GOOD MEDICAL PRACTICE 2019

FOREWORD

This booklet serves as a guide to medical practitioners in Malaysia to meet the standards of care and professionalism set out by the Malaysian Medical Council. It contains the moral, ethical and professional obligations expected from medical practitioners and which are considered safe, effective and trustworthy by the medical profession and the community. It complements the Code of Professional Conduct, and all other guidelines and directives issued by the Council from time to time.

This edition of Good Medical Practice is a revision of the booklet issued by the Council in 2001 and incorporates some new topics which are relevant to current practice, as suggested by the medical fraternity at large.

This booklet is not a charter of rights. It is not exhaustive and cannot cover all forms and aspects of professional practice, which continue to evolve as new approaches to patient care are influenced by techniques and technological advances in understanding and treating diseases.

It also serves to enhance public awareness of such standards expected from the doctors who treat them. Such awareness will hopefully encourage greater adherence by the doctors to these guidelines.

I urge all medical practitioners to adhere to the principles laid down in this booklet, and in all other Guidelines and directives issued by the Council, at all times.

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THE TEN GOLDEN RULES OF GOOD MEDICAL PRACTICE

1. *Make the care of your patients your first concern.*

2. *Practise with kindness, empathy, professionalism and integrity.*

3. *Respect privacy, dignity and confidentiality of your patients.*

4. *Be competent and keep your professional knowledge and skills up to date.*

5. *Establish and maintain good relationship with your colleagues.*

6. *Appreciate your own professional limitations and seek opinion from colleagues.*

7. *Preserve patient's autonomy and allow second opinion.*

8. *Avoid publicity, self-promotion and abuse of position.*

9. *Be conscious of cost of healthcare and appreciate patient's limitations in paying fees.*

10. *Promote global health.*

This Good Medical Practice 2019 was adopted by the Council
on the 388th MPM Meeting on the 18th day of June, 2019
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Preamble

The five basic ingredients of Good Medical Practice are Professional Integrity, Ethical Behaviour, Communication Skills, Treating Patients with Dignity and being a Team Player. These five factors will be seen to be guiding the sentiments and philosophies reflected in this booklet.

This booklet contains the principles of medical practice which have been considered safe, effective, ethical and trustworthy by peers and the community.

It is, however, never easy to set strict guidelines on Good Medical Practice, and it is not possible to lay down guidelines acceptable to every practising doctor, granted that there are as many types of practices as there are as many types of doctors.

It needs to be stressed at the outset that the intention of laying down these guidelines is not to confine the doctor in a moral straitjacket, thereby forcing him to practice restricted or defensive medicine, at the unfair risk of being unrealistic and unproductive to himself and to his patient.

The practitioner must therefore be always prepared to explain and justify his actions and decisions whenever there is question or doubt raised about his practice.

The guidelines laid out in this booklet on Good Medical Practice are generally intended to be positive in approach, and to convey to doctors what they should do. Some sections or parts are purposefully lengthy in favour of clarity and comprehensiveness.

These guidelines have been prepared with the Malaysian doctor in mind, though clearly the professional code which governs the form and manner of medical practice are universal in concept, and internationally accepted and implemented.

Explanatory Note: Whenever a gender-specific term is used, it should be understood as referring to both genders, unless explicitly stated. The words “hospital” and “healthcare facility”, as well as “doctor” and “medical practitioner” are used interchangeably and have the same meanings.

1. The Doctor and Society

The doctor is traditionally held in esteem by society as a highly qualified professional who is expected to serve his fellow human beings in a dedicated and selfless manner. His opinion on matters not just medical is often sought and received with respect. He is frequently invited to participate in community activities and organisations. He may be called upon to provide character references and to certify important documents. As such, his behaviour is expected to be beyond probity.

2. The Doctor as a Person and his Facility

2.1 The Doctor the Person

2.1.1 There is much truth in the statement: “Doctor, heal thyself”. This relates to the concept of a sick doctor who has at his disposal the means to relieve the suffering of others but not his own suffering.

2.1.2 The doctor must seek independent, objective advice from a medical colleague when he needs medical care, being aware of the risks of self-diagnosis and self-treatment. He must recognize the effect of fatigue on his health and how this may impact his ability to care for his patients, and endeavour to work safe hours whenever possible.

2.1.3 If the doctor knows or suspects that he has a health condition or impairment that could adversely affect his judgment, performance or his patient’s health, he must not rely on his own assessment of the risk he poses to his patients but must consult his own doctor for advice and help, to modify his practice as necessary. This also applies to a doctor who may have a drug dependence problem.

2.2 Conduct and Appearance of the Doctor

2.2.1 The doctor is expected to conduct himself with professionalism and self-regulation, which implies that he practises within the established and accepted moral, legal and ethical norms, and regulates himself to uphold them. These norms safeguard the interests of the patient and allow the doctor to practise his profession as he has been trained and with personal dedication, without the need for external regulations.

2.2.2 The doctor is expected to keep himself abreast of new developments in medicine generally and in his specialty specifically, to maintain the highest level of professional care. The upgrading of practical skills is an essential additional requirement. Considerable responsibility is required on his part to utilise all available components of continuing his professional development, including self-study and distance learning, to achieve these objectives.

2.2.3 The physical appearance of the doctor in the way he dresses, grooms himself, the way in which he presents himself in terms of cleanliness, neatness and personal hygiene, are to the patient just as important as the doctor's demeanour in terms of his manners, behaviour, confidence and general composure.

2.2.4 Untidy physical appearance may, though not necessarily, lead to an erroneous assumption by a patient that the doctor lacks discipline and a systematic approach to clinical problems. Indeed, given the fact that the patient is meeting the doctor in many instances for the first time ever, these first impressions may influence the nature and course of future doctor-patient consultations and confidence.

2.2.5 To the person who is entrusting his own life and health, or that of his loved ones, these aspects of external presentation are manifestly as important as the doctor's inner qualities and professional capability. For, in the patient's perspective, the image of the doctor is cast in the mould of physical and moral perfection.

2.3 The Facility and Service

There are certain reasonable expectations of the appearance of the clinic and consultation rooms, which must appeal to the patient.

2.3.1 The CLINIC SIGNBOARD should conform to stipulations and should be clear and concise. Adequate illumination is important, without being decorative.

2.3.2 The WAITING ROOM should have a calm, soothing and reassuring ambience. The seating must be comfortable. The room should be clean and illuminated sufficiently for casual reading. A few simple paintings, photographs or educational posters add to the general pleasantness of the room. Some current light reading materials for the patient, neatly arranged, help to reduce the anxiety and boredom of waiting.

2.3.3 The CONSULTATION ROOM should be roomy, neat and tidy, and soothing to the eyes and pleasant to the nose.

It is acceptable to display certificates or scrolls of recognised medical degrees, diplomas and certificates in the consultation room.

Clinical equipment, like BP set, ophthalmoscope, etc., should be in good working order and clean and neatly arranged. A wash-basin with hand drying material within reach will reflect a hygienic

practice. An untidy and cluttered consultation room may indicate a very busy doctor, but on the other hand may mean to the patient that the doctor is not systematic and methodical.

2.3.4 The NURSING STAFF must be neatly dressed, courteous, pleasant, friendly and sympathetic in their handling of the patient and the accompanying persons. They must be efficient and be able to prioritise patients and their problems, so that the doctor will be able to see the more ill patients earlier.

3. The Doctor and the Patient

3.1 Doctor - Patient Relationship

3.1.1 The relationship between a doctor and his patient is best described as a professional partnership and collaborative effort to maintain or restore good health in the patient.

3.1.2 The relationship paves the way for frank discussion in which the patient's needs and preferences and the doctors' clinical expertise are shared to select the best management and treatment option. In this context, the professional relationship is preferably autonomous and patient-oriented rather than paternalistic and doctor-oriented.

3.1.3 For the patient, the first encounter with the doctor is an experience with vast implications for future professional relationship. The patient who seeks medical help is in an anxious frame of mind. The courage that he has to muster to attend a clinic is immense, and the experience of stepping into the doctor's consultation room can be unnerving. By that one crucial act, the patient, with the sole and simple hope of finding a solution to his health problem, makes many bold personal sacrifices. He surrenders his individuality and privacy to the doctor, literally lays bare his soul,

exposing his innermost secrets and personal problems to the doctor who, in truth and essence, is a total stranger. The doctor's only claim to this privilege is his education and training as a compassionate healer.

3.1.4 This applies also to concerned family members who seek such care and advice for their loved ones.

3.1.5 The doctor is expected to be physically and mentally prepared for this role, day-in and day-out, patient after patient, *ad infinitum.* It is a noble but challenging task, with high expectations from the community.

3.1.6 The patient, on the other hand, takes the doctor's work for granted. He rarely is aware of the doctor's sentiments or his physical and mental state at that point in time. Whether the doctor has been stretched to his physical and mental limits during his work, or whether he has had any rest or a square meal, are of no immediate concern to the patient. In fact, the patient will normally assume that the doctor seeing him is generally fit and well-rested and, submerged in his own misery, the patient's all-consuming concern is for an immediate solution to his own medical problem.

3.1.7 The doctor is at all times expected to provide an acceptable standard of professional care, exhibit the norms of good clinical practice and present himself in the following manner:

3.1.7.1 Be attentive and a good listener, attaching importance to even the most trivial of the patient's complaints, making the patient feel that he is the most important person in that consultation room, and his problems are indeed most significant.

3.1.7.2 Be gentle and concerned and avoid making statements which may upset the patient. Only then can the patient feel comfortable, relaxed and at ease with the doctor.

3.1.7.3 Avoid criticising the patient when he relates what may appear to be irrelevant or trivial, but which is apparently important to him.

3.1.7.4 Be gentle and concerned when examining the patient, making the patient feel relaxed and co-operating through every step of the physical assessment, periodically pausing to explain the need for a particular step and observing for any signs of discomfort. The physical examination of the patient is to be carried out in the presence of a chaperone (see also section 3.3 on chaperone).

3.1.7.5 Be clear and discreet when discussing the possible diagnoses, keeping the well-being of the patient at heart, without alarming or frightening him. It is useful to be cautious and guarded in what should be revealed at this stage, pending the outcome of further investigations. The doctor must keep in mind the mental state of the patient, the gravity of the findings, and the wishes of the next-of-kin.

3.1.7.6 Give the relevant options when discussing treatment, and the limitations and possible complications.

3.1.7.7 During consultation, the following are some aspects of good standard of practice and etiquette expected of the doctor:

3.1.7.8 Ensure that the patient is able to converse or understand the language of communication or obtain the assistance of a person/chaperone who can act as an interpreter.

3.1.7.9 Be patient and compassionate, without making the patient feel that you are busy or in a hurry to get to another assignment.

3.1.7.10 Avoid criticising colleagues in the presence of patients on their previous treatment.

3.1.7.11 Be gentle when seeking clarifications in the history – in, manner and tone of voice.

3.1.7.12 Cultivate a friendly and amicable relationship, which will give the patient confidence and trust in you.

3.1.7.13 Avoid being stern and business-like. Give time for the patient to settle down in the consultation room and to measure out the doctor who is an untested stranger. A few casual questions by you, like "Where are you working?", "How old are you?", " go a long way to establishing a friendly atmosphere and convivial beginning.

3.1.7.14 Avoid presenting yourself as the embodiment of noble perfection and giving the impression that the patient has finally reached the ultimate healer.

3.1.7.15 Avoid patronising your patients. Be firm but pleasant in your discussions without being condescending. Avoid developing private and

personal relationship with your patient and discourage any attempt by a patient to become personally and privately involved with you.

3.1.7.16 Video recording of the consultation by the doctor and/or the patient needs the agreement of both parties prior to the recording. A doctor may want to record the proceedings for future reference in management. The patient must be informed and his consent obtained. Similarly, the patient must inform the doctor if he wishes to record the consultation for future reference or to obtain advice from family members or to seek further clarifications and second opinion. Covert recording may become a point of dispute. In the overall consideration, recording of the consultation is for the benefit of the patient and the doctor.

3.1.7.17 In private practice, trying to satisfy a patient's demands may sometimes be considered necessary from a financial angle, in the belief that a "customer is always right." In such instances, the doctor's approach must be based on the principles of good medical practice, and these should not be sacrificed for pecuniary or material interests. The doctor must take it as his duty to gently educate and correct a patient's erroneous or mistaken concepts of medical treatment and healthcare.

3.1.7.18 Should there be a reason to disagree with a patient's opinion or impression to treatment option, the doctor must be positive in presenting his views without belittling the patient or making him feel inadequate and ignorant. Tact and dignified

diplomacy are the keys to a successful and enduring doctor-patient relationship.

3.1.7.19 Never take advantage of a patient's predicament or plight to further your own interests or ambitions.

3.1.7.20 The doctor, whenever possible, must avoid providing medical care for any one with whom he has a close personal relationship, particularly family members. Providing care to close friends and colleagues and those who are working with you may also create situations of emotional or personal involvement leading to lack of objectivity in the care. However, when this is unavoidable, then good medical practice should guide careful management.

3.1.7.21 Non-discrimination of Patients

A doctor is obliged to provide access to medical care and treat patients without prejudice of gender, race, religion, creed or social standing, sexual orientation, or disability or socio-economic status. A doctor shall not allow his personal moral bias or prejudices about patient’s habits or lifestyles to influence his management of patients. Where a doctor feels unable to continue his care for a patient due to such beliefs, this should be tactfully discussed with the patient and he should be referred to another doctor who is able and willing to care for the patient. An example of such a situation is a request for an abortion.

3.2 Doctor - Patient Confidentiality

3.2.1 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.

3.2.2 There is 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.

3.2.3 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 legal requirement.

3.2.4 Doctors who use clinical patient materials in medical publications or at medical conferences must avoid revealing personal details of the patients in the presentation. Photographs when used should not reveal identifying facial or physical features, unless consent has been given by the patient.

3.2.5 When discussing patient data at in-house hospital mortality and morbidity meetings, direct reference to patient's name, identity and personal details should be avoided. At times the details of such proceedings, when recorded, may have to be disclosed through court order and it is therefore important to be factual without being incriminating.

3.2.6 In the final analysis, good standard of professional practice dictates that the doctor must exert all in his powers to preserve patient privacy and 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 treatment and health care.

4. The Doctor and his Practice

4.1 Prescribing

4.1.1 A doctor should not issue a prescription without examining the patient, unless the doctor is already familiar with the patient and his illness and his medications through previous consultation.

4.1.2 A doctor must not prescribe medications to a caller, who has not yet established a personal doctor-patient contract, merely on listening to a complaint over the telephone or any other electronic device.

4.1.3 Before prescribing medication for a patient, and conforming to safe medical practice, the doctor must find out if the patient has had any adverse reactions to medications previously taken, and whether he has any allergies, asthma, skin diseases, gastro-intestinal upsets or any higher centre reactions, like giddiness, headache, or nausea. It should also be enquired if he is on treatment for any other illnesses, and, if possible, the names of medications he is already taking.

4.1.4 These simple questions will give the patient the confidence that the doctor is concerned about the current medication, so that side effects and adverse reactions are avoided; neither will he be

receiving the same medications already prescribed by another doctor.

4.1.5 The doctor must inform the patient the purpose of the medications, and potential side effects and adverse reactions that may arise, and the steps to be taken if such occur.

4.1.6 The name of the medicine, preferably both the generic and commercial, should be clearly labelled on the packet or containers and instructions when to take the medicine and also how to keep them safely.

4.1.7 Medications should be prescribed in most circumstances, for an appropriate convenient duration, particularly for diseases that may need close periodic monitoring. A doctor should provide a date for review and make it clear why regular reviews are important, and explain to the patient what they should do if they suffer side effects or adverse reactions.

4.1.8 In the case of repeat prescription for regular follow-up patients, the doctor must record the reason for repeat prescribing and also be satisfied that procedures for repeat prescribing and for generating repeat prescriptions are secure. He must ensure that the right patient is issued with the correct prescription, the correct dose is prescribed, particularly for patients whose dose varies during the course of treatment, that the patient's condition is periodically reviewed by the doctor or an appropriate healthcare professional and that any changes to the patient's medicine are quickly incorporated into their record.

4.1.9 At each review the doctor should confirm that the patient is taking his medicines as directed, and check that the medicines are still needed, effective and tolerated, particularly following a hospital stay, or changes to medicines following a hospital or home visit.

He should also consider whether requests for repeat prescriptions received earlier or later than expected may indicate poor adherence, leading to inadequate therapy or adverse effects.

4.1.10 Repeat prescription without clinical review is discouraged. Disease conditions fluctuate over time; dosages and even indications need regular reappraisal. Consequently, automatic refill prescriptions are to be kept to a minimum, taking into consideration the patient's convenience, understanding of his illness and the availability of safety-net mechanisms. Automated refills might seem to improve patient adherence to treatment. However, inadequate supervision could result in undetected complications and ensuing medicolegal liability.

4.1.11 Only the treatment, drugs, or appliances that serve the patient's needs, should be prescribed.

4.1.12 The doctor must avoid prescribing habit-forming medicines, particularly sedatives and tranquilizers in large quantities to patients since this may lead to or promote substance abuse. There is also the risk of overdose by unstable patients.

4.1.13 Dispensing of medication in the clinic should be on the direction and supervision of the doctor in the absence of a qualified dispenser or pharmacist.

4.1.14 Patients should be warned against self-medication or purchasing controlled medication like antibiotics and sedatives without prescription.

4.1.15 In general, the doctor must advise the patient on the importance of keeping and maintaining a handy personal note-book in which the medications that he is currently on can be recorded for ease

of reference by any other doctor during follow-up or in an emergency.

4.2 Treatment

4.2.1 The patient should not be made to feel that a treatment is being forced upon him, especially elective procedures which are invasive. Unless absolutely lifesaving, the patient should be allowed time to consider.

4.2.2 In elective surgery, the doctor is expected to offer options regarding dates and convenience, so that the patient has time to sort out personal and work-related matters. The patient who agrees and gets admitted for surgery must be free of personal, work and domestic tension and must be mentally and physically prepared for the surgery.

4.2.3 Treatment in Emergency: Professional, ethical and humane considerations dictate that doctors render emergency or lifesaving treatment to patients irrespective of their social and financial status or suspicion of being afflicted with serious communicable diseases (when standard or universal precautions should be taken by the doctor and his staff). Refusing to provide emergency treatment for such reasons is considered unprofessional and unethical.

4.2.4 Treating patients in emergencies requires the doctor to consider a range of issues, in addition to the patient's best care. Good medical practice involves offering assistance in an emergency that takes account of the doctor's own safety, his skills, the availability of other options; and continuing to provide that assistance until his services are no longer required.

4.3 Chaperone

4.3.1 A doctor must examine a patient of the opposite gender, or a child, with a chaperone being physically present in the consultation room, with visual and aural contact throughout the proceedings.

4.3.2 A relative or friend of the patient is not a suitable chaperone; as he or she may not fully appreciate the nature of the physical examination performed by the doctor and may even testify against the doctor in the event of allegations of misconduct or physical abuse. Similarly, a relative of the doctor (wife, daughter, etc.), whose impartiality might reasonably be questioned, would be prejudicial as a chaperone.

4.3.3 In situations where the patient requests consultation in private without the presence of a chaperone, this must be accepted by the doctor and a note made in the patient's record. This will serve as the doctor's defence in the event of allegations of misconduct by him.

4.3.4 In instances when no chaperone is available or not being provided, the doctor must make the patient aware of this and arrange for one if the patient requests or insists for a chaperone.

4.3.5 These requisites are designed to allow the doctor to proceed with clear, unhampered clinical examination of the patient, as he deems appropriate to arrive at a proper diagnosis.

4.3.6 At all times, the doctor should be aware of the need for propriety, taking into consideration the cultural and religious sensitivities of the patient. Any lapse might pose a risk of entrapment by unscrupulous parties.

4.4 Consent

The doctor often assumes that a patient who walks into his consultation room gives implied consent for all subsequent procedures. It must be remembered that "implied consent" *per se* is merely a perception and cannot be taken for granted, and may not protect the doctor in the event of any complaints or litigation.

4.4.2 It is important for the doctor to explain the procedures and their purpose: this would include, amongst others, the need for drawing blood for investigation, diagnostic imaging procedures, local infiltrations and injections. At every point, should any objection be raised by the patient and clarification sought, the patient should be carefully heard out and not brushed aside. Refusal by the patient for procedural investigations or specific treatment should be noted in the patient's record.

4.4.3 Any invasive procedure, however simple, should be undertaken only with informed consent from the patient, properly documented, or in the case of a minor, from the parent, next-of-kin or legal guardian.

4.4.4 Before major invasive procedures are undertaken, the patient must be told the possible post-operative complications, so that there are no surprises after an operation, particularly since such eventualities as intensive care or high-dependency care can be expensive and long drawn. It however needs to be emphasised that such discussion should not be too extensive or detailed whereby the patient is discouraged, or becomes too fearful of complications, to undergo the procedure.

4.4.5 Overall, when a patient is given clear and frank explanations on the purpose and benefits, he would rarely refuse an investigation or procedure.

4.4.6 In the situation where a patient is unable to give consent due to being under influence of alcohol or drugs or confused or comatose, and emergency lifesaving intervention is necessary, and there are no relatives or next-of-kin are present to give consent, then the attending doctor and a colleague, a registered medical practitioner, may take it as consent given and manage the patient in the patient's best interest.

4.5 Medical Cover and Delegation of Duty

4.5.1 A doctor going off duty or on leave must ensure that suitable arrangements are made for the patient's continued care.

4.5.2 The doctor, particularly in solo practice, before proceeding on long leave, should give advance notice to his regular patients and whenever possible give alternative appointments if they are on regular follow-up. In his absence he should arrange for another doctor to provide cover when his patients urgently need consultation.

4.5.3 In the case of hospital patients, the doctor going on leave must ensure effective handover procedures by communicating clearly through proper documented notes with a colleague to continue management in his absence, and perhaps speak with him if the case is requiring special attention. Messages left on handphones or other devices may not be satisfactory or adequate for this purpose. The colleague covering him must agree, and the patient or the next-of-kin must also be made aware of this arrangement.

4.5.4 The doctor covering should have the qualifications, experience, knowledge and the skills to perform the duties for which he accepts responsibility. He is directly accountable for the care of the patients during the period of cover.

4.6 Records of Dangerous and Controlled Drugs

4.6.1 It is good medical practice to maintain stock inventory of all categories and types of medicines in the facility.

4.6.2 Doctors are further required by legislation to maintain proper stock inventory of dangerous and controlled drugs. A record of the prescription of these medications must be kept, together with details of the treatment involving such prescriptions. Such drugs should also be properly and securely stored with the doctor being the person totally responsible. Failure to comply is a serious offense.

4.7 Medical Records and Medical Reports

4.7.1 In general, well-kept Medical Records are the hallmark of a good medical practice. Patient cards and electronic records should contain all relevant information, physical findings and diagnosis in the course of patient management. Such records should be accurate, legible, comprehensive, honest, non-judgmental and up-to-date, and contribute to easy recall of patient information for continuity and follow-up of patients, as well as for future reference such as preparing reports or insurance forms.

4.7.2 Patients must be kept informed of investigations and procedures, their purpose and expected outcome, and consent obtained prior to the procedures. The importance of obtaining valid consent is dealt with in section 4.4 of this booklet.

4.7.3 Investigations and their results and management should be recorded in appropriate detail, with the date and time, and the name of the doctor rubber-stamped and signed. Medical records are integrated so that all healthcare personnel (doctors, nurses, allied health staff) are required to write management details on the same page and signed and stamped with their personal details.

4.7.4 In the case of invasive procedures, the indications for, and the nature of, the procedures, must be clearly documented. Properly justified procedures can be defended by peers in the event of conflict or litigation, but when the clinical notes are sketchy, poorly made out, illegible, vague, ambiguous and untidy with deletions and corrections, this may be difficult.

4.7.5 Notes and records relating to operations and invasive procedures should be written clearly, with attention to indications, findings, relevant details, difficulties encountered and the measures taken. Simple drawings of the procedure carried out, in addition to the notes, may add clarity to the words.

4.7.6 Notes once made out should not be erased or altered, or new words inserted after a lapse of time, as these may indicate defensive or cover-up action by the doctor in the event of unexpected eventualities in the course of the patient management. Any correction must be neatly deleted and still readable. These also apply in electronic recording of clinical notes.

4.7.7 For patients who are at high risk, particularly those who are aged and medically compromised with co-morbidities, the possible risk of surgery and anaesthesia needs to be explained to the patient or next-of-kin, and recorded in the notes.

4.7.8 It is to be noted that while the clinical notes and records are physically kept with the doctor, the clinic and the hospital, the information therein contained belongs, morally and ethically to the patient and, when legally demanded, to regulatory authorities. These documents may be requested by the patient, for his retention in the case of chronic illnesses, or his appointed officers for various purposes, ranging from need to seek second opinion, to seek further treatment elsewhere, or for litigation purposes.

4.7.9 When requests for clinical notes and records are made as above, certified true copies of the documents may be provided.

4.7.10 A doctor is obliged to provide comprehensive Medical Reports when requested by patients or by the next-of-kin, in the case of children and minors, or by the employer or legal representatives with the patient's consent. Any refusal or undue delay in providing such reports is unethical. A fee may be charged for such reports.

4.8 Medical Sick Certificate

4.8.1 The purpose of a doctor issuing a sick certificate for a worker or employee, is to guide the employer regarding employment during the days the person is certified sick; or, for purposes of claiming health insurance claims; or, in the case of students, to seek absence from school or exemption from examinations. Such a person, may come to clinic requesting just a medical sick certificate, feigning an illness. The doctor must evaluate such a request with a good history and physical examination of the person and act judiciously and tactfully.

4.8.2 The doctor must not issue medical sick certificate without examining the patient first and making relevant notes in the patient records. Never pre-sign sick certificates or prescription

pads and leave them unsecured as these may be misused by unauthorized persons in your absence.

4.9 Second Opinion and Relationship with Colleagues

4.9.1 The request by a patient for a second opinion should be handled with due sensitivity and tact. The primary or principal practitioner must accede to such a request, and give full cooperation and make the necessary arrangements for the patient to obtain such opinion. He must make available all relevant information and results of investigations to the colleague, in good faith without attempting to influence the decision of the referred colleague.

4.9.2 The patient may sometimes choose to obtain the second opinion from an undisclosed doctor of his own choice. In such instances, it should be impressed upon the patient that the second doctor must be suitably qualified and experienced, so that a meaningful consultation and opinion is obtained.

4.9.3 The referred practitioner giving the second opinion must deliver his professional opinion without prejudice, and without any aura of superiority, seniority or appearing to be more competent than the primary practitioner. He should then refer the patient back to the primary practitioner, agreeing or disagreeing, or suggesting alternatives, preferably in confidence.

4.9.4 A doctor should himself be prepared to initiate a referral to a colleague for second opinion when the situation demands. He must make the patient understand clearly that this is being done in the patient's interest. The patient should be made to appreciate that this referral is being initiated not because the primary practitioner lacks expertise or confidence, but that there are areas of doubt which merit cross-consultation.

4.9.5 A doctor in private practice has varying levels of expertise and some such doctors are in solo practice in isolated locations. It is therefore useful to have arrangements with colleagues practising nearby to discuss patient's problems, for mutual benefit. This is a useful form of continuing medical education and continuing professional development.

4.9.6 In this age of super-specialisation, it is in the interest of the patient for the doctor to refer him for definitive management by a colleague who has special training or expertise in dealing with a complex clinical problem. A doctor must accept his own limitations in professional knowledge, skill and competence in these special instances and be prepared to refer a patient to another doctor.

4.9.7 An area of some anxiety is the patient who is referred to multiple specialists. Before initiating such referral, the patient must be informed of the reason for the referral. If the referred doctor decides to further refer to a third specialist, the consent of the primary doctor should be obtained as a matter of courtesy.

4.9.8 Fragmentation of treatment must be avoided. Doctors must avoid "over-servicing" their patients. In this setting, and the purpose of multiple referrals must be carefully evaluated and strictly for the patient's need.

4.9.9 Generally, when a patient is referred by a doctor to a specialist colleague, it is good etiquette to provide feedback in the form of a written status report to the referring doctor about the patient and the management undertaken. It is also proper to return the patient to the referring doctor for continuation of care.

4.10 Professional Fees

4.10.1 The doctor in private practice may be uncomfortable discussing fees and charges with his patients before treatment, but this is necessary so that the patient is fully aware of the cost of treatment and whether his insurance will cover it or whether he can personally afford it.

4.10.2 The doctor must appreciate that the patient who seeks treatment, does so out of dire necessity for cure from critical illness. It is not like purchasing a luxury consumer item, which can be delayed or postponed. The doctor who discusses professional charges with his patients must keep in mind the patient's desperate situation and his financial status.

4.10.3 The doctor must charge reasonably. He must also be fully conscious about the limited financial resource of patients.

4.10.4 The doctor should give an initial estimate of his own professional fees and the possible hospital charges, which, however, are determined by the hospital. It is useful for the patient to be given this estimate prior to hospital admission and commencement of treatment. The patient must also be warned that should there be a need for additional procedures and intensive or high dependency care, the charges may escalate.

4.10.5 In private hospital practice, when the expenses begin to exceed initial estimates for patients who unexpectedly require intensive or long-term care, this must be immediately brought to the attention of the patient or the next-of-kin. If there is inability to meet the rising bill, the doctor must make all efforts to transfer the patient to a public or less expensive private hospital and personally make the necessary arrangements to facilitate such a transfer. The colleague or hospital must accept this transfer in

general good faith and patient care and without making disparaging remarks about the referring practitioner or the hospital.

4.11 Family Members and Friends

4.11.1 Unknown to the doctor coming in contact for the first time with a patient, there is a whole retinue of family members and friends in the background. These people do not normally appear on Day One but emerge soon after surgery or other major treatment, or when there are complications or the patient turns critically ill. They then have a barrage of queries: why it happened, what went wrong, what is next, will the patient survive, and so on.

4.11.2 It is important for the doctor to appreciate the influence and interest that these family members and friends have on the patient, and to treat them with courtesy and respect, while taking pains to answer their queries, however irrelevant or exasperating they may be.

4.11.3 In the event of unforeseen eventualities during patient management, it is this initial pleasant and cordial line of communication and dialogue that will most often see the doctor through the crisis and without acrimonious outcome.

5. The Doctor and Practice Related Matters

5.1 Calling Card

The doctor's calling card should limit the information therein contained to name, registrable qualifications, officially recognised honours and titles, address of clinic or place of practice and contact numbers. Logos are permissible but not the red crescent symbol or other national and

international symbols. Sometimes the cards are also used as appointment cards. Calling card should not, as a rule, be distributed to members of the public for purpose of touting for patients or advertising, or be left in public areas for convenient pick up by anyone.

5.2 Publicity and Self-promotion

5.2.1 A doctor's best publicity agent is his own patient. The opinion and impression that the patient has about his doctor and the kind and considerate treatment that he had received, when communicated to others, are the factors which influence patient's relative and friends to seek the same doctor.

5.2.2 Self-aggrandisement and promoting oneself, such as the best doctor in town, the most experienced, the most skilled, and sometimes done with derogatory remarks about one's colleagues, is a demeaning form of doctor behaviour. In the long run such behaviour will be his own undoing, for patients will soon become wise to the tactics employed by such a doctor and avoid him.

5.2.3 Publicity seeking behaviour of even a handful of doctors would reflect adversely on the profession as a whole.

5.2.4 Voluntary public service and charitable projects by a doctor, providing advice on illness and healthcare to the people in rural and remote areas are laudable. However, he must avoid exploiting the event by allowing photographs of him examining such members of the public, and to appear with news coverage of his activities in the media, which may have elements of self-promotion.

5.3 The Internet and the Social Media

5.3.1 The Internet is a powerful - and in future, possibly the principal – medium for circulation of information. A great proportion of the population are active on social media, uploading many aspects of their personal life to share with friends and the rest of the world. These digital footprints can persist virtually permanently in cyberspace. Even application for the “right to be forgotten online” or deletion does not guarantee total removal of such content from every website. The doctor who may choose to conduct his professional life and his social interactions in full view of the digital world, should be aware that such self-revelations may be publicised far and wide, and even amplified through third-party postings, with risks for reputational damage.

5.3.2 A doctor may be permitted to use websites to provide information on his practice and healthcare facility without laudatory remarks about his professional experience and clinic subject to regulatory stipulations and approval by relevant authority.

5.4 Pharmaceutical and Medical Equipment Firms

5.4.1 The doctor is often approached by representative of pharmaceutical firms to prescribe or promote some new medicine in the market, or to influence the purchase of such medicine by the hospital pharmacist. Representative of medical equipment and appliances may operate in similar manner. The decision by the doctor to accept such a proposal must be based on the principle that it is entirely for the patient's benefit. The doctor must not accept any favours, direct or indirect gifts and loans or other inducements, in the course of such activity.

5.4.2 The doctor may be offered travel grants or fully paid trips and hospitality, or some equally attractive inducement, to attend

conferences promoting a single new pharmaceutical product or appliance or equipment. Although these may have educational value, the doctor must carefully evaluate the motives, expectations and the hidden agenda of such offers, and the ultimate payback expected. Discretion in dealing with such matters will help to preserve the credibility and impartiality of the medical profession.

5.4.3 In all dealings with members of the pharmaceutical and equipment industry, the doctor must avoid making decision or participating in transactions where there is a direct conflict of interest.

5.4.4 Offers of training or attendance of conferences by such firms are advised to be made through healthcare or academic organisations or professional bodies which may then choose the doctor based on rotation or eligibility.

5.5 Plagiarism

5.5.1 The doctor in clinical practice or in an academic position often publishes papers and articles in medical and non-professional literature. The contents of such articles are primarily educational with the objective to inform readers of results of approved research, highlight some new innovative procedure or report an interesting case. He must avoid material which may constitute plagiarism, which is simply defined as copying other people's composition or written materials and claiming or implying as if they are his own and by not crediting the original author. Such an act is considered conduct derogatory to the dignity of the medical profession.

5.6 Continuing Professional Development

5.6.1 A doctor in clinical practice is expected to be up-to-date in his professional knowledge and skill, so that he can provide the most effective and current treatment. It is a statutory requirement that the doctor takes steps to accrue minimum annual continuing professional development (CPD) points according to the MMC Grading System by attending or participating in various activities organised by accredited providers, when he applies for his annual practising certificate (APC).

6. The Doctor as a Team Player

6.1 The medical profession survives on trust and the public's unquestioned faith in this credibility. It is morally unacceptable for a doctor, whatever his personal impressions may be about a colleague, to adversely comment on his professional competence to patients or members of the public.

6.2 The doctor must treat his colleagues fairly. The doctor must not allow his views of a colleague's lifestyle, religious, social or political inclinations, culture, race, colour, gender, sexual orientation, or age to prejudice his professional relationship with him.

6.3 The doctor who is senior in service and experience, must accept his responsibility and always be available to guide and train his junior colleagues (including house officers), with understanding, patience and tolerance. Any behaviour which may be considered to be bullying, harassing or distressing to the junior colleague is totally unacceptable, and is contrary to the traditional concept that junior doctors learn through apprenticeship from their senior colleagues.

6.4 The doctor must treat his nursing and other healthcare staff with respect and understanding, listen and act sympathetically to legitimate work or service grouses. The doctor must obtain their services as part of a team and help to create a working environment that is pleasant, and harmonious and committed to a socially and professionally fulfilling service to the patient.

6.5 Healthcare is increasingly provided by multidisciplinary and multi-specialty teams. The doctor is expected to work constructively within teams and to respect the skills and contributions of colleagues and other healthcare staff. In the case of management by multiple specialists, the primary doctor who saw the patient initially must assume the role of liaison to keep the patient and family members informed.

6.6 For a doctor to project himself to a patient as being better or superior to his colleagues, in terms of skill, expertise, experience, or professional ability, is an undesirable attitude, and patients normally feel uneasy when facing such negative behaviour in a doctor.

6.7 It is improper for a doctor to demean a colleague and to imply to a suffering patient that he could have done better, or that the other has "messed up". There are indeed patients who will come to a doctor hoping he will react in such a manner so that they could take legal action against the doctor earlier consulted.

6.8 It is mutually beneficial for a family doctor to maintain cordial working relationship with his colleagues in the same geographical area. This may take some effort, especially in an urban location, with large number of doctors practising in the same area, but it is a move that has immense benefits.

6.9 A doctor must avoid looking at colleagues in his area of practice as competitors or rivals. It is more useful for doctors to project the image of

a team, with common practice guidelines, so that patients will appreciate this and avoid clinic hopping.

6.10 On the other hand, a doctor may have good reason or grounds to believe that a colleague is practicing unethically or immorally, or is mentally or physically incapable of handling or treating patients. It is then his duty to bring the matter up to the attention of the relevant higher authority or the Malaysian Medical Council, in the interests of the public.

6.11 When a doctor refers a patient to another doctor for special investigation or treatment, it is unethical to request for kickbacks, gifts or favours in return. The premise for referral must be quality of care.

6.12 Finally, the doctor must remember that he has attained his medical education and training through teaching by, and apprenticeship with, his peers. It is therefore an honour and privilege for him to have the opportunity to perpetuate the art and craft of medical practice by imparting his knowledge and sharing his experiences with his colleagues, trainees and students at all times.

7. The Doctor, the Employer and Third-Party Administrators

7.1 The doctor, besides his role as healer, is the patient's advocate in medical interactions with the patient's employer, in respect of medical leave, fitness to work, disability certifications and other health issues.

The doctor, is also required to prepare reports for insurance claims. The doctor's duty to the insurer is to provide a fair and true account of the patient's illness and management, striving to neither over- or under-estimate the disease burden or disability.

7.2 The doctor who is employed as the medical provider for a corporate body has to balance the interest of the patient against the doctor's

responsibility to his employer. An area of potential conflict of interest is medical assessments.

7.3 The establishment and presence of Managed Care Organisations (MCOS), or Third-Party Administrators (TPA) or Healthcare Managements Organisations (HMOs) (the names being applied interchangeably but with the same meaning) in the country has to a large extent influenced the way doctors manage patients employed by corporate bodies. Primary care doctors managing such patients have come increasingly under scrutiny and pressure to act as “gate-keepers”, taking cost controlling risks, on a prepaid fee system and managing patients according to schedules and operating procedures by such organisations.

7.4 The doctor must remember his primary professional responsibility to patients when having to work under such stringent financial and operational constraints and controlled patient care, imposed by such organisations. It is important to preserve good doctor-patient relationship and doctor-patient confidentiality in whatever adverse practice environment, and the doctor must demonstrate that he is there to provide patients with individual care and concern for their health and welfare at all times.

7.5 The doctor should not feel intimidated or pressurised and yield to unfair administrative actions by corporate employers, particularly when employees are to be terminated from service, side-lined or penalised, for treatable illness with no permanent or long-term disabilities or effects. 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. In this context, the doctor must continue to exercise a balanced approach in all clinical management decisions.

8. The Doctor in Solo Practice

8.1 The doctor in solo practice often has financial obligations, having to bear rentals of premises, leasing, staff salaries and other expenses. Such a doctor may be vulnerable to demands by patients, employers, or even touts.

8.2 The doctor should not compromise on professional and ethical principles to accommodate unfair demands by such persons for financial reward or benefits. Once a doctor allows himself to be subjected to such influences, his reputation and his credibility will be tarnished.

8.3 The doctor must not tout nor canvass for patients, nor lobby with employers to be placed on their panel. The doctor must appreciate that he needs patience and time to build up his practice. Once a good and reliable reputation has been established and recognised in the community, he will be sought out.

9. The Doctor and Research

The doctor performing clinical research, particularly involving patients and human volunteers, before commencing must obtain approval from the institutional ethics committee or other related bodies. Any funding or other assistance rendered by the pharmaceutical industry and any conflict of interest in such research must be declared to the ethics committee. There are various ethical requirements which the doctor must familiarize himself with and comply, amongst which are the voluntary informed consent by the persons to participate and also to withdraw, and avoiding any harm to the participants. The doctor is required to exhibit integrity and honesty in interpretations and to report the study results whether favourable or otherwise.

10. The Doctor in Institutional Practice

10.1 The doctor practising in an institutional healthcare facility has to be mindful of the escalating cost of healthcare provision and delivery. High-tech diagnostic and treatment tend to be expensive, and doctors must evaluate the need for such procedures before ordering them for their patients.

10.2 The doctor must be aware that health resources generally are costly, precious and finite. As such, it is his duty as a guardian of such health resources, to preserve and ensure sustained high quality.

10.3 The doctor must also be conscious of the fact that he is in a position to safeguard the global environment by helping to dispose clinical wastes and toxic by-products of the drugs and chemicals used in medical practice in a manner that is least harmful.

10.4 The fundamentals of patient care by doctors are universal and apply equally whether the doctor is in public or in private practice.

10.5 In hospitals with wards with classes, the doctor must bear in mind that the "class" refers to the comfort facilities in the rooms and not to the standard or level of medical care. Treatment should not be varied according to the patient's ability to pay or the class of ward. This attitude must also be impressed upon the nursing and other healthcare staff.

10.6 Patients newly admitted to the ward should be seen as soon as possible, examined and treatment commenced without undue delay. Patients need to be attended to regularly, and rounds conducted at least once a day, and more frequently for ill patient. The doctor must appreciate that to the patient, the most comforting and important event for the day is the visit by the doctor, his gentle touch and concern and a few caring words.

11. The Doctor in Dilemma and Indemnity Cover

11.1 A patient who is dissatisfied with his treatment has a right to complain about his care, and this right to complain and to expect a prompt, open and constructive response, including an explanation, must be acknowledged. The doctor has a professional responsibility to deal with complaints positively and honestly.

11.2 The patient's complaint must not prejudice any further treatment which may be needed. If agreeable, further care of the patient should be handed over to a colleague.

11.3 If a patient has suffered serious harm for whatever reason, the doctor should act immediately to put matters right. The patient must receive a proper explanation of the short- and long-term effects.

11.4 When appropriate, the doctor should offer words of comfort and empathise with the patient and family members, which is a social etiquette. Such an act is not an admission of guilt or liability.

11.5 If a patient has died, the doctor should explain, to the best of his knowledge, the reasons for, and the circumstances of, the death to the next-of-kin. In instances where the patient had been terminally ill or at high risk for any interventions, this must have been at the outset brought to the attention of the next-of-kin.

11.6 The doctor, subject to his legal right not to provide evidence which may lead to criminal proceedings being taken against him, must co-operate fully with any formal enquiry into the treatment of the patient. Relevant information should not be withheld.

11.7 In the doctor's own interest and those of his patients, he must obtain appropriate professional indemnity cover for his practice.

11.8 The doctor who is providing locum service must ensure that the indemnity coverage includes such practice as well. The annual indemnity cover is a mandatory requirement for issuance of the annual practising certificate (APC).

11.9 When the doctor has knowledge or information of any impending criminal or civil or ethical proceedings against him, he should, as soon as possible, and definitely before responding on his own to the patient's legal counsel, inform, in writing, the firm providing such indemnity cover, to obtain early legal advice.

Annexure

A revised version of the Declaration of Geneva was adopted by the World Medical Association *(WMA)* General Assembly on October 14, 2017, in Chicago.

As a member of the medical profession:
I solemnly pledge to dedicate my life to the service of humanity;
The health and well-being of my patient will be my first consideration;
I will respect the autonomy and dignity of my patient;
I will maintain the utmost respect for human life:
I will not permit consideration of age, gender, nationality, political affiliation, race, sexual orientation, social standing or any other factor to intervene between my duty and my patient;
I will respect the secrets that are confided in me, even after the patient has died;
I will practise my profession with conscience and dignity and in accordance with good medical practice;
I will foster the honour and noble traditions of the medical profession;
I will give my teachers, colleagues and students the respect and gratitude that is their due;
I will share my medical knowledge with my patients and to the advancement of healthcare;
I will attend to my own health, well-being, and abilities in order to provide care of the highest standard;
I will not use my medical knowledge to violate human rights and civil liberties, even under threat;
I make these promises solemnly, freely and upon my honour.

References and Further Reading

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10. Sale of Drugs Act 1952
11. Control of Drugs and Cosmetics Regulations sections 2,7 and 9: 1984

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4. Expert Witness, 2019
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7. Plagiarism, 2017
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