

MALAYSIAN MEDICAL COUNCIL'S POSITION ON MANAGED CARE

The Medical Act provides that the Malaysian Medical Council ("MMC") shall have disciplinary jurisdiction over all persons registered under this Act. Section 29 (2) of the Act states:

"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);
- 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."

In the exercise of its function under section 29(2) of the Medical Act, the MMC relies upon its Code of Professional Conduct ("Code") and its guidelines which supplement the Code, in particular, "The Duties of a Doctor" which contains "Good Medical Practice" and "Confidentiality". The MMC's Code and its guidelines do not prescribe ideal behaviour, but the minimum standards of conduct expected of a registered medical practitioner.

There are specific provisions in relation to managed care in the Private Health Care Facilities and Services Act 1998. They include, among others:

- (i) "The licensee of a private healthcare facility or service shall ensure that the medical and dental management of patients vests in a registered medical practitioner and a registered dental practitioner respectively." (Section 78a)
- (ii) "where the facility or service is a private hospital, private ambulatory care centre, private hospice or private psychiatric hospital, there is established a Medical Advisory Committee whose members shall be registered medical practitioners representing all medical practitioners practising in the facility or service to advise the Board of Management, the licensee and person in charge on all aspects relating to medical practice." (Section 78b)
- (iii) Interpretation of managed care organization (Section 82)
- (iv) "The licensee of a private healthcare facility or service or the holder of a certificate of registration shall not enter into a contract or make any arrangement with any managed care organization that results in-
 - (a) a change in the powers of the registered medical practitioner or dental practitioner over the medical or dental management of patients as vested in paragraph 78(a), and a change in the powers of the registered medical practitioner or visiting registered medical practitioner over the medical care management of patients as vested in paragraphs 79(a) and 80(a);
 - (b) a change in the role and responsibility of the Medical Advisory Committee, or Medical and Dental Advisory Committee as provided under section 78, the Midwifery Care Advisory Committee as provided under section 79 or the Nursing Advisory Committee as provided under section 80;
 - (c) the contravention of any provisions of this Act and the regulations made under this Act;

- (d) the contravention of the code of ethics of any professional regulatory body of the medical, dental, nursing or midwifery profession or any other healthcare professional regulatory body; or
- (e) the contravention of any other written law.” (Section 83)
- (v) “A licensee or the holder of a certificate of registration having a contract or an arrangement with a managed care organization shall furnish such information relating to such contract or arrangement to the Director General as he may, from time to time, specify.” (Section 84)
- (vi) “A managed care organization or the owner of a managed care organization having a contract or an arrangement with a licensee of a private healthcare facility or service or a holder of a certificate of registration shall furnish such information relating to the organization as may be required by the Director General.” (Section 85)
- (vii) “The Director General shall maintain a Register of managed care organizations having any contract or arrangement with any licensee of a private healthcare facility or service or any holder of a certificate of registration and such Register may contain such particulars as may be determined by the Director General.” (Section 86)

The Thirteenth Schedule of the Regulations (2006) to the Private Healthcare Facilities and Services Act contains the professional fees for procedures carried out in private hospitals and other healthcare facilities. These fees are accepted as the maximum professional fees chargeable. Managed care organisations or third party payers sometimes request for discounts on the professional fees by private arrangement with the private hospitals as an inducement to refer corporate patients. Managed care organisations or third party payers sometimes restrict a patient’s right of choice of a registered medical practitioner or health care facility. The MMC’s position is that both these practices are unethical.

It is apparent from the aforesaid that all registered medical practitioners have legal and ethical duties in relation to managed care. A licensee who is not a registered medical practitioner or a managed care organization has legal duties.

The following excerpts, from the MMC’s Code and its guidelines, are of particular relevance to managed care. However, they are not exclusive and everyone involved in managed care whether they be registered medical practitioners, non-registered medical practitioners or managed care organizations shall have to be conversant with and comply with the provisions in the MMC’s Code and all its guidelines, where relevant.

A. CODE OF PROFESSIONAL CONDUCT

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 and considerate 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 appropriate professional colleagues.

1.2. The Practitioner and Requests for Consultation

1.2.1. In conformity with his own sense of responsibility, 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.

2.1.4. Certificates, Notifications, Reports, etc.

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.

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.

2.2.2. Abuse of Confidence

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

4.1. Advertising and Canvassing

4.1.1. Advertising. whether directly or indirectly, for the purpose of obtaining patients, or promoting his own professional advantage, 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 qualification, or depreciating those of others, or of being associate with, or employed by, those who procure or sanction such advertising or publication, canvassing, or employing any agent or canvasser, for the purpose of obtaining patients; or of sanctioning, or of being associated with or employed by

those who sanction, such employment e.g. 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, 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.

B. GOOD MEDICAL PRACTICE

3.2 Doctor - Patient Confidentiality

Medical confidentiality is a traditional principle and an integral requirement of doctor-patient relationship. Central to this principle is the preservation of the dignity, privacy and integrity of the patient. When a third party seeks medical information, such request should only be entertained on the explicit written consent of the patient or the next-of-kin.

It is well to remember that there is a wide difference between what is interesting to the public (and therefore newsworthy) and what is of public health interest. In any event, the patient's protection is an overriding consideration, and must be weighed carefully before allowing any form of disclosure.

Legal or statutory requirements sometimes override the limits of patient-doctor confidentiality, and the doctor is often required by law to disclose information regarding illness and treatment. The patient should then be made aware of this public duty...

In the final analysis, good medical practice dictates that the doctor must exert all in his powers to preserve patient confidentiality. The information that the doctor has come to possess is, in the first place, through the patient's voluntary revelations and consent to submit to physical examination and diagnostic investigative procedures. It is the patient's belief that such information will be kept private and used solely for his benefit.

3.6 Second Opinion

The request by a patient for a second opinion should be handled with due sensitivity and tact. It is good medical practice to accede to such a request, and the doctor must give full co-operation for the patient to obtain such opinion. He must make available all relevant information and investigation results to the colleague, in good faith without attempting to influence the decision of the colleague.

5. The doctor and the employer

There is an increasing presence and influence of Managed Care Organisations (MCOS) or Healthcare Managements Organisations (HMOs) in the country in recent years. Panel doctor serving corporate bodies have come increasingly under scrutiny and pressure to act as primary care doctors, taking cost controlling risks, or in other words, to act as gate-keepers, on a prepaid fee system. This requires that the doctor operate according to schedules and manuals drawn MCOs or HMOs.

It is good medical practice for the doctor to remember his primary professional responsibility to patients when operating under such stringent financial constraints and controlled patient care, which may be imposed by MCOs or HMOs. It is important to preserve good relationship and confidentiality in whatever adverse practice environment, and to remember at all times that doctors exist because there are patients who need individual care, and the doctor's primary concern is for their health and welfare.

The doctor should not feel pressurised and yield to unfair administrative actions by employers, particularly when employees are to be terminated from service, or penalised, for treatable illness with no permanent or long-term disabilities. In such circumstances, the doctor, in the interests of the patient, should seek independent opinion from colleagues to support his findings and views if he finds himself compromised, and being used as a tool by employers to enforce their own unfair, unilateral decisions.

C. CONFIDENTIALITY

I. Principles

1. Patients have the right to expect that there will be no disclosure of any personal information, which is obtained during the course of a practitioner's professional duties, unless they give consent. The justification for this information being kept confidential is that it enhances the patient-doctor relationship. Without assurances about confidentiality patients may be reluctant to give doctors the information they need in order to provide good care.

2. The professional duty of confidentiality covers not only what a patient may reveal to the practitioner, but also what the practitioner may independently conclude or form an opinion about.

3. Confidentiality is an important duty, but it is not absolute. A practitioner can disclose personal information if:

(a) it is required by law (paragraphs 15-20);

(b) the patient consents – either implicitly for the sake of their own care or expressly for other purposes; or

(c) it is justified in the public interest (paragraphs 34-48).

4. When disclosing information about a patient, the practitioner shall:

(a) use anonymised or coded information if practicable and if it will serve the purpose

(b) be satisfied that the patient:

(i) has ready access to information that explains that their personal information might be disclosed for the sake of their own care, or for clinical audit, and that they can object;

(ii) has not objected

(c) get the patient's expressed consent if identifiable information is to be disclosed for purposes other than their care or clinical audit, unless the disclosure is required by law or can be justified in the public interest

- (d) keep disclosures to the minimum necessary, and**
- (e) keep up to date with, and observe, all relevant legal requirements, including the common law and data protection legislation.**

5. When a practitioner is satisfied that information should be disclosed, the practitioner shall act promptly to disclose all relevant information.

6. A practitioner shall respect, and help patients to exercise, their rights to:

(a) be informed about how their information will be used, and

(b) have access to, or copies of, their health records.

II. Protecting information

7. A practitioner shall take steps to ensure that the patient's confidentiality is maintained regardless of the technology used to communicate health information. Practitioners leaving messages on answering machines or voice messaging systems should leave only their names and telephone numbers and not the confidential information. This same caution must be exercised when sending confidential material by mail, facsimile or electronic mail.

9. If a practitioner is concerned about the security of personal information in premises or systems provided for the practitioner's use, he or she shall follow the MMC's guidelines on raising concerns about patient safety, including concerns about confidentiality and information governance.

10. When a practitioner is responsible for personal information about patients, the practitioner shall ensure that the information and any documentation about it are effectively protected against improper disclosure at all times. Professional expertise should be used when selecting and developing systems to record, access and send electronic data. The practitioner shall ensure that administrative information, such as names and addresses, can be accessed separately from clinical information so that sensitive information is not displayed automatically.

IV. Disclosures with consent

21. A practitioner may release confidential information in strict accordance with the patient's consent, or the consent of a person authorized to act on the patient's behalf. **Seeking patient's consent to disclosure of information is part of good medical practice.**

Disclosures for which expressed consent shall be sought

28. As a general rule, a practitioner shall seek a patient's expressed consent before disclosing identifiable information for purposes other than the provision of care.

29. Where a practitioner or the health care facility in which the practitioner practises have contractual obligations to third parties, such as companies, insurance companies or managed care organizations, the practitioner shall obtain a patient's consent before

undertaking any examination or writing a report for the third party. Before seeking consent, the practitioner shall explain the purpose of the examination or report and the scope of the disclosure. The practitioner shall ensure that the final report is shown to the patient and the patient's consent is thereafter obtained before submission and that the copies of reports are given to the patient, upon request.

30. A practitioner shall ensure that the relationship between the practitioner or that of the health care facility in which the practitioner practises with third party payers such as insurance companies or managed care organizations do not contravene the Principles of Confidentiality.

X. Disclosure after a patient's death

61. **The practitioner still has an obligation to keep personal information confidential after a patient dies.** The extent to which confidential information may be disclosed after a patient's death will depend on the circumstances. If the patient had asked for information to remain confidential, the patient's views should be respected. Where a practitioner is unaware of any directions from the patient, he or she should consider requests for information taking into account:

- (a) whether the person requesting the information has locus standi;
- (b) whether the disclosure of information may cause distress to, or be of benefit to, the patient's partner or family;
- (c) whether disclosure of information about the patient will in effect disclose information about the patient's family or other people;
- (d) whether the information is already public knowledge or can be anonymised;
- (e) the purpose of the disclosure.

D. MEDICAL RECORDS & MEDICAL REPORTS

1.16. Disclosure to Third Party Payers and MCOs

Medical Records of patients who are employees of corporate bodies, or who are under healthcare insurance cover, belong physically and, as stated above, intellectually to the practitioner (and the healthcare facility or services) and ethically to the patient. Release of information from the Medical Records to Third Party Payers and Managed Care Organisations, and through them to the employers, should only be made with the informed consent of the employee/patient.

Employees may be compelled to sign a blanket document of consent by the corporate employers giving the Third Party Payers or Managed Care Organisations the right to obtain confidential information from the healthcare providers.

Such blanket consent, without reference to specifics, is not to be encouraged. Informed consent for disclosure must be on a case-by case basis and should be obtained by the practitioner personally from the patient.

This is to safeguard the patient's right as some points in the disclosure may adversely affect or influence the patient's employment status.

E. DOCTORS IN CONFLICT SITUATIONS

8. Doctors in private hospitals

There are basically four models of employment, or engagement, of doctors by private healthcare facilities:

- a. Doctors have no financial involvement in the private hospital share-holding and income and are employed full time with fixed basic pay, plus income based on work output.
- b. Doctors have no financial involvement but are given visiting rights to practise in the private hospital and derive income based on rates or schedules fixed by the hospital.
- c. Doctors buy shares into the private hospital, which provides them the right to practise, and also to enjoy the profits.
- d. Doctors own or rent private clinic space within the private hospital and run autonomous clinics, but use the inpatient facilities and services in the hospital, either by choice or as a condition of practice in that hospital.

The Private Health Care Facilities and Services Act 1998 (and the Regulations 2006) stipulate rules by which private hospitals should conduct their affairs. Besides the provisions of this Act, the Board of Management of private hospitals may also lay down various local administrative and contractual conditions by which the doctors practising therein are bound.

Corporate bodies which have injected large capital in setting up a private hospital employ or engage doctors under various terms and conditions. These conditions are designed to protect the financial and business interests of these bodies and for recovery of investment (ROI). Some of these conditions pose ethical conflicts for the doctor.

Private hospitals enter into business arrangements with managed care organizations, or directly with the corporate client, to provide health care services for employees. Some of these arrangements require doctors to reveal diagnosis and treatment details of the employees to the third party. The third party often obtains blanket consent from the employee to facilitate this arrangement. This is not acceptable and specific consent for disclosure should be obtained as and when necessary.

The extent of such disclosures must be explained to the employees while obtaining his/her consent for the release of confidential medical information. In such circumstances, too, the doctor's primary professional responsibility to his patient, in the context of doctor-patient confidentiality, should not be compromised, and the person in charge of the private hospital must be advised as such.

Private hospitals are known to act as their own preferred provider organization (PPO) by setting up a chain of primary care clinics which would refer patients only to the parent

hospital for investigations and management. This practice is a hybrid of the managed care system and is not encouraged by the Malaysian Medical Council. This restrictive referral system with its implications and restrictions must be explained to the patient, as there are fine ethical issues involved in such arrangements, primarily the employee being denied choice of doctors and hospitals.

c. Fee Splitting

The definition of fee splitting in the Private Healthcare Facilities and Services (Private Medical Clinics or Private Dental Clinics) Regulations 2006 is as follows:

“Fee Splitting” means any form of kickbacks or arrangements made between practitioners, healthcare facilities, organisations or individuals as an inducement to refer or to receive a patient to or from another practitioner, healthcare facility, organisation or individual.

As defined above, the basis of referral or acceptance of patients between practitioners must be based on quality of care (and not on considerations of monetary benefits).

Fee splitting which implies that a practitioner makes an incentive payment to another practitioner for having referred a patient to him, is unethical practice. Fee sharing between two practitioners managing a patient is permissible, the basis for such sharing being that the practitioners must have direct responsibility and involvement in the management of the patient.

9. Doctors in Managed Care Organizations

The doctors working within the system of the traditional or “classic type” managed care organizations, MCOS (or HMOs) can be considered to be under a special kind of employment, since their services are often pre-paid and they are subject to certain prearranged conditions of professional service to employees of their corporate clients.

The ethical conflicts are many and primarily involve doctor patient confidentiality and rights. Some of these contentious issues are:

- a. The patient records and documents “belong” or are freely accessible to the third party administrators, namely the MCO, and medical information on the employee is to be made available at all times (for every clinic attendance) to the MCO. The employee is said to have given blanket consent to this release of information by virtue of having accepted employment with the corporate body.
- b. The doctor can only prescribe medications contained in a schedule prepared by the MCO. Drugs not in the schedule may be prescribed only after approval has been obtained.
- c. The doctor has to obtain prior approval before ordering investigations not on the MCO Schedule, and has to obtain approval before referring the employee to a specialist or a private hospital for further management.

The doctor, acting as the so-called “gate-keeper”, takes all the risks in the management of his patients, and is liable to disciplinary action in the event of professional negligence, which may arise because of the unfriendly professional environment in which he operates under the system.

The pre-payment scheme imposes on him to provide professional care within the *per capita* allocation for each employee. Should he exceed this allocation without seeking prior approval, the doctor may be blacklisted and fall out of favour with the MCO for continued retention on the panel.

In all instances, the doctor in a managed care system has to place the interests of the patient and confidentiality above all other considerations. He should refrain from entering into a contract with a managed care organization if there are potential areas of ethical conflict in his professional autonomy and doctor-patient relationship.

The nature and stipulations of contacts between the licensee or the holder of registration of managed care organisation and the licensee or the holder of registration of a private healthcare facility or service are laid out in the Private Healthcare Facilities and Services, 1998.

F. DISSEMINATION OF INFORMATION BY THE MEDICAL PROFESSION

2.1 A registered medical practitioner must not at any time abrogate his duties as the healer, examiner, researcher, rationer and provider of healthcare service, on grounds of over-powering technology, pharmaceutical industry, or the influence of market forces and managed care organisations.

Words denoting one gender shall include the other gender. Words in the singular shall include the plural and vice versa.

Adopted by the Malaysian Medical Council on 16 January 2012.