (see appendix V11 - Health Authority)

**Clinical conditions which may make it dangerous to operate a motor vehicle.**

- report to Manitoba Highways and Transportation, Driver and Vehicle Licensing at 1-204-945-5340 (in writing, FAX to 1-204-945-5324)

**Protection for Persons in Care Act**

1-204-788-6366

1-800-440-6366

**Vulnerable Persons Living with a Mental Disability Act**

1-204-945-5039

1-800-757-9857

As a physician licensed to practise medicine in Manitoba, you have a legal obligation to report these incidences. Limiting the spread of communicable disease is an important function of physicians. The Communicable Disease Control Manual, containing treatment protocols for the most significant infectious diseases, has been included with this package.

(also at <http://www.gov.mb.ca/health/publichealth/cdc/protocol>)

## **The College of Physicians and Surgeons of Manitoba: History and Activities**

An Act relating to medical practitioners in this province was passed on May 3, 1871. From 1871 to 1876, the provincial medical regulatory body operated under the name "The Provincial Medical Board of Manitoba". The name was changed to "The College of Physicians and Surgeons of Manitoba" (the College), February 28, 1877.

Every person registered in the Manitoba Medical Register in accordance with The Medical Act is a member of the College.

The affairs of the College are conducted by a Council. Councillors are elected from the profession by electoral districts. By 2008, there will be 8 districts including the district defined as the City of Winnipeg. There will be 9 councillors elected from the City of Winnipeg, 1 from each of the 6 rural districts and 1 from the City of Brandon. In addition, there is one councillor elected from the Clinical Assistant Register, two councillors appointed by the Faculty of Medicine and four lay members (two appointed by the Council and two by the Lieutenant Governor in Council).

The principal functions of the Council are:

- **Qualifications & Licensure**  
defines those requirements necessary for the safe practice of medicine and the capabilities required for the performance of various clinical procedures.
- **Evaluation of Competence and Maintenance of Standards**  
through the educational process, standards can be established against which performance is measured and objectives of good patient care met.
- **Rules of Conduct**  
establishment of rules and minimum standards enable the profession to self-govern and take action where there is a failure to comply with guidelines of ethical or safe clinical practice.

The medical profession has a long-standing tradition of self-regulation. Professional self-regulation is dependent upon the concern of each individual physician, not only for patients under the physician's care but also for the patients of other colleagues. The College believes that every physician, as a member of a self-governing profession, should share in the responsibility of the College in assuring the public that appropriate standards of practice and conduct are followed by all.

## **MISSION STATEMENT AND ORGANIZATIONAL PHILOSOPHY**

Service to the public and the profession.

### **A. Mission Statement**

1. **Role of the College** - Responsible for the maintenance of standards of medical practice through the administration of The Medical Act which includes The Code of Ethics.
2. **Intended Jurisdiction** - The Medical Act extends only to members of the College and physicians in training or to those who confirm in writing their acceptance of the authority of the College.
3. **Service Goals** - Those served by the College are primarily consumers of medical care services and physician members of the College (both student and duly qualified). Also served are those organizations which provide health care as well as public health services. Secondly, those served would be other organizations with an interest in health care.

### **B. Organizational Philosophy**

The College operates under the authority of a governing board (Council) made up of thirty-seven people; the Chair is elected. The Chief Executive Officer (Registrar) is an employee of the board. The officers of the College are the President, President-Elect, Past-President, Registrar and Treasurer.

Policy formation takes place through standing committees all of which are chaired by councillors. An Executive Committee conducts the business of Council on a day to day basis and is comprised of the Chairs of the standing committees and officers.

### **C. Management Philosophy**

Management has an equal rights and equal pay philosophy with preference given to promotion from within to fill vacancies.

## LEGISLATION

Legislation directly governing the College includes:

- The Medical Act
- Bylaw 1 - The College of Physicians & Surgeons
- Bylaw 2 - Continuing Medical Education
- Bylaw 3A - Laboratory Facilities
- Bylaw 3B - Diagnostic Imaging and Radiation Oncology Facilities
- Bylaw 3C - Nuclear Medicine Facilities
- Bylaw 3D - Non-Hospital Medical/Surgical Facilities
- Bylaw 4 - Institution of New Electoral Districts
- Bylaw 5 - The Manitoba Prescribing Practices Program
- Bylaw 6: Central Standards Committee
- Bylaw 7 – Corporations
- Regulation 42/87
- Regulation 25/2003
- Regulation 183/99

Copies of the above may be obtained from the College. (There will be a nominal charge for each.) Copies of other legislation relative to health care may be obtained either from Statutory Publications, 200 Vaughan St. (lower level), Winnipeg Manitoba R3C 1T5, Phone (204) 945-3101 or on the internet at <http://www.gov.mb.ca/chc/statpub/free/legdbindexeng-m.html>.

## REGISTRATION

Contact the CPS to confirm your registration status. Conditional registrants in general practice who wish to apply for full registration must obtain the LMCC (Licentiate of the Medical Council of Canada Qualifying Examination Parts I and II) within five years of the date of first being issued conditional registration and certification from the College of Family Physicians of Canada (CFPC) within seven years of the date of first being issued conditional registration.

Conditional registrants must keep the College informed of any change in practice location. Conditional registration remains valid only while the physician is practising in the province. Unauthorized moves may result in the revocation of your temporary work permit.

For information on the Medical Council of Canada Qualifying examinations, contact the Medical Council of Canada at 1-613-521-6012 or visit their web site at <http://www.mcc.ca> Information about the CFPC certification exam is available from the College of Family Physician of Canada at <http://www.cfpc.ca>. (905) 629-0900, or the Manitoba Chapter at (204) 668-3667.

### Contact the College of Physicians and Surgeons of Manitoba at:

The College of Physicians & Surgeons of Manitoba  
1000 – 1661 Portage Ave., Winnipeg, Manitoba R3G 3T7

Phone: (204) 774-4344 or 1-877-774-4344 toll free in Manitoba  
Fax: (204) 774-0750  
Internet homepage: <http://www.cpsm.mb.ca>

# Professional Organizations and Support Services

## 4 Manitoba Medical Association (MMA)

The MMA describes its role as that of “a professional association of physicians helping physicians.” Varied economic, social and political issues important to Manitoba’s practicing physicians are represented and promoted. In accordance with the *Manitoba Medical Association Membership Dues Act*, all practicing physicians in Manitoba must pay dues to the MMA. After the College of Physicians and Surgeons grants you your license, you will receive a letter informing you of this.

The MMA offers services in several key fields:

- Health Policy Advocacy
- Negotiation Services
- Health Promotion
- Personal Insurance Programs
- Liability Insurance (Canadian Medical Protective Association, or CMPA) and CME Rebate Programs
- Maternity/Parental Benefits Program
- Physician Retention Program
- Physicians at Risk Program
- Communication

### Health Policy Advocacy

The MMA is the voice of physicians in Manitoba and interacts with Manitoba Health to try to reach consensus on medical service issues. Positions taken by the MMA are established by its elected Board of Directors, based on the recommendations of its committees and practice blocs.

### Negotiation Services

A primary objective of the MMA is to safeguard and enhance physicians’ economic interests. The MMA is the sole and exclusive bargaining agent for all fee-for-service physicians, government-employed doctors, salaried emergency physicians, pathologists and various groups of physicians employed by Regional Health Authorities throughout the province. The Association also provides professional negotiation advice and assistance to many physicians who are remunerated through a variety of alternate funded agreements.

With regard to fee-for-service physicians, the Association negotiates increases to the Manitoba fee schedule for insured medical services, and funding for various benefit programs described elsewhere in this brochure. Through ongoing negotiation with Manitoba Health, new insured services are added to the fee schedule. Assistance is provided in resolving various compensation problems, including claims disputes with Manitoba Health. The MMA also advises its members on billing for uninsured services, and investigations by the Medical Review Committee.

The MMA is involved in negotiating employment conditions for some physician groups, and has had a major role in defining medical staff bylaws.

## **Health Promotion**

Through its Council on Health Care and Promotion, a collection of volunteer committees, the MMA is very active in health promotion, lobbying, and professional and public education. The Council and its subcommittees also study and respond to legislative initiatives in the realm of health care and promotion. For example, the Association continues to take the lead over the past few years in lobbying aggressively and successfully for smoking bans in all indoor public places and workplaces province-wide. Other health care issues that the Council has brought to the forefront of public attention over the years are numerous and diverse. Some past and current examples relate to fetal alcohol syndrome, seatbelt and helmet use, graduated driver licensing, health care directives, organ donation, gambling addiction, the association between SIDS and sleeping position, and physical education/fitness.

## **Personal Insurance Programs**

The MMA offers a variety of group insurance plans, designed specifically for doctors and their dependents, at very competitive rates. Currently, nearly 1,400 members and dependents are participating in one or more of the plans. Most of these plans are experience-rated and operated on a not-for-profit basis so all profits are returned to the participants. That means that if, in a given year, premiums collected exceed claims and operating expenses, refunds are paid out to participating members. Term life, disability income, office overhead, accident, and extended health benefits are available through the MMA.

## **Physicians at Risk Program (PAR)**

PAR is a peer assistance program wholly funded by the MMA that helps physicians and their families experiencing difficulties in their private and professional lives. If you develop any social, marital, financial, legal, behavioral, or chemical dependency difficulties, the Physicians at Risk Program is available as a confidential service, and a male or female colleague can be contacted via a 24-hour telephone answering service at **1-204-237-8320**.

Making a career move to a new country can be extremely stressful for a variety of reasons both professional and social, and some of your peers have drawn upon this service as a useful resource. A piece of advice offered from the people who run the service is *Don't wait until your problems seem unmanageable before seeking assistance*. The Physicians at Risk (PAR) program is designed to help you resolve problems before they become severe or precipitate major crises.

Of particular importance to rural physicians is that the PAR program has over the years established an informal network of community and local resources, as well as good people to talk to all over Manitoba. A *Family Support Coordinator* is available as a resource for your family to deal with difficulties that arise when a physician experiences personal problems.

## **Communication**

The MMA keeps physicians up to date on medical economic issues, health policy, and MMA services and activities through the newsletter *Rounds*, the *President's Letter*, and the annual reports booklet. The newsletter is a key source of information and advice on fees for insured medical services and related billing issues. Reference documents (e.g., College guidelines, information on direct billing for uninsured services, health promotion posters, etc.) are published as required to assist physicians in their practice.

The MMA also plays a crucial role in providing the media with information about medical/political issues and making the views of the medical profession known.

## **Negotiated Benefit Programs**

The MMA negotiates provincial funding for, and administers, the following benefit programs:

### **CMPA Rebate Program**

Physicians who receive their income either directly or indirectly from Manitoba Health and have held a Manitoba licence during the applicable calendar year are eligible to claim a rebate on their annual malpractice insurance (CMPA) dues.

### **Continuing Medical Education (CME) Rebate Program**

This program reimburses fee-for-service physicians a portion of their continuing medical education expenses paid in the previous calendar year.

### **Maternity/Parental Benefits Program**

The Maternity/Parental Benefits Program provides partial income replacement for a physician parent who wants to take a leave from practice because of the birth or adoption of a child. Physicians who receive their income directly or indirectly from Manitoba Health are eligible.

### **Physician Retention Program**

Eligible physicians accrue shares of increasing value the longer they remain practicing in Manitoba. Physicians are eligible for a benefit if they have received income directly or indirectly from Manitoba Health for services provided in five consecutive program years. Program years run from April 1 to March 31. Physicians must have held a Manitoba licence to practice medicine during each program year.

For more information on these benefit programs, call toll free **1-888-322-4242**.

## **Other Services**

Members of the MMA:

- have the option of purchasing or leasing a new car at a significant discount through an MMA plan. Members pay only the cost of the vehicle to the dealer with a small markup, and save themselves the hassle of shopping around and negotiating prices.
- may shop at Price Costco, a major wholesaler in Winnipeg
- may receive discounts on long-distance telephone charges through West Can Telecommunications
- are eligible for some free legal assistance as well as discounted rates on a number of other legal services
- can purchase house insurance through an MMA-approved provider.

For more information about the MMA and its programs, phone toll free at: **1-888-322-4242**.

## 5 Canadian Medical Association (CMA) and MD Management

The MMA is the local chapter of the Canadian Medical Association, which advocates physicians' interests at the national level and influences national health and health care policy. In order to become a full voting member of the MMA, you have to be a member of the CMA as well. Membership with the CMA is not mandatory, but is strongly recommended by the MMA, given the services it offers. You can reach the CMA toll free at: **1-888-855-2555** (Member Service Centre).

MD Management is a wholly owned subsidiary of the CMA, and operates on a non-profit basis as a service to its members. It offers a range of *financial and practice management* services and resources, both of which are very useful to someone setting up a life and practice in Manitoba. You can reach MD Management toll free at: **1-800-267-2332**.

Through MD Management, you can:

- set up a bank account at higher interest rates and lower service charges than are available elsewhere.
- make investments through mutual funds that have consistently outperformed the vast majority of Canadian funds.
- receive assistance and advice on negotiating loans and interest rates.

Each of these services has little or no service charges.

The CMA and MD Management provide professional development, online services and deliver several publications to their members including:

- The Canadian Medical Association Journal, a general scientific, general medical journal in Canada that is published biweekly.
- Strategy, the CMA/MD Management financial newsletter, published monthly.
- CMA Interface, the monthly newsletter of the CMA.
- Canadian Journal of Rural Medicine, published four times annually by CMA for the Society of Rural Physicians of Canada.
- A number of books of clinical and professional interest to physicians.
- CMA Infobase, the number one source for more than 2,000 current, evidence-based clinical practice guidelines.
- Osler: free unlimited access to OVID/Medline and MDConsult, premiere medical information databases, texts and journals.

Pamphlets and booklets outlining CMA services will be sent to you when you become a member of the MMA. Internet homepage: <http://www.cma.ca>.

## **6 Manitoba College of Family Physicians (MCFP)**

The Manitoba College of Family Physicians Inc. represents over half of the primary care physicians in Manitoba. It is an organizational chapter of the national College of Family Physicians of Canada (<http://www.cfpc.ca>).

The delivery of primary health care in our province faces many challenges for all family physicians, rural and urban alike. The model and delivery of primary care is being re-examined within Manitoba and the College of Family Physicians is an active player in this process.

All new physicians in primary care practice are invited to become members. The annual general meeting is held each year in conjunction with a 3 day provincial continuing medical education event called the Annual Scientific Assembly. This is a great opportunity to meet colleagues and exchange ideas and experiences while furthering your education.

Please call, fax or visit both the Manitoba College of Family Physicians and the national College of Family Physicians websites to voice your concerns, ask questions or share your expertise.

For information about the Annual Scientific Assembly or other Manitoba College of Family Physicians activities, visit the Manitoba website at <http://www.mcfp.mb.ca>.

## 7 Society of Rural Physicians of Canada

The Society of Rural Physicians of Canada (SRPC) was initiated in 1992 by a group of doctors to promote sustainable working conditions for rural physicians. The working principle is that Canada's rural population must have access to excellent health care delivered by a stable, well-trained, well-equipped and rested medical staff.

The SRPC is working toward that goal by developing policies for improving the delivery of health care, by championing rural medicine through the media and by interacting with federal and provincial governments, medical schools and professional medical associations across the country.

The SRPC has established a Library of Rural Medicine; in 1995 it launched an Internet discussion site (RuralMed), a website (<http://www.srpc.ca>), and in June 1996 the first issue of Canadian Journal of Rural Medicine (CJRM) was published. The CJRM appears winter, spring, summer and fall. The SRPC has developed curriculum papers on Advanced Skill sets in Obstetrics, Anesthesia and Surgery, and a Rural Elective Registry.

Among the Society's functions and accomplishments are:

- the development of ideas and policies for improving the delivery of health care to rural areas, and advocating those ideas through the media and at the government, medical school and professional organizations level (e.g., input to the Scott Report);
- the support of rural doctors and communities in crisis;
- the promotion and development of relevant, useful continuing medical education, including a national annual course in rural medicine, and pioneering satellite CME transmissions;
- the encouragement and facilitation of research into rural health questions;
- the establishment of a library of rural medicine, the Canadian Journal of Rural Medicine, and an Internet discussion group (RuralMed);
- the fostering of communication among rural physicians (including a monthly national conference call) and among other groups with an interest in rural health care;
- attendance at provincial rural forums.

SRPC membership is open to communities, educators, researchers, administrators, and all rural doctors -- anyone with an interest in rural medicine.

If you have any questions please contact:

**Society of Rural Physicians of Canada**  
P. O. Box 893  
Shawville, QC J0X 2Y0

By phone or fax: **(819) 647 3971**  
E-mail: [admin@srpc.ca](mailto:admin@srpc.ca)

## 8 Malpractice Insurance – Canadian Medical Protective Association

*“All Physicians should have adequate protection against medico-legal difficulty arising from professional work. Any doctor, no matter how careful and skillful, may be complained about or sued. Medico-legal trouble arises not only because a doctor has in fact been wrong, but also when a patient believes the doctor has been wrong. A medical malpractice or negligence lawsuit brought against a doctor, whether it is well founded or not, entails loss of time, much worry and often heavy expense.”*

-Canadian Medical Protective Association

A recent amendment to The Medical Act (of Manitoba) effective January 1, 2000 requires all members to “...carry a policy of professional liability insurance issued by a company licensed to carry on business in the province that is acceptable to the College”. Members who are uncertain regarding the acceptability of their coverage should forward details to the College for review. In future, all members will be required to sign an “affirmation of compliance” in order to obtain a license. The vast majority of Canadian doctors purchase their coverage through the Canadian Medical Protective Association (CMPA), and you will receive the Membership Application and Information Booklet upon your licensure with the College of Physicians and Surgeons of Manitoba.

Coverage with the CMPA is provided on an “occurrence basis.” This means that you will be protected for any claim arising out of professional work done during your membership with the CMPA, regardless of when the claim is made.

Members of the CMPA are eligible to receive

- Assistance in the defense of a lawsuit arising from professional work; such assistance includes the retaining of a lawyer approved by the CMPA, the payment of legal expenses, the payment of a court award or a settlement and the payment of costs, all as provided in the Association’s by-law;
- Advice and legal assistance, as necessary, in connection with Coroners’ Inquests and similar inquiries and the proceedings of Complaints, Discipline and Fitness to Practise Committees of a medical licensing authority;
- Advice and legal assistance, as necessary, concerning hospital matters which threaten loss of a staff appointment or practice privileges;
- Advice about how to deal with dissatisfaction expressed by a patient or a patient’s family and about how to respond to a lawyer’s letter.

The cost of coverage varies depending on the type of work you do in your practice.

You can reach the CMPA at **1-800-267-6522** or <http://www.cmpa.ca>

## **CMPA Rebate Programs**

Manitoba Health provides funding to the Manitoba Medical Association (MMA) for the Professional Liability Insurance Fund (PLIF) which is used to subsidize fee-for-service physicians for CMPA dues. The MMA administers the CMPA Rebate programs to partially rebate physicians' annual liability insurance costs. The MMA will mail claim forms to all eligible physicians at least once per year, usually in early February.

For more information, please call the MMA toll free at **1-888-322-4242**.

## **9 Library Services - Neil John Maclean Health Sciences Library**

The Neil John Maclean Health Sciences Library (located at 230 Brodie Centre at the Bannatyne campus) has the largest collection of health care related materials in Manitoba. As a University of Manitoba library, it serves the health science faculties as well as the staff and students of teaching sites in the Province. You can do your own literature searches through the computerized databases MEDLINE and BISON if you have an internet connection.

The Neil John Maclean Health Sciences Library is in the process of updating its services, and further information will be available in the near future. In the meantime, you can find more information on the Library's web site at: <http://www.umanitoba.ca/libraries/health> .

## 10 Continuing Medical Education

In order to maintain their medical skills and keep up to date with developments in their fields, it is important that doctors continue to learn throughout their careers. The current guidelines of the College of Physicians and Surgeons of Manitoba recommend that every practising physician in Manitoba should participate in at least 100 hours of continuing medical education per 2 year period. Of those, up to 50 hours can be carried out independently (reading journals, watching videos, teaching and studying), but 50 are to be in an accredited group learning environment, which the College defines as:

- All scientific sessions of international, national and provincial conventions.
- University courses, lectures, seminars and district scientific meetings.
- MMA section scientific meetings.
- Short-term residencies. (*see first point below under "Other Programs"*)
- Accredited Review sessions, courses.
- Formal ward rounds, grand rounds, etc.
- Clinical path conferences.
- Peer review, e.g. area hospital standards, medical records, and death review.

Programs presented by the Department of Continuing Medical Education at the University of Manitoba Faculty of Medicine are the main vehicles by which doctors fulfill the group learning requirements of the College. Lectures and workshops cover a variety of topics of interest to practicing physicians and are coordinated under the following programs. The department of Continuing Medical Education is accredited by the Committee on Accreditation of Canadian Medical Schools and the Accreditation Council of Continuing Medical Education in the US.

### **Rural Education Program - Department of Continuing Medical Education**

The Rural Education Program is designed to provide rural physicians with updates on major medical topics of particular interest to rural practitioners. Program objectives of enhanced clinical competence and improved patient care are met through realistic and practical case studies. Sessions are based on community requirements but are open to physicians from other areas of the province as well. Instruction is provided by the clinical staff of the Faculty of Medicine, local speakers and others coordinated by local program chairs.

There are approximately eight sessions offered every year in each of the RHAs throughout the province. Many sessions are videoconferenced to nearby centres so that physicians in smaller communities may also have access. Depending on your interests, you can either register annually for all sessions offered in your region (usually 7-9), or you may register for individual sessions.

If you choose the annual registration, you are also entitled to attend any *Continuing Medical Education for Family Physicians – Urban Program* session held during that year.

## **Continuing Medical Education for Family Physicians (CME-FP) for Urban Physicians - Department of Continuing Medical Education**

This program is designed to provide a forum for lectures and discussion of medical problems. The emphasis will be on the practical application of information in an office practice situation. These one-day sessions are run monthly at the Faculty of Medicine campus in Winnipeg.

The program covers approximately 40 hours of lectures and workshops in the academic year commencing in October and ending in June. The programs are run on the first Friday of the month. The choice of programming is directed by a planning committee of community based general / family physicians.

As with the *Rural Education Program*, you can register for sessions annually or individually. With an annual registration you are entitled to attend *Rural Education Program* sessions.

### **Registering**

Annual program schedules for CMEFP are mailed to all family practitioners every August. Schedules for the *Rural Education Program* are sent out to all rural family practitioners every August as well, followed by region-specific advertisements for regional sessions which are mailed every month or so. In order to register for either of these programs, just fill out the registration form and return it along with the registration fee to CME. Payment can be made by cheque, Visa or Mastercard. These fees can be claimed back under the MMA's CME rebate program.

### **Other programs**

In addition to these major programs, the Department of Continuing Medical Education also offers physicians

- opportunities to carry out self designed clinical electives – this is a self-directed learning opportunity in a post graduate setting for a period of time as negotiated between the physician and the participating department (e.g., two weeks in psychiatry). At present, there is no provision for post-graduate training for physicians on work permits.
- a series of programs on subject matter of potential interest to specialists and generalists alike (e.g., Emergency Medicine, Orthopedics, Anesthesia),
- the opportunity for certification by the College in the reading of EKG's (a requirement in order to bill for this service),
- physician clinical assessments as required, individualized continuing education programs for physicians who may be either self-referred or referred by the College of Physicians and Surgeons.

If you have any questions pertaining to continuing medical educational opportunities, please feel free to call the Department of Continuing Medical Education, Faculty of Medicine at:

**1-204-789-3660.**

## **11 University of Manitoba Health Sciences Bookstore**

The University of Manitoba Bookstore is owned and operated by the University of Manitoba. For those involved in the health professions, there is a Health Sciences bookstore on the Bannatyne campus next to the Health Sciences Centre. The bookstore is located on the main floor of the Brodie Centre directly below the Neil John Maclean Library.

This specialty store offers over 100,000 different titles available for order, a variety of products for all of our customers and a great computer department to help you find the hardware and software you need.

### **Health Sciences Book Store**

727 McDermot Avenue, University of Manitoba  
Winnipeg, Manitoba, Canada, R3E 3P5

Ph: (204) 789-3601 Fax: (204) 789-3901

Internet site: <http://www.umanitoba.ca/campus/bookstore/depts/hsb.php>

## 12 Health Links

Health Links is a government funded confidential telephone health information and referral assistance service based in the Misericordia General Hospital in Winnipeg. The telephone service is offered free of charge to all Manitobans via a toll free number.

Health Links nursing staff can be reached at **1-888-315-9257**.

The service provides primary health care advice via the telephone 24 hours a day, 7 days a week from specially trained registered nurses (RNs) who:

- answer health related questions
- provide rapid professional telephone assessment to determine if patients require immediate attention.
- assist patients with decision making
- identify appropriate referrals and resources
- assistance with referrals to health care available within the community.
- provide follow-up when required.

Patient access to telephone health information seems to be a cost effective service that may contribute to a smoother, more appropriate use of health resources, increased consumer satisfaction with the health care system and a public that is better informed about health issues and service options. Patients can access Health Links 24 hours a day, 7 days a week.

## 13 Office of Rural and Northern Health

**MANDATE:** Providing Manitobans with leadership and programming related to education, recruitment and retention of health care professionals in rural and northern Manitoba communities.

The Office of Rural and Northern Health (ORNH) plays a key role in assisting regional health authorities in Manitoba increase the number of health care professionals who choose rural and northern Manitoba as a place to live and practise their professions. Throughout Manitoba the ORNH aims to target rural and northern students interested in health care careers as well as health care professionals practicing in rural and northern Manitoba.

**Project Coordinator:** Regional Health Authorities of Manitoba (RHAM)  
**Funding Agency** Manitoba Health  
**Supporting Agencies** Health Care Stakeholders – U of M, AMM, RRC

### INITIATIVES & PROGRAMMING

Continuing Medical Education

- GP Anesthesia Training Program
- Preceptor Development Workshop

Cooperative Marketing, Return of Service Agreements, Manitoba Medical Students Rural Interest Group (MMSRIG), Enhanced Rural Curriculum, Summer Work Experience & Training (SWEAT), and Rural Week.

### COMMITTEE REPRESENTATION

Academic & Professional Issues, Deans Council, Admissions

For more complete details visit us online at [www.ornh.mb.ca](http://www.ornh.mb.ca) or contact:

Office of Rural and Northern Health  
Wayne Heide, Administrative Director  
Unit D – 101 1st Ave NW  
Dauphin, MB R7N 1G8  
Phone: **204-622-6210** Fax: **204-622-6211**  
Toll-free: **1-866-244-ORNH (6764)**  
Email: [whaide@ornh.mb.ca](mailto:whaide@ornh.mb.ca)  
General Email: [info@ornh.mb.ca](mailto:info@ornh.mb.ca)

Dr. Don Klassen, Medical Director  
Boundary Trails Health Centre  
Box 2000  
Winkler, MB R6W 1H8  
Phone: **(204) 331-8876**  
Fax: **(204) 331-8804**  
Email: [drdon@valleycable.com](mailto:drdon@valleycable.com)

# Practising Medicine

## 14 Referring Patients to Consultants and other Facilities

When your level of experience or clinical facility is unable to provide needed medical care for a patient, you must either consult with another physician or refer your patient to another physician for continuation of care.

In Canada, a “**consult**” means asking another physician (who may or may not be a specialist) for advice concerning the care of a particular patient. The primary doctor in this case retains responsibility for the patient.

A “**referral**,” on the other hand, means transferring responsibility for the care of a patient to another physician, and involves apprising the new physician of the patient’s condition and pertinent medical history before the transfer occurs.

In general, patterns of referral in Manitoba result from historical relationships, geography and transportation issues, and physician and patient preference. Upon arrival in your community, you will need to learn what local patterns are, and you can learn this from local physicians, nursing staff, or referral to patient charts. You will develop your own routines as you get to know the specialists and facilities available.

For a given patient with a particular condition, your options in order of preference are:

1. Contact the specialist who previously treated the patient for the present problem.
2. Contact the specialist that physicians from your area usually refer to for conditions like your patient’s.
3. Contact the emergency department at the nearest secondary care facility, or if you suspect that the required medical attention can only be provided by a tertiary care facility, contact the physician on call at the department of interest. For less urgent cases you may also use the services of multispecialty private clinics such as the Manitoba Clinic, or the Winnipeg Clinic, but they often have waiting lists.

Learning how to access specialty services is a major source of difficulty for rural doctors. Depending on whom you consult, you may have to wait months for a response, and sending a patient to a tertiary centre in Winnipeg can be a bureaucratic hassle. It is important for you to develop your professional relationships, and as you gain experience, you will learn which avenues are most effective for getting your patients served. Attending Continuing Medical Education sessions is a good way to get to know local physicians as well as Winnipeg specialists who come to deliver presentations. As a physician with conditional registration, your Practice Advisor may have some useful advice on issues of referral as well. You may be able to contact specialists through the U of M Faculty of Medicine internet site (<http://www.umanitoba.ca/faculties/medicine/units>), or at the following clinics and hospitals:

### **Major Hospitals and Clinics in Winnipeg**

St. Boniface General Hospital - Emergency	237-2260
Health Sciences Centre – Adult Emergency	787-3167
Health Sciences Centre - Children’s Emergency	787-2306
University Medical Group	789-3645
Manitoba Clinic	774-6541
Winnipeg Clinic	957-1900
St. Boniface Clinic	925-9595

### **Major Hospitals and Clinics in Brandon**

Brandon General Hospital - Emergency	579-4166
Brandon Clinic	728-4440
Western Medical Clinic	727-6451

Remember, patients are best served by teams of health care professionals, and other physicians are useful resources to discuss how best to care for your patients. Decisions on patient care should be made cooperatively between the concerned physicians.

### **Receiving Care Outside Manitoba**

Manitoba Health provides benefits for care provided in Canada under the provisions of *The Canada Health Act* and in accordance with the Regulations under the *Health Services Insurance Act*.

The Province of Manitoba has signed agreements for the reciprocal billing of “insured” hospital and medical services with every province and territory in Canada (with the exception of Quebec physicians). Payment is based on rates in the province where the service is rendered. Any patient is free to go anywhere in Canada to seek medical services, but transportation costs remain their responsibility. The *Manitoba Transportation Subsidy Program* may subsidize the transportation costs for select cases, but peripheral costs such as food and hotel are not covered.

When select medical services are not available locally, funding will be considered for elective care out of Canada. However, Manitoba Health will only pay for those services which a specialist has identified as unavailable in Canada, and medically necessary. Patients may still incur considerable costs above the coverage offered by Manitoba Health.

For more information on Out of Province Benefits, phone **1-204-786-7303**.

## 15 Prescribing Practices

A major hurdle to overcome in adjusting to medical practice in a new country is learning which drugs are available and are typically used to treat a given illness. Doctors who have come from other countries to practice in Manitoba have repeatedly emphasized the difficulty of this process, and have pointed out that the *Compendium of Pharmaceuticals and Specialties* (CPS) published by the Canadian Pharmacists Association is too extensive for easy reference. Two books that have been found useful by other international medical graduates are:

- **Drugs of Choice** – published annually by the Canadian Medical Association and sells for around \$25. It is under 200 pages, and is organized by disease. Primary and second-line therapies as applied in Canada are listed by their generic names along with the approximate costs of treatment. Brief *additional instructions* and notes are included under every heading, and an appendix lists drugs according to their function (e.g., ACE inhibitors, Anticholinergics, Antihistamines, etc.)
- **Therapeutic Choices** – published by the Canadian Pharmacists Association and edited by Dr. Jean Gray. It sells for around \$70, has 800 pages but is still small enough to fit in a clinic jacket pocket. It also lists therapies according to disease, often incorporating flowcharts and tables outlining diagnostic guidelines and treatment strategies.

Often doctors practicing in their countries of origin become familiar with drugs according to their **trade names**, but are less familiar with their **generic names** – the CPS lists drugs by their trade names. This presents difficulties when those medications are marketed under trade names in Canada that are different from what you are used to. When you are unable to remember the generic name, and the above resources don't help, feel free to **ask your local pharmacist**. They may have access to *Martindale: The Extra Pharmacopoeia*, which exhaustively lists the trade names of drugs in every country. This book is prohibitively expensive (around \$500) and is likely of limited utility once you have been practising for a couple of months. If the pharmacist does not have access to a copy, they can phone the Manitoba Pharmaceutical Association and get the information you need.

There are also a number of online resources (downloadable to handheld devices) which can be very useful (Epocrates, etc)

Another challenge encountered by international medical graduates in Canada is that while equivalent drugs may be available here, they often come in **different dosages**. This will take some getting used to, but is an inevitable part of learning treatment conventions.

Hopefully the resources listed above will help you in your transition, but rest assured, after a couple of months you will be quite familiar with Canadian prescription practices and life will once again become a comfortable routine.

## 16 Pharmacare

Pharmacare is a Manitoba drug benefit program that subsidizes the cost of medications when the user is seriously affected by high prescription drug costs. Coverage is based on total family income and the amount paid for eligible prescription drugs.

Pharmacare does not pay the entire cost of eligible drugs. Each user is assigned a **deductible** according to annual family income, and is responsible for drug costs until the deductible is reached.

In order to qualify for Pharmacare, users must

- be eligible for Manitoba Health coverage. (see The Canadian Health System)
- not have their prescription costs covered by other provincial, federal, or private insurance programs.
- incur prescription costs that exceed their Pharmacare deductible.

The Pharmacare benefit year is April 1 to March 31. New *Pharmacare Application Forms* are sent out to pharmacies and previous Pharmacare users every year in late March. Applicants must fill out the form and send it to Manitoba Health along with copies of their *Revenue Canada Notice of Assessment* (which will indicate their total income) sometime during the benefit year. Only one *Application Form* is filled out per family, as spouses are assessed together and dependents are included under their parents' health insurance.

Any drug purchases made in Manitoba during the benefit year will automatically be credited to the deductible through a central database, the Drug Program Information Network (DPIN) and the applicant will receive a cheque from Pharmacare for the total exceeding the deductible at the end of the year. Patients purchasing drugs in other provinces should send their receipts to Pharmacare in order to be reimbursed for their costs.

You can find more detailed information at <http://www.gov.mb.ca/health/pharmacare/index.html>

### Manitoba Drug Benefits and Interchangeability Formulary

The Manitoba Drug Benefits Formulary lists therapeutically effective drugs of proven high quality for coverage under the Pharmacare drug benefit program. The Pharmacare drug benefits is divided into three parts. Part 1 includes drug products that are eligible Pharmacare benefits under all prescribed circumstances. Part 2 includes drugs products that are eligible Pharmacare benefits only when prescribed for the terms and conditions indicated. For drug products not covered under Part 1 or 2 a request for Exception Drug Status covered will be considered under Part 3.

In the case of new brands of currently listed products (generics), evaluation on comparative bioavailability studies and/or comparative clinical studies is undertaken in order to determine compliance with accepted standards for interchangeability, prior to placement in the Interchangeability Formulary. Prices of different brands are listed only for interchangeable products. Pharmacists can dispense any product within an interchangeable category. However, they will only be reimbursed for the least expensive drug.

A complete Manitoba Drug Benefits and Interchangeability Formulary is provided to health professionals every twelve to eighteen months- with Bulletin updates released every three to four months.

The Formulary has been included with this package to ensure that you are not left without it between your arrival and the next update. If you wish, you may also access the Formulary on the Internet at

<http://www.gov.mb.ca/health/mdbif>

## **DPIN**

The Drug Programs Information Network (DPIN) computer system keeps track of prescription and drug histories for everyone insured by Manitoba Health. The system has several benefits.

- Users don't need to pay for drugs at the point of sale once their deductible is reached.
- By documenting drug histories, it helps prevent adverse drug interactions.
- It identifies users who are abusing the health care system by visiting multiple doctors and having identical prescriptions filled by different pharmacies.
- If the patient cannot provide you with the names of their current drugs, then you can access this information through the DPIN system. *N.B. To do this, you need the patient's verbal consent and must document it in the patient's chart.*

Local pharmacies can access the DPIN as can several hospital emergency departments.

For more information, please contact Pharmacare at **1-800-786-7141**.

## 17 Fee-for-Service Billings

Although a variety of physician payment mechanisms are used throughout the province, most physicians in Manitoba work on a fee-for-service basis and are paid directly by Manitoba Health. After you register with the College of Physicians and Surgeons, you should obtain your billing number<sup>3</sup> and Physician's Manual through Manitoba Health (300 Carlton Street, Winnipeg). The *Physician's Manual* is a guide to billing procedures, rules and regulations, and tariff codes. It also lists the fees for all insured services.

In order to be paid for your services, you must submit your billing number and a list of all the medical services (referred to by their tariff codes) that you have provided in the relevant time period. There are two ways that your billings can be submitted:

1. The majority of doctors submit their billings via personal computer directly to Manitoba Health. An "electronic claims program" information manual is available which also includes names of vendors who can sell you the necessary interface software for connecting with the Manitoba Health computer. The electronic system provides rapid input and faster payments. Payments are made bi-monthly, at mid-month and month-end.
2. At present, doctors still have the option of submitting billings on paper claims, but this is more cumbersome. Because of the added time required to process these submissions, physicians using this system are reimbursed usually within 6 weeks from the date the claims are received. Payments are made bi-monthly, at mid-month and month-end.

Most physicians do not do their own billing. Clinic staff (or a hired billing service) often take care of this aspect. The procedure is fairly straightforward, and becomes even easier with experience. Most doctors have a fairly constant set of services that they provide and the associated tariff codes become quite familiar. Reconciling payments against submitted claims, ensuring all special codes are appropriately utilized, payment delay queries, and submission of special reports are important aspects of this type of work.

Under treaty terms, Aboriginal residents enjoy coverage for health services not insured under the provincial health plan. The **Medical Services Branch of Health Canada** provides a limited number of goods and services to First Nations and Inuit people when those services are not available through other agencies (e.g., Manitoba Health, Welfare, private insurance). Some of the services paid for are Medical Transportation, Vision Care Services, Dental services, Prescription Drugs, and some Medical Equipment and Supplies. For more information on services offered by Medical Services, call **1-204-983-8886** or **1-800-665-8507**.

You should realize that the Manitoba Health Insurance Plan does not pay for every service fee-for-service physicians are asked to provide. Obtain a copy of the *MMA Guide to Fees for Uninsured Services*, which provides a list of uninsured services and suggested fees which must be paid by the user.

For questions regarding billing procedures, contact Manitoba Health at **1-204-786-7394**.

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<sup>3</sup> A billing number used for paying physicians and tracking patient services. However, a billing number may not be required when other payment arrangements have been made.

## 18 Patient Transportation Services (Ambulance)

Although the Manitoba government subsidizes ambulance services, approximately 70% of the cost is usually the direct responsibility of the patient, who will be billed following usage of the service. Ambulance services should therefore be used only when the patient is medically too unstable to undergo a trip by bus, taxi, or car.

Since the formation of the Regional Health Authorities (RHAs), the way patient transportation services are administrated has been changing. Most ambulance services are now either the property of the RHAs or operate under contract with the RHAs.

When you refer a patient to a larger centre for further medical treatment, patient transport is usually arranged through the local hospital, or at the discretion of the RHA, through a regional interfacility transfer co-ordination site. If the situation is very urgent, the Lifeflight air ambulance service may be required (see Lifeflight section).

The cost of Lifeflight itself is covered completely by the government. However, the ground ambulance trips to the airport, and from the destination airport to the hospital are the responsibility of the patient, and may cost the patient up to \$250 each.

If you are working out of a clinic and you experience a patient emergency, you should dial either 911 or your municipality's emergency number if your municipality does not subscribe to 911 services, to arrange for an ambulance. In non-emergent circumstances you may call your local hospital or regional interfacility transfer co-ordination site.

<b>Cases in Which the Patient is not responsible for the Ambulance Costs</b>	
Following are exceptions in which other agencies will be billed for the Ambulance services:	
<b>Patient</b>	<b>Agency Responsible for Costs</b>
Treaty Aboriginals	Federal Government
Motor Vehicle Accident victims	Autopac (vehicle insurance)
Welfare Recipients	Manitoba Social Services
Inpatients transferred temporarily to another hospital for tests or treatment unavailable locally	<ul style="list-style-type: none"> <li>• When the duration of stay is &lt;24 hours, the patient remains a ward of the first hospital, and the hospital will pay for the ambulance.</li> <li>• When the duration of stay is &gt;24 hours, the patient is considered to have been released from the first hospital, and admitted into the second hospital, and the connecting ambulance trip becomes the responsibility of the patient.</li> </ul>
Personal Care Home Residents requiring short term tests or treatments in a hospital	As described above, with the Personal Care Home acting as the first hospital.

## Potential Problems

### *Patients who are unable to pay*

As ambulance services are not insured by Medicare, people are encouraged to purchase private insurance packages to protect them from incurring these costs. However, when patients are not covered by private insurance and are unable to pay the bill in its entirety, most ambulance services offer time payment plan options whereby the bill can be paid in monthly increments. This may place you in a difficult situation, but remember that your primary concern and interest is safe patient care.

### *Refusal of services by patients*

**The referring physician is obligated to inform the patient of their responsibility to pay transportation costs.** Sometimes patients refuse ambulance service, preferring to arrange their transportation privately and thereby avoid the cost, which may be several hundred dollars. Again your primary concern and interest should be safe patient care. In the past some physicians have told patients to accept the service and not pay the bill when it comes. Such approaches should be avoided as you run the very real risk of having your contract terminated. You are strongly encouraged to indicate the positive health benefits of an ambulance transfer to the patient. If you continue to have concerns you may also wish to discuss this with your Regional Health Authority.

### *Referrals to Saskatchewan*

In the western part of Manitoba physicians often refer their patients to Yorkton, Saskatchewan instead of Manitoba facilities. If upon arrival in Yorkton (which is very close to the border) the local doctors decide that they are ill-equipped to care for the patient, the patient may be sent to a larger Saskatchewan centre such as Regina. While Manitoba will pay the health care costs according to the portability clause of the *Canada Health Act*, ambulance services remain the responsibility of the patient. Because Saskatchewan will not subsidize the transportation of Manitoba patients, patients will be required to pay a surcharge. The trip from Yorkton to Regina can cost the patient \$2500 by ground ambulance, and \$6000 by air. You may wish to consider the use of Lifelight or ground ambulance service to a Manitoba centre instead.

## **Lifelight Air Ambulance**

The Manitoba Air Ambulance Program (Lifelight) is the only licensed specialized air ambulance service in the province of Manitoba. Lifelight provides the primary means of air transport for all seriously ill or injured Manitobans from areas outside an 80 mile radius of Winnipeg in rural and northern Manitoba to urban referral centres in Winnipeg. Lifelight can provide “intensive care in the air.” Critical care physicians, emergency physicians and obstetricians provide 24-hour coverage for the program. Flight nurses with advanced critical care training and extensive experience triage all calls, stabilize patients pre-transport and facilitate pre-hospital care throughout the medivac.

The following information is provided by Lifelight.

### **Eligibility for Lifelight**

The patient must:

1. Be a temporary or permanent resident within Manitoba.
  - a. All in province Lifelight transportation will be insured according to Manitoba Health policy if the patient is a resident of Manitoba (registered with Manitoba Health, with the exception of those persons covered by other statutes).
  - b. All other patients transported by Lifelight will be billed on a cost recovery basis.
2. Meet the priority Code 3 or 4 status. (*see appendix III -Interfacility Emergency Transportation*)
3. Priority Code 2 patients that meet the following criteria will be responded to and transported at the discretion of the Lifelight medical/nursing personnel, and in consultation with the attending physician or practitioner.
  - a. Patient’s medical condition dictates that the patient must be stretcher-bound.
  - b. RN escort is required for maintenance of an acceptable minimum standard of care during transport.
  - c. Patient’s condition requires pressurized aircraft transportation with availability of O<sub>2</sub>, suction or cardiac monitoring.
  - d. Patient’s medical condition makes lengthy ground transportation potentially hazardous.
  - e. Ambulatory patients may be accepted as an “add on” in accordance with Lifelight policy, at the discretion of Air Ambulance Staff.

If patients are ineligible for Lifeflight but are in the NPTP (Northern patient transport) zone, and according to the referring physician cannot be transported by commercial means, the Flight Nurse (FN) may offer to make arrangements for an alternate aircraft, which will be paid for out the RHA's NPTP budget.

4. Require transportation only within the Province of Manitoba.
5. Out of province transfers may be considered on an individual basis, at the discretion of the medical director or their designate in accordance with management policy.
6. Be inappropriate for ground transport, and be suitable for air transportation (i.e. consider distance from receiving hospital, response time).
7. If, in the opinion of the Flight Nurse and Chief Flight Nurse, a patient is not eligible for transport on Lifeflight, but the referring physician is in disagreement, the issue shall be referred to the Medical Director for final decision.

Non-Manitoba residents will be eligible for Lifeflight transportation if they meet the policy criteria outlined in statements 2, 3, 4, 5, and 6 and cost recovery from private provincial insurance is ensured.

<b>Accessing Lifeflight</b>
1. Stabilize the patient.
2. Arrange receiving physician/bed.
3. Obtain Consent for Air Transport.
4. Call Lifeflight at 1-204-945-8990.
5. Give Flight Nurse pertinent medical data.
6. Complete Air Ambulance Transfer Form <sup>4</sup>
7. Prepare documentation for receiving facility.
8. After Lifeflight's departure, call 1-204-986- 6336, and notify Winnipeg Ambulance Department of Lifeflight's E.T.A.

For further information regarding Lifeflight, call the Chief Flight Nurse at **1-204-945-0849**.

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<sup>4</sup> The *Air Ambulance Transfer Form* should be available at your facility. If it is not, then contact Lifeflight.

## **19 The Manitoba Home Care Program**

The **Manitoba Home Care Program** is a community-based service that provides home support to individuals, regardless of age, who require health services or assistance with activities of daily living. Home care provides assistance to individuals to help them stay in their homes for as long as is safely possible.

The Home Care Program also ensures coordination of admission to facility care when living in the community is not a viable alternative for a client.

The program is available to Manitobans of all ages and is based on assessed need. The assessment takes into account other resources available to the individual including family supports, community resources and other programs.

### **Home Care Roles and Responsibilities - Regional Health Authorities**

The Regional Health Authorities (RHAs) have operational responsibility for Home Care including planning, delivery and ongoing management of the services.

The RHA's are responsible for:

- accepting referrals and determining eligibility for home care services, based on a multi-disciplinary assessment;
- developing a plan of care which takes into account the needs of the individual and family as well as available community resources;
- determining the amount and type of services to be provided by home care;
- securing, scheduling and supervising the appropriate resources to meet home care service requirements;
- developing and maintaining a "pool" of service providers and resources to ensure continuity in the availability of resources;
- managing the personal care home placement process for individuals whose care can no longer be provided in the community;
- developing and maintaining liaisons with other components of the health care system to ensure a collaborative and coordinated approach to the delivery of health services across the continuum of care.

### **Service Delivery:**

The following core services/components of Home Care are delivered by the Regional Health Authorities to their residents:

- professional assessment to determine eligibility for Home Care
- care planning
- case management
- coordination of services
- nursing services
- therapy assessment
- health teaching
- personal care
- meal preparation
- respite/family relief

- access to adult day care
- cleaning and laundry
- assessment for, and facilitation of, Personal Care Home placement, i.e. paneling
- medical equipment and supplies required to support the care plan

Specialty programming includes:

- Self-Managed Care Program/Family-Managed Care option
- Home Oxygen Therapy Program
- Community Intravenous Therapy Program
- Clustered Care or group shared care
- terminal care/palliative care
- supportive housing/alternative housing options

### **Client Eligibility:**

Any resident of Manitoba may request a professional assessment from Regional Health Authority staff to determine whether they are eligible for Home Care.

There is no charge for any of the services provided by the Home Care Program; however, fees may be charged for community support services provided by other organizations.

To be eligible for the **Manitoba Home Care Program** an individual must:

- be a Manitoba resident, registered with Manitoba Health,
- require health services or assistance with activities of daily living,
- require service to stay in their home for as long as possible, and
- require more assistance than that available from existing supports and community resources.

### **Referrals:**

The Regional Health Authorities (RHAs) have established various intake systems. Some have a centralized number for referral while others have referrals sent directly to the Case Coordinator in the local office. Where the volume warrants it, RHAs have a contact at the hospital for Home Care referral and assessment.

Please contact the Home Care Manager in your RHA for further information.

Home Care information is also available on the websites of the RHAs and of Manitoba Health. The Manitoba Health information is at [www.gov.mb.ca/health/homecare](http://www.gov.mb.ca/health/homecare).

## 20 Mental Health Resources

A range of resources exists across the province for individuals with mental health needs. Each region has a somewhat different array of mental health services and a different group of providers. There is, however, an outline of core mental health services that are to be provided to a greater or lesser extent by each Regional Health Authority across the province.

Some communities have a listing of mental health resources on the back cover of the phone book or on a separate one or two page phone book insert. Where no detailed phone book listing is available, ask your local Regional Health Authority for a complete listing of mental health resources available in your region.

### CORE MENTAL HEALTH SERVICES

**Assessment, Identification & Case Management Services** (phone your RHA for listing)

Community Mental Health and hospital ambulatory care provide multidisciplinary services to individuals with mental health problems including service to the target populations of:

- children and adolescents with mental health problems
- adults with acute care needs
- adults with severe and persistent mental health problems
- older adults with mental health problems / psychogeriatrics

**Acute Psychiatric Care & Treatment** (phone hospitals directly)

Inpatient psychiatric acute care hospital beds are located in specific general hospitals serving regional populations across the province.

#### Psychiatric units exist or are opening soon in the following locations:

Brandon General - 25 adult acute care psychiatric beds	726-1122
Portage General - 8 adult acute care psychiatric beds	239-2211
Dauphin General - 10 adult acute care psychiatric beds	638-3010
Eden Mental Health Centre, Winkler	325-4325
Selkirk Mental Health Centre – serving the Interlake, North Eastman and	482-3810
South Eastman – 43 adult acute care psychiatric beds	
St. Anthony's in The Pas - 4 adult acute care psychiatric beds	623-6431
Thompson General - 10 adult acute care psychiatric beds	677-2381

#### Winnipeg Acute Care Hospitals:

- child, adolescent, adult, psychogeriatric & forensic	
Health Sciences Centre – PscHealth	787-3200
St. Boniface - McEwan Building	237-2815
Seven Oaks General	632-7133
Salvation Army Grace Hospital	837-0111
Victoria General	269-3570
Concordia General – planned by the WRHA	

Specialized long-term care beds exist in Winnipeg and Brandon for children and adolescents, for adults with severe and persistent mental illness and for psychogeriatrics.

**Mobile Crisis Intervention** ..... (phone your RHA for listing)

Screening, psychiatric assessment, crisis intervention, and short-term follow up services are provided in collaboration with other community resources. A variety of providers offer this service across the province. Some regions provide a crisis line separate from, or in combination with, the mobile crisis services.

**Crisis Stabilization** ..... (phone your RHA for listing)

Short-term residential care is available for voluntary clients who require specialized services in the community but do not need hospitalization through Crisis Stabilization Units or Safe Homes in most regions across the province.

**Supportive Housing** ..... (phone your RHA for listing)

Assistance is provided to persons with severe or persistent mental health problems to choose, get and keep housing.

**Self-Help and Family Support** ..... (phone your RHA for listing)

These are formal associations of individuals with a common disorder or disorders providing mutual aid and support within the membership. Groups in your region include associations such as:

- Anxiety Disorders Association of Manitoba
- Canadian Mental Health Association of Manitoba
- Manitoba Schizophrenia Society
- Mood Disorders Association of Manitoba (previously called the Society of Depression and Manic Depression of Manitoba)

**Psychosocial Rehabilitation** ..... (phone your RHA for listing)

Programs serve persons with severe and persistent mental illness who require individual skill development and environmental supports to sustain their living in the community. These services include:

- housing with supports including supervised congregate living
- vocational assessment, placement and training services, and
- social recreational resources that are accessible, affordable and responsive to individual needs and choices

**Intensive Case Management** ..... (phone your RHA for listing)

Services to provide assessment, intervention and long term, flexible supports to adults with severe and persistent mental illness are available to address the multiple and diverse needs of clients using a rehabilitation case management model of services delivery.

**Prevention, Promotion, & Public Education** ..... (phone your RHA for listing)

Services are provided through consultation and education to the public and professional groups by self help, and where appropriate by staff from any of the mental health resources including specialized prevention initiatives such as:

- Community Trauma Post-Intervention Services with immediate assistance to a group of individuals or a community following a traumatic incident or disaster.

**Long Term Treatment & Rehabilitation** .....(phone 1-204-482-3810)

Selkirk Mental Health Centre, the provincial mental health facility, is an accredited mental health centre that provides treatment and rehabilitation to people suffering from severe and persistent mental illness whose challenging needs cannot be met by other service providers. The Centre provides specialized functions such as Psychogeriatrics and Forensic treatment and rehabilitation.

- Selkirk Mental Health Centre receives referrals for assessment and treatment from physicians, community mental health workers, hospitals, personal care homes and federal nursing stations.

**OTHER CENTRALIZED RESOURCES**

**Office of the Chief Provincial Psychiatrist** .....(phone 1-204-945-4615)

Responsibilities include the administration of the Mental Health Act, placing people under supervision who are unable to manage their affairs, provision of professional consultation to various sectors of the mental health system, and provision of administrative direction to the Mental Health Review Board.

**Mental Health Review Board** .....(phone 1-204-788-6709)

Established under The Mental Health Act, the Board hears appeals regarding specified aspects of the admission or treatment of a patient in a psychiatric facility. Legislation also requires that there be a yearly, automatic review for patients on a Leave Certificate and an automatic review of all involuntary patients after the filing of a third Renewal Certificate, and annually thereafter.

**Manitoba Health - Mental Health Administration** ..... (phone 1-204-945-6708)

Central functions of the mental health administration within Manitoba Health include setting provincial policy and priorities, establishing standards, monitoring & evaluating programs and services, researching and disseminating best practice models, and facilitating ongoing mental health education.

## 21 Personal Health Information Policy

The *Personal Health Information Act (PHIA)* became law in December, 1997. It requires health care facilities to have policies in place that protect personal health information during its collection, use, disclosure, storage and destruction.

### Access

PHIA recognizes that patients should be able to see, or get a copy of, any document that contains their personal health information. They may also request a correction to any information that they feel is inaccurate or incomplete.

### Privacy

PHIA also recognizes that personal health information is particularly private and sensitive, and as such, should be held in the strictest confidence by those who maintain it.

In order to protect patients' right to privacy, the Act imposes obligations on health care professionals, health care facilities, and governments (referred to in the Act as "trustees") when they collect, use, and share personal health information. Generally speaking, no one can use or disclose personal health information without consent. However, there are some exceptions:

- A doctor could share personal health information about a patient with another practitioner without the patient's consent to assist him or her in providing health care. The patient may instruct the doctor not to share any information.
- A hospital could contact a patient's family and inform them that the individual was hurt or incapacitated in some way if the individual could not personally inform them.
- A physician could use a patient's personal health information without consent if it would prevent serious harm to the patient or to someone else.

For a complete list of the exceptions, *see Section 22(2) of PHIA*. This can be found at:  
<http://www.gov.mb.ca/health/phia>.

To obtain a copy of the PHIA, contact:

**Legislative Unit - Manitoba Health**

300 Carlton Street

Winnipeg MB R3B 3M9

Phone: (204) 788-6612

FAX: (204) 945-1020

As a new physician to the province, you should contact your office manager, hospital and/or health authority for a copy of their policy.

# Issues

## 22 Cross-Cultural Issues in Health Care

Manitoba has a rich cultural heritage that extends from the original population of Manitoba, the Aboriginal peoples, through the arrival of explorers, fur traders and settlers, and through the successive waves of immigrants from central Europe and Asia.

In your practice, you may encounter patients who require or expect to receive medical services in other languages<sup>5</sup> and who have different healthcare practices.

Manitoba is officially bilingual and if you work in a designated francophone community, the operating language may be French. The designated areas are St. Boniface, Ste. Anne, St. Claude, St. Pierre-Jolys, Ste. Rose du Lac and Manitou. In south-central Manitoba, there are pockets of German speaking Canadians. While most speak English, there are some, mostly elderly, who will not.

Manitoba's Aboriginal (First Nations) population is composed of several different groups speaking their own ancestral languages. In spite of efforts to provide modern medical care to urban and rural populations, Manitoba Aboriginals have poorer health than the provincial average, and are consequently high users of the health care system.

Because some northern communities do not have adequate water and sewage facilities, communicable disease and children's respiratory illnesses are a serious concern. Much of the rural Aboriginal population is also quite mobile, making communicable disease control more difficult to achieve. However, the largest difference between the Aboriginal population and other Manitobans is the widespread incidence of type 2 Diabetes Mellitus and related complications.

When First Nations patients access the health care system, difficulties may arise not only because of language barriers, but also because of different perspectives on health and health care. Traditionally, Aboriginal medicine takes a more holistic approach to health, and Western clinical compartmentalization is often poorly understood by Aboriginal clients. However, there is wide variation in adherence to tradition.

As might be expected, elders are more likely to follow the old ways, but more and more young people are returning to tradition as well.

Community Health Representatives can be a valuable resource when dealing with Aboriginal patients. They are generally people from the community who have been hired to help Aboriginal patients through the health care system and tend to their spiritual needs. Elders and traditional healers can also help restore patients to health, but it may be difficult for westerners to find them. Here again the Community Health Representatives may be helpful. There are often Aboriginal staff at local nursing stations or health centres who have relevant experience and are often willing to offer informal advice.

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<sup>5</sup> See "Guidelines for Communication in Cross-Cultural Practice"

There are a number of information resources available:

- The Department of Aboriginal Services at the Health Sciences Centre in Winnipeg is experienced in dealing with issues relating to serving aboriginal clientele in a western medical environment, and may be reached at **1-204-787-3427**.
- Aboriginal Health Services in Winnipeg offers a Cross Cultural Workshop almost every week. The two-day session provides an overview of aboriginal culture, spirituality, and social issues, and an optional third day consists of a sweet grass ceremony held in a sweat lodge. If you are interested in pursuing this, you should call Catherine Morrissette Sinclair at **1-204-787-1087**.
- The Aboriginal Health and Wellness Centre at 181 Higgins in Winnipeg can provide advice on aboriginal healing and perhaps help connect you with local resources. Their number is **1-204-925-3700**.
- If a large portion of your patient population is Aboriginal, meeting with the local tribal council and community may help you understand each other's expectations.
- There are a number of books available in the field of Aboriginal health care.
  - *Health Care and Cultural Change* by T. Kue Young and *Aboriginal Health in Canada: Historical, Cultural, and Epidemiological Perspectives* by James B. Waldram, Ann Herring, and T. Kue Young are both excellent resources.
  - For background information and a broader examination of the issues see *Aboriginal Peoples in Canada: Contemporary Conflicts* by James Frideres.
  - For insight into Aboriginal culture and communication, see Brant cc: *Native Ethics and Rules of Behaviour* published in the Canadian Journal of Psychiatry, 1990; 35: 534-9 (August)

The above references can be obtained either through the University of Manitoba Bookstore at **1-204-789-3601** or through the Neil John MacLean Health Sciences Library at **1-800-432-1960 extension 3464**.

Under treaty terms, **Aboriginal residents** enjoy coverage for health services not insured under the provincial health plan. The **Medical Services Branch of Health Canada** provides a limited number of goods and services to First Nations and Inuit people when those services are not available through other agencies (e.g., Manitoba Health, Welfare, private insurance). Some of the services paid for are Medical Transportation, Vision Care Services, Dental services, Prescription Drugs, and some Medical Equipment and Supplies. For more information on services offered by Medical Services, call **1(204) 983-8886** or **1-800-665-8507**.

The **Metis** people are descended from mixed marriages of Aboriginals and Europeans who arrived in the early days of the fur trade. Being somewhat marginalized by both Aboriginal and European communities, they formed their own communities, and became a politically important group in the events surrounding the formation of the province of Manitoba. Being culturally distinct, they are not covered by the same treaty agreements as First Nations people, and are therefore not eligible for additional benefits. For more information regarding Metis culture today, phone the Manitoba Metis Federation at **1 (204) 956-7767**.

Cultural groups who came to Manitoba in the past faced many challenges in their efforts to become established members of Manitoba society. Over years and sometimes over generations, they struggled to overcome barriers of language, discrimination, and unfamiliarity with the customs, laws and way of life in Manitoba.

Many communities have succeeded in becoming integral parts of the multicultural society of Manitoba while retaining and enhancing their individual cultures as living and vibrant parts of the life of this province. Their success has resulted in a richly varied cultural life which the entire community can share.

In your practice, you will likely encounter patients who have a Mennonite or Hutterite heritage. The **Mennonites** immigrated to Manitoba in several waves beginning in the 1870s. They came in order to practise their religious conviction of pacifism, and to escape war and persecution in Europe. Although many are still deeply religious, to be Mennonite today is as much a statement of ethnicity as it is of faith. Although many speak Low German, a dialect picked up in 18th century Prussia, today the vast majority speak English as well.

Like the Mennonites, **Hutterites** have similar Anabaptist roots dating back to shortly after the Protestant Reforms of 16th century Europe. Believing strongly in pacifism, Hutterites also firmly reject materialism, and live communally on colonies throughout southern Manitoba.

### **Patients' Expectations of their Physicians**

Although each cultural group will have their own perspective of what the doctor patient relationship should be, there is a small revolution happening in the way physician services are viewed. The traditional western image of the doctor as patriarchal authority in the patient's health is evolving to that of the doctor as a member of the health care team and a resource for patients to draw upon. In Canada, patients are becoming accustomed to taking responsibility for their own medical care, choosing from a wide range of primary health care providers, and although physicians may recommend treatment options, final decisions rest with the patient.

Doctors who have come to practise in Manitoba from other countries have often commented that patients here are more active in their care. While this may take some getting used to, it is generally a positive transition which you will come to appreciate.

## 23 Advanced Health Care Directives

Advanced health care directives are also known as “**living wills.**” They permit people to legally express their wishes regarding medical treatment in the event that they become incapable of communication. **In Manitoba, advanced health care directives are legally binding.** The directives must be respected to the same degree as though the patient were present to communicate them.

Health care directives are valid and legally binding even if they have not been written on a prepared form or witnessed, but they must be signed and dated. It is recommended that people with health care directives carry them on their person at all times, and that family, friends, and physicians are aware of their existence. Physicians should document the existence of health care directives on patients’ charts, but are not, however, obliged to search for directives before undertaking treatment measures.

Individuals may designate or identify a “**proxy**” to make treatment decisions on their behalf should they become incapacitated. Because it is impossible to anticipate every set of circumstances, the proxy is empowered to make decisions based upon the health care directive and discussions with the patient. People should be counseled to choose their proxies carefully to make sure that their wishes are understood, and will be respected. As with the health care directives, decisions made by the proxy are legally binding. For physicians, an advanced health care directive can greatly facilitate difficult treatment and intervention decisions concerning patients who are unable to communicate their wishes.

Physicians should be aware of issues of treatment surrounding death and be available to advise patients in drafting their health care directives. For more information concerning the role of the physician, see Appendix IV - “*Do Not Resuscitate*” and *Supportive Treatment Orders* or contact the Manitoba Medical Association at **1 (204) 985-5888**.

For Health Care Directive forms to fill out with your patients, please visit the Manitoba Health web site: <http://www.gov.mb.ca/health/livingwill.html>.

## 24 Family Issues - Your Own Family

Most doctors coming to practice in Manitoba do not come alone. They are often married, and often have children. Children usually adapt the most easily, as they enter a fairly structured social environment in school. Spouses face the same issues as do their physician partners.

### Working

In September 1998, the Canadian Government announced a project that would allow spouses of physicians to work if they wish, even though they may not be permanent residents. The only requirement is that the physician must have work in Canada that will last at least 6 months. You need to contact the Government of Canada at **1-888-242-2100** and request the application kit “Applying to Change Terms and Conditions or Extend Your Stay in Canada”. There is a \$150 application fee. Volunteer work is another option spouses may wish to consider. Hospitals, schools, libraries, and community health centres are almost always willing to accept volunteers, and this can provide a valuable structure to help spouses adapt to Canadian life.

### Studying

Alternatively, spouses and children may wish to further their education at a Manitoba college or university. **A list of secondary institutions can be found in the Welcome To Manitoba guide included with this package.** Correspondence, or distance education is another option. The University of Manitoba offers several such programs, and it is possible to complete a degree in this fashion. On the other hand, you are not limited to Manitoba institutions, and may just as easily study with other universities. There is an extensive listing of distance education programs on the International Centre for Distance Learning web site at <http://www-icdl.open.ac.uk/icdl/index.html>.

The application procedure is usually as follows:

1. The applicant applies to the institution, and includes necessary documentation (educational transcripts, etc.)
2. The institution gives the applicant approval to enter one of its programs.

## 25 Immigration and Registration Issues

### Temporary Work Permits

Temporary work permits are usually valid for a specified job, employer and time period. It is incumbent upon the physician to apply for a renewal/extension of the work permit before the expiration date. To do so, the physician must submit the appropriate application to the immigration authorities at the Citizenship and Immigration Canada (CIC) Case Processing Centre (CPC) in Vegreville, Alberta. Applications may be downloaded from [www.cic.gc.ca](http://www.cic.gc.ca) or requested from **1-888-242-2100**

Human Resources and Skills Development (HRSD – formerly HRDC) validation is required for the initial work permit and for any subsequent extension/renewal. The physician must initiate the immigration work permit application process, and the employer must initiate the process of obtaining HRSD validation.

### Permanent Resident Applications

Generally speaking Canadian immigration legislation requires that applications for permanent resident (landed immigrant) status be submitted through a Canadian immigration office **outside of Canada**. Many physicians in Manitoba submit applications to the Canadian Consulate in Buffalo, New York. These applications are normally processed in the Skilled Worker category, and the processing time may exceed 24 months. During this time you must ensure that your temporary work permit does not expire.

You may wish to obtain permanent HRSD validation from your employer in support of your application for permanent resident status. To do so, your employer must submit an application to HRSD requesting permanent validation. This request must first be approved by Manitoba Health.

Manitoba Health uses the following guidelines in considering approval of a permanent validation permit, in support of a physician's application for permanent resident status:

- that you have worked for your employer for 2 years;
- that you have indicated a commitment to remaining in the community, or in Manitoba (e.g., purchased a home, bought into a medical practice, become involved in your community);
- that you have initiated action to achieve full licensure with the College of Physicians and Surgeons of Manitoba.

When you apply for permanent residence status, you and all of your family members must:

- undergo an immigration medical examination,
- pass criminal and security clearances,
- have valid passports or travel documents.

## **Citizenship**

You and your family must have permanent resident (landed immigrant) status to become Canadian citizens. Generally speaking, permanent residents of Canada are eligible to apply for Canadian citizenship after living in Canada as a permanent resident for 3 years. The 3-year period may be reduced for persons who worked in Canada temporarily prior to becoming permanent residents.

To become a Canadian citizen you must:

- be 18 years of age or older,
- be a permanent resident of Canada,
- have lived in Canada for at least 3 of the 4 years before applying,
- be able to communicate in either English or French,
- know about Canada,
- know about the rights and responsibilities of citizenship.

For additional information on citizenship and immigration visit the CIC website ([www.cic.gc.ca](http://www.cic.gc.ca)), or contact the CIC Call Centre at **1 - 888 - 242-2100**.

## 26 Delegation of Physician Services

The College of Physicians and Surgeons of Manitoba (CPSM) and the College of Registered Nurses of Manitoba (CRNM) have jointly developed a *Guideline for Shared Competencies and Delegated Physician Services* (September 2002). The guideline sets out the appropriate principles and requirements for a physician to delegate the authority to provide certain physician services, unique to the practice of physicians, to registered nurses.

The Guideline outlines the scope of the practice of medicine and the scope of the practice of registered nurses. It recognizes shared competencies (the overlap in the scopes of practice of registered nurses and physicians) and promotes optimal use of these competencies in the interest of patient care. It is inappropriate to delegate shared competencies.

Delegation of physician services applies to those functions unique to the practice of physicians. The principles for delegation must be satisfied for these services to be delegated to registered nurses. Physicians, registered nurses and agencies (facility or organization where health services are provided) must satisfy six principle areas:

- **Patients**  
the appropriateness of the patient (or patient group) and the service itself.
- **Physician and Registered Nurse collaboration**  
agreement regarding delegation with established parameters and clinical guidelines.
- **Competence**  
of both the physician and the registered nurse.
- **Context**  
meeting standards and having mechanisms for monitoring quality and safety.
- **Education**  
required competencies are defined, taught, evaluated, re-evaluated with record keeping.
- **Evaluation**  
periodic review of the delegation decision.

You should note that the *Registered Nurses Act* gives expanded responsibilities for the practice of nursing and includes assessing health status, planning, providing and evaluating treatment and nursing interventions, counseling and teaching to enhance health and well-being. Regulations are being developed to set out the terms under which a registered nurse may order and receive reports of screening and diagnostic tests, prescribe drugs and perform minor surgical and invasive procedures.

The **Guideline for Shared Competencies and Delegated Physician Services** (September 2002) may be obtained by calling the CRNM (1-800- 665-2027) or the CPSM (774-4344) or accessing on the web at [http://www.umanitoba.ca/colleges/cps/Guidelines\\_and\\_Statements/132.html](http://www.umanitoba.ca/colleges/cps/Guidelines_and_Statements/132.html)

# APPENDICES

## APPENDIX I - *Canada Health Act – An Overview*<sup>1</sup>

*"The principles of the Canada Health Act began as simple conditions attached to federal funding for medicare. Over time, they became much more than that. Today, they represent both the values underlying the health care system and the conditions that governments attach to funding a national system of public health care. The principles have stood the test of time and continue to reflect the values of Canadians."*

-- (Roy J. Romanow, Q.C. November, 2002)

### **What is the Canada Health Act?**

The *Canada Health Act* is Canada's federal health insurance legislation.

The Act sets out the primary objective of Canadian health care policy:

*"...to protect, promote and restore the physical and mental well-being of residents of Canada and to facilitate reasonable access to health services without financial or other barriers."*

The *Canada Health Act* establishes criteria and conditions related to insured health care services and extended health care services that the provinces and territories must meet in order to receive the full federal cash contribution under the Canada Health and Social Transfer (CHST).

The aim of the *Canada Health Act* is to ensure that all eligible residents of Canada have reasonable access to medically necessary insured services on a prepaid basis, without direct charges at the point of service for such services.

### **Key Definitions under the CHA**

There are two types of services defined in the *Canada Health Act*.

**Insured health care services** are medically necessary hospital, physician and surgical-dental services provided to insured persons.

Insured hospital services are defined under the *Canada Health Act* and include medically necessary in- and out-patient services such as standard or public ward accommodation; nursing services; diagnostic procedures such as blood tests and x-rays; drugs administered in hospital; and the use of operating rooms, case rooms and anaesthetic facilities.

Insured physician services are defined under the Act as "medically required services rendered by medical practitioners." Medically required physician services are generally determined by physicians in conjunction with their provincial and territorial health insurance plans.

Insured surgical-dental services are services provided by a dentist in a hospital, where a hospital setting is required to properly perform the procedure.

**Extended health care services** as defined in the *Canada Health Act* are certain aspects of long-term residential care (nursing home intermediate care and adult residential care services), and the health aspects of home care and ambulatory care services.

**Insured persons** are eligible residents of a province or territory. A resident is defined in the *Canada Health Act* in relation to a province as:

*"...a person lawfully entitled to be or to remain in Canada who makes his home and is ordinarily present in the province, but does not include a tourist, a transient or a visitor to the province."*

Persons excluded under the *Canada Health Act* include serving members of the Canadian Forces or Royal Canadian Mounted Police and inmates of federal penitentiaries.

### **Requirements of the *Canada Health Act***

The *Canada Health Act* contains the following nine requirements that the provinces and territories must meet in order to qualify for the full federal cash contributions:

- five program criteria that apply only to insured health care services;
- two conditions that apply to insured health care services and extended health care services; and
- extra-billing and user charge provisions that apply only to insured health care services.

### **The Criteria**

#### ***1. Public Administration (section 8)***

The public administration criterion, set out in section 8 of the *Canada Health Act*, applies to provincial and territorial health care insurance plans. The intent of the public administration criterion is that the provincial and territorial health care insurance plans be administered and operated on a non-profit basis by a public authority, accountable to the provincial or territorial government for decision making on benefit levels and services, and whose records and accounts are publicly audited.

#### ***2. Comprehensiveness (section 9)***

The comprehensiveness criterion of the *Canada Health Act* requires that, in order to be eligible for federal cash transfer payments, the health care insurance plan of a province or territory "must insure all insured health services provided by hospital, medical practitioners or dentists (i.e. surgical-dental services which require a hospital setting) and, where the law of the province so permits, similar or additional services rendered by other health care practitioners."

#### ***3. Universality (section 10)***

Under the universality criterion, all insured residents of a province or territory must be entitled to the insured health services provided by the provincial or territorial health care insurance plan on uniform terms and conditions. Provinces and territories generally require that residents register with the plans to establish entitlement.

Newcomers to Canada, such as landed immigrants or Canadians returning from other countries to live in Canada, may be subject to a waiting period by a province or territory, not to exceed three months, before they are entitled to receive insured health care services.

#### ***4. Portability (section 11)***

Residents moving from one province or territory to another must continue to be covered for insured health care services by the "home" jurisdiction during any waiting period imposed by the new province or territory of residence. The waiting period for eligibility to a provincial or territorial health care insurance plan must not exceed three months. After the waiting period, the new province or territory of residence assumes responsibility for health care coverage.

Residents who are temporarily absent from their home province or territory or from Canada, must continue to be covered for insured health care services during their absence. This allows individuals to travel or be absent from their home province or territory, within a prescribed duration, while retaining their health insurance coverage.

The portability criterion does not entitle a person to seek services in another province, territory or country, but is intended to permit one to receive necessary services in relation to an urgent or emergent need when absent on a temporary basis, such as on business or vacation.

If insured persons are temporarily absent in another province or territory, the portability criterion requires that insured services be paid at the host province's rate. If insured persons are temporarily out of the country, insured services are to be paid at the home province's rate.

Prior approval by the health care insurance plan in a person's home province or territory may also be required before coverage is extended for elective (non-emergency) services to a resident while temporarily absent from their province or territory.

### **5. Accessibility (section 12)**

The intent of the accessibility criterion is to ensure that residents of a province or territory have reasonable access to insured hospital, medical and surgical-dental services on uniform terms and conditions, unprecluded or unimpeded, either directly or indirectly, by charges (user charges or extra-billing) or other means (e.g., discrimination on the basis of age, health status or financial circumstances). In addition, the health care insurance plans of the province or territory must provide:

- reasonable compensation to physicians and dentists for all the insured health care services they provide; and
- payment to hospitals to cover the cost of insured health care services.

Reasonable access in terms of physical availability of medically necessary services has been interpreted under the *Canada Health Act* using the "where and as available" rule. Thus, residents of a province or territory are entitled to have access on uniform terms and conditions to insured health care services at the setting "where" the services are provided and "as" the services are available in that setting.

### **The Conditions**

**Information (section 13(a))** — the provincial and territorial governments are to provide information to the Minister of Health as may be reasonably required, in relation to insured health care services and extended health care services, for the purposes of the *Canada Health Act*.

**Recognition (section 13(b))** — the provincial and territorial governments are to recognize appropriately the federal financial contributions toward both insured and extended health care services.

### **Extra-billing and User Charges**

The provisions of the *Canada Health Act* which discourage extra-billing and user charges for insured health services in a province or territory are outlined in sections 18 to 21. If it can be determined that either extra-billing or user charges exist in a province or territory, a mandatory deduction from the federal cash transfer to that province or territory is required under the Act. The amount of such a deduction for a fiscal year is determined by the federal Minister of Health based on information provided by the province or territory in accordance with the Extra-billing and User Charges Information Regulations described below.

**Extra-billing (section 18):** Under the *Canada Health Act*, extra-billing is defined as the billing for an insured health service rendered to an insured person by a medical practitioner or a dentist (i.e. a surgical-dentist providing insured health services in a hospital setting) in an amount in addition to any amount paid or to be paid for that service by the health care insurance plan of a province or territory. For example, if a physician were to charge patients five dollars for an office visit that is insured by the provincial or territorial health insurance plan, the five-dollar charge would constitute extra-billing. Extra-billing is seen as a barrier or impediment for people seeking medical care, and is therefore contrary to the accessibility criterion.

**User Charges (section 19):** The *Canada Health Act* defines user charges as any charge for an insured health service other than extra-billing that is permitted by a provincial or territorial health care insurance plan and is not payable by the plan. For example, if patients were charged a facility fee for receiving an insured service at a hospital or clinic, the fee would be considered a user charge. User charges are not permitted under the Act as, like extra-billing, they constitute a barrier to access.

## **Other Elements of the Act Regulations (section 22)**

Section 22 of the *Canada Health Act* enables the federal government to make regulations for the administration of the Act in the following areas:

- prescribing which services to include in the CHA definition of “extended health care services;”
- prescribing which services to exclude from hospital services;
- prescribing the types of information that the federal Minister of Health may reasonably require from a province or territory to qualify for a full federal transfer; and
- prescribing how provinces and territories are required to give recognition to the Canada Health and Social Transfer in their documents, advertising or promotional materials.

The only regulations in force under the Act are the Extra-billing and User Charges Information Regulations, which require the provinces and territories to provide estimates of extra-billing and user charges prior to the beginning of a fiscal year so that appropriate penalties can be levied, as well as financial statements showing the amounts actually charged so that reconciliations with the actual deductions can be made.

## **Penalty Provisions of the *Canada Health Act***

### ***Mandatory Penalty Provisions***

Under the *Canada Health Act*, provinces and territories that allow extra-billing and user charges are subject to mandatory dollar-for-dollar deductions from the federal transfer payments under the CHST. For example, if it has been determined that a province has allowed \$500,000 in extra-billing by physicians, the federal transfer payments to that province would be reduced by that amount.

### ***Discretionary Penalty Provisions***

Breaches of the five criteria and two conditions of the *Canada Health Act* are subject to discretionary penalties. The amount of any deduction from federal transfer payments under the CHST is based on the gravity of the default.

The *Canada Health Act* sets out a consultation process that must be undertaken with the province or territory before discretionary penalties can be levied. To date, the discretionary penalty provisions of the Act have not been applied.

## **Health Care Services Outside the Act**

Although the *Canada Health Act* requires that insured health services be provided to insured persons in a manner that is consistent with the criteria and conditions set in the Act, not all Canadian residents or health services fall under the scope of the Act. There are two categories of exclusion for insured services:

- services which fall outside the definition of insured health care services; and
- certain services and groups of persons are excluded from the definitions for insured services and insured persons.

These exclusions are as follows:

### **Non-Insured Health Care Services**

In addition to the medically necessary insured hospital and physician services covered by the *Canada Health Act*, provinces and territories also provide a range of programs and services outside the scope of the Act. These are provided at provincial and territorial discretion, on their own terms and conditions, and vary from one province or territory to another. Additional services that may be provided include pharmacare, ambulance services, optometric services and dental services.

The additional services provided by provinces and territories may be targeted to specific population groups (e.g., children or seniors, or social assistance recipients), and may be partially or fully covered by provincial and territorial health insurance plans.

A number of services provided by hospitals and physicians are not considered medically necessary, and thus are not insured under provincial and territorial health insurance legislation. Uninsured hospital services for which patients may be charged include preferred hospital accommodation unless prescribed by a physician, private duty nursing services, and the provision of telephones and televisions. Uninsured physician services for which patients may be charged include telephone advice, the provision of medical certificates required for work, school, insurance purposes and fitness clubs, testimony in court, and cosmetic services.

### **Non-Insured Persons**

The *Canada Health Act* definition of “insured person” excludes members of the Canadian Forces, persons appointed to a position of rank within the Royal Canadian Mounted Police, persons serving a term of imprisonment within a federal penitentiary, and persons who have not completed a minimum period of residence in a province or territory (a period that must not exceed three months). In addition, the definition of “insured health services” excludes services to persons provided under any other Act of Parliament (e.g., foreign refugees) or under the workers’ compensation legislation of a province or territory.

The exclusion of these persons from insured health service coverage predates the adoption of the *Canada Health Act* and is not intended to constitute differences in access to publicly insured health care.

1. Health Canada at <http://www.hc-sc.gc.ca/medicare/chaover.htm> accessed June, 2003. Copyright Government of Canada

## **APPENDIX II - Interfacility Emergency Transportation<sup>2</sup>**

College of Physicians and Surgeons of Manitoba

Guideline 143

### **PREAMBLE**

Some acute illnesses, injuries and acute complications of pregnancy require emergency transportation between health care facilities, usually when a facility and personnel are required beyond those locally available. Initial resuscitation and stabilization are of utmost importance. Then, once the need for transfer is recognized, arrangements should be expedited to ensure the health and well-being of the patient.

Transportation by road and/or air is most efficient and safe if the appropriate equipment and personnel travel with the patient. Ensure that the patient is aware of the costs associated with ambulance transfer, if these costs are not publicly funded.

Four levels of acuity are recognized within this guideline in order to facilitate decision-making relating to patient requirements, the type of escort and the appropriate mode of transport, ground or air.

Transfer of care can be a complex interaction between medical personnel. This guideline offers appropriate levels of responsibility.

### **RESPONSIBILITIES OF THE PHYSICIAN**

#### **The Referring Physician**

- Assesses the need for and initiates the transfer .
- Assesses the patient's priority code which will allow for decision regarding type of transport and escort required. The skills of the members of the transporting team should match the patient's identified needs and the potential needs that may occur during the transport. Critically ill, unstable patients will require the presence of a physician as part of the transport team. The type and urgency of transport may require consultation with the receiving physician.
- Physicians who are aware that there is a health care directive must ensure that this is forwarded with the patient during transport.
- Is responsible for patient care during transport, or until the patient is transferred to the receiving physician's direct care.
- Directly communicates with the receiving physician.
- Ensures specific written instructions regarding patient care and treatment during transport are given to the escort personnel.
- The role and responsibility of the referring physician may be assumed by the senior health care personnel at a facility (e.g. nurse at nursing station).
- Communicates to transport personnel and receiving physician regarding appropriate precautions necessary for suspected communicable diseases.
- Will respect the judgement of air and land ambulance personnel, not to transport a patient if it cannot be done safely during inclement weather conditions.

#### **The Transport Physician**

- Does not need to be the referring or the receiving physician.
- Must be able to provide the level of care required for the patient.
- Confers with the referring physician relating to care and treatment during transport.
- Communicates with receiving physician, while en route, if necessary, to discuss the patient status.

2. College of Physicians and Surgeons of Manitoba  
[http://www.umanitoba.ca/colleges/cps/Guidelines\\_and\\_Statements/143.html](http://www.umanitoba.ca/colleges/cps/Guidelines_and_Statements/143.html) accessed June, 2003. Copyright College of Physicians and Surgeons of Manitoba

### **The Receiving Physician**

- Must agree to accept the patient prior to transfer and remain available for consultation until the patient's arrival.
- Must notify the relevant services within the receiving hospital of the patient's anticipated arrival time and medical requirements.
- Confers with the referring physician relating to care and treatment prior to and during transport, or until the patient is transferred to the care of the receiving physician.
- Must communicate to the referring physician the arrangements made for transfer, if not already done.
- Must ensure the receiving hospital's acceptance of the patient.

### **PREPARATION FOR TRANSFER**

- **Resuscitation and stabilization of the patient is essential prior to transport.**
- Stabilization includes evaluation and initiation of treatment to ensure, within reasonable medical probability, that transfer of a patient will not result in death or in loss or serious impairment of bodily functions, parts, or organs.
- The patients' needs must be evaluated and attended to on a systems basis:
  - : airway management<sup>6</sup>
  - : spinal immobilization
  - : respiratory system
  - : cardiovascular system/haemodynamic status
  - : central nervous system
  - : diagnostic studies as required
  - : appropriate wound care
  - : fracture immobilization
  - : nasogastric tubes and urinary catheters if indicated
- Write transport orders.
- Send patient records (e.g. x-rays, laboratory data).
- Obtain family/patient consent for transfer, and for release of medical records.

### **MANAGEMENT DURING TRANSPORT**

The escort should consist of appropriately trained personnel and equipment needed to handle specific patient related problems which may occur en route.

These include:

- airway management
- cardiorespiratory support
- blood volume replacement
- monitoring of vital signs
- administration of appropriate medications
- ongoing communication with receiving institution during transfer
- documentation of patient status en route

### **DOCUMENTATION**

Information transmission is vital with transfer. A written record must be transferred with the patient and include:

- demographic information
- past history
- history of injury or illness
- vital signs pre-transfer
- treatment rendered to patient
- investigations performed including x-rays

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<sup>6</sup> It is extremely difficult to perform tracheal intubation during transport. Therefore, intubation should be carried out **prior** to transport if the patient's respiratory status is questionable.

- fluids and medications administered
- name of referring physician
- name of receiving physician
- a health care directive, if relevant

If the physician believes a transfer appears to be medically inappropriate, but the patient or responsible person insists on transfer, the physician must:

- carefully explain the medical risks related to transfer to the patient or responsible person
- document in detail the explanation given, and the insistence of the patient/responsible person to carry out the transfer

### **TRANSPORTATION OF CHILDREN**

Transportation of the critically ill child requires special attention. The potential for rapid deterioration of a critically ill child and the need for aggressive treatment is often underestimated.

Responsibilities of the referring and receiving physicians, and the preparation for transfer, remain critical aspects in the interfacility transportation of children. Communication is vital.

### **MANAGEMENT DURING TRANSPORT**

- The transferring hospital and physician must ensure that the skills and equipment available during transport will meet the anticipated needs of the patient.
- If transport team/physician lacks paediatric expertise it may be preferable for the receiving physician to act as medical control physician, and to ensure continued communication during transport.

Important management principles of the critically ill child are

- early airway intervention, including intubation
- establishment of appropriate lines prior to transportation and securing of same
- early management of raised intracranial pressure
- temperature control
- commencement of antibiotics early, e.g. meningitis
- recognition and treatment of hypoglycaemia
- maintenance of normal blood pressure for age

Of major importance is the prevention of secondary insults during transportation. Pre-transfer resuscitation and stabilization are vital.

### **TRANSPORTATION OF MENTALLY ILL PATIENTS**

The *Mental Health Act* makes specific provisions for the interfacility transfer of the mentally ill.

Patients who are being transferred from one hospital inpatient unit to another hospital inpatient unit require a Warrant, once both hospitals have agreed to the transfer. In order to obtain a Warrant of Transfer, the Office of the Chief Provincial Psychiatrist must be contacted. A Warrant of Transfer will require a minimum of 24 hours to obtain and is to accompany the patient upon transfer to the second facility.

In any other circumstances involving involuntary patients, the provisions of *The Mental Health Act* apply.

## **CATEGORIZATION OF INTERFACILITY PATIENT TRANSFER**

### **PRIORITY CODE 1: CRITICAL**

Transport ASAP. The patient's condition is unstable, and there is immediate threat to life or function.

#### **Definition**

One or more body systems are abnormal and rapidly deteriorating in association with an acute illness or injury. Intense monitoring and medical interventions are required to correct and stabilize the patient's condition.

- requires immediate specialty care
- examples:
  - abnormal or deteriorating neurological status
  - life threatening cardiac emergencies, e.g.
    - severe chest pain non-responsive to conventional therapy
    - serious cardiac dysrhythmias non-responsive to conventional therapy
    - hypertensive emergencies, severe hypotension/shock after initial treatment at the referring site prior to transfer
  - threat to maternal or fetal life
  - airway compromise/severe respiratory distress
  - multiple trauma associated with above features

#### **Patient Escort**

- physician (if delegated to another health care professional, this individual must be competent to perform any current or anticipated complications)<sup>7</sup>
- nurse or appropriately trained personnel as required

### **PRIORITY CODE 2: EMERGENT**

Transport ASAP. The patient's condition is presently stable but there is potential for deterioration and potential threat to life or function.

#### **Definition**

Vital signs are presently within normal parameters and there is no immediate threat to life or function. However, there is acute illness or injury which could result in deterioration and instability in the patient's condition. Close intensive monitoring required with potential need for acute intervention.

- requires immediate specialty care
- examples:
  - abnormal but not acutely deteriorating neurological status
  - cardiovascular abnormalities presently stable with potential for deterioration
  - acute vascular compromise of limb(s)
  - respiratory compromise with adequate airway and no immediate threat to life
  - multiple trauma with no immediate threat to life
  - pregnancy related emergencies where there is no immediate threat to maternal or fetal life.

#### **Patient Escort**

- physician/nurse or appropriately trained personnel as determined by consultation between referring and receiving physician

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<sup>7</sup> See CPS Statement No. 130 *Delegation of Function: Principles* and Guideline No. 132 *Shared Competencies and Delegated Physician Services*.

### **PRIORITY CODE 3: URGENT**

The patient's condition is stable and there is no immediate threat to life or function. The patient can safely wait for transportation.

#### **Definition**

Vital signs are within normal parameters and there is no immediate threat to life or function. Less intensive monitoring is required. Acute deterioration not anticipated, but interventions may be necessary during transport.

- requires medical care and/or diagnostic evaluation unavailable at referring facility

#### **Patient Escort**

- nurse or appropriately trained personnel as determined by consultation between referring and receiving physician

### **PRIORITY CODE 4: NON-URGENT**

The patient's condition is stable and there is no threat to life or function. Evaluation or diagnostics unavailable in the referring facility.

#### **Definition**

The vital signs are within normal parameters and there is no expected threat to life or limb. Minimal monitoring is required and is expected that no interventions will be required during transport.

- requires diagnostic procedures, evaluation or treatment not available at referring facility
- the transport is pre-arranged in order to provide care.

#### **Patient Escort**

- as required - need not be health care professional

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**APPENDICES:**

Appendix II-A	Categorization of Interfacility Patient Transfers
Appendix II-B	Transfer Checklist
Appendix II-C	General Transport Supplies Kit
Appendix II-D	Drug Transport Kit (Adult/Paediatric)

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## APPENDIX II-A CATEGORIZATION OF INTERFACILITY PATIENT TRANSFERS

PRIORITY CODE	DEFINITION	ESCORT
Code 1: <b>CRITICAL</b>	One or more body systems are abnormal and rapidly deteriorating in association with an acute illness or injury. Intense monitoring and medical interventions are required to correct and stabilize the patient's condition.	<ul style="list-style-type: none"> <li>• Physician (if delegated to another health care professional, this individual must be competent to perform any current or anticipated complications)<sup>8</sup></li> <li>• Nurse or appropriately trained personnel as required.</li> </ul>
Code 2: <b>EMERGENT</b>	Vital signs are presently within normal parameters and there is no immediate threat to life or function. However, there is acute illness or injury which could result in deterioration and instability in the patient's condition. Close intensive monitoring required with potential need for acute intervention.	<ul style="list-style-type: none"> <li>• Physician/nurse or appropriately trained personnel as determined by consultation between sending and receiving physician.</li> </ul>
Code 3: <b>URGENT</b>	Vital signs are within normal parameters and there is no immediate threat to life or function. Less intensive monitoring is required. Acute deterioration not anticipated but interventions may be necessary during transport.	<ul style="list-style-type: none"> <li>• Nurse or appropriately trained personnel as determined by consultation between sending and receiving physician.</li> </ul>
Code 4: <b>NON-URGENT</b>	The vital signs are within normal parameters and there is no expected threat to life or limb. Minimal monitoring is required and is expected that no interventions will be required during transport.	<ul style="list-style-type: none"> <li>• As required - need not be a health care professional.</li> </ul>

<sup>8</sup> See CPS Statement No. 130 *Delegation of Function: Principles* and Guideline No. 132 *Shared Competencies and Delegated Physician Services*.

## APPENDIX II-B TRANSFER CHECKLIST

Patients Name \_\_\_\_\_ Date of Transfer \_\_\_\_\_

- \_\_\_\_ Receiving physician notified and documented
- \_\_\_\_ Receiving hospital notified and documented
- \_\_\_\_ Family notified and documented

**Stabilization of Patient** (If patient does not need the intervention, put N/A in the appropriate area.)

### Respiratory

- \_\_\_\_ airway                      \_\_\_\_ intubation                      \_\_\_\_ oxygen delivery                      \_\_\_\_ flow rate
- \_\_\_\_ suction                      \_\_\_\_ mechanical ventilation
- \_\_\_\_ chest tube                      \_\_\_\_ N/G tube to prevent aspiration

### Cardiovascular

- \_\_\_\_ control bleeding                      \_\_\_\_ replace blood loss
- \_\_\_\_ establish large bore IV's                      \_\_\_\_ Foley catheterization

### Central Nervous System

- \_\_\_\_ intubation and hyperventilation in head injury
- \_\_\_\_ administer appropriate medications after neurosurgical consultation
- \_\_\_\_ cervical spine immobilization

### Diagnostic Studies

- \_\_\_\_ X-ray (chest, other)                      \_\_\_\_ blood studies
- \_\_\_\_ electrocardiogram                      \_\_\_\_ urinalysis

### Wounds

- \_\_\_\_ Clean and dress                      \_\_\_\_ dT adults and children >7 years; dT
- \_\_\_\_ antibiotics                      antibiotics children <7 where wound is dirty and
- \_\_\_\_ tetanus immune globulin if indicated                      immunization status is unclear or deficient

### Fractures

- \_\_\_\_ appropriate splinting and traction
- \_\_\_\_ backboard

### Management during transport

- \_\_\_\_ establish appropriate escort
- \_\_\_\_ written instructions regarding patient care and treatment given to escort

### Written Record to accompany patient includes:

- \_\_\_\_ initial diagnostic impression                      \_\_\_\_ history of illness or injury
- \_\_\_\_ patient demographics                      \_\_\_\_ condition on admission
- \_\_\_\_ vital signs on admission, at time of transfer
- \_\_\_\_ treatment rendered to patient (e.g. medications and route of administration, fluids given, type and volume)
- \_\_\_\_ health care directive, if any

## **APPENDIX II-C GENERAL TRANSPORT SUPPLIES KIT**

### **Suggested items include:**

#### **DRESSING SUPPLIES:**

sterile dressing tray  
Kling (1 - 5 cm., 1 - 10 cm.)  
sterile dressings (10 - 2x2, 5 - 4x4)  
1 - elastoplast tape  
5 - Opsites  
2 - abdominal dressings

#### **MISCELLANEOUS:**

scissors  
tape (1 - waterproof, 1 - 1" cloth)  
tourniquet  
sterile gloves (sizes 6, 7, 7.5, and 8)  
6 - non-sterile gloves  
4 - tongue blades  
2 - tensor bandage  
alcohol swabs  
1% or 2% Betadine swabs

#### **INTRAVENOUS EQUIPMENT:**

##### **Adult IV Catheters**

3 - 16 gauge  
3 - 18 gauge  
4 - 20 gauge

##### **Paediatric IV Catheters**

3 - 21 gauge butterfly  
2 - 23 gauge butterfly  
2 - 25 gauge butterfly  
2 - 22 gauge Jelco

##### **Intraosseous Needles**

1 Jamshidi needle, or  
18 gauge needle with stylet

Buretols (1 microdrip, 1 minidrip)  
2 extension tubing  
2 stopcocks

#### **INTRAVENOUS FLUIDS:**

2 0.9% NS 250 ml  
2 0.3 NS/3.3 D 250 ml  
3 0.9% NS 1000 ml

#### **NEEDLES:**

5 18 gauge  
5 20 gauge

#### **OBSTETRICAL PACKS:**

Commercial or Disposable Type

#### **AIRWAY EQUIPMENT:**

endotracheal tubes  
laryngoscopes  
oral airways - paediatric/adult

#### **APPROPRIATE MONITORING EQUIPMENT**

## APPENDIX II-D DRUG TRANSPORT KIT (ADULT/PAEDIATRIC)

3	Epinephrine (Adrenalin) pre-filled syringes (1:1,000) 1 mg/ml or 30 ml vial
3	Epinephrine (Adrenalin) pre-filled syringes (1:10,000) 1 mg/ml or 30 ml vial
3	Atropine pre-filled syringes (10 ml) 1 mg/10 ml
3	Lidocaine pre-filled syringes (5 ml) 20 mg/ml
1	Sodium Bicarbonate pre-filled syringe (50 ml) 8.4%
1	Sodium Bicarbonate pre-filled syringe (10 ml) 4.2% (paediatric)
2	D50W pre-filled syringes 25 gm
2	D25W pre-filled syringes (paediatric)
2	Verapamil (Isoptin) ampules (2 ml) 5 mg/ml
1	Nitrospray or Nitro tablets
1	Naloxone (Narcan) ampule (1 ml) 2 mg/ml
3	Diazepam (Valium) ampules (2 ml) 10 mg/2 ml
2	Furosemide (Lasix) ampules (2 ml) 10 mg/ml
2	Diphenhydramine (Benadryl) ampules (1 ml) 50 mg/ml
2	Dimenhydrinate (Gravol) ampules (1 ml) 50 mg/ml
2	Oxytocinon (Syntocinon) ampules (1 ml) 10 units/ml
5	Phenytoin (Dilantin) ampules (5 ml) 50 mg/ml
4-5	Normal Saline for injection
4-5	Sterile water for injection
1	Isoproterenol (Isuprel) ampules 1 mg/1 ml
1	Dopamine 200 mg/5 ml
1	Lidocaine 1% without epinephrine (20 ml vial)
1	Mannitol 25% (50 ml vial) or 500 cc bag 20%
1	Magnesium sulphate 20% (20 ml vial)
1	Procainamide (Pronestyl) 100 mg/ml (10 ml vial)
1	Norepinephrine (Levophed) ampules (4 ml) 1 mg 1 ml
1	Methylprednisolone (Solumedrol) ampules 40 mg/ml
5	Adenosine ampules (2 ml) 3 mg/ml

SYRINGES	NEEDLES	MISCELLANEOUS
2 - 1 cc	5 - 21 gauge	5 - 2 x 2
3 - 3 cc	5 - 23 gauge	1" tape
2 - 5 c	5 - 18 gauge, 1½"	tourniquet
2 - 10 cc		alcohol swabs

**ADD:** (if required) Opioid Analgesic (either Demerol or Morphine) Pancuronium

## **APPENDIX III - "Do Not Resuscitate" and Supportive Treatment Orders<sup>3</sup>**

College of Physicians and Surgeons of Manitoba

Guideline 151

### **BACKGROUND**

Patients and family members are often faced with a difficult decision regarding the care and treatment<sup>9</sup> requirements for a person who is very ill and whose death appears inevitable. The physician is expected to inform and discuss with the patient and the family members, the care and treatment measures which can be taken to ensure that the most appropriate care is provided to the patient in the most appropriate fashion. These discussions should include a description of the procedures encompassed by resuscitation efforts and, when possible, should occur in an outpatient setting when general treatment preferences are discussed, or as early as possible during hospitalization, when the patient is likely to be mentally alert and able to make competent decisions.

*All facilities are expected to have policies regarding DNR and supportive treatment orders. Policy makers should determine how cardiopulmonary resuscitation (CPR) practices should be interpreted in light of the facility's mission, the values of the community it serves, as well as ethical and legal requirements. All members of the medical staff should be familiar with the policy.*

### **PATIENTS WHO ARE INCOMPETENT<sup>10</sup>**

If the patient is incompetent, decisions should be made on his/her behalf based on the following principles:

- The treatment decisions must be based on the wishes of the person if these are known (e.g. advance directive exists).
- When the person's wishes are not known, treatment decisions must be based on the person's best interests determined by such considerations as:
  - (a) the diagnosis and prognosis;
  - (b) discussions with the partners and close family members;
  - (c) the person's known values and preferences;
  - (d) aspects of the person's culture or religion that would impact on a treatment decision.

Although every effort should be made to involve the parent/guardian of a child in the preceding discussion, it should be noted that neither consent nor court order are required for a doctor to issue a non-resuscitation direction where the patient is in an irreversible vegetative state. (See *Code of Conduct*, "Communication, Decision Making and Consent, 12-23.)

3. College of Physicians and Surgeons of Manitoba  
[http://www.umanitoba.ca/colleges/cps/Guidelines\\_and\\_Statements/151.html](http://www.umanitoba.ca/colleges/cps/Guidelines_and_Statements/151.html) accessed June, 2003.  
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<sup>9</sup> With respect to the care of the terminally ill, the word "treatment" includes artificial nutrition and hydration.

<sup>10</sup> Determination of competence is made by the attending physician in consultation with other caregivers.

# **APPENDIX IV - Physician Disclosure of Harm That Occurs In the Course of Patient Care<sup>4</sup>**

College of Physicians and Surgeons of Manitoba  
Statement 169

## **BACKGROUND**

Two fundamental ethical principles are:

- physicians must be honest and open with their patients, and
- patients have a right to know their past and present medical status.

It follows from these principles that patients are entitled to full disclosure from the physician when harm occurs in the course of the patient's medical care.

## **SCOPE**

This Statement applies to all members of the College.

In this Statement:

- for a patient who is not competent to make his or her own medical decisions, the word "patient" includes the legal representative of the patient (e.g. substitute decision maker, parent or guardian).
- "harm" includes any non-trivial injury, complication, or adverse consequence, irrespective of the cause.

## **PRINCIPLES**

1. A physician must promptly inform his or her patient of any harm that has occurred in the course of that patient's medical care.
2. A physician must provide full and frank disclosure to the patient respecting the harm.

## **GUIDELINES:**

In making the disclosure, the following guidelines apply:

1. When harm occurs in the course of a patient's medical care, the physician responsible for that patient (including weekend or vacation coverage) must discuss the event with the patient. The discussion should occur promptly, taking into account the patient's medical condition.
2. In the discussion with the patient, the physician should:
  - a. advise the patient of the facts in a straight-forward and non-judgmental way. The discussion should include advice as to the nature, severity, and cause (if known) of the harm.
  - b. advise the patient as to what, if anything, can be done to correct the harm sustained.
  - c. advise of any medical care that the patient requires as a result of the harm that was sustained, and promptly seek appropriate help from other caregivers.
  - d. disclose only what is known at the time of the discussion. Disclosure is a process, avoid speculation.
  - e. accept responsibility for one's own actions, but without admitting liability to the patient. The physician must take care not to potentially prejudice the patient's right to indemnity under any insurance or protection plan. However, concern regarding legal liability that might result following truthful disclosure does not affect the physician's responsibility to be honest with the patient.
  - f. avoid attributing blame to specific individuals. Rarely is an adverse medical event the fault of a single individual.
  - g. consider whether an apology or an expression of sorrow is appropriate. An apology or an expression of sorrow offered at an early stage in the disclosure process can help prevent bad feelings and legal or professional complaints.
3. Where appropriate, the physician may offer the patient a second opinion, the involvement of outside assistance, or the transfer of care to another physician.

4. The physician must document in the patient's chart the discussion with the patient.
5. A patient has the right to decline disclosure, but must do so of the patient's own initiative. Where a patient declines disclosure, the particulars must be recorded in the patient's chart, and the physician must advise the patient that he or she is willing to discuss the matter if the patient so chooses in the future.
6. Where the harm is particularly serious and/or unexpected, provided the patient consents, a meeting between members of the care team and the patient's family may be held. An open and prompt meeting with all relevant records available can promote understanding of the event, and avoid charges of a "cover-up". As well, advice as to what will be done to prevent a similar occurrence with another patient may offer solace to affected patients/families. The discussions at any such meeting must be carefully documented.
7. Where the harm is particularly serious and/or unexpected and the patient is in a health care facility at the time the harm occurs, the physician should promptly inform the appropriate authority of the harm.
8. Where the patient is in a health care facility at the time an event with potential clinical significance occurs, the physician should consider whether it is necessary to inform the appropriate authority of the event in order to prevent possible harm in the future.
9. Errors committed by others may require reporting and disclosure. If in doubt, an event (such as witnessing a significant error made by another person) must be discussed in a confidential way with the Registrar responsible for Standards.
10. Medical learners fulfill their obligations under this Statement if the disclosure is made to the medical learner's supervisor or Program Director.

**A statement is a formal position of the College with which members shall comply.**

4. College of Physicians and Surgeons of Manitoba  
[http://www.umanitoba.ca/colleges/cps/Guidelines\\_and\\_Statements/169.doc](http://www.umanitoba.ca/colleges/cps/Guidelines_and_Statements/169.doc) accessed June, 2003. Copyright  
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## **APPENDIX V - Guidelines for Communication in Cross-Cultural Practice<sup>5</sup>**

### **Monolingual Providers in a Cross-Cultural Practice**

1. Unless you are thoroughly effective and fluent in the target language, always use an interpreter.
2. Avoid using family members as interpreters.
3. Learn basic words and sentences in the target language. Asking interpreters about words or comments that have not been translated prompts attention to detail.
4. Utilize dictionaries of languages used by your patient population. Beware, brief “definitions” provided by translating dictionaries only serve as labels.
5. Become familiar with special terminology used by patients. Specific beliefs, practices, and traditions are often referenced by indirect language or special terms. Local beliefs and moral tenets may lead to overemphasis or underreporting of certain symptoms, issues, and events.
6. Check the quality of translated health-related materials by having them back-translated.
7. Meet with your interpreters on a regular basis. They will provide both a window and a mirror when you deal with another language and another culture.
8. Personal information is often closely guarded and difficult to obtain. Patients often request a specific interpreter or even bring one to the clinic.
9. Evaluate the interpreter’s style and approach to patients. For special situations and problem cases, try to match the interpreter to the task.
10. Be patient. Careful interpretation often requires that the interpreter use long explanatory phrases.

### **Provider-Interpreter- Patient Interactions**

1. Address your patients directly. Avoid directing all of your commentary to and through the interpreter.
2. Be certain the interpreter is thoroughly involved with the patient during an interview.
3. Develop alternatives to taking histories via direct questions. Strangers to direct, Western-style inquiry may respond better to conversational modes.
4. Invite correction and induce the discussion of alternatives: “Correct me if I’m wrong, I understood it this way...” “Do you see it some other way?”
5. Pursue seemingly unconnected issues that the patient raises. These issues may lead to crucial information or uncover difficulties with the interpretation.
6. Come back to an issue if you suspect a problem and get a negative response. Be certain the interpreter knows what you want. Use related questions, change the wording, and come at it indirectly.

7. Provide instructions in the format of lists. Have patients outline their understanding of the plans.
8. If alternatives exist, spell out each one.
9. Emphasize by repetition.
10. Clarify your limitations. The willingness to talk about an issue may be viewed as evidence of “understanding it” or the ability to “fix it.”
11. Rumours, jealousy, privacy, and reputation are crucial issues in closely knit communities. Acknowledge the problem and assure the patient of confidentiality.

### **Language Use in Interpreter-Dependent Interviews**

1. Use short questions and comments. Technical terminology and professional jargon, like the phrase “work-up,” should be reduced to plain English.
2. When lengthy explanations are necessary, break them up and have them interpreted piece by piece in straightforward, concrete terms.
3. Use language and explanations your interpreter can handle.
4. Make allowances for terms that do not exist in the target language.
5. Try to avoid ambiguous statements and questions.
6. Avoid abstractions, idiomatic expressions, similes, and metaphors. It is useful to learn about these usages in the target language.
7. Plan what you want to say ahead of time. Avoid confusing the interpreter by backing up, inserting a proviso, or hesitating.
8. Avoid indefinite phrases using “would,” “could,” “if,” and “maybe.” These can be mistaken for actual agreements or firm approval of a course of action.
9. Ask the interpreter to comment on the patient’s word content and emotions.

5. Adapted from Pustch RW. JAMA, 1985; 254: 3344-8 (Dec 20) Copyright American Medical Association.

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