

Following are the proposed amendments to the Code of Professional Conduct by the Malaysian Medical Council. Comments and proposals are welcome from your organization on or before 30th November 2009 to assist the Malaysian Medical Council in completing this ethical code.

MALAYSIAN MEDICAL COUNCIL

Code of Professional Conduct (Revised - 2009)

**THIS SECTION IS NOT PART OF THE MAIN DOCUMENT.
IT IS ONLY MEANT FOR INFORMATION**

Revision Draft No.10 (14092009)

Brief History of the Project

A committee was appointed by the Malaysian Medical Council in the latter half of 2003 to review and revise the 1987 Code of Professional Conduct, taking into consideration the many new developments in the subject, and also some areas which over the years had been found to need further explanations and expansion.

An earlier draft was submitted to the Council in 2005, and a few feedbacks were received and these were incorporated.

This draft has been left dormant pending the final stages of the preparation of Amendments to the Medical Act 1971, as some preliminary chapters in the proposed new Code relate to the proposed amendments to the Act. Since the Amendments to the Act are almost ready to be presented to Parliament, the time is now found appropriate for the proposed amendments to the Code of Professional Conduct to be presented to Council for study and final approval.

NOTES:

The following principles were set and adhered to in the drafting of the Review of the Code of Professional Conduct (CPC):

1. The 1987 CPC has stood the test of time over the last 20 years and the format and contents should be retained, wherever still appropriate and applicable.
2. The main topic headings as in the 1987 CPC should be retained.
3. New topics/subjects/updates should be introduced without changing the 1987 CPC topic headings (appearing in *italics* in the contents page).
4. The presentation, wherever possible, should be positive (what is correct ethics), rather than negative (what is wrong ethics).
5. When reference is made to 'registered medical practitioner', the gender should be 'neutral' or circumspect.
6. Consensus reached in the two MMC seminars, namely Medical Records & Medical Reports, and Advertising vs. Information, as well as decisions made at various sittings of the Council on various ethical codes should be incorporated in relevant form and section.
7. A Preamble should lay down the Ethical Basis of the CPC.
8. Part III Disciplinary Procedures in the 1987 CPC will be updated consistent with Medical Act 2009-10 and Regulation.
9. The 2009-10 CPC is expected to come into effect only after the Amendment to the Medical Act 2009-10 is passed.
10. When the draft is finalized, Bibliography and Subject Index will be added.

The following **new topics** have been included in this draft CPC.

1. *Disciplinary Punishments*
2. *The Meaning of Serious Professional Misconduct*
3. *Practitioner in Inquiry and Litigation*
4. *Consent for Treatment*
5. *New Clinical Procedures or Interventions*
6. *Confidentiality*
7. *Chaperone*
8. *The Practitioner and Managed Care Organisation*
9. *The Practitioner and Telemedicine*
10. *The Practitioner and the Practice of Traditional/Complementary Medicine*
11. *Aesthetic Medical Practice*
12. *Professional Fees*
13. *Medical Testimony in Court*
14. *End of Life Care*
15. *Brain Death*
16. *Medical (Sick) Certificates*
17. *Termination of Professional Relationship*
18. *Medical Errors and Incidence Reporting*
19. *The Practitioner and Health Tourism*
20. *Announcement in the Lay Press Regarding Practice*
21. *Articles, Contributions and Books for the Lay Public*
22. *Lectures to Lay Public*
23. *Lectures to Colleagues*
24. *Directional Signboards*
25. *Banners*

Progress NOTES

1. First draft of CPC 2004 on 16 February 2004
2. Second draft CPC (Proposal I) on 10 June 2004
3. Panel discussion in sections on (1) 22/8/2004, (2) 13/9/2004 (3)20/9/2004
4. Third Draft CPC on 20/9/2004
5. Fourth Draft CPC (17/10/2004) after panel meeting on 05/10/2004
6. Fifth draft CPC (26/10/2004) further revised by panel through e-mail
7. Sixth draft CPC (05/11/2004) after panel meeting on 02/11/2004
8. Seventh draft after presentation to Council members on 20/02/2005
9. Periodic additions following council rulings on certain topics.
10. Updating following final draft of Amendments to Medical Act 1971.

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PREAMBLE

THE ETHICAL BASIS OF THE CODE OF PROFESSIONAL CONDUCT

The Profession of the Healer is very ancient, going to the beginnings of civilization. As healers in this honourable tradition, from time immemorial, the professionals of medicine are dedicated to preventing disease, to relief of suffering, to healing sickness, to provide comfort and counsel, and always to care and never to harm. The trust and confidence, the hope and esteem, placed on the profession by society are qualities earned and nurtured by us through tenets of moral and ethical behaviour, which we hold dearly and guard zealously, handed down by generations of predecessors. By entering this fellowship of healers, we vow to deliver care to all human beings, with utmost respect to life and dignity, irrespective of culture, faith or ethnicity, gender or age, wealth or social status. The scientific principles which have evolved to provide the foundation to our practice as healers do not change the traditional legacy of care and cure to which we have sworn allegiance.

The Practice of the Healing Art is a privilege and honour, and we dedicate our lives to strive to be cultured and humble, learned yet willing to learn, impeccable in professional integrity and behaviour, and always prepared to understand human suffering and feelings, ever conscious of the health and welfare of fellow human beings. We pledge never to take emotional, personal or pecuniary advantage of our patients and their families.

As Practitioners we continually upgrade our knowledge in the art and science of medicine and hone our skills that we may serve our patients to the best of our ability, neither claiming superiority, nor advertising our skills. We also recognize the limits of our own personal competence and capability and are prepared to seek the assistance and counsel of our colleagues and cooperate with others to ensure care that is in the best interest of our patients. We take responsibility as guardians of our patients' health and welfare, protect them from futile, ineffective or harmful care. We eschew the use of unproven remedies or to claim unproven outcomes contrary to the best expertise and experience and the consensus of the profession.

The Relationship between us and our patients is privileged, as we gain access to their most intimate emotions and secrets in the course of our management of their illness. We communicate with concern and tact with our patients, and we strive to establish and preserve their confidence and trust. We are bound by our code of behaviour to protect and preserve confidentiality of information, and we obtain explicit consent for any disclosure, except in very exceptional circumstances required by law or in the larger interest of the community.

We are a part of a larger healthcare family and we have an ethical obligation to work together with our colleagues, nurses, and ancillary and support staff, to provide care to our patients without compromise. We are guided by ethical standards in any research involving our patients. We impart our skills and knowledge to young doctors and students and staff so that the tradition of healing and professional ethics will live and thrive into the future.

INTRODUCTION

THE CODE OF PROFESSIONAL CONDUCT AND GUIDELINES IN RELATION TO THE MEDICAL ACT

The practice of Medicine is an ancient profession and the community has great expectations of its practitioners and places great trust in them. Without this trust it would be impossible to practise medicine and the profession expects a high standard of professional and personal conduct from its members. These are embodied in various Codes of Ethics, which vary in detail from country to country, but all place first and foremost the health and welfare of the individual and the family under the care of a practitioner.

Underpinning the Code of Ethics are statutes which make it an offence punishable under the law of the country to transgress certain outer limits of the expected norms of professional conduct. These minimum standards of conduct are assessed by the peers in the profession, assembled as the Malaysian Medical Council established under the Medical Act 2009. Breaches of these minimum standards are referred to as 'serious professional misconduct' or 'infamous conduct in a professional respect.'

The Medical Act 2009 is the legislation relating to the registration and practice of medical practitioners and the Medical Regulations 2009 to the Act empower it, to deal with all disciplinary matters involving registered medical practitioners.

The **Code of Professional Conduct** of the Malaysian Medical Council provides the yardstick for the conduct and behaviour of registered medical practitioners in their clinical practice and in all areas of professional activity.

This document, issued under the authority of the Malaysian Medical Council, outlines the minimum standards of conduct that will make a practitioner liable, after proper inquiry, to be found guilty of serious professional misconduct. It follows that these guidelines discuss not ideal behaviour, but the minimum standards of conduct expected of a registered medical practitioner. By publishing this document it is the desire of the Malaysian Medical Council that no practitioner will have committed professional misconduct on grounds of ignorance of the expected standards of professional conduct in this country.

The **Guidelines** issued and revised by the Malaysian Medical Council from time to time complement the Code of Professional Conduct, providing additional explanations on the many topics in the Code, and should be read in conjunction with the Code.

All medical practitioners on the Medical Register should obtain a copy of the Code of Professional Conduct and all relevant Guidelines published by the Malaysian Medical Council. Newly registered practitioners will receive copies on registration. The Council expects that all registered practitioners will study this Code and Guidelines and direct any enquiries to the Secretary of the Council. Medical practitioners may also wish to consult the Ethics Committees of the Malaysian Medical Association, the Academy of Medicine of Malaysia and other specialist organisations.

PART I

THE MALAYSIAN MEDICAL COUNCIL

1. COMPOSITION AND REGULATORY FUNCTIONS

The Malaysian Medical Council is established as a body corporate with perpetual succession and a common seal, under *Part II.3 of the Medical Act 2000*. The Council shall have 33 members, with the Director General of Health who shall be the President, the Deputy Director General who shall be the Deputy President, and 31 other fully registered medical practitioners as members, made up of 17 elected (15 fully registered medical practitioners resident in Peninsular Malaysia, one (1) fully registered medical practitioner resident in Sabah and one (1) resident in Sarawak), and nine (9) nominated (from among the representatives of recognised local training institutions to be nominated from among the members of the faculty by the governing bodies of the respective recognised local training institutions), three (3) fully registered medical practitioners from the public service to be nominated by the Director General, two (2) fully registered medical practitioners from the private sector to be nominated by the Director General. Such nominated members shall be appointed by the Minister.

The Council has the powers to regulate the standards of practice, to register qualified medical practitioners, to regulate the conduct of registered medical practitioners and to investigate into complaints relating to the practice and conduct of medical practitioners and impose disciplinary punishments when necessary, to recognise training institutions offering training of medical practitioners, approve training institutions for the purpose of training of provisionally registered medical practitioners, recognise training institutions offering specialist training, issue certificates and badges, and to control and administer funds, amongst other powers and functions.

The Council has the power to establish a Disciplinary Panel, members of which shall be appointed by the Council and from which Panel members of the Preliminary Investigating Committees and Disciplinary Boards shall be drawn. The Preliminary Investigating Committee shall investigate into a complaint received about a registered medical practitioner, or from information received, and shall submit the report to the President who shall, if the Preliminary Investigating Committee finds that there are sufficient grounds for disciplinary proceedings to be taken against the registered medical practitioner, constitute a Disciplinary Board which shall then conduct the inquiry and make the order of disciplinary punishment.

2. POWERS OF THE MALAYSIAN MEDICAL COUNCIL

2.1. DISCIPLINARY JURISDICTION OF THE COUNCIL

Disciplinary jurisdiction over all registered medical practitioners is conferred upon the Malaysian Medical Council by *Part IV Section 29 of the Medical Act, 2009*, which reads as follows:

29. (1) *The Council may exercise disciplinary jurisdiction over all registered medical practitioners duly registered under this Act.*
- (2) *The Council may exercise disciplinary jurisdiction over any registered medical practitioner who-----*
- (a) *has been convicted in Malaysia or elsewhere of any offence punishable with imprisonment, (whether in itself only or in addition to, or in lieu of a fine);*
 - (aa) *has had his qualification withdrawn or cancelled by the authority through which it was acquired or by which it was awarded;*
 - (b) *has been guilty of serious professional misconduct as stipulated in the Code of Professional Conduct and any other guidelines and directives issued by the Council;*
 - (c) *has obtained registration by fraud or misrepresentation;*
 - (d) *was not at the time of his registration entitled to be registered;*
 - (f) *has since been removed from a Register of medical practitioners maintained in any place outside Malaysia.*

In exercising its powers of jurisdiction, the Council may order any registered medical practitioner to appear before its Preliminary Investigation Committee or Disciplinary Board of the Council. Failure to comply with such order without valid reason is tantamount to contempt and the Council may impose disciplinary punishment on the practitioner as it deems appropriate.

2.2. DISCIPLINARY PUNISHMENTS

30. (1) *The Council may, in the exercise of its disciplinary jurisdiction, impose any of the following punishments:*
- (a) *reprimand the practitioner;*
 - (b) *order such medical practitioner's registration be subjected to conditions which may include but are not limited to one or more of the following –*
 - (i) *that the medical practitioner seek medical treatment;*
 - (ii) *direct that such conditions, relating to the medical practitioner's practice of medicine, as it considers appropriate, be imposed on the medical practitioner's registration;*
 - (iii) *order that the medical practitioner undergo educational courses or programmes as may be specified by the Council; or*

- (iv) order that the medical practitioner report on his medical practice to such medical practitioner or persons as may be specified by the Council;
 - (c) order the name of such registered person to be suspended from the Register for such period as it may think fit;
 - (d) make such order as aforesaid in paragraph (c) but suspend the application, thereof, subject to such conditions as the Council may think fit, for a period or periods in the aggregate, not exceeding two years; or
 - (e) order the name of such medical practitioner to be struck off from the register.
- (2) The Council may also impose a fine as may be decided by the Council in addition to the above mentioned punishments.
- (3) The Council may, if it considers fit, suspend the practice of a registered medical practitioner for a period to be determined by the Council pending completion of an investigation, inquiry or disposal of any appeal. No medical practitioner shall practise as a medical practitioner during the period of suspension, and any person who contravenes this order shall be guilty of an offence.
- (4) Where upon due inquiry into any complaint or information referred to it, a Disciplinary Board is satisfied that it is necessary for the protection of the members of the public or is otherwise in the public interest, or is in the interest of a registered medical practitioner, the Council may order for his registration to be suspended for such period not exceeding 12 months. No medical practitioner shall practise as a medical practitioner during the period of interim suspension, and any person who contravenes this order shall be guilty of an offence.

3. THE MEANING OF ‘SERIOUS PROFESSIONAL MISCONDUCT’

The phrase ‘infamous conduct in a professional respect’ was classically defined by Lord Esher¹: “If it be shown that a medical man, in the pursuit of his profession, has done something with respect to which he would be *reasonably regarded* as disgraceful or dishonourable by his professional brethren of good repute and competency, then it is open to the General Medical Council to say that he has been guilty of ‘infamous conduct in a professional respect.’ “

“The question is not merely whether what a medical man has done would be an infamous thing for any one else to do, but whether it is infamous for a medical man to do. There may be some acts which, although they would not be infamous in any other person yet they are done by a medical man in relation to his profession, that is, with regards either his patients or to his professional brethren, may be fairly considered ‘infamous in a professional respect.’”

The term ‘*reasonably regarded*’ was defined by the Privy Council in 1988 as “if the doctor’s conduct falls short, either by act or omission, of the standard of conduct expected among doctors.” The practitioner has so behaved in a professional capacity that the established acts under scrutiny would be reasonably regarded by his colleagues as constituting professional misconduct.²

“Infamous conduct in a professional respect means no more than serious misconduct judged according to the rules, written and unwritten, governing the profession.”

and that the General Medical Council’s jurisdiction extended to serious misconduct.

Lord Justice Scrutton [1930],³ stated:

The preferred term ‘**serious professional misconduct**’ refers to any act in the above context and is to be construed as, and including, any act considered as ‘infamous conduct in a professional respect’ as defined above.

¹ Lord Esher MR in *Allison v General Medical Council* [1894] 1AB 750:

² Jefferies J in *Ongley v The Medical Council of New Zealand* (1984) 4 NZAR 369

³ Lord Justice Scrutton in *R v General Medical Council of Medical Education and Registration of the United Kingdom* (1930) 1KB 562 at 569

Further, the term ‘infamous conduct’ has itself become outdated, and its previous place in the English Medical Act 1956 has been replaced in later Acts by the more contemporary term ‘serious professional misconduct’.⁴

4. CONVICTIONS IN A COURT OF LAW

In considering convictions the Council is bound to accept the determination of any court of law as conclusive evidence that the practitioner was guilty of the offence of which he was convicted. Practitioners who face a criminal charge should remember this if they are advised to plead guilty, or not to appeal against a conviction merely to avoid publicity or a severe sentence. It is not open to a practitioner who has been convicted of an offence to argue before the Preliminary Investigation Committee or Disciplinary Board of the Malaysian Medical Council that he was in fact innocent. It is therefore unwise for a practitioner to plead guilty in a court of law to a charge to which he believes that he has a defence.

5. PRACTITIONER IN LITIGATION AND INQUIRY

A practitioner is expected to co-operate fully with any formal inquiry but may exercise the legal right not to provide evidence which may lead to criminal proceedings being taken against the practitioner.

In the event of any impending litigation or ethical proceedings against the practitioner initiated by the patient or agent(s) of the patient, the practitioner should obtain appropriate legal advice. In such circumstances, the practitioner may have to disclose contents of patient’s records to the legal firm in the course of seeking advice, and consent from the patient or the next of kin for such disclosure is not a requirement.

6. MEDICAL TESTIMONY IN COURT

The medical practitioner may be required to appear in court in response to allegations of medical negligence, to provide testimony or to provide expert opinion. The practitioner, in all these instances, is expected to provide factual, unbiased and honest information and opinion to help the courts arrive at a sound and just decision. Practitioners appearing as expert witnesses should not have any prior direct involvement or vested interest in the particular case or patient.

PART II – FORMS OF SERIOUS PROFESSIONAL MISCONDUCT

This part of the Code mentions aspects of serious professional misconduct which have in the past led to disciplinary proceedings or which in the opinion of the Council could give rise to such proceedings. It is not a complete code of professional conduct and does not specify all criminal offences or forms of professional misconduct which may lead to disciplinary action. To do this would be impossible, since, from time to time with changing circumstances, the Council’s attention is drawn to new forms of professional misconduct.

Any abuse by a practitioner of any of the privileges accorded upon registration, or any grave dereliction of professional duty or ethical conduct, may give rise to a charge of serious professional misconduct. In discharging their respective duties, the Preliminary Investigating Committee and the Disciplinary Board of the Malaysian Medical Council must proceed as judicial bodies. Only after considering the evidence in each case can the Disciplinary Board decide whether a practitioner’s behaviour amounts to serious professional misconduct or determine the gravity of a conviction.

In the following paragraphs, areas of professional conduct and personal behaviour, the breach of which may be considered serious professional misconduct, are considered in groups under four main headings:

1. Professional Responsibilities.
2. Professional Privileges and Skills.
3. Preservation of the Dignity and Reputation of the Medical Profession.
4. Advertising, information and related professional matters

1. PROFESSIONAL RESPONSIBILITIES

⁴ Yong Pung How J in *Wong Kok Chin v Singapore Society of Accountants*. High Court (Singapore) District Court Appeal No.3 of 1988, MLJ 27 Apr 1990.

1.1 Responsibility for Standards of Medical Care to Patients

- 1.1.1 The public is entitled to expect that a registered medical practitioner will provide and maintain a good standard of medical care. This includes:
 - (a) conscientious assessment of the history, symptoms and signs of a patient's condition;
 - (b) thorough professional attention, examination and where necessary, diagnostic investigations;
 - (c) competent, considerate and appropriate professional management;
 - (d) prompt action upon evidence suggesting the existence of a condition requiring urgent medical intervention;
 - (e) readiness, where the circumstances so warrant, to consult appropriate professional colleagues who can contribute to care.
- 1.1.2 In an emergency, the practitioner should act without delay to preserve the continued health and life of a patient, keeping in mind the principle that the preservation of life is the paramount concern of the medical practitioner. The practitioner, towards this end, should ensure facilities and equipment in the place of practice adequate to provide such care.
- 1.1.3 A comparable standard of practice is to be expected from medical practitioners whose contributions to a patient's care are indirect, for example those in laboratory and radiological specialties, who may not be directly involved in the treatment or management of the patient.
- 1.1.4 Apart from the practitioner's personal responsibility to the patients, a practitioner who undertakes to manage, or to direct, or to perform clinical work for organisations offering medical services, or for healthcare facilities, should satisfy himself that those healthcare organisations provide adequate and acceptable standards of clinical and therapeutic facilities for the services offered.
- 1.1.5 A question of serious professional misconduct may also arise from a complaint or information about the conduct of a practitioner, which suggests that the welfare of the patient has been endangered by the practitioner persisting in independent practice of a branch of medicine which is not evidence based and without the appropriate knowledge and skills.
- 1.1.6 In pursuance of its primary duty to protect the public, the Council may institute disciplinary proceedings when a practitioner appears to have seriously disregarded or neglected professional duties to patients.
- 1.1.7 The Council is not ordinarily concerned with errors in diagnosis or treatment, or with the kind of matters which give rise to action in the civil courts for negligence, unless the practitioner's conduct in the case has involved such a disregard of professional responsibility to the practitioner's patient or such a neglect of professional duties as to raise a question of serious professional misconduct.

1.2 Consent for Medical Examination and Treatment

Good communication between the practitioner and patient is essential for consent for treatment. Patients should be given adequate information in a way they can understand and sufficient time to enable them to make decisions about their medical care. It is a general rule that a practitioner shall examine and treat patients only with their consent.

When a patient registers at a clinic and enters the consultation room voluntarily, it is may be taken to mean that consent has been given for all events subsequent to that action, in what is often referred to as "implied consent". The patient may, however, not be aware of this type of submission. It is imperative that the practitioner informs the patient and obtains consent for procedures like intimate physical examination, invasive procedures, taking specimens for examination, and special diagnostic procedures. The same principles apply in biomedical research.

No consent is valid if obtained under the following conditions:

- a. when there is coercion or threat or force;
- b. when the party giving consent is not aware of the full implications of consent; and

- c. when the patient is incompetent and therefore cannot give a valid consent, then consent should be obtained from the next of kin.

In a grave situation where consent cannot be obtained at all, and in matters of life and death, the decision is within the discretion of the individual practitioner, having regard to the practitioner's duty as the protector of the life and health of the patient. Under such circumstances consultation with a colleague is desirable.

Medical practitioners are required by law to obtain consent from patients for giving anaesthesia (general and regional) and for transfusing blood and blood products.

In all instances of consent taking, the practitioner who is performing the procedure must personally take the consent from the patient or next of kin. It is preferable for a witness to sign the consent form along with the patient and the practitioner.

With the development of various sub-specialties and particular risks inherent in such highly specialised procedures, the consent taken by the practitioner may have to include such special risks for the practitioner's own defence in the event of alleged negligence.

1.3 Confidentiality⁵:

Patients have the right to expect that there will not be disclosure of any personal information, which is learnt during the course of a practitioner's professional duties. A practitioner may release confidential information in strict accordance with the patient's consent, or the consent of a person properly authorized to act on the patient's behalf. When such permission is granted the practitioner should only disclose such relevant confidential information for a specific purpose.

A registered medical practitioner is responsible for confidential information obtained from a patient. The practitioner must ensure that the information is effectively protected against improper disclosure when it is disposed of, stored, transmitted or received.

When patients give consent for disclosure of information about themselves, the practitioner must ensure that they understand what will be disclosed, the reasons for disclosure and the likely consequences.

The practitioner must respect requests by patients that information should not be disclosed to third parties, except in exceptional circumstances (for example, where health or safety of others would otherwise be at serious risk).

In the event that a practitioner decides to disclose confidential information, without consent, the practitioner must be prepared to explain and justify such decision. Any breach of confidentiality will be considered serious professional misconduct.

1.4 The Practitioner and Requests for Consultation

- 1.4.1 A medical practitioner should arrange consultation with a colleague whenever the patient or the patient's next of kin desire it, provided the best interests of the patient are so served. It is always better to suggest a second opinion in all doubtful, difficult or anxious cases.

It should be remembered that a practitioner suffers no loss of dignity or prestige in referring a patient to a colleague whose opinion could contribute to the better care of the patient.

- 1.4.2 The attending, or primary, practitioner may nominate the consulting practitioner and should advise accordingly, but should not refuse to refer to a registered medical practitioner selected by the patient or next of kin.

⁵ Confidentiality. MMC Guideline 2001.

- 1.4.3 The arrangements for consultation should be made or initiated by the attending practitioner. The attending practitioner should acquaint the patient of the approximate expenses which may be involved in specialist consultations and examinations.
- 1.4.4 It is the duty of the consulting practitioner to avoid any word or action which might disturb the confidence of the patient in the attending practitioner. Similarly, the attending practitioner should carefully avoid any remark or suggestion which may seem to disparage the skill or judgement of the consulting practitioner.
- 1.4.5 The practitioner consulted shall not attempt to secure for the practitioner the care of the patient seen in consultation. At the end of consultation or further management where mutually agreed upon specifically between the referring, or primary, practitioner and the consulting practitioner, the patient should be returned to the referring practitioner with a report including results of investigations and advice on further care of the patient.
- 1.4.6 The consulting practitioner is normally obliged to consult the referring practitioner before other consultants are called in.
- 1.4.7 The medical practitioner's communication with patients in the course of management refers to verbal and non-verbal communication, including gestures, facial expression, voice intonation, etc. It also includes modes of communication, through the telephone, e-mail or short message service (sms) messaging. The importance of communication in a friendly and convivial but not patronizing atmosphere cannot be over-emphasised.

1.5 New Clinical Procedures or Interventions

- 1.5.1 New clinical services, procedures or other interventions are "clinical services, procedures or other interventions that are being introduced into a health care facility for the first time and depend for some or all of their provision on the professional input of registered medical practitioners.
- 1.5.2 They may be clinical services, procedures or other interventions which:
- (i) have been established in other organisational settings and are deemed by a responsible body of professional opinion to be ones that will benefit patients; or
 - (ii) are experimental, and therefore subject to review by a properly constituted Research Ethics Committee. They do not include new pharmacological products."

1.5.3 The safety of new clinical services, procedures or other interventions, and their potential to improve patient outcomes, are overriding considerations in determining whether to approve their introduction. In addition, cost, risks and cost-benefit have to be considered⁶.

1.5.4 A practitioner may wish to introduce a procedure or treatment modality in an area of modern medicine which is not current accepted practice. Under these circumstances, the practitioner is required to obtain the permission of the relevant authority or professional body, including the ethical committee in the institution where the patient is to be subjected to the new procedure or modality, and to obtain valid consent from the patient after having explained to the patient the nature of the new procedure or treatment and the likely outcome, including risks.

⁶ Credentialling: Competency and Practice to Establish Monitoring Mechanism for Highly Specialised Procedures. MMC Guideline 12 Feb 2008

1.5.5 Patients have access to a great variety of medically related information on the internet and in publications, particularly on new clinical procedures and interventions. The practitioner has a duty to advise patients on the reliability and relevance of these to their own health problems.

1.6 The Practitioner and the Practice

Partners. Assistants and Locum Tenentes

There is an ethical obligation on a practitioner not to damage the practice of a colleague who has been in professional association lately, or to take advantage of previous professional relationship.

The practitioner after discontinuing with a colleague's professional association and working relationship in a clinic, and choosing to set up independent practice, should ensure that there are no conflicting issues in setting up such practice, should not remove patient records from the colleague's clinic and should not entice or canvass for patients treated in the previous clinic, even if treated by the practitioner, to transfer to the practitioner's new clinic.

1.6 Chaperone

Respect for the patient must be manifested at all times. Additionally, during the physical examination, it is essential that every effort is made to ensure that the patient is comfortable and is not embarrassed.

In a physical examination of a patient, it is advisable for the medical practitioner to have a chaperone present. At times, the patient may request that no chaperone be present, in which case the practitioner should request the chaperone to be close by in case assistance is needed and the patient's request should be documented.

In every consultation the medical practitioner must keep in mind the possibility of misunderstandings that may lead to a complaint. Given that the practitioner has to deal with individuals of many different temperaments and personalities, who may be under stress or emotionally disturbed, the presence of a chaperone provides the practitioner with an environment to conduct a clear, unhampered clinical examination of the patient and at the same time helps the patient to be relaxed and comfortable.

1.7 Delegation of Medical Duties

1.7.1 Employment of Unqualified or Unregistered Persons

The employment by a registered practitioner in the practitioner's professional practice, of persons not qualified or registered under the Medical Act, and the permitting of such unqualified or unregistered person to attend, treat or perform operations upon patients in respect of matters requiring professional discretion or skill, is in its nature fraudulent and dangerous to the public. Any registered practitioner who so employs an unqualified or unregistered person has committed serious professional misconduct.

1.7.2 Covering for Unqualified or Unregistered Person

It is serious professional misconduct for any registered practitioner who by the practitioner's presence, countenance, advice, assistance, or cooperation, knowingly enables an unqualified or unregistered person, whether described as an assistant or otherwise, to attend, treat, or perform operation upon a patient in respect of any matter requiring professional discretion or skill, to issue or procure the issue of any certificate, notification, report, or other document of a kindred character, or otherwise to engage in professional practice as if the said person were duly qualified and registered.

1.7.3 Association with Unqualified or Unregistered Person

It is serious professional misconduct for any registered medical practitioner who, either by administering anaesthetics or otherwise, assists an unqualified or unregistered person to attend, treat, or perform an operation upon any other person in respect of matters requiring professional discretion or skill.

The foregoing part of this paragraph does not purport to restrict the proper training and instruction of medical students, or the legitimate employment of midwives, medical assistants, nurses, dispensers, and skilled mechanical or technical assistants, under the immediate personal supervision of, or accountability by, a registered medical practitioner.

1.8 Medical Research⁷

In the scientific application of medical research carried out on a human being, conforming to ethically-permitted bio-medical research, it is the duty of the practitioner to remain the protector of the life and health of that person on whom such research is being carried out. It is also the practitioner's responsibility as a researcher to ensure that patients benefit from the findings of the research.

- 1.8.1. In any research on human beings, each potential subject must be adequately informed of the aims, methods, anticipated benefits and potential hazards of the study and the discomfort it may entail. The potential subject should be informed that he or she is free to withdraw his or her consent to participation at any time. The practitioner should obtain the subject's freely-given informed consent, preferably in writing. At all times, the practitioner must ensure that the risk to the subject is justified.
- 1.8.2. The practitioner may combine medical research with properly designed professional care, the objective being the acquisition of new medical knowledge, only to the extent that medical research is justified by its potential diagnostic or therapeutic value *and care* for the patient.
- 1.8.3. A medical practitioner shall use great caution in divulging discoveries or new techniques or treatment through non-professional channels.
- 1.8.4. The results of any research on human subjects should not be suppressed whether adverse or favourable.

1.9. The Practitioner and the Pharmaceutical/Medical Equipment Industry⁸

The medical profession, the pharmaceutical industry and the medical equipment industry have common interests in the research and development of new drugs of therapeutic value and the development of new equipment or appliance for the management of the patient.

- 1.9.1 It is unethical for an individual practitioner to accept from a commercial entity monetary gifts or loans or expensive items of equipment for personal use, or sponsored private travels or holidays.
- 1.9.2 A prescribing practitioner should not only choose but also be seen to be choosing the drug or appliance which, in the practitioner's independent professional judgement, having due regard to cost, will best serve the medical interests of the patient. A practitioner should therefore avoid accepting pecuniary or material inducement which might compromise, or be regarded by others as likely to compromise, their integrity, or conflict with their obligations to patients in the independent exercise of professional judgement in prescribing or treatment.
- 1.9.3 No objection can, however, be taken to grants of money or equipment by firms to institutions such as hospitals, healthcare centres and university departments, when they are donated specifically for purposes of research or patient care.
- 1.9.4 A medical practitioner should be unbiased and objective in expression with regard to choice of products and avoid promoting a particular product in the literature and

⁷ Malaysian Guidelines for Good Clinical Practice MOH (1999) and Clinical Trials and Biomedical Research. MMC Guideline 009/2006

⁸ Relationship between Doctors and Pharmaceutical Industry MMC Guidelines 007/2006

brochures, although the practitioner may have personal preferences based on experience and clinical situation.

- 1.9.5 The association of a practitioner with any commercial enterprise engaged in the manufacture or sale of any substance, which is claimed to be of value in the prevention or treatment of disease but which is unproven or of an undisclosed nature or composition, may be considered as serious professional misconduct.
- 1.9.6 A medical practitioner may design instruments or equipment which the practitioner may wish to make available to other practitioners. The best method of placing an instrument in the market is to sell interests outright to a manufacturer. The periodic collection of royalties or other modes of reimbursement, though not improper, may raise questions of vested interest promotion of the product by the practitioner. There is no objection to the inventor's name being associated with or attached to the instrument if so desired.
- 1.9.7 A medical practitioner agreeing to attend commercially sponsored medical conferences must ensure that the main purpose of the conference must be to exchange professional or scientific information; hospitality during the conference should be secondary to the professional exchange of information; the name of the commercial entity providing financial support should be publicly disclosed; and the presentation of material by the practitioner must be scientifically accurate, giving a balanced review of possible diagnosis and treatment options, and not be influenced by the sponsoring organization. A practitioner should scrupulously avoid endorsement of a particular brand of drugs or products in this presentation.

1.10 The Practitioner and Managed Care Organisation/Third Party Payer

- 1.10.1 The medical practitioner must ensure that in association with any managed care organisation or third party payer, professional practice must not violate the codes of professional conduct. In any contractual agreement with such organisation, the practitioner must ensure that there is no conflict of interest in the provision of care for the patient, must not enter into any financial arrangement that includes incentives or disincentives that impact on patient care, must not be forced to practice below professional standards or beyond the practitioner's clinical capability, and must not provide information to such organisation about the patient's illness without the patient's explicit consent.
- 1.10.2 In any contractual agreement with such an organisation, the practitioner must ensure that doctor-patient relationship and patient confidentiality are not compromised, that information on treatment options are not withheld from the patient, and that the patient receives management and procedures that will materially benefit the patient, and that in all matters, the patient's interest should receive paramount consideration.

1.11 The Practitioner and Telemedicine

Telemedicine refers to health care delivery in which medical practitioners examine and manage patients in distant locations through the use of telecommunications and information technology. The ever expanding vista of technology continues to create immense possibilities and opportunities for critical discussion amongst healthcare workers across landmasses in real time. The decisions thus reached affect the lives of people since patients and their illnesses are involved.

Such far reaching implications in the health care sector have to be protected by medical ethical considerations, doctor-patient confidentiality and the patient's right to safeguard privacy. Practitioners involved in telemedicine practice have to be conscious of the clinical and professional responsibility in their consultation, examination and management of their patients, and must adhere to the Code and related Guidelines.

1.12 The Practitioner and the Practice of Unconventional (Traditional/Complementary) Medicine

A medical practitioner should not practice traditional or complementary medicine or prescribe health supplements or traditional medications. However, such medication approved and based on clinical evidence, and accepted into mainstream medical practice, may be considered favourably.

1.13 Aesthetic Medical Practice⁹

- 1.13.1 Aesthetic Medicine is defined as an area of multidisciplinary medical practice carried out by registered medical (and dental) practitioners to provide treatment which is evidence-based, with the objective of addressing the aesthetic desires of clients (patients).
- 1.13.2 Aesthetic Medicine is not a spin-off of traditional or complementary medicine, and is recognised to be scientific in its approach and practice. Such practice may be through non-invasive and minimally invasive modalities.
- 1.13.3 A registered medical practitioner may employ non-medical, unregistered persons (like beauticians, cosmetic therapists and others) to assist in his practice, but should not be associated with such persons as business or professional partners or equal practitioners or provide cover of any description or nature for the independent aesthetic practice of such unregistered persons. The registered medical practitioner shall be held liable for all untoward occurrences or events that may become the subject of a complaint.
- 1.13.4 The sign boards of a healthcare facility in which a registered medical practitioner practises aesthetic medicine, shall not carry the words 'aesthetic medicine practitioner' in that or in any other connotative form implying the practice of aesthetic medicine.
- 1.13.5 However, the availability of aesthetic medicine in the scope of services provided by a medical practitioner may be carried in any announcements or information about clinics or healthcare facilities in the print or electronic media as permitted by existing instructions and directives.

1.14 Stem Cell Research and Therapy

Although there are many controversies surrounding stem cell research, it is important for local scientists and clinicians to be involved in stem cell research provided that these conform to ethical guidelines. It is vital for medical practitioners to keep abreast of current advances in science, especially when there is an enormous potential of revolutionising therapy in the form of cell replacement therapy. Steps are continuously being taken to readdress essential issues in stem cell research and consider the evolution of emerging therapies.

Stem cell research is important to the future of medicine because with adequate research, stem cells have the potential to treat degenerative conditions by transplanting human stem cells into patients. However, many of the current therapy relating to stem cell are considered experimental and belonging to the realm of scientific research. Until such time stem cell therapy is accepted on evidence-base, medical practitioners must strictly adhere to existing guidelines. Any infringement by medical practitioners may lead to disciplinary procedures.

1.15 Professional Fees

- 1.15.1 A medical practitioner is allowed to recover reasonable charges for professional care, advice and visits and the value of any medicine or any medical or surgical appliances rendered, made or supplied to the patient. If the practitioner chooses to, or does not

⁹ Guideline on Aesthetic Medical Practice MMC 18 Jan 2008

choose to, adhere to any specific fee schedules, such information must be made known to the patient before commencing treatment and management. To avoid misunderstanding, it is best to give an estimate of the professional charges to the patient and obtain acquiescence before commencing treatment.

- 1.15.2 A medical practitioner is allowed to recover reasonable charges for medical reports on patients, expert opinion and attendance in courts and to provide medical testimony.
- 1.15.3 It is unethical for a practitioner to demand a percentage of the costs or damages to be awarded or to make the fees contingent upon the outcome of a matter in which the practitioner appears as an expert.
- 1.15.4 Unreasonable or exorbitant professional fees may be considered a matter for the Council to investigate if there are elements of exploitation or behaviour prejudicial to good medical practice, amounting to serious professional misconduct.

1.16 End of Life Care

- 1.16.1 A medical practitioner has a heavy responsibility in managing patients with terminal illness as technological developments continually extend the range of treatment options available to prolong life even when organ or system failure would have naturally resulted in death.
- 1.16.2 Factors to be taken into consideration in initiating life support are the best interest of the patient, prevention and treatment of needless suffering, distress and pain.
- 1.16.3 At the end of life, there is a duty to ensure comfort and basic nursing care for the patient and the practitioner must ensure at all times that the patient has a peaceful and dignified death.
- 1.16.4 Euthanasia and assisted suicide of patients are prohibited by law and no medical practitioner may carry out or help or assist in any way.

1.17 Brain Death¹⁰

The question of brain death only arises when a patient is on life support. On a diagnosis of brain death, the patient is certified dead, and the patient is removed from life support systems.

The certification of brain death is to be done only by registered medical practitioners experienced in the diagnosis of brain death using strict guidelines.

Practitioners involved in organ transplantation are not allowed to certify brain death.

2. PROFESSIONAL PRIVILEGES AND SKILLS

2.1 Privileges Conferred by Law

2.1.1 Prescribing of Drugs

The prescription of controlled drugs is restricted by law to members of the medical profession and certain other professions, and the prescribing of such drugs is subject to statutory restrictions.

The prescription, or supply of drugs including drugs of dependence, otherwise than in the course of legitimate medical treatment, is considered serious professional misconduct. Disciplinary proceedings may also be taken against practitioners convicted of offences

¹⁰ Guideline on Brain Death MMC 008/2006

against the laws which control drugs where such offences appear to have been committed in order to gratify the practitioner's own addiction or the addiction of other persons.

2.1.2 Dangerous Drugs

The contravention by a registered medical practitioner of the provisions of the Dangerous Drugs Ordinance and the Regulations made under it may be the subject of criminal proceedings, and any conviction resulting therefrom may be dealt with as such by the Council in exercise of their powers under the Medical Act, 1971. Any contravention of the Ordinance or Regulations, involving an abuse of the privileges conferred upon registered practitioners, whether such contravention has been the subject of criminal proceedings or not, is serious professional misconduct.

2.1.3 Sale of Poisons

The employment by any registered practitioner, who has legal responsibility for scheduled poisons or preparations containing scheduled poisons that are sold to the public, of assistants who are left in charge but are not legally qualified to sell scheduled poisons to the public, poses a danger to the public. Such an act is considered a serious professional misconduct.

2.1.4 Records, Reports, Notifications and Certificates

Medical records of patients contain patient's personal particulars, details of illness, diagnosis and management generated by the medical practitioner and results of investigations. The practitioner should record findings and management accurately and precisely and avoid adverse or demeaning or derogatory remarks about the patient or any colleague, nursing or ancillary staff. Patient records in any media should not be tampered with, erased, or blacked out; when corrections are made these should be indicated clearly and signed and dated by the practitioner. Failure to adhere to these practices may raise questions of credibility of the practitioner and may be considered serious professional misconduct.

Copies of medical records may be requested by patients or their appointed or authorised agents with consent by the patient. The release of such records, or parts of the records containing results of investigations, by the medical practitioner is to be encouraged. In cases where there is refusal by the practitioner (or the healthcare facility where he is working) to release medical records for various reasons, the matter has to be dealt with through court order.

A registered medical practitioner is in certain instances bound by law to give, or may from time to time be called upon or requested to give, particulars, notifications, reports, copies of medical records and other documents of a similar character, signed by him in his professional capacity, for subsequent use either in the courts or for administrative purposes. The practitioner is expected to provide such reports and copies of records within specified periods. It may be considered serious professional misconduct for a practitioner to refuse, or delay without acceptable reasons, to provide medical reports.

All requests for medical reports must be accompanied by written consent for release of information given by the patient or the next of kin.

Any registered practitioner who has signed or given under his name and authority any medical document, which is untrue, misleading or improper, shall be charged with serious professional misconduct.

2.1.5 Medical (Sick) Certificates

Medical practitioners are expected to follow certain principles when certifying fitness or unfitness for work for patients in employment based on their

illness and inability to perform their duties at the workplace. As a rule, medical leave should only be granted for such periods consistent with the anticipated incapacity of an employee, and to be unfit to discharge the normal duties of his workplace or deemed serious enough to warrant recuperation. The patient may be reviewed at the end of such period before being granted further medical leave, whether for acute or chronic illnesses.

Generally, medical leave should not be granted to exceed sixty (60) days at one time for chronic or long-standing illnesses even though the treatment may often extend into many months. This also includes patients with prolonged disablement.

In cases of an illness from which a patient is not expected to recover sufficiently to be able to return to work or to be gainfully employed, or when a patient has permanent disabilities, or when medical leave has been granted continuously for long periods, but with periodic review, medical practitioners are required to cooperate with a medical board to determine a patient's fitness to work.

Backdating of medical leave is to be avoided unless there are special circumstances which the practitioner is fully aware of, and the reason for backdating should be clearly stated in the medical certificate.

A medical practitioner allowing or endorsing the granting of medical leave by persons other than the practitioner, or granting medical leave without documented evidence of having examined the patient, may raise a question of serious professional misconduct.

Practitioners are expected to exercise the most scrupulous care in issuing all such documents, especially in relation to any statement that a patient has been examined on a particular date.

2.1.6 Induced Termination of Pregnancy

Induced non-therapeutic termination of pregnancy, is serious professional misconduct, and is also an offence under the Penal Code.

Therapeutic termination of pregnancy is ethically and legally permissible to preserve the life and health of the mother.

2.2 PRIVILEGE CONFERRED BY CUSTOM

2.2.1 Abuse of Trust

Patients grant practitioners privileged access to their homes and confidence and some patients are liable to become emotionally dependent upon the practitioner. Good medical practice depends upon the maintenance of trust between practitioners and patients and their families, and the understanding by both that proper professional relationships will be strictly observed. In this situation practitioners must exercise great care and discretion in order not to damage this crucial relationship. Any action by a practitioner which breaches this trust may raise a question of serious professional misconduct.

2.2.2 Abuse of Confidence

A practitioner may not improperly disclose information that is obtained in confidence from or about a patient.

2.2.3 Undue Influence

A practitioner may not abuse relationship with patients and may not exert improper influence upon patients to obtain favours and gifts or to alter the patient's will in the practitioner's favour or to benefit someone else.

2.2.4 Personal Relationship between Practitioners and Patients

A practitioner may not enter into an emotional or sexual relationship with a patient.

2.2.5 Establishing Professional Relationship with Patients

A practitioner has a responsibility to provide care to a patient whether in an emergency or otherwise. It is unethical to deny treatment to a patient with an infectious disease, and the practitioner is expected to take normal precautions to prevent contacting or spreading diseases.

A practitioner may choose not to establish professional relationship with a new patient if for whatever personal reasons the practitioner may not be able to provide satisfactory care, unless in an emergency. The practitioner may convey this decision to the patient and suggest alternative sources of care.

2.2.6 Termination of Professional Relationship

In circumstances when a practitioner for whatever reason decides to terminate the professional management of a patient, the practitioner must clearly indicate the intentions to the patient, or the patient's family, and take the necessary steps to transfer the management to a colleague and to facilitate continuity of care.

When a patient decides to terminate the services of a practitioner, the practitioner must accept the decision without acrimony and provide assistance and records to facilitate transfer of care to the practitioner of the patient's choice.

3. PRESERVATION OF DIGNITY AND REPUTATION OF THE PROFESSION

The medical practitioner is expected at all times to observe proper standards of personal behaviour in keeping with the dignity of the profession.

3.1 Respects for Human Dignity and Life^{11,12}

The utmost respect for human life should be maintained even under threat, and no use should be made of any medical knowledge contrary to the laws of humanity.

The practitioner shall not countenance, condone or participate in the practice of torture or other forms of cruel, inhuman or degrading procedures, whatever the offence of which the victim of such procedure is suspected, accused or guilty, and whatever the victim's beliefs or motives, and in all situations, including armed conflict and civil strife.

The practitioner shall not provide any premises, instruments, substances or knowledge to facilitate the practice of torture or other forms of cruel, inhuman or degrading treatment or to diminish the ability of the victim to resist such treatment.

3.2 Personal Behaviour

The public reputation of the medical profession requires that every medical practitioner should observe proper standards of personal behaviour, not only in professional activities. The conviction of a practitioner for a criminal offence may lead to disciplinary proceedings even if the offence is not directly connected with the practitioner's profession.

¹¹ Ethical Implications of Doctors in Conflict Situations. MMC Guideline 005/2006

¹² Declaration of Tokyo, 1975

A practitioner who treats patients or performs other professional duties while under the influence of alcohol or drugs, or who is unable to perform professional duties because of being under the influence of alcohol or drugs, has committed acts of serious professional misconduct.

Drunkenness or other offences arising from misuse of alcohol (such as driving a motor vehicle when under the influence of drink) or drug abuse, indicates habits discreditable to the profession and may be a source of danger to the practitioner's patients. Convictions for drug abuse and drunkenness are considered serious professional misconduct.

3.2.1 Dishonesty: Improper Financial Transactions

A practitioner is liable to disciplinary proceedings if convicted of criminal deception (obtaining money or goods by false pretences), forgery, fraud, theft or any other offence involving dishonesty.

The Council considers as serious professional misconduct acts committed in the course of a practitioner's professional practice or against patients or colleagues. Among the circumstances that may have this result are the improper demands of fees from patients or their family.

The Council also takes a serious view of the prescribing of drugs or appliance for improper motives. A practitioner's motivation may be regarded as improper if the practitioner has prescribed a drug or appliance for personal financial benefit or if the practitioner has prescribed a product manufactured or marketed by an organisation that offers an improper inducement.

3.2.3 Fee-Splitting

Fee-splitting or any arrangement or inducement to refer a patient to another practitioner, institution, or organisation, or individual is considered serious professional misconduct. The premise for referral must be quality of care and the specific needs of the patient.

However, fee sharing between practitioners assisting, or acting for, the other, is permissible. In all such arrangements, the practitioners must be directly involved in the professional management of the patient.

3.2.4 Abusive or Violent Behaviour

Any abusive and improper behaviour by a practitioner towards a patient, colleagues or staff in the course of the practitioner's professional duties is unacceptable and would be considered serious professional misconduct.

A conviction for assault or indecency would render a practitioner liable to disciplinary proceedings, and would be regarded with particular gravity if the offence was committed in the course of a practitioner's professional duties or against patients, staff or colleagues.

3.3 Incompetence to Practice

Medical practitioners with inability to perform their professional duties at a competent level, thereby endangering their patients, have an ethical obligation to inform their superiors about their problems.

Where a practitioner becomes aware of a colleague's incompetence to practice, whether by reason of taking drugs or by physical or mental incapacity, whereby patient safety or standards are observed to be compromised, it is serious professional misconduct to remain silent. It is the ethical responsibility of the practitioner to draw this to the attention of a senior colleague who is in a position to act appropriately, or to those in authority so that a formal inquiry may be carried out.

3.4 Incident Reporting and Clinical Risk Management

At all times in the delivery of care to patients, the practitioner is strongly expected to exercise utmost diligence and be aware of possible risks in the course of such care.

Practitioners who make mistakes, inadvertently or negligently, in the course of their professional care, with adverse or unwanted outcome, must avoid concealing them from the patient or those in authority. Incidents of this nature must be recorded in the patient records/notes. It would be unethical for the practitioner not to be truthful in such an event. The primary objective of incident reporting is to avoid future such incidents in the interest of patient care.

3.5 The Practitioner and Commercial Undertakings

The practitioner is the trustee for the patient and accordingly must avoid any situation in which there is a conflict of interest with the patient.

A general ethical principle is that a practitioner should not associate with commerce in such a way as to let it influence, or appear to influence, treatment of patients.

The association of a practitioner with any commercial enterprise engaged in manufacture or sale of any substance which is claimed to be of value in the prevention or treatment of disease, but is unproven or of an undisclosed nature or composition, will be considered serious professional misconduct.

A practitioner has a duty to declare an interest before participating in discussions which could lead to the purchase by an institution of goods or services in which the practitioner, or a member of the practitioner's immediate family, has a direct or indirect pecuniary interest. Non-disclosure of such information may, under certain circumstances, amount to serious professional misconduct.

Where the practitioner has a financial interest in any facility to which patients are referred for diagnostic tests, for procedures or for inpatient care, it is ethically necessary for the practitioner to disclose to the patient the practitioner's interest in the facility.

4. ADVERTISING, INFORMATION AND RELATED PROFESSIONAL MATTERS ¹³

The medical profession has long accepted the convention that medical practitioners should refrain from self-advertisement. In the Council's opinion self-advertisement is not only incompatible with the principles which should govern relations between members of a profession but could be a source of danger to the public. A practitioner successful at achieving publicity may not be the most appropriate doctor for a patient to consult. Patients who are suffering from a serious illness are extremely vulnerable and advertising may raise illusory hopes of cure.

4.1 Advertising and Information

4.1.1 **Advertising**, whether directly or indirectly, for the purpose of obtaining patients, or promoting the practitioner's own professional advantage, or to gain advantage over market competition, or, for any such purpose, of procuring or sanctioning, or acquiescing in, the publication of notices commending or directing attention to the practitioner's professional skill, knowledge, services, or qualifications, or deprecating those of others, or of being associated with, or employed by, those who procure or sanction such advertising or publication, and canvassing, or employing any agent, or tout, or canvasser, for the purpose of obtaining patients, in any manner, channel or media; or of sanctioning, or of being associated with or employed by those who sanction, or being a party to, abetting or condoning such employment e.g. by private hospitals, clinics and other medical institutions, are in the opinion of the Council, contrary to the public interest and discreditable to the profession of Medicine. Any registered medical practitioner who resorts to any such practice may be considered to have committed serious professional misconduct.

¹³ Dissemination of Information by the Medical Practitioners MMC Guideline 001/2006

- 4.1.2 **Providing Information** in relation to the medical profession, is the act by which a healthcare provider disseminates factual information to the public generally on health promotion and specifically on diseases, their prevention, control and treatment, and on any other aspects related to these modalities, without the medical practitioner contravening the ethical codes of professional conduct, or without any designs to obtaining patients, profiting financially or, appearing directly or indirectly, to promoting his own professional advantage or product, or appearing to be for these purposes.
- 4.1.3 The Council recognises that the profession has a duty to disseminate information about advances in medical sciences and therapeutics provided it is done in an ethical manner. Exceptions are when the information is of a confidential nature, or when it may be conceived to cause public panic or to affect national security.
- 4.1.4 A medical practitioners should not claim to be the best or the only one in a particular field of practice or specialty. There are really no effective methods of determining whether a practitioner can claim to be so. Claims of ‘firsts’ or ‘breakthroughs’, although of considerable public interest, are also contentious. These types of announcements should not be made by the practitioner involved. It is best left to the academic and professional bodies and officers so authorised to verify such claims and make appropriate public announcements
- 4.1.5 A practitioner should avoid discussions in the lay press on controversial points of medical science, or any new procedures and treatment. Such matters are more appropriate to medical journals and for discussion in professional societies.
- 4.1.6 A practitioner providing medical information in any media, including the electronic media, should adhere strictly to established codes of conduct. Frequent appearances by the same practitioner on the media, is discouraged as these raise the suspicion that the practitioner is seeking publicity for personal benefit.

4.2 The Practitioner and Health Tourism

Practitioners working in healthcare facilities which are accredited to participate in health tourism, which may necessitate the canvassing for patients in foreign countries, may, under special circumstances, and after approval from regulatory bodies in the Ministry of Health, will be allowed to provide information in brochures regarding their qualifications, experience and expertise in special procedures. Such brochures should only be distributed in foreign countries.

Practitioners in such practice are still subject to the Medical Act, the Code of Professional Conduct and other related and relevant regulations when managing foreign patients in Malaysia.

4.3 Announcement in the Lay Press Regarding Practice

An announcement by the Malaysian Medical Association (MMA), or any other recognized and approved professional association, on the commencement or change of address of practice is permissible as a service to the community.

4.4 Articles, Contributions and Books for the Lay Public

- 4.4.1 It is permissible for the practitioner’s name to be published in articles, contributions and books for the lay public. The name can be followed by a brief description of qualifications and primary place of practice. These should not be unduly emphasised by large or heavy type.
- 4.4.2 There must not be any laudatory editorial references to the practitioner’s professional status or experience.

4.4.3 Where the publication has arisen as a result of research on any instrument or drug provided by a commercial firm, this should be stated and a disclaimer regarding any financial interest of the author(s) with the firm be inserted.

4.4.4 Photograph of the practitioner in connection with articles or contributions in the media are allowed. Photographs and testimonials of patients are not allowed.

4.5 Lectures to Lay Public

4.5.1 A practitioner who proposes to deliver a lecture should request the chairman beforehand to be circumspect in any introductory remarks concerning his professional status or achievements.

4.5.2 Publicity about the lecture can be in any media to inform the public of the name and appointment of the practitioner as well as the venue, date and time of the lecture. The place of practice of the practitioner should not be published.

4.6 Lectures to Colleagues

4.6.1 A medical practitioner may be in a position to educate colleagues, or present some new method of treatment or innovation. Such talks must be organised only through professional bodies or hospitals and not through pharmaceutical or equipment firms. The practitioner must exercise caution when promoting a particular drug or product and should declare to the audience the practitioner's interest in the drug or product.

4.6.2 Information about such talks may be circulated through the professional bodies or hospitals only.

4.6.3 The practitioner must caution against any media reporting any unproven modalities of management or treatment such that it appears that the practitioner advocates such treatment to the public.

4.7 Press Interviews

4.7.1 Medical practitioners engaged in active medical or surgical practice should avoid giving interviews expounding their personal opinions on diseases and their treatment to reporters of the print, electronic or airwave media, except through an Association, an authorised organisation or institution. *(Amended at MMC Meeting on 10/5/2005)*

4.7.2 The medical practitioner in charge of the authorised organisation assumes full responsibility for any practitioner giving the interview and acting under its auspices.

4.8 Professional Calling Cards, Letterheads and Rubber Stamps

A practitioner may carry calling cards but should not distribute calling cards with the purpose of soliciting for patients.

The calling cards/letterheads should only contain the name of the practitioner, registrable and accredited professional qualifications, designation, state and national awards, home, practice as well as e-mail address, telephone and facsimile numbers. Logos may be printed as long as they are appropriate for a medical practitioner. A recent photograph of the practitioner (passport size) may be allowed only on the calling card. Medical etiquette demands that medical practitioners be circumspect about their qualifications, awards and honours. It is permissible to list all registered and accredited qualifications acquired by examinations or following an appropriate period of supervised training. Practitioners must not print awards and honours awarded by bodies other than the national and state governments.

A medical practitioner may claim to practice as a specialist in two closely related specialties, but this information must be available on only the one and the same calling card.

4.9 Signboards

A signboard should serve to provide guidance and information about a clinic. It should not be viewed as a means of soliciting for patients. The use of a large signboard to indicate a medical practice is considered unethical in many parts of the world. However as the custom is already prevalent in Malaysia and as a signboard does help patients to find a doctor, it is recommended that their use should continue, provided:

- 4.9.1 There shall not be more than two signboards on the premises of the clinic to indicate the identity of the practice.
- 4.9.2 Signboards may be illuminated in a style that is appropriate for a medical practice.
- 4.9.3 The total size of the signboard or signboards, if there are two shall not exceed 3.0 sq. meters.
- 4.9.4 Where signs are painted on walls, the perimeter of the lettering shall not enclose an area in excess of those specified above.
- 4.9.5 When the practice is within a commercial complex, there is no objection to the clinic name appearing in the general directory signboard in the lobby.
- 4.9.6 The use of the Red Crescent/Red Cross emblems on any private medical premise is not allowed.

4.10 Directional Signboards

The use of directional signboard/s, with the word "Clinic" and an arrow pointing in the direction of the clinic leading from the main road, is permissible. The name of the clinic must not appear in such a directional signboard, which should be within 1 km on the main road before turning to the clinic. Only two such directional signboards are allowed, one each from each direction on the main road.

4.11 Name Plates/Doorplates

The name plates and door plates displayed outside a practice should be plain and not exceed 1,000 sq cm. They may bear the practitioner's name, his registrable qualifications, and titles, if any. The consultation hours should be indicated on the same name plate. If there is more than one practitioner working in the same clinic, separate name plates will be permitted for each practitioner and the above rules will also apply. Visiting practitioners may have a name plate. Only those practitioners working in the clinic are allowed name plates.

4.12 24 Hour Clinic

Notification of the availability of 24-hour professional service should be on the door plate pertaining to consultation hours. A registered medical practitioner should be available at all times in the 24-Hour Clinic. In the event that an emergency arises that requires the practitioner to be called away, the practitioner should instruct the clinic nurse to do the following: (1) to inform patients turning up that the practitioner is away on emergency duty and is not available, (2) not to accept any new patients until the practitioner is back in the clinic, and (3) arrange for the patient to go to the nearest clinic for treatment where there is any degree of urgency.

4.13 Banners:

A temporary banner to announce the opening of a new healthcare facility may be allowed for the purpose of public information. The size should conform to that allowed for a signboard. It should not be displayed for a period longer than one (1) calendar month prior to the date of opening. The banner is only permitted to be displayed at the entrance to the premise. It should only contain the date of the opening and the name of the clinic or hospital. Any other information is unethical.

Members of the Review Panel:

Dato' Dr. Abdul Hamid Abdul Kadir (chairman)
Dr. M K Rajakumar (Family Practice/Acad Family Phy) (late)
Prof Dr. Looi Lai Meng (Pathologist/MCO Ethics)
Dato Dr. Mahmud Mohd Nor (Surgeon/PIC MMC)
Dato Dr. Zaki Morad Mohd Zaher (Nephrologist/MOH)
Dato Dr. K Kulaveerasingam (Radiologist/APHM)
Dato Dr. K Inbasegaran (Anaesthetist/Acad Medicine) (late)
Dr. Ravindran Jegasothy (O&G/MMA Ethics Comm)

Secretariat:

Dr. Wan Mazlan bin Mohamed Woojdy (MMC Secretary)
Mr. C. Perumal (MMC Legal officer)

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