MALAYSIAN MEDICAL COUNCIL

Memo to Medical Practitioners

DRAFT OF CODE OF PROFESSIONAL CONDUCT 2019

1. Attached is the penultimate draft (Version 8A) of the revised Code of Professional Conduct (2019), with the main content of the Code.

2. Procedure to be adopted:

    a. The draft is circulated to members of the MMC and to all registered medical practitioners for perusal and comments.
    b. The draft is uploaded to the MMC Website so that it can be accessed by all registered medical practitioners individually and all professional bodies.
    c. Comments, as well as any proposals for any further topics to be added are welcome and will be considered by the MMC Committee to Review CPC.
    d. The closing date for any comments is **31 January 2019**. Responses may be submitted through **email and/or hard copy** to MMC for attention of the Committee.
    e. The Committee will review and consider all comments and responses received by the closing date.
    f. The draft will be submitted to the Legal Advisor to Council for comments.
    g. The final draft will then be presented to MMC for formal approval and adoption by **19 February 2019**.

3. Notes to Version 8A are attached as annexure to this memo, detailing the steps taken and the changes and additions to the 1987 CPC.

4. It is strongly advised that the draft be read in conjunction with, and in reference to, the 1987 CPC so that the changes proposed are understood and appreciated.

5. The following sections (not in Version 8A) will be incorporated into the FINAL copy of the 2019 CPC:
   a. Foreword by the Yang di Pertua, Majlis Perubatan Malaysia (MMC).
   b. Table of Contents.
   c. Disciplinary Procedures as per Medical (Amendment) Act 2012, Medical Regulations 2017, and Standing Orders for Disciplinary Procedures 2018 in **Part III of the Code.**
   d. Explanatory Notes on Terminology used.
   e. List of References.
   f. (Index)

6. This penultimate draft has been prepared by a current MMC Committee comprising Dato Dr Abdul Hamid Abdul Kadir (Chairman), with members Dr Fadzilah bt Hassan, Prof Lim Thiam Aun, Dato Zaki Morad bin Mohhd Zaher, Prof Zabidi Azhar bin Hussin, Prof Zaleha Abdullah Mahdy, Prof Dato Yang Faridah bt Abdul Aziz, and assisted by Secretariat Dr Arulalan Tan Sri Kumaran and Puan Nabila Hasmin Ahmad.

Dato Dr Abdul Hamid Abdul Kadir
Chairman, Committee to Review Code of Professional Conduct
15 December 2018

NOTES TO THE CODE OF PROFESSIONAL CONDUCT DRAFT VERSION 8A

1. This penultimate Draft Version 8A has been prepared with necessary revisions of various sections of the CPC 1987, consonant with experiences accrued by Council during the past 30 years since the previous Code.
2. This draft should be read in conjunction with, and reference to, the CPC 1987 to appreciate the changes/amendments proposed.
3. Various sections have been expanded for easier appreciation and understanding by medical practitioners, with the aim of making the Code as comprehensive as possible.
4. Other changes within the text are indicated in red.

5. The following sections have been expanded:

Part I Powers of the Malaysian Medical Council

Pages 1-2: Meaning of Serious Professional Misconduct (which replaces "infamous conduct in a professional respect").

Part II 1. **Neglect or Disregard of Professional Responsibilities**

Page 6: 1.2 Practitioner and Request for Consultation (expanded)

1.3 Practitioner and his Practice (expanded)

Page 9: 1.4 Practitioner and the Pharmaceutical/Medical Equipment Industry (expanded)

Page13: 2.1.4 Certificates, Notifications, Reports, etc.

6. The following new sections have been added:

Part II: 1. Neglect or Disregard of Professional Responsibilities

Page 8: 1.4 Partnership with Unqualified or Unregistered Persons

Page 10: 1.7 The Practitioner and Third-Party Administrators

1.8 The Practitioner and the Practice of Traditional & Complementary Medicine

1.9 Professional Fees

Page 11: 1.10 Expert Testimony in Court

1.11 End of Life Professional Management

Part II: 2. Abuse of Professional Privileges and Skills

Page 13: 2.1.4.2 Medical Sick Certificates

2.1.4.5 Patients Medical Records and Clinical Notes

2.1.4.6 Denial of Disclosure of Medical Records

Page 14: 2.1.5 Medical Reports

Page 15: 2.2.5 Practitioner's Fitness to Practice

2.2.6 Medical Errors and Incident Reporting

Page 16: 2.2.7 Chaperone

Part II: 3. Conduct Derogatory to the Reputation of the Medical Profession

Page 18: 3.2.3 Fee Splitting and Kick-Back Arrangements

3.2.4. Indecency and Violence

Page 19: 3.5 Plagiarism

Part II: 4. Advertising, Canvassing and Related Professional Offences

Pages 19 to 24: Section 4.1 Advertising and Canvassing.

Subsection 4.1.1 has been broken down into sub-subsections so that the charges in inquiries can be more specifically stated according to the alleged circumstances.

Decisions on various related matters have been either amended or re-written.
New sections

Page 23: 4.11 Banners and 4.12 Billboards or Hoardings

Appendices

Page 24: Appendix I: The Declaration of Geneva 2017

Page 25: Appendix II: Professional Calling Cards, Letterheads, Rubber Stamp

III. Signboards

Page 26: IV. Name Plates and Doorplates

Page27: V. 24-Hour Clinics

Part III: Disciplinary Procedures

Pages 28-42: The Disciplinary procedures as legislated in the Medical (Amendment) Act 2012 and Medical Regulations 2017.

The Standing Orders for the disciplinary procedures have been approved by Council.

==========

Draft CPC 2019 Version 8A

PART 1

POWERS OF THE MALAYSIAN MEDICAL COUNCIL

DISCIPLINARY JURISDICTION OF THE COUNCIL

Disciplinary jurisdiction over registered medical practitioners is conferred upon the Malaysian Medical Council by Section 29 of the Medical (Amendment) Act 2012 which reads as follows:

1. The Council shall have disciplinary jurisdiction over all persons registered under this Act.

2. The Council may exercise disciplinary jurisdiction over any registered person 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 awarding authority through which it was acquired or by which it was awarded;

b. has been guilty of infamous conduct in any professional respect;

c. has obtained registration by fraud or misrepresentation;

d. was not at the time of his registration entitled to be registered; or

e. has since been removed from the register of medical practitioners maintained in any place outside Malaysia.

THE MEANING OF SERIOUS PROFESSIONAL MISCONDUCT

The phrase 'infamous conduct in a professional respect' was defined by Justice Lopes L.J in 1894: "If it is shewn 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.' "

Lord Esher M.R., during the same a judgment, adopted the definition as propounded by Justice Lopes, and further observed: "The question is, not merely whether what a medical man has done would be an infamous thing for anyone else to do, but whether it is infamous for a medical man to do it….. There may be some acts which, although they would not be infamous in any other person, yet if they are done by a medical man in relation to his profession, that is, with regard either to his patients or to his professional brethren, may be fairly considered 'infamous conduct in a professional respect."

In another judgment, delivered in 1930 Lord Justice Scrutton stated: "Infamous conduct in a professional respect means no more than **serious misconduct** judged according to the rules, written and unwritten, governing the profession."

In a judgment of the Lords of the Judicial Committee of the Privy Council delivered on 24th March 1999, adopted the term **"serious professional misconduct"**

"Serious professional misconduct is a successor of "infamous conduct in a professional respect", but it was not suggested any real difference of meaning is intended by the change of words.

Serious professional misconduct may arise where the conduct is quite removed from the practice of medicine, but is of a sufficiently immoral or outrageous or disgraceful character.

Pursuant to the above, the Malaysian Medical Council attests to the principle that **'serious professional misconduct'** means a failure to meet the minimum standards of professional medical practice set by the Council in the *Code of Professional Conduct, guidelines and directives*. Degrees of concurrent acts of moral turpitude, dishonesty, or incompetence may determine the severity of punishment.

References:

Lord Esher MR in Allison v General Medical Council [1894] 1AB 750:
Jefferies J in Ongley v The Medical Council of New Zealand (1984) 4 NZAR 369
Lord Justice Scrutton in R v General Medical Council of Medical Education and Registration of the United Kingdom (1930) 1KB 562 at 569

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 during inquiry before the Disciplinary Board 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. In all such instances, the advice of a legal counsel should be sought.

PART II

FORMS OF SERIOUS PROFESSIONAL MISCONDUCT

This part mentions certain kinds of criminal offences and 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 does not pretend to be a complete code of professional ethics, or to specify all criminal offences or forms of professional misconduct which may lead to disciplinary action. To do this would be impossible, because 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 and opportunities afforded to him or any grave dereliction of professional duty or serious breach of medical ethics may give rise to a charge of serious professional misconduct. In discharging their respective duties, the Preliminary Investigation Committee and the Malaysian Medical Council must proceed as judicial bodies. Only after considering the evidence in each case can this committee of Council determine the gravity of a conviction or decide whether a practitioner's behaviour amounts to serious professional misconduct.

In the following paragraphs areas of professional conduct and personal behaviour which need to be considered have been grouped under four main headings.

1. Neglect or disregard of professional responsibilities.
2. Abuse of professional privileges and skills.
3. Conduct derogatory to the reputation of the medical profession.
4. Advertising, canvassing and related professional offences.

1. NEGLECT OR DISREGARD OF PROFESSIONAL RESPONSIBILITIES

1.1. Responsibility for Standards of Medical Care to Patients

In pursuance of its primary duty to protect the public, the Council may institute disciplinary proceedings when a practitioner appears seriously to have disregarded or neglected his professional duties to his patients.

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. sufficiently thorough professional attention, examination and where necessary, diagnostic investigation;

c. competent, compassionate, considerate, timely and appropriate professional management;

d. appropriate and prompt action upon evidence suggesting the existence of condition requiring urgent medical intervention; and

e. readiness, where the circumstances so warrant, to consult, or refer the patient to appropriate professional colleagues.

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 pathology and radiological specialties.

Apart from a practitioner's personal responsibility to his patients, practitioners who undertake to manage, or to direct or to perform clinical work for organisations offering private medical services should satisfy themselves that those organisations provide adequate clinical and therapeutic facilities for the services offered.

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 his standard of care and/or **duty of care (which is a lack of attention, caution and prudence that a reasonable person in the circumstances would apply)** to his patients or such a neglect of his professional duties as to raise a question of serious professional misconduct.

A question of serious professional misconduct may also arise from a complaint or information about the conduct of a practitioner which suggests that he has endangered the welfare of the patient by persisting in independent practice of a branch of medicine in which he does not have the appropriate knowledge and skill and has not acquired the experience which is necessary.

1.2. The Practitioner and Requests for Consultation

1.2.1. In conformity with his own sense of responsibility, a medical practitioner whether in primary care practice or hospital practice, 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 or 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 and expertise could contribute to the better care of the patient.

1.2.2. The primary or attending practitioner, who is the practitioner first seeing the patient referred to him by a primary care practitioner or from the out-patient or emergency department of the healthcare facility, may nominate the practitioner to be consulted through referral, called the **referred consultant,** and should advise the patient accordingly, but he should not refuse to refer to a registered medical practitioner selected by the patient or next of kin.

1.2.3. The arrangements for referral for consultation should be made or initiated by the primary attending practitioner. He should acquaint his patient of the approximate expenses which may be involved in specialist consultation and examination. A referral letter and relevant results of laboratory, imaging and any special investigations, shall be made available by the primary attending practitioner to the referred consultant.

1.2.4. It is the duty of the **referred consultant** to avoid any word or action which might affect the confidence of the patient in the primary attending practitioner. Similarly, the primary attending practitioner should carefully avoid any remark or suggestion which would seem to disparage the skill or judgment of the referred **consultant.**

1.2.5. The **referred consultant** shall not attempt to secure for himself the care of the patient seen for consultation. At the end of consultation or further management where mutually agreed upon specifically between the primary attending practitioner and the referred **consultant**, the patient must be returned to the primary attending practitioner with a report including results of investigations and advice on further care of the patient.

1.2.6. The referred consultant is normally obliged when circumstances permit, to consult the primary attending practitioner before other consultants are called in.

1.2.7 In instances when the patient requests the **referred consultant** to take over further management, the primary attending practitioner should accept this request and choice by the patient amicably in the interest of the patient.

1.3. The Practitioner and his Practice

Partners, Assistants and Locum Tenentes.

There is an ethical obligation on a practitioner not to damage the practice of a colleague **or employer** with whom he has been in professional association lately. This would include the practitioner setting up own practice close to the previous clinic, procuring medical records of patients previously treated by him, inducing such patients to transfer to his new clinic, or any other similar actions which may be deemed unethical.

In employing locum Tenentes, the practitioner must ensure that the person is fully registered with the Medical Council and has a valid Annual Practising Certificate.

1.4. Improper Delegation of Medical Duties

1.4.1. Employment of Unqualified or Unregistered Persons.

The employment by a registered practitioner in his professional practice, of persons not qualified or registered under the Medical (Amendment) Act 2012, 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, or providing certificates of any kind, is in the opinion of the Council in its nature fraudulent and dangerous to the public. Any registered practitioner who shall be proved to the satisfaction of the Council to have so employed an unqualified or unregistered person will be liable to disciplinary punishment.

1.4.2. Covering.

Any registered practitioner who by his 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, will be liable, on proof of the facts to the satisfaction of the Council, to disciplinary punishment. At all times, the practitioner should access the website of the Malaysian Medical Council Medical Register to confirm the status of persons before employing.

1.4.3. <u>Association with Unqualified or Unregistered Persons.</u>

Any registered medical practitioner who, either by administering anaesthetics or otherwise, assists an unqualified or unregistered person to attend, treat, or perform any invasive procedure upon any other person in respect of matters requiring professional discretion or skill, will be liable on proof of the facts to the satisfaction of the Council to disciplinary punishments.

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

1.4.4. Partnership with Unqualified or Unregistered Persons

Any registered practitioner who shall be proved to the satisfaction of the Council to have formed a professional partnership with an unqualified or unregistered person, or is employed professionally by such unqualified or unregistered person, will be liable on proof of the facts satisfactory to Council, to disciplinary punishment.

1.5. Medical Research

In the scientific application of medical research carried out on a human being, it is the duty of the practitioner to remain the protector of the life and health of that person on whom biomedical research is being carried out.

1.5.1 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. He or she should be informed that he or she is at liberty to abstain from participation at any time. The practitioner should then obtain the subject's freely-given informed consent, preferably in writing.

1.5.2. The practitioner can combine medical research with 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 for the patient.

1.5.3. A medical practitioner shall use great caution in divulging discoveries or new techniques or treatment through non-professional channels.

1.5.4. The results of any research on human subjects should not be suppressed whether adverse or favourable.

1.5.5 In any research the approval of the institutional ethics committee or the Medical Research and Ethics Committee (MREC) of the Ministry of Health should be obtained prior to commencing the research.

Nuremberg Code 1947

1.6. The Practitioner and the Pharmaceutical / Medical Equipment Industry

The medical profession and the pharmaceutical industry have common interests in the research and development of new drugs of therapeutic value.

1.6.1. A prescribing practitioner should not only choose but also be seen to be choosing the drug or appliance which, in his independent professional judgment, and having due regard to economy, will best serve the medical interests of his patient. Practitioners should therefore avoid accepting any pecuniary or material inducement which might compromise, or be regarded by others as likely to compromise, the independent exercise of their professional judgment in prescribing matters.

1.6.2. It is improper for an individual practitioner to accept from a pharmaceutical firm monetary gifts or loans or expensive items of equipment for his personal use. However, the payment made by such firm for professional work or consultation on contract by an independent medical practitioner is permitted.

1.6.3. No objection can, however, be taken to grants of money or equipment by firms to institutions such as hospitals, health care centres and university departments, when they are donated specifically for purposes of research or patient care.

1.6.4. A practitioner may design instruments, equipment or related product to be used in healthcare for the diagnosis, prevention, monitoring or treatment of illness or handicap. Such product must be approved and registered with the Medical Devices Authority of Ministry of Health as required by the Medical Devices Act 2012 (Act 737) before being made available for use by healthcare providers, including the practitioner himself.

1.6.5 A practitioner may receive personal travel grants and hospitality from pharmaceutical or medical instrument/equipment companies for conferences or educational meetings, for purposes of educational and personal professional advancement, provided that such funding should not be more than what he would be spending if he went on his own expenses.

Medical Devices Act 2012, *www.mdbgov.my*

Australian Medical Association, Code of Ethics, 1980.
Code of Conduct of the Pharmaceutical Association of Malaysia in s.11 “Symposia, Congresses and other means of verbal communication” ss11.2 “Sponsorship.”

1.7. The Practitioner and Third-Party Administrators (TPA)

1.7.1 The practitioner must ensure that in his association with any third-party administrator or payer (TPA/TPP), insurance firm, or managed care organisation (MCO), his professional practice shall not violate the Codes of Professional Conduct and MMC Guidelines. The practitioner shall ensure that there is no conflict of interest in the provision of care for his patient, and any form of incentives, limitations, control or contractual restrictions which may impact or influence the standard or duty of care of the patient must be avoided. At all times, patient-doctor confidentiality must be preserved, and specific consent must be obtained from the patient before release of information on illness, investigation results and management to employer or to third party.

1.8. The Practitioner and the Practice of Traditional Complementary Medicine

The practitioner should not prescribe or promote traditional health supplements or traditional medications unless such products are evidence based.

Managed Care Organisations. MMC Position Paper 2017
Sale of Drugs Act 1952 section 2
Control of Drugs and Cosmetics Regulations 1984 section 2,7 and 9

1.9. Professional Fees

The practitioner may, to avoid any conflict with patient on the professional fees charged by him after treatment, or for any medical reports, provide the patient with information on such matters and the basis for the charges before such treatment is commenced or report provided.

The improper or unreasonable demand or acceptance of professional fees from patients contrary to the statutory provisions which regulate the conduct of the health care services of the Government of Malaysia, which

may be the substance of a complaint to the Council, may result in disciplinary proceedings.

1.10 Expert Testimony in Court

A practitioner may be requested/required to provide expert opinion in court, and such opinion shall be unbiased and honest and bereft of conflict of interest.

It is unethical for a practitioner to demand a percentage of the costs or damages awarded by the court and to make the attendance fees contingent upon the outcome of a matter in which he appears as an expert.

Any breach of any of these matters may, upon being proved to the satisfaction of the Council, be subject to disciplinary punishment.

1.11 End of Life Professional Management

A practitioner's primary responsibility in the care and treatment of any patient is to take measures in the best interest of the patient. Any decision to prolong life through life support or other measures or to terminate such support by a practitioner must be made in the practitioner's best professional judgment, in consultation with colleagues and the next of kin.

Euthanasia and assisted suicide by patients are prohibited by law and any practitioner proven to have participated in these will be subject to disciplinary punishment.

2. ABUSE OF PROFESSIONAL PRIVILEGES AND SKILLS

2.1 Abuse of Privileges Conferred by Law

2.1.1. Prescribing of Drugs

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

The Council regards as serious professional misconduct the prescription or supply of drugs including drugs of dependence otherwise than in the course of

bona fide treatment. Disciplinary proceedings may - be taken against practitioners convicted of offences 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 practitioner of the provisions of the Dangerous Drugs Act 1952 and the Regulations made thereunder 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 (Amendment) Act 2012. But any contravention of the Act or Regulations, involving an abuse of the privileges conferred thereunder upon registered practitioners, whether such contravention has been the subject of criminal proceedings or not, will if proved to the satisfaction of the Council, render a registered practitioner to disciplinary punishment.

2.1.3. Sale of Poisons

The employment for his own profit and under cover of his own qualifications, by any registered practitioner who keeps a medical hall, open shop, or other place in which scheduled poisons or preparations containing scheduled poisons are sold to the public, of assistants who are left in charge but are not legally qualified to sell scheduled poisons to the public, is in the opinion of the Council a practice professionally discreditable and fraught with danger to the public, and any registered practitioner who is proved to the satisfaction of the Council to have so offended will be liable to disciplinary punishment.

2.1.4. Certificates, Notifications, Reports, etc.

2.1.4.1. Registered practitioners are in certain cases bound by law to give, or may from time to time be called upon or requested to give particulars, notifications, reports and other documents of a kindred character, signed by them in their professional capacity, for subsequent use either in the Courts or for administrative purposes.

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

2.1.4.2 **Medical sick certificates** are issued by practitioners for guidance on employment by the employer. Council views the issuance of medical sick certificates without proper examination of patients, pre-signing of such certificates, failure to keep proper records in patient's notes, back-dating for unacceptable reasons, or for lengthy durations without interim examination even for chronic illnesses, and such related matters, as serious professional misconduct. The stating of the diagnosis of the illness in the medical sick certificate is permissible only with consent of the patient. Medical sick certificates should be signed by the practitioner and his name and MMC registration numbers stamped, with the date issued, clearly indicated. Backdating of medical sick certificates, which is defined as the issuance of a medical sick certificate on a date **after** the consultation or treatment, are allowed only under special circumstances when the practitioner has treated the patient and is aware of his medical condition.

2.1.4.3 Any registered practitioner who shall be proved to the satisfaction of the Council to have signed or given under his name and authority any such certificate, notification, report or document of a kindred character, which is untrue, misleading or improper, will be liable to disciplinary punishment.

2.1.4.4 The issuance of electronic medical sick certificates can lead to inadequate information on the patient and the practitioner examining the patient for such purpose. Such electronic certificates do not fulfil the requirements for documents issued for the purposes mentioned above.

2.1.4.5 Patient Medical Records and Clinical Notes

A medical record is documented information, whether written or electronic, by a practitioner, on his personal findings on examination and management of a patient's illness in the best of times, and can be demanded by the patient and the courts of law.

Erasure or "blacking out" of entries already made in the records, tampering or altering of entries in the clinical notes, may be interpreted as attempts to cover up management errors or adverse events, and may become a matter for disciplinary inquiry by the Medical Council

2.1.4.6 Denial of Disclosure of Medical Records

A medical practitioner may, besides the absence of written consent from a patient or legal next-of-kin or guardian, deny disclosure of the contents of the

Medical Record, if in his considered opinion, the contents if released may be detrimental or disparaging to the patient, or any other individual, or liable to cause serious harm to the patient's mental or physical health or endanger his life. The practitioner may also deny disclosure particularly if the patient is deceased. In such instances, the practitioner is required to justify his decision to deny disclosure.

2.1.5 Medical Reports

Medical Reports are documents prepared by a medical practitioner on a patient on factual information based on Medical Records.

A medical practitioner may be required to provide comprehensive medical reports when requested by patients or by the legal next of kin, in the case of children or minors, or by the employer with the specific consent by the patient or legal next-of-kin. Any refusal or undue delay in providing such report, or withholding because of payment of hospital charges or professional fees, is unethical and may become the subject of a disciplinary inquiry.

MMC Guideline on Medical Records and Medical Report 002/2006

2.1.6. Induced Non-therapeutic Abortion

The Medical Council regards induced non-therapeutic abortion a serious professional misconduct and if proved to the satisfaction of the Council, a practitioner is liable to disciplinary action. A criminal conviction in Malaysia or elsewhere for the termination of pregnancy in itself affords grounds for disciplinary action.

2.2. Abuse of Privileges Conferred by Custom

2.2.1. Abuse of Trust

Patients grant practitioners privileged access to their homes and confidences and some patients are liable to become emotionally dependent upon the practitioner. Good medical practice depends upon 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 the question of serious professional misconduct.

2.2.2. Abuse of Confidence

A practitioner should not improperly disclose information which he obtained in confidence from or about a patient.

2.2.3. Undue Influence

A practitioner should not exert improper influence upon a patient to lend him money or to obtain gifts or to alter the patient's will in his favour.

2.2.4. Personal Relationships between Practitioners and Patients

A practitioner should not enter into an emotional or sexual relationship, or any act which may be interpreted as sexual harassment with a patient (or with a member of a patient's family) which disrupts that patient's family life or otherwise damages, or causes distress to, the patient or his or her family.

2.2.5 Practitioner's Fitness to Practice

A medical practitioner who knows or suspects that he is unable to perform his professional duties to the best level, thereby endangering patients, has an ethical obligation to inform his senior colleague about his problems, and may voluntarily cease practising.

General Medical Council, Professional Conduct and Discipline: Fitness To Practice, London: GMC, 1985

2.2.6 Medical Errors and Incident Reporting

A medical practitioner who commits errors in the course of care of patients, with adverse or unwanted outcome, must avoid concealing them from the patient or those in authority and must record such events in the patient records/notes. It would be unethical for the practitioner not to be truthful in such an event. Failure to comply which may be the substance of a complaint may be subjected to a disciplinary inquiry.

2.2.7 Chaperone

A medical practitioner shall ensure when consulting or examining a patient of the opposite sex to have the presence of a chaperone with visual and aural contact, within the consultation room or bedside. This is for the protection of the practitioner and the patient, and to ensure that the patient is comfortable and not embarrassed by any appropriate physical examination.

A request by a patient that no chaperone be present must be documented in the medical record or notes and signed by the patient. However, the practitioner should request the chaperone to be in an adjoining area in case assistance is needed.

Any complaint of alleged misconduct by a practitioner in the absence of a chaperone may be subject to disciplinary procedures.

3. CONDUCT DEROGATORY TO THE REPUTATION OF THE MEDICAL 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. Respect for Human Life

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 procedures 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 member should observe proper standards of personal behaviour, not only in his professional activities but at all times. This is the reason why 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.

3.2.1. Personal Misuse or Abuse of Alcohol or Other Drugs

In the opinion of the Council, conviction for drunkenness or other offences (driving a motor car when under the influence of drink) indicate habits which are discreditable to the profession and may be a source of danger to the practitioner's patients. Convictions for drug abuse and drunkenness may lead to an inquiry by the Malaysian Medical Council.

A practitioner who treats patients or performs other professional duties while he is under the influence of alcohol or drugs, or who is unable to perform his professional duties because he is under the influence of alcohol or drugs is liable to disciplinary proceedings.

3.2.2. Dishonesty: Improper Financial Transactions

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

The Council takes a particularly serious view of dishonest acts committed in the course of a practitioner's professional practice or against his patients or colleagues. Such acts, if reported to the Council, may result in disciplinary proceedings.

The Council also takes a serious view of the prescribing or dispensing of drugs or appliance for improper motives. A practitioner's motivation may be regarded as improper if he has prescribed a drug or appliance purely for his financial benefit or if he has prescribed a product manufactured or marketed by an organisation from which he has accepted an improper inducement.

3.2.3 Fee Splitting or Kick-back Arrangement

The Council regards fee-splitting or any form of kick back arrangement as an inducement to refer a patient to another practitioner as unethical. The premise for referral must be quality of care. Violation of this will be considered by the Council as serious professional misconduct.

However, fee sharing where two or more practitioners are in partnership or where one practitioner is assistant to or acting for the other is permissible.

3.2.4. Indecency and Violence

Any 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 his patients or colleagues.

A practitioner shall treat colleagues and staff with due respect at all times and avoid any act, verbal or physical, which may cause harm or injury. Any complaints in this respect to the Medical Council may be the subject of a disciplinary inquiry.

3.3. A Colleague's Incompetence to Practice

Where a practitioner becomes aware of a colleague's incompetence to practice, whether by reason of taking drugs or by physical or mental incapacity, or has a medical condition which may pose a risk to his patient, or repeated acts of poor standard of patient care, then it is the ethical responsibility of the practitioner to draw this to the attention of a higher authority who is in a position to act appropriately.

3.4. 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 himself with commerce in such a way as to let it influence, or appear to influence, his attitude towards the treatment of his patients.

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 is unproven or of an undisclosed nature or composition will be considered as serious professional misconduct

A practitioner has a duty to declare an interest before participating in discussion which could lead to the purchase by a public authority of goods or services in which he, or a member of his 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 he refers patients for diagnostics tests, for procedures or for inpatient care, it is ethically necessary for him to disclose his interest in the institution.

3.5 Plagiarism

Plagiarism is the wrongful appropriation, close imitation or purloining and publication of another author's language, thoughts, ideas or expressions, without authorisation and representation of that author's work as one's own, as by not crediting the original author.

Plagiarism, in whatever degree or form as stated above, or in a related manner, by a registered medical practitioner, has both ethical and legal implications and is considered a serious professional misconduct and may be subjected to disciplinary inquiry.

---

4. ADVERTISING, CANVASSING AND RELATED PROFESSIONAL OFFENCES

The medical profession in this country has long accepted the convention that doctors 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. In extreme cases advertising may raise illusory hopes of a cure.

4.1. Advertising and Canvassing

4.1.1. In the opinion of the Council, a registered medical practitioner contrary to the public interest and discreditable to the profession of medicine, who resorts to any of the following practices renders himself liable, on proof of the facts to the satisfaction of the Council to disciplinary punishment:

4.1.1.1 advertising, whether directly or indirectly, for the purpose of obtaining patients

4.1.1.2 promoting his own professional advantage, or, for any such purpose, of procuring or sanctioning, or acquiescing in, the publication of notices

4.1.1.3 commending or directing attention to the practitioner's professional skill, knowledge, service or qualifications

4.1.1.4 deprecating the skill, knowledge, service or qualifications of others

4.1.1.5 being associated with, or employed by, those who procure or sanction such advertising or publication,

4.1.1.6 canvassing or employing any agent or canvasser, for the purpose of obtaining patients

4.1.1.7 sanctioning or being a party to, abetting or condoning or of being associated with, or employed by those who sanction such employment, e.g. private hospitals, clinics and other medical institutions.

The above, in the opinion of the Council, are contrary to the public interest and discreditable to the profession of Medicine, and any registered medical practitioner who resorts to any such practice renders himself liable, on proof of the facts to the satisfaction of the Council to disciplinary punishment.

4.1.2. 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.

4.2. Announcement in the Lay Press Regarding Practice

4.2.1 An announcement by the Malaysian Medical Association and by any professional body representing a section of the medical community provided such organisation is registered with the Registrar of Societies, Malaysia, on the commencement or change of address of practice is permissible as a service to the community.

4.2.2 Practitioners should avoid discussions in the lay press on controversial points of medical science and treatment. Such matters are more appropriate to medical journals and for discussion in professional societies. Any doubts on this matter should be referred to the medical council for clearance and guidance.

4.3. Articles, Contributions and Books for the Lay Public

4.3.1 It is permissible for the practitioner's name to be published. 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.

4.3.2 There must not be any laudatory editorial references to the practitioner's professional status or experience.

4.3.3 The practitioner should not allow references to identify privately owned institutions with which he is professionally associated.

4.3.4 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.

4.3.5 Photograph of the practitioner in connection with articles or contributions in the media are allowed. *Photographs of patients are not allowed unless with the explicit consent of the patient or his next of kin.*

4.3.6 Certain contributions may not fail to promote the practitioner's professional advantage, and he should shoulder responsibility for any such result and be prepared if challenged to answer for it before a professional tribunal. The publication of books and articles by a named author who poses as an authority on the treatment of a disease may contribute to self-advertisement and thus unethical ab initio. Such material may lead to self-diagnosis by the reader, which is thought to be contrary to public interest, and this point must be stressed in the article.

4.4 Lectures to Lay Public

4.4.1 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.

4.4.2 When a reporter from the media is present, the practitioner must intimate that he does not desire any report of the talk to carry his qualifications, professional status or place of practice.

4.4.3 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.

4.5 Lectures to Colleagues

4.5.1 Medical practitioners may be in a position to educate their 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.

4.5.2 Information about such talks may be circulated through the professional bodies or healthcare facilities.

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

4.6 Press Interviews

4.6.1 Interviews with a newspaper reporter on subjects relating to disease and their treatment should be avoided by a medical practitioner engaged in active medical or surgical practice, except through an Association or an authorised organisation (includes institution). The practitioner should not give the address of his place of practice.

4.6.2 An authorised organisation/institution is defined as any *bona fide* college, society or medical organisation.

4.6.3 The authorised organisation then assumes responsibility for any practitioner acting under its auspices.

4.7. Professional Calling Cards, Letterheads and Rubber Stamps

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

The information permitted on professional calling cards, letterheads and rubber stamps is contained in Appendix II.

4.8. Signboards

A signboard for the purpose of assisting patients to locate a practitioner is permissible provided it conforms to the limits laid down by the Council as contained in Appendix III.

4.9. Name Plates / Doorplates

These should conform with the limits laid down by the Council as contained in Appendix IV.

4.10. 24 Hour Clinics

These should conform with the requirements laid down by the Council as contained in Appendix V.

4.11. Banners

A temporary banner to announce the opening of a new healthcare facility may be allowed for the purpose of public information provided it satisfies any local government requirement. 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.

4.12. Billboard or Hoarding

A **billboard** (also called a **hoarding)** is a large outdoor advertising structure, typically erected on road shoulders or spanning across roads. Billboards carry advertisements about practitioners and healthcare services for attention of vehicle drivers, and are considered dangerous distractions.

Billboards, of any dimension, promoting any healthcare facility or service are not permitted.

==========

Appendices

Appendix I – Declaration of Geneva

Adopted by the 2nd General Assembly of the World Medical Association, Geneva, Switzerland, September 1948, amended by the 22nd World Medical Assembly, Sydney, Australia, August 1968, and the 35th World Medical Assemble, Venice, Italy, October 1983.

Revised and adopted in 2017 as the Declaration of Geneva.

At the time of being admitted as a member of the Medical Profession:

I solemnly pledge myself to consecrate my life to the service of humanity;

I will give to my teachers the respect and gratitude which is their due;

I will practice any profession with conscience and dignity;

The health of my patient will be my first consideration;

I will respect the secrets which are confided in me, even after the patient has died;

I will maintain by all the means in my power, the honor and the noble traditions of the medical profession;

My colleagues will be my brothers;

I will not permit consideration of religion, nationality, race, party politics or social standing to intervene between my duty and my patient;

I will maintain the utmost respect for human life from its beginning even under threat and I will not use my medical knowledge contrary to the laws of humanity;

I make these promises solemnly, freely and upon my honour.

Appendix II – Professional Calling Cards, Letterheads and Rubber Stamps

The calling card, letterheads and rubber stamps shall only contain the name of the practitioner, registrable professional qualifications, **recognised** State and National awards, home address and telephone number(s), practice address(es)

and telephone number(s). Rubber stamps used in Medical Sick Certificates and other similar certificates should also include the MMC Registration Number.

Appendix III – Signboards

The rules and regulations on signboards by the local state authorities, are to be complied with.

The Council stipulates the following limits to signboards for registered practitioners: -

1. There shall not be more than two (2) signboards to indicate the identity of the medical clinic or practice.

2. It / they shall not be floodlit or illuminated.

3. The total combined area of the signboard or signboards (if 2 signboards are used) should **NOT** exceed 2.787 sq. metres (30 sq.ft.) This includes letterings fixed or painted on walls or any other backing where the perimeter enclosing the letterings should not exceed 2.787 sq. metres (30 sq. ft.) in total.

The Council felt that clinics may actually require more than one signboard and agreed that it be restricted to a maximum of two provided the total combined areas of the two signboards do not exceed 2.787 sq. metres

Adopted by Council at its 35th Meeting on 29th July 1985.

A signboard should serve to provide guidance and information about a clinic. It should not be a means for soliciting patients. The use of a large signboard to indicate a medical practice is considered unethical.

There shall not be more than two signboards on the premises of the clinic to indicate the identity of the practice.

Signboards may be illuminated in a style that is appropriate for a medical practice.

The total size of the signboard or signboards, if there are two, shall not exceed 3.0 sq. meters.

Where signs are painted on walls, the perimeter of the lettering shall not enclose an area in excess of those specified above.

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.

The use of the Red Crescent/Red Cross on any private medical premise is a contravention of the Geneva Convention and is illegal.

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 if it conforms to local government regulations. The name of the clinic may appear in such a directional signboard, which should be within 1km on the main roads before approaching the clinic in either direction.

Appendix IV – Names Plates/Doorplates

1. Nameplates should be plain and should not exceed 930.25 sq. cm. (1 sq. ft.) in dimension.

2. The name plates may bear the following:

2.1. the practitioner's name

2.2. his registrable qualifications in small letters

2.3. titles may be included

3. A separate doorplate not exceeding 930.25 sq. cm. (1 sq. ft.) is permitted to indicate his consultation hours.

4. Where it is considered necessary for an assistant to have his own nameplate the normal rules relating to plates continue to apply.

5. Visiting practitioners may have their nameplates, provided the day(s) and hour(s) of practice are stated.

6. Nameplates of practitioners who do not practise in the clinic are not permitted to be exhibited.

Adopted by Council at its 35th Meeting on 29th July 1985.

Appendix V – 24 Hour Clinic

1. No additional signboard permitted.

2. Notification of the availability of 24-hour service should be on the doorplate pertaining to consultation hours or on the existing clinic signboard.

3. Qualified and registered practitioners should be available at all times and his availability should be within a reasonable period of time not exceeding thirty (30) minutes.

4. A practitioner may not operate more than one 24-hour clinic at the same time.

5. In the event that an emergency arises requiring the practitioner to be called away, the clinic should do one of the following:

5.1. not to accept any new patients until the practitioner is back in the clinic; or

5.2. inform intending patients that the practitioner is not available.

Adopted by Council at its 35th Meeting on 29th July 1985.

==========