Government of
Northwest Territories

Northwest Territories Standards of Practice for Physicians

The minimum standard of profession behaviour and good practice expected of Medical Practitioners licensed to practice in the Northwest Territories.

Effective as of November 1, 2023

CONTENTS

INTRODUCTION

The ***Standards of Practice*** are the **minimum standards** of professional behaviour and ethical conduct expected of all medical practitioners registered and practicing in the Northwest Territories. Standards are enforceable under the *Medical Profession Act* S.N.W.T. 2010,c.6 (the "**Medical Profession Act**") and will be referenced in complaints resolution and discipline hearings.

These standards complement the Canadian Medical Association's *Code of Ethics and Professionalism.*

Standards of Practice are purposely concise. When assessing an alleged breach of these Standards, the Complaints Officer considers the context of the matter on a case-by-case basis.

Standards of Practice will evolve over time, and substantive changes will be adopted only after consultation with the profession.

There are a number of Standards of Practice and sections of Standards that apply solely to physicians practicing medicine in private businesses that are not contracted or employed by the Northwest Territories Health and Social Services Authority. These areas are clearly identified at the beginning of each Standard and in **bold font.**

NWT Standards of Practice for Physicians have been adapted from the College of Physicians and Surgeons of Alberta's *Standards of Practice* with permission.

DEFINITIONS

In this document, the term:

"**Board of Inquiry**" means the Board of Inquiry established in section 64 of the *Medical Profession Act*.

"**Complaints Officer**" means the Complaints Officer appointed under section 44 of the *Medical Profession Act*.

"**Custodian**" refers to a Health Information Custodian, as is as defined in section 1 of the *Health Information Act*.

"**Healthcare professional**" means a medical practitioner under the *Medical Profession Act*, a dentist licensed under the *Dental Profession Act*, a registered midwife licensed under the *Midwifery Profession Act*, or a nurse practitioner or registered nurse registered under the *Nursing Profession Act*.

"**HIA**" means the *Health Information Act*, S.N.W.T. 2014, c. 2.

"Inquiry Panel" means the panel selected to hear a complaint, as defined in section 42 of the *Medical Profession Act*.

"M**ay**" means that the medical practitioner may exercise reasonable discretion.

"M**edical practitioner**" means any person who is licensed as a medical practitioner under the *Medical Profession Act*, and means any person who is registered or who is required to be registered by the Registrar as a physician or surgeon.

"**Must**" refers to a mandatory requirement.

"**Patient**" means an individual who is involved in a medical practitioner-patient relationship, and the individual remains a patient for a period of one (1) year from the date the individual ceased to be in the medical practitioner-patient relationship. This type of relationship is formed when there is a reasonable expectation that care will extend beyond a single encounter and medical practitioner has engaged in one or more of the following activities:

(a) Gathered clinical information to assess a person;
(b) Provided a diagnosis;
(c) Provided medical advice or treatment;
(d) Provided counselling to the patient;
(e) Created a patient file for the patient;
(f) Billed for medical services provided to the patient;
(g) Prescribed a drug for which a prescription is needed to the patient.

All references to the "patient" in these Standards include the patient's legal guardian

or substitute decision maker, where applicable.

"Registrar" means the Registrar of Professional Licensing, Government of the Northwest Territories, as appointed under the *Medical Profession Act*.

"Substitute Decision Maker" means a person who may give or refuse consent to a treatment on behalf of an incapable patient.

"Territorial Medical Director" means the Territorial Medical Director of the Northwest Territories Health and Social Services Authority, as appointed under the *Northwest Territories Health and Social Services Authority Medical and Professional Staff Bylaws.*

"Unprofessional conduct" is as defined in Part 2 of the *Medical Profession Act*.

PROCESS MAP – APPROVAL OF STANDARDS OF PRACTICE FOR PHYSICIANS

1. **Standard identified for consideration in the NWT**
   - Federation of Medical Regulatory Authorities of Canada (FMRAC) recommends a model standard to member Medical Regulatory Authorities (i.e. the Office of Professional Licensing within the Department of Health and Social Services (DHSS)). **As FMRAC has no authority over its members, it is the discretion of each individual medical regulatory authority to adopt or adapt FMRAC's recommendations as it deems appropriate and/or feasible; or
   - A standard from a provincial College of Physicians and Surgeons (or a standard otherwise proposed by DHSS, NWT Medical Association, or Territorial Practitioner Executive Committee) is identified as desirable to be used in the NWT; or
   - Jurisdictional scan of all provinces' standards is completed by a Policy Officer in the DHSS to identify consensus of standards.

2. **Develop Proposed NWT Standard**
   - A Policy Officer of the DHSS drafts the proposed standard(s).
   - **NWT Standard of Practice must be similar to the standards of provincial Colleges of Physicians and Surgeons to allow labour mobility.

3. **Input of Groups representing physicians:**
   - A reasonable timeframe to review proposed Standards will be determined (for example, a minimum of two weeks, or more, depending on length or number of standards for review).

   Territorial Practitioner Executive Committee (TPEC)
   - In line with *Medical and Professional Staff Bylaws*, TPEC will provide input/ recommendations through the Chief Executive Officer of the NTHSSA.
   - Chief Executive Officer will provide the input to the Deputy Minister of the Department.

   NWT Medical Association
   - President (or delegate) will provide the input to the ADM of Finance, Policy and Planning of the Department.

4. **Discussion on Proposed Standards**
   - Representatives to participate: Territorial Medical Director (or delegate), President (or delegate) of the NWT Medical Association, and DHSS Director of Policy and Legislation (or delegate).
   - Electronic distribution of materials to reach consensus on wording of proposed standard(s); In-person meetings as needed.
   - **Input must be considered, however it is non-binding on the Department, as the regulator of the medical profession. There must be a collaborative effort

to reconcile outstanding issues to develop a standard that is acceptable to the physicians (that can be attained by and protects the physician) and the regulator (for the purpose of protection of the public).
- ** All parties to keep the interests of the public and the medical profession as a whole foremost in discussions.

5. **Medical Association support**
    - President (or delegate) will confirm support on behalf of membership on the final draft Standards.

6. **Department approval of Standard**
    - The Deputy Minister of the DHSS approves the proposed standard.

7. **Approved Standard Posted**
    - Final version of standard posted on DHSS website.

8. **Periodic Review**
    - Standards will be reviewed, as needed when a change is identified by a stakeholder (NWT Medical Association, TPEC, or Complaints Officer, etc.), or changes are made to other jurisdictions' standards of practice.

ADVERTISING (Administration of Practice)

The NWT Physician Standards of Practice are the minimum standards of professional behaviour and ethical conduct expected of all medical practitioners registered in the NWT. Standards of Practice are enforceable under the *Medical Profession Act* and will be referenced in the management of complaints and in disciplines hearings.

1. A medical practitioner who is responsible for an advertisement[1] **must** ensure the information provided:
   a) conforms to the *Code of Ethics and Professionalism*;
   b) contains factual and relevant information about the nature of the practice;
   c) includes the practice discipline as identified on the member's license issued by the Registrar;
   d) is accurate, clear and explicitly states all pertinent details of an offer, with disclaimers as prominent as other aspects of the message;
   e) is supported by evidence that is readily available to the public;
   f) is compatible with the best interests of the public and upholds the reputation of the medical profession;
   g) is not false, incomplete, misleading or deceptive;
   h) does not include claims, representations, endorsements or testimonials regarding the service or business;
   i) does not create unreasonable expectations of beneficial treatment such as guarantees or warranties about results; and,
   j) does not encourage the indiscriminate or unnecessary use of health services.

2. A medical practitioner **must** promptly comply with direction from the Complaints Officer to:
   a) substantiate any advertising claim or representation;
   b) confirm whether a specific advertisement is made by or on behalf of the medical practitioner; or

[1] Advertisement is any message (spoken, text or image-based), in any medium, about a medical practitioner and or a clinic, group, product or service with which a medical practitioner is associated, the content of which is controlled directly or indirectly by the medical practitioner.

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c) change or stop using any advertising message(s) that the Complaints Officer deems in violation of any part of this standard or the *Code of Ethics and Professionalism*.

3. A medical practitioner **must not** directly or indirectly participate in advertising that:
   a) discredits, disparages or attacks another product, service, facility, clinic, provider or group;
   b) promises or offers more effective services or better results than those available from another provider unless substantiated to the satisfaction of the Registrar based on publically available information; or
   c) offers any inducement to provide a medical service to a patient, including but not limited to:
      i. time-limited prices for a service;
      ii. discount coupons, gift certificates, or prizes for a service;
      iii. communal gatherings ("parties") where consultation or medical services are offered;
      iv. a service in conjunction with "makeovers" created for entertainment or promotional purposes; or,
      v. events including "education sessions" where registration fees are donated.

4. A medical practitioner **must not**:
   a) disclose the name or identifying features of a patient unless the medical practitioner has obtained the patient's prior written consent to use the information for advertising purposes; or,
   b) use a protected title listed in s. 82 of the *Medical Profession Act* alone or in combination with other descriptors to imply specialization in an area or branch of medicine.
5. Despite 4(b), a medical practitioner **may** use a protected title as authorized by the Department of National Defence.

6. A medical practitioner **may** indicate a practice interest only if the:
   a. area of interest falls within the context of the member's practice discipline;
   b) area of interest is a demonstrated, significant focus of the member's practice; and,
   c) medical practitioner pursues continuing medical education related to the area of interest.

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CODE OF ETHICS (Administration of Practice)

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1. A medical practitioner **must** comply with the *Code of Ethics* adopted in regulations under the *Medical Profession Act*.

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CONSCIENTIOUS OBJECTIONS (Medical Practice)

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1. A medical practitioner **must** communicate promptly and respectfully to the patient, and to the Territorial Medical Director, about any treatments or procedures the medical practitioner declines to provide based on the medical practitioner's rights respecting one's freedom of conscience and religion under the *Canadian Charter of Rights and Freedoms* (the "Charter").

2. A medical practitioner **must not** withhold information about the existence of a procedure or treatment because providing that procedure or giving advice about it conflicts with their right to freedom of conscience and religion.

3. A medical practitioner **must not** promote their moral or religious beliefs when interacting with patients.

4. When section 2a of the Charter, 'freedom of conscience and religion', prevents a medical practitioner from providing or offering access to information about a legally available medical or surgical treatment or service, the medical practitioner **must** ensure that the patient who seeks such advice or medical care is offered timely access to:

    (a) A medical practitioner who is willing to provide the medical treatment, service or information; or

    (b) A resource that will provide accurate information about all available medical options.

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DISCLOSURE OF HARM (Physician-Patient Relationship)

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1. When a patient suffers harm, with harm being defined as an outcome that negatively affects the patient's health and/or quality of life, the responsible medical practitioner **must** ensure that the patient receives disclosure of that information.

    a. If the medical practitioner is the only healthcare professional treating the patient, then it is the medical practitioner's responsibility to disclose that information to the patient.

    b. In a team setting, the medical practitioner **must** cooperate with other members of the team (in the hospital setting this will also include the administration) to identify the most suitable person(s) to disclose that information to the patient.

    c. In all settings, disclosure of harm is to be considered part of a process that will also address circumstances that led to the patient's suffering harm, and necessary steps to prevent recurrence of the harm if an untoward and avoidable event occurred.

2. Disclosure **must** occur whether the harm is a result of progression of disease, a complication of care or an adverse event and whether the harm was preventable.

Note: This standard does not preclude the medical practitioner from complying with the requirements in the *NWT Critical Incident Reporting Guidelines.*

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DUTY OF TREATING MEDICAL PRACTITIONERS TO REPORT A MEDICAL PRACTITIONER TO THE COMPLAINTS OFFICER (Collaboration)

The NWT Physician Standards of Practice are the minimum standards of professional behaviour and ethical conduct expected of all medical practitioners registered in the NWT. Standards of Practice are enforceable under the *Medical Profession Act* and will be referenced in the management of complaints and in disciplines hearings.

1. A medical practitioner acting as the treating medical practitioner of another physician (the "medical practitioner-patient"), **must** report a medical practitioner to the Complaints Officer when their medical practitioner-patient presently has a physical, cognitive mental and/or emotional condition where it is reasonably foreseeable[2] that patients of the medical practitioner-patient or others within the context of their medical practice[3], could be seriously harmed[4] (whether physically or psychologically) as a result of the medical condition.

2. The treating medical practitioner **must** make all reasonable efforts to understand the nature and scope of the medical practitioner-patient's practice and seek information, with the consent of the medical practitioner-patient, about the impacts of the medical condition on the practice.

3. If the treating medical practitioner is unable to ascertain that their own threshold to report has been met, the treating medical practitioner **must** seek appropriate advice (e.g. the Canadian Medical Protective Association).

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[2] Reasonably foreseeable: The determination of what is reasonably foreseeable is based on what a reasonable physician would do given the same set of circumstances and requires a judgment call on the part of the physician. The following factors should be considered:

(a) whether the physician's condition is being appropriately managed and harm would only be anticipated if such management was not maintained.
(b) whether there is sufficient information available to make a judgment about the physician-patient's management of their health condition.
(c) whether there is sufficient information to suggest that appropriate management will only occur with monitoring or oversight mechanisms in place.
(d) whether the harm anticipated, if it materializes, would be irreversible; and/or whether the harm anticipated, if it materializes, would cause more than minimal pain (physical or psychological) or other injury.

[3] The practice of medicine includes not only patient care but all activities, such as working with other health care workers, teaching, research and administrative work done in the context of medical practice

[4] Serious harm is defined as that which is either irreversible or would result in more than minor pain or injury.

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4. The medical practitioner-patient **must** be advised of their duty to self-report to the Complaints Officer.

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DUTY TO REPORT A COLLEAGUE (Collaboration)

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1. A medical practitioner **must** report another medical practitioner (e.g. the colleague) to the Complaints Officer as soon as the medical practitioner has reasonable grounds that the conduct of the other medical practitioner places patients at risk or is considered unprofessional conduct under the *Medical Profession Act*.

2. Knowledge of conduct that should be reported in clause 1 includes, but is not limited to, situations in which a medical practitioner:
    a. Makes sexual advances to or enters into a sexual relationship with a patient;
    b. Presently has a physical, cognitive, mental or emotional condition[5] that is negatively impacting the work[6] or is reasonably likely to negatively impact the work of the medical practitioner;
    c. Repeatedly or consistently fails to address their behaviour in a manner that interferes with the delivery of care to patients, the ability of other medical practitioners, learners or healthcare workers to provide care to patients, or
    d. Is not competent in the care of patients.

3. When a patient discloses information leading a medical practitioner to believe on reasonable grounds that another medical practitioner has engaged in behaviour that is a sexual boundary violation with the patient, the first medical practitioner **must**:
    a. Provide the patient with information about how to file a complaint with the Complaints Officer;
    b. Offer to file a third person complaint with the patient's permission, if the patient does not wish to file a complaint personally; or
    c. At a minimum, document the sexual boundary violation indicating that the patient does not wish to report to the Complaints Officer when the patient does

[5] Conditions would include, but not be limited to, the following: blood borne viral infections; conditions affecting primary senses (vision, hearing, etc.); neurological conditions affecting cognition, motor or sensory functions, seizure disorder; psychiatric conditions; substance misuse; physical disability; metabolic conditions.

[6] "Negative Impact" is defined as harm to patients or others as a result of the practice of medicine. The practice of medicine includes research, education and administration, in addition to the practice associated with patients.

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not give permission to proceed with a third party complaint; however, the name of the medical practitioner may be reported to the Complaints Officer without providing the name of the patient.

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DUTY TO REPORT SELF (Collaboration)

The NWT Physician Standards of Practice are the minimum standards of professional behaviour and ethical conduct expected of all medical practitioners registered in the NWT. Standards of Practice are enforceable under the *Medical Profession Act* and will be referenced in the management of complaints and in disciplines hearings.

1. A medical practitioner **must** report the following personal circumstances to the Registrar at the time of registration or whenever the medical practitioner becomes aware thereafter, and in the NTHSSA's Information and Verification Attestation Form:

    a. Any physical, cognitive, mental and/or emotional condition[7] that is negatively impacting[8] the medical practitioner's work or is reasonably likely to negatively impact the medical practitioner's work in the future.

    b. A sexual or inappropriate personal relationship between the medical practitioner and the patient.

    c. Any voluntary or involuntary loss or restriction of diagnostic or treatment privileges granted by an administrative authority (e.g. hospital) or other regulatory authority, or any resignation in lieu of further administrative or disciplinary action.

    d. Any findings of unprofessional conduct by a regulatory authority in another jurisdiction.

    e. Any charges or convictions of a criminal offence.

    f. Any findings of professional negligence or malpractice.

2. A medical practitioner **must** adhere to restrictions imposed by the Registrar, to the satisfaction of the Registrar, or withdraw from medical practice.

[7] Conditions would include, but not limited to, the following: blood borne viral infections; conditions affecting primary senses (vision, hearing, etc.); neurological conditions affecting cognition, motor or sensory functions, seizure disorder; psychiatric conditions; substance misuse; physical disability; metabolic conditions.

[8] "Negative Impact" is defined as harm to patients or others as a result of the practice of medicine. The practice of medicine includes research, education and administration, in addition to the practice associated with patients.

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INFORMED CONSENT

The NWT Physician Standards of Practice are the minimum standards of professional behaviour and ethical conduct expected of all medical practitioners registered in the NWT. Standards of Practice are enforceable under the *Medical Profession Act* and will be referenced in the management of complaints and in disciplines hearings.

1. A medical practitioner **must** obtain a patient's informed consent prior to an examination, assessment, treatment or procedure; such consent may be implied, expressed orally or in writing as appropriate.
2. If a patient is under the age of 19 years, a medical practitioner **must**:
    a. Determine whether the patient is a mature minor with the capacity to give informed consent; and
    b. If the patient is not a mature minor, seek informed consent from the patient's legal guardian, in accordance with legislation[9].
3. If an adult patient lacks capacity to give informed consent, a medical practitioner **must** seek informed consent from the patient's legal guardian or substitute decision maker, in accordance with relevant legislation.[10]
4. A medical practitioner who has reasonable grounds to believe an informed consent decision by a legal guardian or substitute decision maker is not in the best interests of the patient **must** seek appropriate legal advice (e.g. from sources such as the Canadian Medical Protective Association).
5. A medical practitioner obtaining informed consent from a patient, or the patient's legal guardian or substitute decision maker **must** ensure the decision maker:
    a. Is aware of their right to withdraw consent at any time;
    b. Is free of undue influence, duress or coercion in making the consent decision;
    c. Receives a proper explanation that includes but is not limited to:
        i. Diagnosis reached;
        ii. Advised interventions and treatments;

[9] Parents can reasonably be assumed to be the guardian of the child in accordance with the *Children's Law Act*, SNWT 1997, c. 14. Other people may be entitled to be a guardian by an agreement in accordance with the *Family Law Act*, appointed in a parent's will, or by a court order (e.g. adoption, foster parent, care under the *Child and Family Services Act*).

[10] Legislation such as, *Personal Directives Act*, SNWT 2005, c. 16; *Guardianship and Trusteeship Act*, SNWT 1994, c. 29; *Mental Health Act*, RSNWT 1988, c. M-10.

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iii. Exact nature and anticipated benefits of the proposed examination, assessment, treatment or procedure;

iv. Common risks and significant risks;

v. Reasonable alternative treatments available and the associated common risks and significant risks; and

vi. Natural history of condition and the consequences of forgoing treatment.

d. Demonstrates a reasonable understanding of the information provided and the reasonably foreseeable consequences of both a decision and a failure to make a decision.

6. A medical practitioner who assesses the capacity of a patient to give informed consent **must**:

    a. Use accepted capacity assessment processes;

    b. To the extent possible, conduct the capacity assessment at a time and under circumstances in which the patient is likely to be able to demonstrate full capacity; and

    c. Inform the patient of the nature and consequences of the capacity assessment.

7. A medical practitioner **may** delegate responsibility for obtaining informed consent to another healthcare professional only when confident the delegate has the appropriate knowledge, skill and judgement to meet the expectations of this standard.

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MEDICAL ASSISTANCE IN DYING (Medical Practice)

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1. A medical practitioner who carries out any assessment – preliminary or otherwise – of whether or not a patient meets the eligibility criteria for medical assistance in dying or who receives, considers or fulfills a written request for medical assistance in dying **must** do so in accordance with the *Medical Assistance in Dying Interim Guidelines for the Northwest Territories*.

2. A medical practitioner who receives an enquiry from a patient with respect to medical assistance in dying **must** ensure that contact information for the NWT Medical Assistance in Dying Central Coordinating Service is provided to the patient, or to another person identified by the patient, without delay.

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PATIENT RECORD CONTENT (Administration of Practice)

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1. A medical practitioner who provides assessment, advice and/or treatment to a patient **must**:
    a. Document the encounter in a patient record (paper or electronic);
    b. Ensure the patient record is:
        i. An accurate and complete reflection of the patient encounter to facilitate continuity in patient care;
        ii. Legible and in English;
        iii. Compliant with relevant legislation and institutional expectations; and
        iv. Completed as soon as reasonable to promote accuracy.
2. A medical practitioner **must** ensure the patient record contains:
    a. Clinical notes for each patient encounter including:
        i. Presenting concern, relevant findings, assessment and plan, including follow-up when indicated;
        ii. Prescriptions issued, including drug name, dose, quantity prescribed, directions for use and refills issued;
        iii. Tests, referrals and consultations requisitioned, including those accepted and declined by the patient;
    b. Information pertaining to the consent process;
    c. A cumulative patient profile (CPP) contextual to the medical practitioner-patient relationship (the longer and more complex the relationship the more extensive should be the record) detailing:
        i. Patient identification (i.e., name address, phone number, personal health care number, contact person in case of emergencies);
        ii. Current medications and treatments including complementary and alternative therapies where those therapies have been disclosed;
        iii. Allergies and drug reactions;
        iv. Ongoing health conditions and identified risk factors;

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v. Medical history, including family medical history;

vi. Social history (e.g., occupation, life events, habits);

vii. Health maintenance plans (immunizations, disease surveillance, screening tests); and

viii. Date the CPP was last updated.

d. Laboratory, imaging, pathology and consultation reports;

e. Operative records, procedural records and discharge summaries;

f. Any communication with the patient concerning the patient's medical care, including unplanned contacts; and

g. A record of missed and/or cancelled appointments.

3. Despite clause 2, a medical practitioner **may** indicate that the required documents are available in the electronic health/medical record or other database that can be reliably accessed for the length of time the record must be maintained.

4. A medical practitioner **may** amend or correct a patient record in accordance with the HIA through an initialled and dated addendum or tracked change including the following circumstances:

   a. The correction or amendment is routine in nature, such as a change in name or contact information;

   b. To ensure the accuracy of the information documented; or

   c. At the request of the patient identifying incomplete or inaccurate information.

5. Despite clause 4(c), a medical practitioner **may** refuse to make a requested correction or amendment to a patient record in accordance with the HIA.

6. A medical practitioner **may** append additional information to a patient record in accordance with the HIA.

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