

The Malaysian Medical Council (MMC) approved the revised guidelines on Confidentiality at its meeting on 11 October 2011. All practitioners are reminded to comply with these guidelines which will be used by the MMC in any disciplinary proceedings.

CONFIDENTIALITY

A medical practitioner registered with the Malaysian Medical Council (MMC) has rights, privileges and responsibilities. The practitioner is expected to meet the standards of competence, care and conduct set by the Malaysian Medical Council. This document sets out the MMC's guidelines on confidentiality. It is an extension of the principles stated in the MMC's Code of Professional Conduct, its guideline "Good Medical Practice" and other guidelines of the MMC.

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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.

8. Many improper disclosures are unintentional. The practitioner shall not discuss a patient's information in an area where the practitioner can be overheard or leave patient's records, either on paper or on screen, where they can be seen by other patients, unauthorized health care staff or the public. The practitioner shall take all reasonable steps to ensure that consultations with patients are private.

9. If a practitioner is concerned about the security of personal information in premises or systems provided for the practitioner's use, the practitioner 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.

Electronic Medical Records

11. Electronic medical records offer an enhanced capacity to manage patient information. The practitioner has a responsibility, as a custodian of patient's medical records, to ensure the integrity, confidentiality and availability of the medical records.

12. The practitioner shall ensure that there is an information governance policy with protocols and procedures to ensure that patient information is documented, maintained and disclosed, in accordance with all the Principles of Confidentiality as stated in this document, at all times, particularly during the transition from paper based records to electronic records.

13. The practitioner shall ensure particular cognizance is taken of the following key principles:

(a) seek patient's consent to disclosure of information, whether or not patients can be identified from the disclosure. Any exemptions are subject to existing provisions under the relevant MMC guidelines.

(b) anonymised data where unidentifiable data will serve the purpose

(c) keep disclosures to the minimum necessary.

14. The measures that should be taken to ensure confidentiality include (The list is not exhaustive):

(a) physical security measures to prevent unauthorized access;

- (b) access and authorization processes to ensure only legitimate users have access to the medical record and that each user has the appropriate level of access to the medical records;
- (c) the maintenance of audit logs to support the authenticity of additions to the medical records;
- (d) the protection of any part of an electronic medical record from being deleted.
- (e) read-only formats for external documents stored in the medical records;
- (f) adequate protection whenever medical records are disclosed to health care providers or patients;
- (g) regular back-up of the medical records, preferably daily for in-patients;
- (h) adequate virus protection to ensure the medical records are not modified or destroyed by external factors;
- (i) contingency plans for disaster recovery and denial of service attacks;
- (j) ensure that no hardware contains any personally identifiable patient information prior to disposal which must be complete; and
- (k) enhanced security e.g. additional encryption or authentication processes, when networks are more exposed e.g. wireless devices and remote access, or where the equipment that store information are on drives that are at risk of loss or theft e.g. laptops, personal digital assistants (PDAs)

III. DISCLOSURES REQUIRED BY LAW

Disclosures required by statute

15. The practitioner shall disclose information to satisfy a specific statutory requirement, such as notification of a known or suspected case of certain infectious diseases.

16. Various regulatory bodies have statutory powers to access patient's records as part of their duties to investigate complaints, accidents or health professionals' fitness to practise. The practitioner shall satisfy himself or herself that the disclosure sought is required by law or can be justified in the public interest. Many regulatory bodies have codes of practice governing how they will access and use personal information.

17. Whenever practicable, the practitioner shall inform patients about such disclosures, even if their consent is not required unless that would undermine the purpose.

18. Patient records or other personal information may be required by the MMC or other statutory regulators for an investigation into a healthcare professional's fitness to practise. If information is requested, but not required by law, or if the practitioner is referring concerns about a health professional to a regulatory body, the practitioner shall, if practicable, seek the patient's expressed consent before disclosing personal information. If a patient refuses to consent, or if it is not practicable to seek their consent, the practitioner shall contact the appropriate regulatory body, to help him or her decide whether the disclosure can be justified in the public interest

Disclosures to courts or in connection with legal proceedings

19. The practitioner shall disclose information if ordered to do so by a judge or presiding officer of a court. The practitioner shall object to the judge or the presiding officer if attempts are made to compel him or her to disclose what appears to be irrelevant information, such as information about a patient's relative who is not involved in the proceedings.

20. The practitioner shall not disclose personal information to a third party such as an advocate or solicitor, police officer or officer of a court without the patient's expressed consent, unless it is required by law or can be justified in the public interest.

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.

Sharing information within the healthcare team or with others providing care

22. Modern medical practice usually involves teams of doctors, other health care providers, and sometimes people from outside the health care professions. The importance of working in teams is explained in the MMC's guideline "Good Medical Practice". To provide patients with the best possible care, it is often essential to exchange confidential information between members of the team, on a need to know basis.

23. A practitioner shall ensure that patients understand why and when information may be shared between healthcare team members, and any circumstances in which healthcare team members may be required to disclose information to third parties.

24. Where the disclosure of relevant information between health care professionals is clearly required for treatment to which a patient has agreed, the patient's expressed consent may not be required. For example, expressed consent would not be needed where a practitioner discloses relevant information to have a referral letter typed, or a practitioner makes relevant information available when requesting diagnostic investigations.

25. There will also be circumstances where, because of a medical emergency, a patient's consent cannot be obtained, but relevant information must, in the patient's interest, be transferred between health care providers.

26. If a patient does not wish a practitioner to share a particular information with other members of the healthcare team, those wishes must be respected, except in circumstances where this would put others at risk of death or serious harm.

27. All members of a healthcare team have a duty to ensure that other team members understand and observe confidentiality. Any one receiving personal information in order to

provide or support care is bound by a legal duty of confidence, whether or not they have contractual or professional obligations to protect confidentiality.

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

V. THE PATIENT'S INTEREST

Disclosure in the patient's medical interests

31. Disclosure of personal information without consent may be justified where failure to do so may expose the patient to risk of death or serious harm. Where the patient is exposed to a risk so serious that it outweighs the patient's privacy interest, the practitioner shall seek consent to disclosure where practicable. If it is not practicable to seek consent, the practitioner shall disclose information promptly to a relevant person or authority. The practitioner shall generally inform the patient before disclosing the information. If the practitioner seeks consent and the patient withholds, the practitioner shall consider the reasons for this, if any, which are provided by the patient. If the practitioner remains of the view that disclosure is necessary to protect the patient from death or serious harm, the practitioner shall disclose information promptly to a relevant person or authority.

32. Rarely a practitioner may judge that seeking consent for the disclosure of confidential information may be damaging to the patient, but that the disclosure would be in the patient's interests. For example, a practitioner may judge that it would be in a patient's interests that a close relative should know about the patient's terminal condition. In such circumstances information may be disclosed without consent.

Disclosures where a patient may be a victim of neglect or abuse

33. If a practitioner believes a patient to be a victim of neglect or physical, sexual or emotional abuse and that the patient cannot give or withhold consent to disclosure, the practitioner shall give information promptly to a relevant person or statutory agency, where the practitioner believes that the disclosure is in the patient's best interests. If, for any reason, the practitioner believes that disclosure of information is not in the best interests of an abused or neglected patient, the practitioner shall discuss the issues with an experienced colleague. If the practitioner decides not to disclose information, the practitioner must be prepared to justify the decision.

VI. THE PUBLIC INTEREST

Disclosures in the public interest

34. Personal information may be disclosed in the public interest, without the patient's consent, and in exceptional cases where patients have withheld consent, where the benefits to an individual or to society of the disclosure outweigh the public and the patient's interest in keeping the information confidential. In all cases where a practitioner considers disclosing information without consent from the patient, the practitioner shall weigh the possible harm (both to the patient, and the overall trust between doctors and patients) against the benefits which are likely to arise from the release of information.

35. Before considering whether a disclosure of personal information "in the public interest" would be justified, the practitioner must be satisfied that identifiable data are necessary for the purpose, or that it is not practicable to anonymise the data. In such cases the practitioner shall still try to seek patient's consent, unless it is not practicable to do so, for example because:

- (a) the patients are not competent to give consent; or
- (b) the records are of such age and/or number that reasonable efforts to trace patients are unlikely to be successful; or
- (c) the patient has been, or may be violent; or obtaining consent would undermine the purpose of the disclosure (e.g. disclosures in relation to crime); or
- (d) action must be taken quickly (for example in the detection or control of outbreaks of some communicable diseases) and there is insufficient time to contact patients.

36. In cases where there is a serious risk to the patient or others, disclosures may be justified even where patients have been asked to agree to a disclosure, but have withheld consent.

37. The practitioner shall inform the patient that a disclosure will be made, wherever it is practicable to do so. The practitioner shall document in the patient's record any steps taken to seek or obtain consent and the reasons for disclosing information without consent

38. Ultimately, the “public interest” can be determined only by the courts; but the MMC may also require the practitioner to justify his or her actions if a complaint is made about the disclosure of identifiable information without a patient’s consent.

Disclosures for medical teaching, research, clinical audit and other secondary uses

39. Medical teaching, research and clinical audit are essential to the provision of good care. Research, epidemiology, public health surveillance, health service planning, and education and training are among the important secondary uses made of patient information. Each of these uses can serve important public interests.

40. For many secondary uses, it will be sufficient and practicable to disclose only anonymised or coded information. When identifiable information is needed, or it is not practicable to remove identifiable information, it will often be perfectly practicable to get the patient’s expressed consent.

41. Where teaching, research or audit is to be undertaken by the team which provided care, or those working to support them, the practitioner may disclose identifiable information, provided he or she is satisfied that patients have been informed that their data may be disclosed, and their right to the disclosure and have not objected.

42. If a patient does object, the practitioner shall explain why information is needed and how this may benefit their care. If it is not possible to provide safe care without disclosing information, the practitioner shall explain this to the patient and the options open to him.

43. Where medical research and/or audit are to be undertaken, the information shall be anonymised wherever that is practicable. Where it is not practicable to anonymise data, or anonymised data will not fulfill the requirements of the research and/or audit, expressed consent shall be obtained before identifiable data is disclosed.

44. In considering whether it is practicable to seek consent the practitioner shall take account of:

- (a) the age of records and the likely traceability of patients
- (b) the number of records, and
- (c) the possibility of introducing bias because of a low response rate or because particular groups of patients refuse, or do not respond to, requests to use their information.

45. When considering whether the public interest in disclosures for secondary uses outweighs the patient’s and the public interest in keeping the information confidential, the practitioner shall consider:

- (a) the nature of the information to be disclosed
- (b) what use will be made of the information
- (c) how many people will have access to the information
- (d) the confidentiality and security arrangements in place to protect the information from further disclosure
- (e) the advice of an expert, who is not directly connected with the use for which disclosure is being considered, and

(f) the potential for distress or harm to patients.

46. It might not be practicable for the healthcare team, or those who usually support them, to anonymise or code information or to seek the patient's expressed consent:

- (a) for the disclosure of identifiable information for important secondary uses, or
- (b) so that suitable patients can be recruited to clinical trials or other approved research projects.

47. If that is the case:

- (a) identifiable information may be sent to a repository or "safe haven", where they exist and have the capabilities and are otherwise suitable to process the information (including anonymising or coding it) and to manage the disclosure of information for secondary uses or, if that is not practicable.
- (b) the task of anonymising or coding the information or seeking patient's consent to disclosure can be delegated to someone incorporated into the healthcare team on a temporary basis and bound by legal and contractual obligations of confidentiality.

48. The practitioner shall only disclose identifiable information for research if that research is approved by a Research Ethics Committee. The practitioner shall alert Research Ethics Committees to disclosures of identifiable information without consent when applying for approval for research projects.

VII. DISCLOSURES ABOUT PATIENTS WHO LACK CAPACITY TO CONSENT

49. When making decisions about whether to disclose information about a patient who lacks capacity, the practitioner shall:

- (a) make the care of the patient the first concern
- (b) respect the patient's dignity and privacy, and
- (c) support and encourage the patient to be involved, as far as they want and are able, in decisions about disclosure of their personal information.

50. The practitioner shall also consider:

- (a) whether the patient's lack of capacity is permanent or temporary and, if temporary, whether the decision to disclose could reasonably wait until they regain capacity
- (b) any evidence of the patient's previously expressed preferences
- (c) the views of anyone the patient asks the practitioner to consult, or who has legal authority to make a decision on their behalf, or has been appointed to represent them
- (d) the views of people close to the patient on the patient's preferences, feelings, beliefs and values, and whether they consider the proposed disclosure to be in the patient's best interests, and
- (e) what the practitioner and the rest of the healthcare team know about the patient's wishes, feelings, beliefs and values.

51. If a patient who lacks capacity asks a practitioner not to disclose personal information about their condition or treatment, the practitioner shall try to persuade them to allow an relevant person to be involved in the consultation. If they refuse, and the practitioner is

convinced that it is essential in their best interests, the practitioner may disclose relevant information to a relevant person or authority. In such a case the practitioner shall tell the patient before disclosing the information and, if appropriate, seek and carefully consider the views of an advocate or carer. The practitioner shall document in the patient's record the discussions and the reasons for deciding to disclose the information.

52. The practitioner may need to share personal information with a patient's relatives, friends or carers to enable the practitioner to assess the patient's best interests. But that does not mean they have a general right of access to the patient's records or to have irrelevant information about, for example, the patient's past healthcare. The practitioner shall also share relevant personal information with anyone who is authorised to make decisions on behalf of, or who is appointed to support and represent, a mentally incapacitated patient

Disclosures in relation to the treatment sought by children

53. Problems may arise if a practitioner considers that a patient who is a child lacks capacity to give consent to treatment or disclosure. If such patients ask the practitioner not to disclose information about their condition or treatment to a third party, the practitioner shall try to persuade them to allow a relevant person to be involved in the consultation. If they refuse and the practitioner is convinced that it is essential, in their medical interests, the practitioner may disclose relevant information to a relevant person or authority. In such cases the practitioner shall inform the patient before disclosing any information, and where appropriate, seek and carefully consider the views of an advocate or carer. The practitioner shall document in the patient's record the discussions with the patient and the reasons for deciding to disclose information.

VIII. SHARING INFORMATION WITH A PATIENT'S SPOUSE, PARTNER, CARERS, RELATIVES OR FRIENDS

54. The practitioner shall establish with the patient what information they want to share, who with, and in what circumstances. This will be particularly important if the patient has fluctuating or diminished capacity or is likely to lose capacity, even temporarily. Early discussions of this nature can help to avoid disclosures that patients would object to. They can also help to avoid misunderstandings with, or causing offence to, anyone the patient would want information to be shared with.

55. If a patient lacks capacity, the practitioner shall share relevant information in accordance with the advice in paragraphs 49 to 53. Unless they indicate otherwise, it is reasonable to assume that patients would want those close to them to be kept informed of their general condition and prognosis.

56. If anyone close to the patient wants to discuss their concerns about the patient's health, the practitioner shall make it clear to them that, while it is not a breach of confidentiality to listen to their concerns, the practitioner cannot guarantee that the practitioner will not tell the patient about the conversation. The practitioner might need to share with a patient,

information which was received from others, for example, if it has influenced the practitioner's assessment and treatment of the patient. The practitioner shall not refuse to listen to a patient's spouse, partner, carers or others on the basis of confidentiality. Their views or the information they provide might be helpful in the care of the patient. The practitioner will need to take cognizance of whether the patient would consider the practitioner's listening to the concerns of others about the patient's health or care to be a breach of trust, particularly if they have requested the practitioner not to listen to certain people.

IX. GENETIC AND OTHER SHARED INFORMATION

57. Genetic and some other information about a patient might, at the same time, be similar to others, with whom the patient shares genetic or other links. The diagnosis of an illness in the patient might, for example, point to the certainty or likelihood of the same illness in a blood relative.

58. Most patients will readily share information about their own health with their children and other relatives, particularly if they are advised that it might help those relatives to:

- (a) get prophylaxis or other preventative treatments or interventions
- (b) make use of increased surveillance or other investigations, or
- (c) prepare for potential health problems.

59. However, a patient might refuse to consent to the disclosure of information that would benefit others, for example, where family relationships have broken down, or if their natural children have been adopted. In these circumstances, disclosure might still be justified in the public interest (refer paragraphs 34 to 49). If a patient refuses consent to disclosure, the practitioner will need to balance the practitioner's duty to make the care of the patient the first concern against the practitioner's duty to help protect the other person from serious harm. If practicable, the practitioner shall not disclose the patient's identity when advising others of the risks they face.

60. The practitioner shall be guided by the following:

- (a) The use or disclosure of genetic information without consent may proceed only when the practitioner has a reasonable belief that this is necessary to lessen or prevent a serious threat to the life, health or safety of a genetic relative.
- (b) Reasonable steps shall be taken to obtain the consent of the patient or a relevant person to use or disclose genetic information.
- (c) Prior to any decision concerning the use or disclosure, the practitioner shall discuss the case with practitioners with the appropriate expertise to assess fully the specific situation.
- (d) Where practicable, the patient's identity shall not be apparent or readily identifiable in the course of inter-professional communication.
- (e) Disclosure of genetic information without consent shall generally be limited to relatives no further removed than third degree relatives.
- (f) All stages of the process shall be fully documented including how the decision to use or disclose without consent was made.

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.

62. Particular difficulties may arise when there is a conflict of interest between parties affected by the patient's death. For example, if an insurance company seeks information about a deceased patient in order to decide whether to make a payment under a life assurance policy, the practitioner shall not release information without the consent of the patient's executor, or next-of-kin, who has been fully informed of the consequences of disclosure.

63. There are circumstances in which a practitioner shall disclose relevant information about a patient who has died, for example:

- (a) to help a coroner or other similar officer in an inquest or fatal accident inquiry
- (b) when disclosure is required by law or is justified in the public interest, such as for education or research
- (c) for National Confidential Inquiries or for clinical audit
- (d) on death certificates, which the practitioner shall complete honestly and fully
- (e) for public health surveillance, in which case the information should be anonymised or coded, unless that would defeat the purpose
- (f) when a parent asks for information about the circumstances and causes of a child's death.

64. Archived records relating to deceased patients remain subject to a duty of confidentiality, although the potential for disclosing information about, or causing distress to, surviving relatives or damaging the public's trust will diminish over time.

XI. MEDIA INQUIRIES ABOUT PATIENTS

65. Practitioners are sometimes approached by the media for comment about medical issues. Where such comment includes information about patients, the practitioner shall respect the patient's right to confidentiality. Before releasing any information, the practitioner shall:

(a) Remember that information which the practitioner has learnt in a professional capacity shall be regarded as confidential whether or not the information is also in the public domain.

(b) Expressed consent shall be obtained from the patient before discussing matters relating to their care, with the media, whether or not the patient's name or other identifying information is to be revealed. Expressed consent shall be obtained if patient will be identified from the details disclosed.

(c) Remember that a patient can be identified from information other than name or addresses. Details which in combination may reveal a patient's identity include their condition or disease, age, occupation, the area where they live, medical history or the family.

(d) Always consider and act in accordance with the best medical interests of patients when responding to invitations to speak to the media about patients.

XII. MALAYSIAN MEDICAL COUNCIL GUIDELINES

1. Duties of a Doctor - Good Medical Practice and Confidentiality
2. Brain death
3. Clinical trials and biomedical research
4. Dissemination of information by the medical profession
5. Ethical implications of doctors in conflict situations
6. Expert witness
7. Medical genetics & Genetic services
8. Medical records & Medical reports
9. Organ transplantation
10. Relationships between doctors and the pharmaceutical industry
11. Assisted reproduction
12. Stem cell research and Stem cell therapy
13. Managing impaired registered medical practitioners
14. Aesthetic medicine
15. Audio and visual recordings
16. Credentialling
17. Guidelines for medical practice for doctors beyond the age of 70 years

PRACTITIONERS WHO DECIDE TO DISCLOSE OR NOT TO DISCLOSE CONFIDENTIAL INFORMATION MUST BE PREPARED TO EXPLAIN AND JUSTIFY THEIR DECISIONS

XIII. REFERENCES

1. Malaysian Medical Council. *Confidentiality* (2008)
2. General Medical Council. *Confidentiality* (2009)
3. National Health and Medical Research Council, Australia. *Use and disclosure of genetic information to a patient's genetic relatives* (2009)

4. Joint Computing Group of the General Practitioners Committee and the Royal College of General Practitioners. *Good practice guidelines for general practice electronic patient records* (version 3) (2003)
5. Personal Data Protection Act (2010)
6. HMSO. Data Protection Act (1998)

XIV. GLOSSARY

“Relevant person”, in relation to a data subject, howsoever described, means—

(a) in the case of a data subject who is below the age of eighteen years, the parent, guardian or

person who has parental responsibility for the data subject;

(b) in the case of a data subject who is incapable of managing his own affairs, a person who is appointed by a court to manage those affairs, or a person authorized in writing by the data subject to act on behalf of the data subject; or

(c) in any other case, a person authorized in writing by the data subject to make a data access request, data correction request

(Section 4 Personal Data Protection Act 2010)

XV. ACKNOWLEDGEMENTS

The Council is grateful for:

(a) feedback from the Academy of Medicine; and

(b) permission from the General Medical Council for use of excerpts from its guidance, *Confidentiality* (2009)

The MMC’s 2011 guidelines on Confidentiality were drafted by a committee comprising Dr Milton Lum Siew Wah (Chairperson), Puan Sri Datuk Dr Suraiya H Hussain, Associate Prof Dato Dr Sirajoon Noor S M Abdul Ghani, Datuk Dr Abdul Gani Mohammed Din and Dr Tee Lian Kim.

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