CODE OF PROFESSIONAL CONDUCT 2019

FOREWORD

The members of the medical profession are required to abide by the Code of Professional Conduct of the Malaysian Medical Council. Consonant with the motto of the Council “Safeguarding Patients, Guiding Doctors”, the objective of the Code is to ensure propriety in professional practice by medical practitioners and prevention of abuse of professional privileges.

This edition of the Code, which has been adopted by the Malaysian Medical Council at its 388th meeting, has been revised from the 1987 Code and new sections relevant to the current state of development of ethical professional care have been added.

It also makes reference to the statutory implications of practice and disciplinary procedures as defined in the Medical Act 1971 (Amended 2012) and Regulations 2017.

I urge all medical practitioners to familiarise with the revised 2019 edition of the Code and abide by it.

Tan Sri Dato’ Seri Dr. Noor Hisham bin Abdullah
PSM, PJN, SPMS, SPMP, DPMP, SSAP, SSNS, DMPN, KMN, MD
President
Malaysian Medical Council

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Code of Professional Conduct 2019
is on the
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INTRODUCTION

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

The practice of Medicine is an ancient profession and the community has great expectations of its practitioners and places great trust in them. The relationship between practitioners and patients is privileged, and it is on this basis that practitioners gain access to the most intimate emotions and secrets of patients in the course of management of their illness. Without this privilege and trust it would be impossible to practice medicine and the profession expects a high standard of professional and personal conduct from its members. These are embodied in various Codes of Medical Professional Ethics, which vary in detail from country to country, but all place the health and welfare of the individual and the family under the care of a practitioner of the foremost importance.

The Malaysian Medical Council is composed of peers in the medical profession, and is established under the Medical Act 1971 (Amended 2012).

The Code of Professional Conduct, issued under the authority of the Malaysian Medical Council, provides the yardstick for the conduct and behaviour of registered medical practitioners in their clinical practices and in all areas of professional activity. To complement the Code, and to provide additional explanations on the many topics in the Code, the Council has documents on Good Medical Practice and Confidentiality, and other Guidelines, as well as periodic directives, and these should be read in conjunction with the Code. The Code and the guidelines discuss, not ideal behaviour, but the minimum standards of conduct expected of a registered medical practitioner and assessed by the Malaysian Medical Council.

The Medical Act 1971 (Amended 2012) is the legislation relating to the registration of medical practitioners and the practice of Medicine, and with the Medical Regulations 2017 to the Act, empower these objectives, to deal with all disciplinary matters involving registered medical practitioners. The statutes underpinning the Code

of Professional Conduct make it an offence punishable, after due process of inquiry, when there are transgressions of the expected norms of practice.

By publishing this Code, it is the desire of the Malaysian Medical Council that no practitioner will have committed professional misconduct on grounds of ignorance of the expected standards of professional conduct in this country.

It is important that all registered medical practitioners should obtain a copy of the Code of Professional Conduct and all related guidelines. The Council expects all registered medical practitioners to familiarise themselves with this Code and Guidelines and direct any enquiries to the Chief Executive Officer of the Council. Medical practitioners may also wish to consult the Ethics Committees of the Malaysian Medical Association, the Academy of Medicine of Malaysia and other medical professional organisations on matters in which they need clarifications.

Explanatory Notes:

a. Where reference has been made to one gender, it should be read as applicable to both genders.

b. The words “must, should and may” are used throughout the Code. To appreciate the level of importance and usage of these nodal verbs, the following guidelines are provided:

   i. “Must” is used to indicate the overriding duty and the principles that must be upheld;

   ii. “Should” is used to indicate advice on the best practice and what is strongly encouraged. Failure to comply with the advice, depending on the circumstances in which the breach has occurred, may be actionable; and

   iii. “May” indicates an optional course of action which is permissible within the obligations laid down in the Code.

PART I

POWERS OF THE MALAYSIAN MEDICAL COUNCIL

Section 4A of the Medical Act 1971 (Amended 2012)

4A. (1) The Council shall have the power to do all things expedient or reasonably necessary for or incidental to the carrying out of its functions under this Act.

(2) Without prejudice to the generality of subsection (1), the powers of the Council shall include power to –

a. ensure that the provisions of this Act and the regulations are administered, enforced, given effect to, carried out and complied with;
b. regulate the standards of practice of registered medical practitioners;
c. regulate the professional conduct and ethics of registered medical practitioners;
d. approve or refuse any application for registration or certification in accordance with this Act or regulations;
e. determine any fees or fines payable;
f. issue certificates;
g. borrow or raise money from time to time by bank overdraft or otherwise for any of the purposes specified in this section; and
h. recognize and accredit medical qualifications based upon the recommendation of the Joint Technical Committee establish under Malaysian Qualifications Agency Act 2007 [Act 679] for the purpose of registration.

DISCIPLINARY JURISDICTION OF THE COUNCIL

Disciplinary jurisdiction over registered medical practitioners is conferred upon the Malaysian Medical Council by Section 29 of the Medical Act 1971 (Amended 2012) which reads as follows:

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

2. The Council may exercise disciplinary jurisdiction over any registered person who –
   a. has been convicted in Malaysia or elsewhere of any offence punishable with imprisonment (whether in itself only or in addition to or in lieu of a fine);
   aa. has had his qualification withdrawn or cancelled by the awarding authority through which it was acquired or by which it was awarded;
   b. was alleged to have committed serious professional misconduct as stipulated in the Code of Professional Conduct and any other guidelines and directives issued by the Council;
   c. has obtained registration by fraud or misrepresentation;
   d. was not at the time of his registration entitled to be registered; or
   e. has since been removed from the register of medical practitioners maintained in any place outside Malaysia.

THE MEANING OF SERIOUS PROFESSIONAL MISCONDUCT

The Malaysian Medical Council attests to the principle that ‘serious professional misconduct’ means a failure to meet the minimum standards of professional medical practice as set out in the Code of Professional Conduct, guidelines and directives issued by the Council, as stated under Disciplinary Jurisdiction of the Council in Section 29 (2)(b) of Medical Act 1971 (Amended 2012).

The Council endorses the definition of serious professional misconduct laid out by the Privy Council (*Lord Clyde in Roylance v General Medical Council [1999] 3 WLR 541, [1999] Lloyd's Rep Med 139*), as follows:

> “Misconduct is a word of general effect, involving some act or omission which falls short of what would be proper in the circumstances. The standard of propriety may often be found by reference to the rules and standards ordinarily required to be followed by a medical practitioner in the particular circumstances. The misconduct is qualified in two respects. First, it is qualified by the word "professional" which links the misconduct to the profession of medicine. Secondly, the misconduct is qualified by the word "serious". It is not any professional misconduct which will qualify. The professional misconduct must be serious.”

> “It is not simply misconduct in the carrying out of medical work which may qualify as professional misconduct. But there must be a link with the profession of medicine. Precisely what that link may be and how it may occur is a matter of circumstances. The closest link is where the practitioner is actually engaged on his practice with a patient…”

> “But certain behaviour may constitute professional misconduct even although it does not occur within the actual course of the carrying on of the person's professional practice, such as the abuse of a patient's confidence or the making of some dishonest private financial gain.”

> “But that definition is clearly not, and was not intended to be, exhaustive or comprehensive. To take the point a stage further, serious professional misconduct may arise where the conduct is quite removed from the practice of medicine, but is of a sufficiently immoral or outrageous or disgraceful character.”

Degrees of concurrent acts of moral turpitude, dishonesty, or incompetence may determine the severity of punishment.

CONVICTIONS IN A COURT OF LAW

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

It is therefore unwise for a practitioner to plead guilty in a court of law to a charge to which he believes that he has a defence. In all such instances, the advice of a legal counsel should be sought.

PART II

FORMS OF SERIOUS PROFESSIONAL MISCONDUCT

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

Any abuse by a practitioner of any of the privileges and opportunities afforded to him or any grave dereliction of professional duty or serious breach of medical ethics may give rise to a charge of serious professional misconduct. In discharging their respective duties, the Preliminary Investigation Committee and the Disciplinary Board and the Council must proceed as quasi-judicial bodies. Only after considering the evidence in each case can the Council determine the gravity of a conviction or decide whether a practitioner's behaviour amounts to serious professional misconduct.

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

1. Neglect or Disregard of Professional Responsibilities
2. Abuse of Professional Privileges and Skills
3. Conduct Derogatory to the Reputation of the Medical Profession
4. Advertising, Canvassing and Related Professional Offences

1. NEGLECT OR DISREGARD OF PROFESSIONAL RESPONSIBILITIES

1.1 Responsibility for Standards of Medical Care to Patients

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

The public is entitled to expect that a registered medical practitioner will provide and maintain a good standard of medical care. This includes:

a. conscientious assessment of the history, symptoms and signs of a patient's condition;
b. sufficiently thorough professional attention, examination and where necessary, diagnostic investigation;
c. competent and considerate professional management;
d. appropriate and prompt action upon evidence suggesting the existence of a condition requiring urgent medical intervention; and
e. readiness, where the circumstances so warrant, to consult, or refer the patient to appropriate professional colleagues.

A comparable standard of practice is to be expected from medical practitioners whose contributions to a patient’s care are indirect, for example those in pathology and radiological specialties.

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

The Council is not ordinarily concerned with errors in diagnosis or treatment, or with the kind of matters which give rise to action in the civil courts for negligence, unless the practitioner's conduct in the case has

involved such a disregard of the standard of care that he should have provided to his patients or such a neglect of his professional duties as to raise a question of serious professional misconduct.

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

1.2 The Practitioner and Requests for Consultation

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

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

1.2.2 The primary practitioner, who is the practitioner first seeing the patient, or the practitioner to whom care of the patient has been transferred, may manage the patient himself or may refer the patient to another practitioner or specialist, called the referred practitioner. The primary practitioner should advise the patient accordingly, but he should not refuse to refer to a registered medical practitioner selected by the patient or next of kin.

1.2.3 The arrangements for consultation should be made or initiated by the primary practitioner, and should be followed up with a referral letter and relevant results of laboratory, imaging and any other investigations.

He should acquaint his patient of the approximate expenses which may be involved in specialist consultations and examination.

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

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

Similarly, a primary practitioner who had received the patient on transfer must provide feedback in the form of a written status report to the doctor who had earlier transferred the patient to him.

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

1.2.7 In instances when the patient requests the referred practitioner to take over further management, the primary practitioner should accept the right of choice by the patient amicably.

1.3 The Practitioner and his Practice
Partners, Assistants and *Locum Tenentes*.

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

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

1.4 Consent for Medical Examination and Treatment

Obtaining valid consent is an important component of a sound doctor-patient relationship. For the consent to be valid, it should satisfy the requirements of informed consent. It must be given freely and voluntarily, and not induced by fraud or deceit. It must be obtained in a language which the person understands, or with the help of an interpreter. The patient or person giving consent must have the legal capacity and soundness of mind, and must be aware of the implications of undergoing the proposed procedure. The procedure must be explained together with alternative procedures and the known complications. The patient or person giving consent must be given sufficient opportunity to seek further explanations.

1.5 Confidentiality

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

A practitioner may release confidential information in strict accordance with the patient's written consent, or the consent of a person properly authorized to act on the patient's behalf. When such permission is granted, the practitioner should only disclose such relevant confidential information for a specific purpose. Release of confidential information is sometimes a statutory requirement, and the patient must be informed of such disclosure.

1.6 Improper Delegation of Medical Duties

1.6.1 Employment of Unqualified or Unregistered Persons

The employment by a registered practitioner in his professional practice, of persons not qualified or registered under the Medical Act 1971, and the permitting of such unqualified or unregistered person to attend, treat or perform operations upon patients in respect of matters requiring professional discretion or skill, or providing certificates of any kind is, in the opinion of the Council, in its nature fraudulent and dangerous to the public. Any registered practitioner who shall be proved to the satisfaction of the Council to have so employed an unqualified or unregistered person will be liable to disciplinary punishment.

1.6.2 Covering

Any registered practitioner who by his presence, countenance, advice, assistance, or cooperation, knowingly enables an unqualified or unregistered person, whether described as an assistant or otherwise, to attend, treat, or perform any invasive or other medical procedures upon a patient in respect of any matter requiring professional discretion or skill, to issue or procure the issue of any certificate, notification, report, or other document of a kindred character, or otherwise to engage in professional practice as if the said person were duly qualified and registered, will be liable, on proof of the facts to the satisfaction of the Council, to disciplinary punishment.

1.6.3 Association with Unqualified or Unregistered Persons

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

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

1.7 Partnership with Unqualified or Unregistered Persons

Any registered practitioner who knowingly forms a professional partnership with an unqualified or unregistered person, will be liable on proof of the facts satisfactory to Council, to disciplinary punishment.

1.8 Medical Research

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

1.8.1 In any research on human beings, each potential subject must be adequately informed of the aims, methods, anticipated benefits and potential hazards of the study and the discomfort it may entail. He or she should be informed that he or she is at liberty to abstain from participation at any time. The practitioner should then obtain the subject's freely-given informed consent, preferably in writing.

1.8.2 The practitioner can combine medical research with professional care, the objective being the acquisition of new medical knowledge, only to the extent that medical research is justified by its potential diagnostic or therapeutic value for the patient.

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

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

1.8.5 In any research involving human subjects, the approval of the relevant institutional ethics committee and/or the Medical Research and Ethics Committee (MREC) of the Ministry of Health should be obtained prior to commencement.

1.9. The Practitioner and the Pharmaceutical/Medical Equipment Industry

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

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

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

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

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

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

1.10 The Practitioner and Third-Party Administrators (TPA)

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

patient before release of information on illness, investigation results and management to an employer or to a third party.

1.11 The Practitioner and the Practice of Traditional and Complementary Medicine

The practitioner should not prescribe or promote traditional health supplements or traditional medications, or practise traditional treatment methods, unless such products or practices are evidence based.

1.12 Professional Fees

The practitioner should avoid any conflict with the patient on the professional fees charged by him after treatment, or for any medical report, and should provide the patient with written information on estimated charges and the basis for them before treatment is commenced or report provided.

The improper or unreasonable or unjustified demand or acceptance of professional fees from patients contrary to the relevant schedules and provisions must be avoided.

1.13 Expert Testimony in Court

A practitioner may be requested or required to provide expert opinion in court, and such opinion must be unbiased and honest and bereft of conflict of interest, and confined to the practitioner’s area of expertise.

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

1.14 End of Life Professional Management

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

A practitioner must not be involved in euthanasia and/or assist in suicide of patients.

A practitioner may be confronted with a Living will (or Advance Medical Directive) (AMD) which is a written statement detailing a person's desires regarding future medical treatment in circumstances in which he is no longer able to express informed consent. The circumstances may be imminent death, terminal illness, or severe and irreversible conditions. Any decision by the practitioner, to comply with or not to comply with the AMD, must be made in consultation with relatives and next-of-kin of the patient.

2. ABUSE OF PROFESSIONAL PRIVILEGES AND SKILLS

2.1 Abuse of Privileges Conferred by Law

2.1.1 Prescribing of Drugs

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

The Council regards as serious professional misconduct the prescription or supply of drugs including drugs of dependence otherwise than in the course of bona fide treatment. A practitioner may be convicted of offences against the laws which control drugs.

A practitioner must not prescribe such drugs in order to gratify his own addiction or the addiction of other persons.

2.1.2. Dangerous Drugs

The contravention by a registered practitioner of the provisions of the Dangerous Drugs Act 1952 and the Regulations made thereunder may be the subject of criminal proceedings, and any conviction resulting therefrom may be dealt with as such by the Council in exercise of their powers under the Medical Act 1971 (Amended 2012). But any contravention of the Act or Regulations, involving an abuse of the privileges conferred thereunder upon registered practitioners, whether such contravention has been the subject of criminal proceedings or not, will be subjected to disciplinary punishment.

2.1.3 Sale of Poisons

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

2.1.4 Certificates, Notifications, Reports, etc.

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

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

2.1.4.2 Medical sick certificates are issued by practitioners for guidance on employment by the employer. The issuing of medical sick certificates without proper examination of patients, pre-signing of such certificates, failure to keep proper records in patient's notes, back-dating for unacceptable reasons, or issuance of sick certificates for lengthy durations without interim examination even for chronic illnesses, and such related matters, is serious professional misconduct. The stating of the diagnosis of the illness on the medical sick certificate is permissible only with the consent of the patient. Medical sick certificates should be signed by the practitioner and his name and MMC registration numbers stamped, with the date of issue clearly indicated.

Backdating of medical sick certificates, which is defined as the issuance of a medical sick certificate on a date after the consultation or treatment, is allowed onlyunder special circumstances when the practitioner has

treated the patient and is aware of his medical condition, and the practitioner must accept responsibility for his actions in this respect.

2.1.4.3 Electronic medical sick certificates must satisfy all the requirements of issuance as well as ensure security and restricted accessibility.

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

2.1.4.5 Patient's Medical Records and Clinical Notes

A medical record is the documented personal and confidential information, whether written or electronic, of the patient. Besides the patient's personal details, it also contains the practitioner's personal findings on the examination and management of his illness. The records must be kept in safe and secure custody at all times. The records may be requested for by the patient and demanded by the courts of law.

A practitioner must avoid the erasing, obliterating, tampering or altering of previously made entries in the clinical records, as these may be interpreted as attempts to cover up management errors or adverse events.

2.1.4.6 Denial of Disclosure of Medical Records

A medical practitioner may, on grounds other than the absence of written consent from a patient or legal next-of-kin or guardian, deny disclosure of the contents of the Medical Record, if in his considered opinion, the contents if released may be detrimental or disparaging to the patient, or any other individual, or liable to cause serious harm to the patient's mental or physical health or endanger his life. The practitioner may also deny disclosure particularly if the patient is deceased. In such instances, the practitioner is required to justify his decision to deny disclosure.

2.1.5. Medical Reports

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

A medical practitioner may be required to provide comprehensive medical reports when requested by patients or by the legal next of kin, in the case of minors or persons under disability, or by the employer with the specific consent by the patient. Any refusal or undue or unexplained delay in providing such report, or withholding of such report on the grounds of non-payment of hospital charges or professional fees, is unethical.

2.2. Abuse of Privileges Conferred by Custom

2.2.1 Abuse of Trust

Patients grant practitioners privileged access to their homes and confidences and some patients are liable to become emotionally

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

2.2.2 Abuse of Confidence

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

2.2.3 Undue Influence

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

2.2.4 Personal Relationships between Practitioners and Patients

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

2.2.5 Practitioner’s Inability or Fitness to Practice

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

2.2.6 Medical Errors and Incident Reporting

A medical practitioner who commits errors in the course of management of his patient must avoid concealing them from the patient or those in authority and must record such events in the patient records/notes. It is unethical for the practitioner not to be truthful and honest in such an event.

2.2.7 Chaperone

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

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

3. CONDUCT DEROGATORY TO THE REPUTATION OF THE MEDICAL PROFESSION

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

3.1 Respect for Human Life

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

The practitioner must not countenance, condone or participate in the practice of torture or other forms of cruel, inhuman or degrading procedures, whatever the offence of which the victim of such procedures is suspected, accused or guilty, and whatever the victim's beliefs or motives, and in all situations, including armed conflict and civil strife. The practitioner must not provide any premises, instruments, substances or knowledge to facilitate the practice of torture or other forms of cruel, inhuman or degrading treatment or to diminish the ability of the victim to resist such treatment.

A practitioner engaged in a prison or in places of detention must provide professional care in the interest and well-being of the inmates.

3.2 Personal Behaviour

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

3.2.1 Personal Misuse or Abuse of Alcohol or Drugs

A practitioner's conviction for drunkenness or drug abuse or other offences (driving a vehicle when under the influence of alcohol or drugs) indicate habits which are discreditable to the profession and may lead to an inquiry by the Council.

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

3.2.2 Dishonesty: Improper Financial Transactions

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

A practitioner must not commit dishonest acts in the course of his professional practice or against his patients or colleagues. Such acts, if reported to the Council, may result in disciplinary proceedings.

A practitioner must not prescribe or dispense drugs or appliances for improper motives. A practitioner's motivation may be regarded as improper if he has prescribed a drug or appliance purely for his financial benefit or if he has prescribed a product manufactured or marketed by an organisation from which he has accepted an improper inducement.

3.2.3 Fee Splitting or Kick-back Arrangement

A practitioner must not practise fee-splitting or any form of kick back arrangement as an inducement to refer or to receive a patient from another practitioner, institution, organisation or individual. The premise for referral must be quality of care.

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

3.2.4 Indecency and Violence

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

A practitioner must treat colleagues and staff with due respect and dignity at all times and avoid any act, verbal or physical, which may cause harm or injury, or which may be interpreted as harassment, including gender-related, aggressive pressuring or intimidating behaviour.

3.3 A Colleague’s Incompetence to Practice

Where a practitioner becomes aware of a colleague's incompetence to practice, whether by reason of taking drugs or by physical or mental incapacity, or has a medical condition which may pose a risk to his patient, or repeated acts of poor standard of patient care, then it is the practitioner’s ethical responsibility even without the need to obtain his consent to draw this to the attention of a higher authority who is in a position to act appropriately.

If the practitioner is treating a colleague who is physically or mentally impaired to the extent that patients have been harmed or are at imminent risk of harm, the practitioner must first counsel the colleague to self-report, failing which the practitioner must report the colleague to the relevant authorities even without his consent, in which case the practitioner's obligation to patient confidentiality shall be waived.

3.4 The Practitioner and Commercial Undertakings

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

A practitioner must not associate himself with commerce in such a way as to let it influence, or appear to influence, his attitude towards the treatment of his patients.

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

A practitioner has a duty to declare an interest before participating in any discussion which could lead to the purchase by a public or private authority of goods or services in which he, or a member of his immediate family, has a direct or indirect pecuniary interest. Non-disclosure of such information may amount to serious professional misconduct.

Where the practitioner has a financial interest in any facility to which he refers patients for diagnostics tests, for procedures or for inpatient care, he must disclose his interest in the institution to the patient.

3.5 Plagiarism

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

A medical practitioner who commits plagiarism, in whatever degree, extent or form as stated above, or in any related manner, may have conducted an act derogatory to the reputation of the medical profession.

4. ADVERTISING, CANVASSING AND RELATED PROFESSIONAL OFFENCES

The medical profession in this country has long accepted the convention that doctors should refrain from self-advertisement. In the Council's opinion self-advertisement is not only incompatible with the principles which should govern relations between members of a profession but could be a source of danger to the public. A practitioner successful at achieving publicity may not be the most appropriate doctor for a patient to consult. In extreme cases advertising may raise illusory hopes of a cure.

4.1 Advertising and Canvassing

A registered medical practitioner must not act contrary to accepted ethical norms and to the public interest, and in a manner which is discreditable to the profession of medicine. Such acts include but are not limited to –

i. Advertising, whether directly or indirectly, for the purpose of obtaining patients;
ii. Advertising, whether directly or indirectly, for the purpose of promoting one's own professional advantage;

iii. Procuring, or sanctioning or acquiescing in the publication of notices commending or directing attention to the practitioner's professional skill, knowledge, services or qualification for the purposes set out in (i) and (ii) above;

iv. Procuring, or sanctioning or acquiescing in the publication of notices deprecating the skill, knowledge, services or qualification of other practitioners for the purposes set out in (i) or (ii) above;

v. Being associated with, or employed by, those who procure or sanction advertising as described in (i) or (ii) above;

vi. Being associated with, or employed by, those who procure or sanction the publication of notices as described in (iii) or (iv) above;

vii. Canvassing, or engaging any agent or canvasser, for the purpose of obtaining patients;

viii. Sanctioning the act of canvassing or employment of any agent or canvasser, for the purpose of obtaining patient;

ix. Being a party to, abetting, condoning, being associated with or employed by those who sanction the act of canvassing or employ any agent or canvasser for the purpose of obtaining patients e.g. private hospitals, clinics and other medical institutions.

4.2 Dissemination of Information

The Council recognises that the profession has a duty to disseminate information about advances in medical sciences, healthcare products and therapeutics provided it is done in an ethical manner.

Specifically, registered medical practitioners should be aware of the following matters when disseminating such information, which may amount to self-advertisement and/or may be unethical, depending on the circumstances.

4.2.1 Practitioners may have their name, qualifications and primary place of practice stated in articles, literary contributions and

publications for the lay public. However, practitioners should take every effort to ensure that such publications do not contain laudatory editorial references to the practitioner's professional status or experience.

4.2.2 While photographs of the practitioner in connection with articles or contributions in the media (including social media) are permitted, photographs of patients (whether full or in part) must not be used.

4.2.3 Where a publication has arisen as a result of research on any instrument or drug provided by a commercial firm, this should be stated in the publication, together with a disclaimer/statement regarding any financial interest of the author(s) with the firm. Similarly, if the practitioner presents a lecture/talk which involves a commercial product, this should be declared, as well as any affiliation or financial interest the practitioner may have with the commercial firm in question.

4.2.4 Practitioners may be in a position to educate their colleagues or present some new method of treatment or innovation to other practitioners. In such cases, talks or presentations must be organised only through professional bodies, medical educational institutions or registered healthcare facilities.

4.2.5 Interviews with the media on subjects relating to disease and their treatment should be avoided by a medical practitioner engaged in active medical or surgical practice, except through an association or authorised organisation. An authorised organisation or institution is defined as any *bona fide* college, medical educational institution, medical professional body or society.

4.3 Professional Calling Cards, Letterheads, Name Plates, Signboards, Banners etc.

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

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

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

4.3.4. Name plates and doorplates should conform with the limits laid down by the Council as contained in Appendix IV.

4.3.5. 24-Hour Clinics should conform with the requirements laid down by the Council as contained in Appendix V.

4.3.6. A temporary banner to announce the opening of a new healthcare facility must satisfy local government requirements. The banner is only permitted to be displayed at the entrance to the premise and must not contain the name, photograph or particulars of any registered medical practitioner.

4.3.7. A billboard (also called a hoarding) promoting any healthcare facility must satisfy local government requirements and must not contain the name, photograph or particulars of any registered medical practitioner.

PART III

DISCIPLINARY PROCEDURES

Medical Act 1971 (Amended 2012)
and
Medical Regulations 2017

Disciplinary Panel

In accordance with Regulations 34 to 42, 44 and 45 of Medical Regulations 2017 –

34. (1) A Disciplinary Panel shall be established from which members of the Preliminary Investigation Committee and Disciplinary Board shall be drawn.

(2) The Disciplinary Panel shall consist of the following members who shall be appointed by the Council:

(a) Council members;
(b) fully registered medical practitioners of at least ten years of good standing with current annual practising certificates; and
(c) any person other than in paragraph (a) or (b).

(3) The members of the Disciplinary Panel shall hold office for a term not exceeding three years and may be eligible for reappointment.

(4) The Council may, at any time, revoke the appointment of any member of the Disciplinary Panel.

Preliminary Investigation Committee

35. (1) The Preliminary Investigation Committee shall consist of not more than five members selected from the Disciplinary Panel.

(2) The function of the Preliminary Investigation Committee is to conduct a preliminary investigation into complaints or information touching on any disciplinary matter to determine whether or not there shall be an inquiry.

(3) The quorum of the Preliminary Investigation Committee shall be three.

Disciplinary Board

36. (1) The Disciplinary Board shall consist of the following members who shall be selected from the DisciplinaryPanel:

(a) at least three members of the Council;
(b) three fully registered medical practitioners of atleast ten years of good standing with current annual practising certificates; and
(c) any other person than in paragraph (a) or (b).

(2) The function of the Disciplinary Board is to conduct an inquiry on any complaint or information touching on any disciplinary matter received against any medical practitioner.

(3) The quorum of Disciplinary Board shall be five.

Provisions relating
to Preliminary Investigation Committee
or Disciplinary Board

37. (1) The Council shall appoint a fully registered medical practitioner from among members of the Preliminary Investigation Committee or the Disciplinary Board, as the case may be, to be the chairman of the respective committees.

(2) The chairman shall preside at all meetings of the Preliminary Investigation Committee or the Disciplinary Board, as the case may be.

(3) In the absence of the chairman, the most senior fully registered medical practitioner present at the meeting of such Preliminary Investigation Committee or the Disciplinary Board, as the case may be, shall preside the meeting.

(4) The decision of the Preliminary Investigation Committee or the Disciplinary Board, as the case may be, shall be made by a majority of votes.

(5) In the event of equality of votes, the chairman, or in his absence, the person chairing the meeting shall have a casting vote in addition to his deliberative vote.

(6) The Preliminary Investigation Committee or the Disciplinary Board shall determine its own procedure.

(7) No act done or proceedings taken by the Preliminary Investigation Committee or the Disciplinary Board, as the case may be, shall be invalid on the ground of –

(a) any vacancy in the membership of, or any defect in the constitution of the Preliminary Investigation Committee or the Disciplinary Board; or

(b) any omission, defect or irregularity not affecting the merits of the case.

(8) A member of the Preliminary Investigation Committee or the Disciplinary Board shall, subject to such conditions as may be specified in his instrument of appointment, unless he sooner resigns, hold office for a term not exceeding three years and is eligible for reappointment.

(9) The Council may, at any time, revoke the appointment of any member of the Preliminary Investigation Committee if such person is found by the Council to be no longer a fit and proper person to carry out the functions under sub regulation (1).

(10) A member of the Preliminary Investigation Committee may at any time resign his office by giving a notice in writing to the Council and a copy of the notice to the committee.

(11) The Council may appoint any person it thinks fit to fill the vacancy for the remainder of the term vacated by a member.

Complaint against Registered Medical Practitioner

38. (1) Any complaint or information pertaining to any registered medical practitioner shall be made in writing and addressed to the Council.

(2) The Council shall submit the complaint or information received to the Preliminary Investigation Committee.

(3) The quorum of the Preliminary Investigation Committee shall be three.

In order to carry out this specific role, the Council has established a Complaint Management Committee ("CMC"), comprising of three (3) members of the Council. These three (3) members of the CMC will hold office as members of this Committee for a period of one (1) year, unless otherwise decided by the Council.

The CMC will sit as and when required to scrutinize complaints/information received by the Council against RMPs and to forward the same to one of the Preliminary Investigation Committees (PIC) set up under Regulation 35 of the Medical Regulations 2017.

The CMC is required to ensure that the complaint/information complies with the requirements of Regulation 38(1) before such complaint/information is forwarded to a PIC:

(a) the complaint / information must be in writing; and
(b) the complaint / information must be against an RMP.

Summary Dismissal of Complaint

39. (1) The Preliminary Investigation Committee may recommendto the Council to summarily dismiss any complaint or information if it is satisfied –

(a) the name and address of the complainant is unknown or untraceable;

(b) even if the facts were true, the facts do not constitute a disciplinary matter; or

(c) there is reason to doubt the truth of the complaint or information.

(2) The Preliminary Investigation Committee may, before recommending any summary dismissal, require the complainant to make a statutory declaration of the facts alleged by him.

(3) The Preliminary Investigation Committee shall provide reasons for such recommendation in sub-regulation (1).

Procedure of Investigation

40. (1) Where the Preliminary Investigation Committee has reason to believe that the complaint or information isprobably true, the Preliminary Investigation Committeeshall –

(a) notify the registered medical practitioner concerned of the receipt of a complaint or information with regard to him;

(b) forward a copy of the complaint or information and any supporting statutory declaration and document received to the registered medical practitioner concerned;

(c) require the registered medical practitioner concerned to submit a reply to the complaint or information within thirty days from the receipt of the notification; and

(d) request from the registered medical practitioner concerned for clarification or further documents to be provided within the period of fourteen days from the receipt of the request.

(2) Upon considering the reply and clarification, if any, by the registered medical practitioner concerned, the Preliminary Investigation Committee may recommend to the Council –

(a) no further action shall be taken on the complaint or information received; or

(b) the complaint or information received shall be forwarded to the Disciplinary Board for an inquiry to be held.

(3) If at the close of the investigation, the Preliminary Investigation Committee finds that there are serious grounds to support the allegation against the registered medical practitioner concerned, the Preliminary Investigation Committee may recommend to the Council to appoint a member of the Disciplinary Panel who was not involved with the investigation as the complainant if –

(a) the actual complainant withdraws the complaint or information; or

(b) the actual complainant is not contactable by the Preliminary Investigation Committee.

Recommendation and Record of Investigation

41. (1) The recommendation and record of investigation by the Preliminary Investigation Committee shall be preparedand forwarded to the Council within thirty days from the close of investigation.

(2) The Council may, upon considering the recommendation of the Preliminary Investigation Committee, for reasons to be recorded –

(a) summarily dismiss the complaint or information; or

(b) forward the complaint or information together with the recommendation of the Preliminary Investigation Committee to the Disciplinary Board for an inquiry.

Inquiry by Disciplinary Board

42. (1) Upon receipt of the complaint or information together withthe recommendation of the Preliminary Inquiry Committee,the Disciplinary Board –

(a) may issue an interim order to the registered medical practitioner concerned in accordance with section 29A of the Act;

(b) shall, by a written order, require the attendance of the complainant and any person appears to be acquainted with the circumstances of the complaint or information, before the Disciplinary Board on a date, time and place to be specified in the order; and

(c) shall notify the registered medical practitioner concerned –

(i) the date, time and place at which the inquiry into the complaint or information shall be held; and

(ii) his rights to be present with or without counsel at the inquiry.

(2) The Disciplinary Board shall convene the inquiry on the date, time and place specified in the order and shall proceed to inquire into the allegation made against the registered medical practitioner concerned even if he is not present.

(3) The Disciplinary Board shall examine the complainant and any person in support of the allegation.

(4) The complainant and any person referred to in sub-regulation (3) may be cross-examined by the registered medical practitioner concerned and further be re-examined by the Disciplinary Board if necessary.

(5) The Disciplinary Board shall record all statements made by the complainant and person examined.

(6) For the purposes of the inquiry, the Disciplinary Board may require the complainant or the registered medical practitioner concerned –

(a) to produce any material with regard to the inquiry by the Disciplinary Board and to make copies of such material; or

(b) to attend at a specified time and place to give evidence and to produce any book, document, paper or other record.

(7) After taking the statements of the complainant and the persons referred to in sub-regulation (3), the Disciplinary Board shall –

(a) if the Disciplinary Board finds that there are not sufficient grounds to support the allegation, recommend to the Council that no further action shall be taken on the registered medical practitioner concerned; or

(b) if the Disciplinary Board finds that there are sufficient grounds to support the allegation, frame a charge against the registered medical practitioner concerned and explain to him that he is at liberty to state his defence on the charge framed against him and call witnesses in support of his defence.

(8) If the registered medical practitioner concerned after being informed of his rights elects not to make a statement or call any witnesses in support of his defence, the Disciplinary Board may recommend to the Council to find such registered medical practitioner concerned guilty of the offence charged against him.

(9) If the registered medical practitioner concerned elects to make his defence before the Disciplinary Board, his statement and the statements of his witnesses, if any, shall be recorded and the Disciplinary Board may cross examine him and his witnesses on their statements.

Recommendation by Disciplinary Board

44. (1) After considering the statement of the registered medical practitioner concerned and his witnesses, if any, together with the evaluation report of the Fitness to Practise Committee, if any, the Disciplinary Board shall –

(a) if the Disciplinary Board finds that there are no sufficient grounds to support the charge, recommend to the Council that no further action shall be taken on the registered medical practitioner concerned; or

(b) if the Disciplinary Board finds the registered medical practitioner concerned guilty of the charge, the Disciplinary Board shall inform the registered medical practitioner concerned of its finding and the reasons for its decision.

(2) The Disciplinary Board shall request such registered medical practitioner concerned to make any plea in mitigation and after hearing such plea, if any, recommendto the Council any of the punishments under section 30 ofthe Act.

Decision of Council

45. (1) The Council may, upon considering the records of the inquiry and recommendation of the Disciplinary Board, forreasons to be recorded –

(a) accept the recommendation of the Disciplinary Board and impose the punishment;

(b) direct the Disciplinary Board to reconvene the meeting and inquire further into the complaint or information;

(c) direct that a new Disciplinary Board be constituted and conduct an inquiry into the complaint or information;

(d) direct that the charge be dismissed if the Council finds that no case has been made out against the registered medical practitioner concerned;

(e) reject the recommendation of the Disciplinary Board and makes its decision; or

(f) give such other direction as the Council thinks fit.

(2) The Council shall inform the registered medical practitioner concerned of the decision made under sub-regulation (2).

(3) The Council shall have the right to publish in the media the conclusion of any inquiry done.

Appeal against Orders of the Council

In accordance with Section 31 of the Medical Act 1971 (Amended 2012) –

31. (1) Any person who is aggrieved by any order made in respectof him by the Council in the exercise of its disciplinary jurisdiction may appeal to the High Court, and the High Court may thereupon affirm, reverse or vary the order appealed against or may give such direction in the matter as it thinks proper; the cost of the appeal shall be in the discretion of the High Court.

(2) (Deleted by Act A1443).

(3) The practice in relation to any such appeal shall be subject to the rules of court applicable in the High Court:

Provided that the High Court shall not have power to hear any appeal against an order made under Section 30 unless notice of such appeal was given within one month of the service of the order in the prescribed manner.

Interim Orders

In accordance with Section 29A of the Medical Act 1971 (Amended 2012) –

29A. (1) Where upon due inquiry into any complaint or information referred to it, a Disciplinary Board is satisfied that it is necessary for the protection of the members of the public or it is otherwise in the public interest, or it is in the interest of a registered medical practitioner for his registration to be suspended or to be made subject to conditions, the Board may make an order –

(a) that his registration in the appropriate register be suspended for such period not exceeding twelve months as may be specified in the order (referred to in this Part as an interim suspension order); or

(b) that his registration be continued on hiscompliance, during such period not exceeding twelve months as may be specified in the order, of such requirement as the Disciplinary Board thinks fit to impose (referred to in this Part as an order for interim restricted registration).

(2) The Registrar shall immediately serve a notification of the order under subsection (1) on the registered medical practitioner.

(3) Subject to subsection (1), where a Disciplinary Board has made an order under this section, the Disciplinary Board or another Disciplinary Board appointed in its place –

(a) shall review it within a period of six months beginning on the date on which the order wasmade, and shall thereafter, for so long as the order continues in force, further review it before the end of a period of three months beginning on the date of the decision of the immediately preceding review; and

(b) may review it where new evidence relevant to the order has become available after the making of the order.

(4) Where an interim suspension order or an order for interim restricted registration has been made under this section in relation to any person, the Disciplinary Board that made the order or another Disciplinary Board appointed in its place under subsection (3) may –

(a) revoke the order or revoke any condition imposed by the order;

(b) make an order varying any condition imposed by the order;

(c) if satisfied that to do so is necessary for the protection of members of the public or is otherwise in the public interest, or is in the interest of the registered medical practitioner concerned, or that the registered medical practitioner has not complied with any requirement imposed as a condition of his registration in the order for interim restricted registration, replace that order with the interim suspension order having effect for the remainder of the former; or

(d) if satisfied that the public interest or the interest of the registered medical practitioner concerned would be more adequately served by an order for interim restricted registration, replace the interim suspension with an order for interim restricted registration having effect for the remainder of the period of the former.

(5) The Registrar shall immediately serve a notification of the decision under subsection (4) on the registered medical practitioner.

(6) The Disciplinary Board may apply to the President for an order made under subsection (1) to be extended, and may apply again for further extension.

(7) On such an application, the President may extend (or further extend) for up to six months the period for which the order has effect.

(8) An interim suspension order or an order for interim restricted registration shall be in force until –

(a) the end of the period specified in the order or, if extended under subsection (7), in the order extending it; or

(b) the date on which proceedings are concluded, whichever is the earlier.

(9) While a person's registration in the Register is suspended by virtue of an interim suspension order, he shall not be regarded as being registered notwithstanding that his name still appears in the Register.

(10) Immediately upon the expiry or revocation of the order, the person's rights and privileges as a registered medical practitioner shall be revived from the date of such expiry or revocation, provided that he has complied with all the terms of the order.

(11) Any registered medical practitioner who is aggrieved by the decision of the Disciplinary Board or President under this section may appeal in writing to the Minister.

(12) The Minister may confirm, reverse or vary the decision of Disciplinary Board or President.

(13) The Minister's decision on any appeal under subsection (11) shall be final and binding.

Fitness to Practise Committee

In accordance with Regulation 43 of the Medical Regulations 2017 –

43. (1) During the course of the inquiry, if the Disciplinary Board found that the registered medical practitioner concerned is professionally incompetent or his fitness to practise is impaired by physical or mental disability, the Disciplinary Board may refer the registered medical practitioner concerned to the Fitness to Practise Committee for an evaluation.

(2) The Fitness to Practise Committee shall evaluate any registered medical practitioner referred to in sub-regulation (1).

(3) For the purpose of evaluating the professionalcompetency or fitness to practise of a registered medical practitioner, the Fitness to Practise Committee may, by order in writing, require the attendance of the registered medical practitioner concerned before the Committee on a date, time and place to be specified in the order to answerany question and to produce any required document.

(4) The Fitness to Practice Committee may, upon receipt of the complaint or information alleging that any registered medical practitioner is professionally incompetent or his fitness to practise is impaired by physical or mental disability, evaluate such registered medical practitioner concerned.

Restoration of Name to Register

In accordance with Section 31A of the Medical Act 1971 (Amended 2012) –

31A. (1) No person whose name has been struck off from the Register under paragraph 30(1)(e) shall thereafter be entitled to be registered as a medical practitioner under the provision of this Act, but the Council may, if it thinks fit in any case to do so, on the application of the person concerned, order that the name of such person be restored to the Register provided that a period of three years shall have elapsed since the order was made; and where the name of a person has been suspended from the Register under paragraph 30(1)(c), such person shall be entitled at the expiration of period of suspension, but not earlier, to apply for the certificate of registration and

the annual practising certificate (if the period for which it is issued is still unexpired) to be returned to him.

(2) An application under subsection (1) shall be made in such manner or form and accompanied by such documents, photographs, particulars and fees as may be prescribe.

Appointment of Legal Advisor

In accordance with Regulation 48(1) of the Medical Regulations 2017 –

48. (1) The Council may appoint a legal advisor to assist the Council, Disciplinary Board or Preliminary Investigation Committee during any disciplinary proceedings.

(2) The Council may appoint any person who is and has been an advocate and solicitor for a period of not less than five years to advise the Council, Disciplinary Board or Preliminary Investigation Committee on –

(a) all questions of law arise in the course of any disciplinary proceedings; and

(b) the meaning and construction of all documents produced during the disciplinary proceedings.

Prohibition from Attending Disciplinary Proceedings

In accordance with Regulation 50 of Medical Regulations 2017 –

50. (1) No member of the Council, Disciplinary Board or Preliminary Investigation Committee shall attend orparticipate in any meeting of the Council, DisciplinaryBoard or Preliminary Investigation Committee, as the casemay be, relating to a disciplinary proceeding if –

(a) he was the complainant;

(b) he is personally acquainted with any relevant fact;

(c) he has appeared or likely to appear before the Disciplinary Board for the purpose of making any statement; or

(d) the complainant, the persons appearing before the Disciplinary Board for the purpose of making any statement or the registered medical practitioner is a member of his family or his associate.

(2) For the purposes of this regulation –

"a member of his family", in relation to a member of the Council, Disciplinary Board or Preliminary Investigation Committee, includes –

(a) his spouse;

(b) his parent (including a parent of his spouse);

(c) his child (including an adopted child or stepchild);

(d) his brother or sister (including a brother or sister of his spouse); or

(e) a spouse of his child, brother or sister; and

"associate", in relation to a member of the Council, Disciplinary Board or Preliminary Investigation Committee, means –

(a) a practice or company of which the member or any nominee of his is a partner or employee; or

(b) a partner or employee of the member.

APPENDICES

Appendix I – Declaration of Geneva

Adopted initially by the 2nd General Assembly of the World Medical Association, Geneva, Switzerland, September 1948 and amended on numerous occasions, this version of the Declaration was finally amended and adopted at the 68th WMA General Assembly, Chicago, United States, October 2017.

The Physician's Pledge

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 considerations of age, disease or disability, creed, ethnic origin, 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 to my teachers, colleagues, and students the respect and gratitude that is their due;
I will share my medical knowledge for the benefit of the patient and 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.

Appendix II – Professional Calling Cards, Letterheads and Rubber Stamps

The calling card, letterheads and rubber stamps should only contain the name of the practitioner, registrable professional qualifications, recognised State and National awards, home address and telephone number(s), practice address(es) and telephone number(s). Adjunct academic appointments should be listed only during the period it is officially relevant and removed when such appointments lapse. Rubber stamps used in Medical Sick Certificates and other similar certificates should also include the MMC Registration Number.

Appendix III – Signboards

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

2. The Council stipulates the following limits to signboards for registered practitioners –
   a. There shall not be more than two (2) signboards to indicate the identity of the medical clinic or practice.
   b. They shall not be floodlit or illuminated.

3. The total combined area of the signboard or signboards (if two (2) signboards are used) should not exceed 5.574 sq. metres (60 sg. ft.) This includesletterings fixed or painted on walls or any other backing where the perimeter enclosing the letterings should not exceed 5.574 sq. metres (60 sq. ft.) in total.

4. Clinics may actually require more than one signboard and these should be restricted to a maximum of two provided the total combined areas of the two signboards do not exceed 5.574 sq. metres (60 sq. ft).

5. A signboard should serve to provide guidance and information about a clinic. It should not be a means for soliciting patients.

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

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

8. When the practice is within a commercial complex, there is no objection to the clinic name appearing in the general directory signboard in the lobby.

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

10. The use of directional signboard/s with the word “Clinic” and an arrow pointing in the direction of the clinic leading from the main road is permissible if it conforms to local government regulations. The name of the clinic may appear in such a directional signboard, which should be within 1km on the main roads before approaching the clinic in either direction.

Appendix IV – Names Plates/Doorplates

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

2. The name plates may bear the following –
   a. the practitioner's name;
   b. his registrable qualifications in small letters;
   c. titles may be included; and
   d. official crests and logos, e.g. WHO, red crescent, are not allowed.

3. A separate doorplate not exceeding 929 sq. cm. (1 sq. ft.) is permitted to indicate his consultation hours.

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

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

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

Appendix V – 24-Hour Clinic

1. No additional signboard is permitted.

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

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

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

5. In the event that an emergency arises requiring the practitioner to be called away, the clinic should do one of the following –
   a. not to accept any new patients until the practitioner is back in the clinic; or
   b. inform intending patients that the practitioner is not available.

Acknowledgement

MMC acknowledges the approval granted by the Singapore Medical Council and Medical Board of Australia for inclusion of parts from Ethical Code and Code of Conduct, respectively.

References and Further Reading

1. Medical Act 1971 (Amended 2012), Medical Regulations 2017
2. WMA Declaration of Helsinki Revised 2017
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