GUIDELINE OF
THE MALAYSIAN MEDICAL COUNCIL

MMC GUIDELINE 005/2006

ETHICAL IMPLICATIONS OF DOCTORS IN CONFLICT SITUATIONS

Malaysian Medical Council

PRELUDE

This Guideline complements, and should be read in conjunction with the Code of Professional Conduct of the Malaysian Medical Council (MMC).

In this Guideline, the words "doctor", "medical practitioner" and "practitioner" are used interchangeably, and refer to any person registered as a medical practitioner under the Medical Act 1971. The words "hospital" and "healthcare facility and service" are used interchangeably and refer to any premises in which members of the public receive healthcare services. Words denoting one gender shall include the other gender. Words denoting a singular number shall include the plural and vice versa.

Adopted by the Malaysian Medical Council on 14 November 2006

FOREWORD

The Malaysian Medical Council, with the objective of ensuring that registered medical practitioners are fully aware of the codes of professional medical practice, issues directives and guidelines from time to time. The purpose of these codes, guidelines and directives is to safeguard the patient and members of the public, to ensure propriety in professional practice and to prevent abuse of professional privileges.

The Guidelines are designed to complement, and should be read in conjunction with, the Medical Act and Regulations, Code of Professional Conduct of the Malaysian Medical Council and other Guidelines issued by the Council or any related organisation, as well as any statute or statutory provisions in force and all related statutory instruments or orders made pursuant thereto.

This Guideline on **Ethical Implications of Doctors in Conflict Situations** has been prepared with careful attention to details, cognisant of the current international stand on the subject. The draft has been reviewed numerous times by the Malaysian Medical Council and includes valuable responses from individuals, organisations and professional bodies in the country, before formal adoption by the Council.

The Guideline is available in the printed form as well as in the MMC website. Registered medical practitioners are advised to familiarise themselves with the contents, as they will serve as documents to refer to or to seek clarifications from, when they need guidance on matters of professional ethics, codes of professional conduct and medical practice in general.

Tan Sri Datuk Dr. Hj. Mohamed Ismail Merican
MBBS(Mal), MRCP(UK), FRCP(London)(Edinburgh)(Glasgow),
FAMM, FACP(Hon), FRACP(Hon)
President
Malaysian Medical Council

January 2007

CONTENTS **PAGE**

FOREWORD

ETHICAL IMPLICATIONS OF DOCTORS IN CONFLICT SITUATIONS

SUMMARY

The vast majority of medical practitioners, except for those who are self-employed and running singleton or group primary care practice, are generally in employment in public healthcare facilities, or in the uniformed armed forces medical services, or in corporate bodies, estates and managed care organizations or they may be employed in private healthcare facilities, either as resident or visiting specialists.

Whatever their employment status, medical practitioners are subject to various extraneous restrictions in their professional practice, which may be contractual stipulations, civil service orders, military regulations, or third party payer healthcare administrative protocols.

In such situations, the practitioners frequently come under compulsion to place their duty and allegiance to the healthcare facility or organizations above professional ethical codes of practice, which often compromises various aspects of doctor-patient relationship and confidentiality and interferes with the practitioners' professional responsibility to their patients.

Doctors are sometimes under pressure to provide performance enhancing drugs to sports persons, against the basic tenets of medical practice and sportsmanship.

Doctors may also have external pressure exerted on them to relax their professional ethical codes for political and economic reasons at the expense of public hygiene and health interests.

This Guideline on Ethical Conflicts faced by doctors in employment addresses these facets in the clinical and healthcare practice of doctors, while also touching on human rights issues when providing medical care for prisoners and persons in custody, in attendance at judicial executions or if ordered to perform limb ablations on convicts as a form of punishment.

The Declaration of Tokyo, 1975, is appended at the end of this Guideline.

1. INTRODUCTION

Medical practitioners, except for those who may be operating individual or singleton private clinics, or in group practices, are generally in employment in government or university hospitals. They may also be serving in uniformed services, like the armed forces, either on compulsory service, secondment, contract or direct employment.

They may also be working in private healthcare facilities, wherein they may either be independent operators or salaried, though in both situations they are subject to rules and regulations laid down in their contract.

Doctors may also be employed in in-house clinics by corporate bodies, including workshops and factories, or as medical and health advisors to such corporate bodies. The doctors serving on the panel of managed care organizations, which act as third party payers for corporate clients, are directly or indirectly, also in employment.

The type of their participation in such private employment may be sessional or full-time. Their salary may be fixed (like in a government hospital) or variable depending on their professional contribution as well as on the nature and terms of their individual contractual position in the corporate structure.

Medical practitioners are required by legislation in the Medical Act 1971[1] to provide compulsory government or public healthcare service in our country for a period of three years. This service may be completed in a government healthcare facility, or in whole or part in the uniformed service in the Ministry of Defence.

1. Medical Act, 1971 : Part VII Period of service s. 41

During this period, they are subject to Government Orders, Ministry of Health rules and regulations and the Armed Forces Act and regulations, and any other appropriate statute of any other organization.

2. THE AREAS OF POTENTIAL CONFLICT

After completing the three-year compulsory government or public service, the practitioner may choose to go into private medical practice as primary care doctor, or remain in public healthcare organisations, pursuing postgraduate courses. After obtaining postgraduate specialist diplomas or degrees, the practitioner often either chooses to remain in public service or enter into private specialist practice in private hospitals.

A medical practitioner seeking employment normally enters into a contract, and when starting to work he would be deemed to accept the employer's terms and conditions. Though the Employment Act 1955 does not specify when the contract of employment should be signed between employer and employee, it is beholden on the employee to fully understand the terms of employment and disciplinary procedures before commencement of employment.

Besides his own aspiration to earn a substantial income in his practice, the contribution by the practitioner to the private healthcare facility (like a private hospital), which allows him to practise in that premises, is expected to be financially profitable to the organization as well. Most often the practitioner has to demonstrate his ability to materially contribute to the success of the organization that has employed him and to help recover capital investment and achieve profits. This renders the doctor in the situation of having to provide ethical care to his patients while at the same time being conscious of his own financial survival by producing income for the organization. These create an environment for conflict.

In short, the practitioner's contractual agreement with a private health care organization or service stipulations in a government healthcare facility may, from time to time, raise issues of ethical conflict in the course of his professional duties.

This dual obligation – one to his patients and the other to his employer- raises the spectre of divided loyalty, one ethical and the other financial survival.

There is obviously a third obligation: to the practitioner himself. If it is accepted that every doctor is fundamentally ethical and intellectually stable, then factors related to his humane, moral and human rights sentiments, besides the professional obligations to his patients, come into play. It is the third obligation and the doctor's instincts that will eventually decide the course of his patient-doctor relationship and the doctor-employer status.

3. DOCTORS EMPLOYED IN PUBLIC HOSPITALS

Professional ethical issues of doctors employed in public or government healthcare facilities, including corporatised hospitals, like university teaching hospitals, are often resolved as an internal administrative or service matter within the institution.

When patients take legal action against doctors in government hospitals for negligence or mismanagement, the matter sometimes reach the courts, but mostly are settled out of court.

Legal Disputes

Legal action instituted by a patient (plaintiff) would usually involve both the healthcare facility and the medical practitioner, and the initial

complaint would be directed to the parties allegedly held responsible. If the practitioner individually or personally is complained against, it is within his right to inform the facility and seek a combined defence.

Settlement out of court is less traumatic, more economical, and subject to less public scrutiny, since it usually includes a non-disclosure agreement where the patient is bound not to reveal the details of the case. There would also be a statement to the effect that such settlement is not an admission of guilt.

Be that as it may, the facility may still take direct or indirect action against the practitioner, in the form of disciplinary procedures or limiting the scope of practice, career progress or posting out (in the case of doctors in public facilities) since the non-disclosure agreement does not preclude any such departmental administrative action.

Professional indemnity cover, with the availability of independent legal advice, would be a useful arrangement for doctors in practice. Advice on matters discussed above should be sought by the practitioner prior to any initial response to the plaintiff, the facility wherein he is working and any legal representatives.

Publications in Print and Electronic Media

Practitioners in public facilities (government hospitals, university hospitals or corporatised hospitals) must give priority to ethical principles above personal publicity and departmental interest when making statements related to patients or their management or advances and new techniques, in the print, electronic media or over the radio or television. They should remember that as registered medical practitioners they are subject to the Code of Professional Conduct and the Medical Act and the Regulations, and in the event of breaches, their employment in such public facilities does not *per se* provide immunity from disciplinary procedures.

Locum Service

Doctors in public healthcare service are known to be involved in providing "locum" service to private hospitals and private general practitioners. The Annual Practising Certificate requires the doctor to list the address of his/her principal place of practice and any other places of practice. Any acts of negligence or other breaches of professional conduct while providing locum service, and therefore in an undeclared practice location, may be punishable by the provisions of the Medical Act 1971.

The doctors in government service, like any government employee, are also subject to Government Orders and Bahagian II Kelakuan states as follows:

> ***5. Pekerjaan Luar***
> ***Kecuali setakat yang dia dikehendaki dalam perjalan tugasnya atau diberikuasa dengan nyata oleh Ketua Jabatannya untuk berbuat demikian, seorang pegawai tidak boleh:***
> ***(b) mengusahakan bagi mendapatkan upah apa-apa kerja bagi mana-mana institusi, syarikat, firma atau individu persendirian.***

A breach of the above Order by a government employee (including registered medical practitioners) can be the subject of a disciplinary procedure and, on being found guilty, the employee may be punished by either warning, fine, loss of emolument, suspension of salary rise, reduction in salary, demotion or dismissal from employment.

There is a move to formalize and legalise medical practitioner in public healthcare facilities and services providing locum service in private sector practice. However, until such time this arrangement is finalised, with attention to legal and ethical implications, doctors are best advised to comform to existing regulations in this matter.

4. DOCTORS SERVING POLICE AND PRISONS

The Declaration of Tokyo, 1975, defines **torture** as the **"deliberate, systematic or wanton infliction of physical or mental suffering by one or more persons acting alone or on the orders of any authority, to force another person to yield information, to make a confession, or for any other reasons."**

Prisoners and detainees are known to, or may sustain injuries in the course of interrogations by police. This category of injuries is often treated by a government doctor directed to do so, against their conscience, knowing fully well that they cannot prevent future such occurrences on the same prisoner.

Practitioners are formally required to treat such prisoners or detainees, so that they can be declared fit for further interrogation by the authorities through methods normally employed in these circumstances.

Practitioners who are forced to be present during the process of torture, or to treat a tortured prisoner, without being able to exercise their clinical freedom, should report this to a responsible body. The Malaysian Human Rights Commission (Suhakam) would be an appropriate body to receive such allegations. Other bodies would include, the World Medical Association, the International Committee of the Red Cross and Amnesty International.

The Declaration of Tokyo 1975 further states:

"**A doctor must have complete clinical independence in deciding upon the care of a person for whom he or she is medically responsible. The doctor's fundamental role is to alleviate the distress of his or her fellow men, and no motive whether personal, collective or political shall prevail against this higher purpose.**"

The role of the doctor on prison duty should be solely to provide medical care for inmates. It is not the doctor's role to assist in prison discipline or management. Therefore the issue of the independence of the medical service from the prison service is of great significance and such independence should be unequivocally demanded by the doctor.

It is wrong for a doctor to voluntarily participate in maltreatment even in the expectation of diminishing the damage to individuals. Well-intentioned doctors who accept such a role may be unaware of the long-term psychological trauma and distress to such individuals engendered by their mere presence.

Imprisonment denies the individual of autonomy. Nevertheless he retains the right to medical care of an ethical standard. The doctor attending to a prisoner has the same obligation to obtain consent from the prisoner before instituting treatment.

A person in custody may make a complaint against the police for physical abuse and has a right to seek medical treatment. The examining doctor's report is not usually available to the complainant, and the prisoner must be informed of such constraints placed upon the doctor, when he obtains the prisoner's consent for the examination.

It is within the prisoner's right that the medical report should be made available to him and in instances when this is denied, this may have to be obtained through legal avenues..

In instances when a government pathologist or forensic pathologist is entrusted with performing autopsy on the body of a person dying while under custody, the doctor is bound by his professional ethical code to conduct a proper examination and prepare an honest report.

Capital Punishment

Doctors in government service are directed to be present during the carrying out of capital punishment to certify death.

While certification of death is part of normal medical duties and also extends to death by judicial execution, it is wrong for a doctor, while ostensibly attending executions as a witness, to monitor the execution process and give advice about whether or not the victim is dead, and thus whether or not the execution process should be repeated.

There are obvious moral and ethical issues involved. It is the view of the medical profession that doctors should not be actively involved in such procedures, as medical participation gives a spurious respectability to capital punishment.

Judicial Punishments

Medical practitioners may be directed to amputate parts of the human body in a person (arm, hand, etc.) found guilty in a court of law upholding and delivering judgements under so-called religion-sanctioned punishments. The argument often cited in support, that a medical practitioner is the best qualified person to perform such procedures because of his training, knowledge and skills, and therefore able to save the life of the guilty person, is not acceptable.

Medical practitioners should categorically refuse to perform such acts or procedures on the medical ethical principle that they should first do no harm, whether physical, psychological and emotional or in any other context, on any person. Under no circumstances, threats or any other pressure exerted on him, should the practitioner yield to such directive and commands by any person or any system not upholding the above moral and ethical principles. A practitioner who yields to such pressure is liable to disciplinary procedures.

Refusal of Nourishment

This topic relating to persons who refuse to eat or drink as a form of protest against is well covered in the Declaration of Tokyo, which states:

"When a prisoner refuses nourishment and is considered by the doctor as capable of forming an unimpaired and rational judgement concerning the consequences of such a voluntary refusal of nourishment, he or she shall not be fed artificially. The decision as to the capacity of the prisoner to form such a judgment should be confirmed by at least one other independent doctor. The consequences of the refusal of nourishment shall be explained by the doctor to the prisoner."

5. THE DOCTOR UNDER ABNORMAL PRESSURE

Doctors in government service, whether in clinical or forensic departments, are at times under pressure to yield to requests against established ethical principles. The pressure may be initiated by external forces, which may be political or self-interest groups, and mediated, knowingly or unknowingly, through government or service channels.

Pharmaceutical preparations which have been found to contain ingredients proven to be harmful by international drug control authorities may not be banned immediately but delayed for various reasons. Quite often the final say in these matters is not with the doctors, but with higher authorities who exert control with regards announcements to the public.

Similarly, death and other statistics on infectious diseases are sometimes withheld from the public for various reasons, amongst which public panic and adverse effect on the tourism industry are often cited,

often ignoring the need for creating national awareness and importance of public cooperation in preventive measures. Lack of transparency on such matters by the authorities leaves the doctors in government service often carrying a heavy load on their moral and ethical conscience.

The political and other unacceptable influences hampering the duties of public health doctors can be quite damaging to their morale. Unfortunately, those in administrative power may not appreciate this, and the recourse for doctors will be to give priority to the heath and welfare of the public and ride the consequences armed with only their own irrefutable social conscience.

6. THE DOCTOR IN UNIFORMED SERVICE

The doctor, commissioned as a uniformed officer and serving in the armed forces, is subject to all rules and regulations that apply to uniformed personnel. Whether he has volunteered to serve in the forces, or has been selected to serve the whole or part of his mandatory compulsory service, the doctor is required to relinquish the comparative freedom of civilian life as he becomes regimented into the military environment.

As an officer in uniform, he is expected to think and act like a soldier, and he is constantly reminded by his superior military officers, that he is a soldier first and doctor second. This paradigm shift demands a mental readjustment as he comes to grips with a totally unfamiliar concept.

Be that as it may, while the doctor in the uniformed service is expected to obey any lawful command, his responsibility to the soldier-patient and his professional autonomy in carrying out his duties should not be compromised.

There is a significant element of malingering, or of feigning illness, suspected in soldiers prior to going on parade, severe training exercises, duties in dangerous locations or in combat areas. It then invariably falls on the regimental medical officer to determine whether or not the soldier's complaints are genuine. Though the doctor tends to give the "benefit of the doubt" to the soldier when faced with uncertainty, it is his unwritten duty to maintain the "fighting" personnel strength of the unit. His position as a uniformed officer, coupled with his medical training to identify the truly ill person from the malingerer, give the doctor a special role in maintaining a state of healthy discipline in the regiment.

In the combat zone, the regimental medical officer is required as far as possible to provide emergency medical care to a wounded soldier to get him back to the frontline if the injury is not life threatening. A lacerated wound in the forearm (a walking wounded casualty) would merely merit first aid and the soldier returned to his post with haste. This is obviously contrary to the evidence-based medical approach of debridement and dressings, with rest, antibiotics, and periodic wound inspection till healing is complete.

The conflict here is between treating a wounded soldier in the best medically acceptable manner and in sending him into combat because he is still capable and fit to continue fighting in the front line. The circumstances are unique but the doctor must be satisfied in sending the soldier back to the battle front that his life is not in immediate danger because of the injury. If he feels otherwise, it is still his professional right to retain the soldier in a holding casualty station or to evacuate him to a non-combat area.

7. OCCUPATIONAL HEALTH PHYSICIAN

The Occupational Health Physician or the Industrial Health Physician or the Estate Medical Officer, is employed by a corporate body. He is expected to act as an impartial advisor on matters of health of all those employed in the organization.

Among his duties, he is expected to inspect working and living conditions of the employees. There may be instances when the doctor feels that a particular working environment may create, or exacerbate, existing health problems of certain employees or applicants seeking employment.

The doctor's role in such cases must be to advise the employer, with the subject's consent, of possible health problems that may arise. The employer may attempt to discharge such vulnerable employees rather than modify existing working environment. This is against employment and labour laws.[2]

In the event of any such conflicts, the practitioner must report or refer the matter to relevant human resource departments. Workers should not be dismissed from employment when detected to be inflicted with infectious or communicable diseases, such as tuberculosis or HIV. It is well to remember that persons living with HIV/AIDS need to be protected from social bias.

They should be treated, and whenever possible, allowed to continue working in the same firm with appropriate precautions.

2. International Labour Organisation (ILO)
www.ilo.org/aids

Pre-employment Medical Examination

Pre-employement medical examination conducted on foreign workers includes compulsory HIV/AIDS testing, besides for venereal disease (VDRL) and drug dependence. It is the government policy to repatriate persons with positive test results to their country of origin for further treatment. There are ethical questions raised by the enforcement of this policy, but the argument extended is that these disease are related to personal behavioural and life style problems, and the long term management, beside specific costly disease treatment, would include psychosocial rehabilitation which is best carried out in the country of origin.

Practitioners are often engaged by corporate bodies to conduct pre-employment medical examinations on prospective employees. It is incumbent upon the doctor to obtain consent from the employee before conducting physical examination and drawing blood for investigations. In the case of HIV testing or any other tests of a "personal" nature, the doctor should inform the employee of the test and counsel on the necessary steps to be taken in the event of positive results. It is, however, a recommended and accepted practice that HIV positive persons should not be denied employment.[3]

3. Malaysian AIDS Concil
   No. 12, The Boulevard Shop Office
   Jalan 13/48A, off Jalan Sentul
   51000 Kuala Lumpur
   Tel: 03 4045 1033
   eMail: contactus@mac.org.my

The doctor must also obtain consent from the prospective employee to submit the results of the examination and investigation to the prospective corporate employer. In the event that such consent is not available, the doctor must inform the employer and exert his right not conduct the examination or investigations.[4,5]

Workplace Ergonomics

Sometimes the employer cannot be persuaded to accept that a particular physical process may be harmful to the health of employees. In heavy industry workshops, the manual phase of certain steps in the production line may be harmful to the spine or other parts of the human body and may result in considerable morbidity and chronic disability in workers. The ergonomics of the work station must be brought to the attention of the employers and appropriate preventive measures advised.

The doctor's responsibility is to protect the health of the employees who may be exposed to the hazards, and should take precedence over the obligations to the employers. In instances when employers do not accept the doctor's advice, the matter should be brought to higher national authorities. The doctor, however, should inform the management of the steps he is planning to take and also warn the workers of the possible consequences.

4. The Employment Ordinance 1955 (with Amendments)
5. Industrial Relations Act 1967 (with Amendments)

8. DOCTORS IN PRIVATE HOSPITALS

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

a. Doctors have no financial involvement in the private hospital share-holding and income and are employed full time with fixed basic pay, plus income based on work output.

b. Doctors have no financial involvement but are given visiting rights to practise in the private hospital and derive income based on rates or schedules fixed by the hospital.

c. Doctors buy shares into the private hospital, which provides them the right to practise, and also to enjoy the profits.

d. Doctors own or rent private clinic space within the private hospital and run autonomous clinics, but use the inpatient facilities and services in the hospital, either by choice or as a condition of practice in that hospital.

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

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

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

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

Private hospitals are known to act as their own preferred provider organization (PPO) by setting up a chain of primary care clinics which would refer patients only to the parent hospital for investigations and management. This practice is a hybrid of the managed care system and is not encouraged by the Malaysian Medical Council. This restrictive referral system with its implications and restrictions must be explained to the patient, as there are fine ethical issues involved in such arrangements, primarily the employee being denied choice of doctors and hospitals.

a. Medical Records

The question: to whom do records generated by medical practitioners in the course of management of their patients belong, has long been a matter for discussion.

Medical records belong physically to the doctor and the institution in which he practices, but belong morally and ethically to the patient and legally to the patient and to regulatory authorities. Thus, any disclosure of

information from the patient's record may only be made with the patient's consent. Once such consent is available, it is unethical for the doctor or the healthcare facility to refuse to provide a report or release relevant parts of the medical record of the patient. Request for medical records and/or medical reports may also be obtained through court order.

Medical practitioners are concerned about the extent to which access to patient's records often leads to wider, third-party disclosure of personal medical documents and reports.

Private hospitals, which may employ doctors in any of the above models, and consider them as their servants, may demand access to all medical documents generated by doctors, whether they are of hospital patients or the doctor's private patients. There are ethical conflicts, particularly regarding documents of private patients, who, in exercising their individual rights to confidentiality, would not prefer third party disclosure.

More details on disclosure of patient information and confidentiality is available from the MMC Guidelines on Confidentiality and Medical Records and Medical Reports.

b. Permission to Practise in Other Private Hospitals

A private hospital that has allowed practising rights and employment of doctors in its facility sometimes requires that these doctors do not practise in any other private hospital. This condition is usually articled in the contract between the doctor and the private hospital. Those wishing to do so would probably need to seek prior approval. This, obviously a measure to deny the freedom of doctors to practise where they want, is probably due also to many other factors in the premises, exclusivity of highly skilled specialists as a marketing high-point, and so on, and all primarily guided by a business-interest policy. While this may seem

superficially as an ethical issue, the relevant section in the contractual arrangement between the doctor and the private hospital is of material importance in any such conflict.

c. Fee Splitting

The definition of fee splitting in the Private Healthcare Facilities and Services (Private Medical Clinics or Private Dental Clinics) Regulations 2006 is as follows:[6]

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

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

Fee splitting which implies that a practitioner makes an incentive payment to another practitioner for having referred a patient to him, is unethical practice. Fee sharing between two practitioners managing a patient is permissible, the basis for such sharing being that the practitioners must have direct responsibility and involvement in the management of the patient. Some private hospitals take a share of the doctor's professional fees claiming this as a "service" or administrative fee. This is one form of fee splitting, but prior consent must have been given by the practitioner for this arrangement. Some private hospitals have formulated their own fee schedules, based on which payment is made in full to the doctor, who is then separately charged the so-called service or administrative fees. The acceptance of this arrangement would depend on the doctor himself.

6. Private Healthcare Facilities and Services Act (Private Medical Clinic or Private Dental Clinic) Regulation 2006, Part 1 Preliminary. Section 2(1)

d. Rights of Referral to Other Specialists

Private hospitals may rule that doctors in their employment can only refer hospital and private patients to other in-house specialists, unless a specialist in a particular field is not available in that hospital. This may be designed purposefully to hold such patients within their facility. To the practitioners this would appear ethically unacceptable. In the best interest of the patient, they would feel it is their professional right to refer patients to any specialist of their preference. In such situations it is best to inform the hospital authority the reasons if referral is to be made to a specialist not working in that facility and permission obtained.

9. DOCTORS IN MANAGED CARE ORGANISATIONS

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

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

a. The patient records and documents "belong" or are freely accessible to the third party administrators, namely the MCO, and medical information on the employee is to be made available at all times (for every clinic attendance) to the MCO. The employee is said to have given blanket consent to this release of information by virtue of having accepted employment with the corporate body.

b. The doctor can only prescribe medications contained in a schedule prepared by the MCO. Drugs not in the schedule may be prescribed only after approval has been obtained.

c. The doctor has to obtain prior approval before ordering investigations not on the MCO Schedule, and has to obtain approval before referring the employee to a specialist or a private hospital for further management.

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

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

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

The nature and stipulations of contacts between the licensee or the holder of registration of managed care organisation and the licensee or the holder of registration of a private healthcare facility or service are laid out in the Private Healthcare Facilities and Services, 1998.[7]

7. Private Healthcare Facilities and Services Act 1998, section XV

10. DOCTORS INVOLVED IN SPORTS ORGANISATIONS[8]

The use of banned performance enhancing substances by athletes and sportspersons is a contravention of the ethics of sports. Doctors may be under pressure to provide such drugs to their athletes and players to gain unfair advantage in the fields of sports and games. This is misuse of drugs and is against the ethics of medical practice and the doctor involved, if found guilty, is liable to disciplinary action.

Athletes sometimes plead with sports medicine doctors to obtain such banned performance enhancing substances. The doctor then faces an ethical conflict, but he must be guided by the principle that his primary responsibility in the care of athletes and players is to treat injuries and illnesses and to get them fit to participate in their sports. The doctor may be involved during the training of such sportspersons, to help the coaches and trainers in getting their athletes and players into peak fitness for participation. The doctor's role, however, is to ensure that the athletes and players are fit to undergo intensive training in the normally accepted manner as conducted by the coaches and trainers, without the use of performance enhancing drugs.

---

8. The Copenhagen Resolution endorsed the World Anti Doping (WADA) Code, which is the core document that provides the framework for anti-doping policies, rules and regulations within sport organisations and among public authorities, and entered into force on 1 January 2004.

   Section 5.9 Objectives of the Olympic Council of Malaysia (OCM) states: To ensure the observance of the OIC Medical Code and the World Anti Doping Agency (WADA) Code, the provisions of which shall apply, mutates mutandis, to all persons and competitions under the Olympic Council of Malaysia's jurisdiction.

   Olympic Council of Malaysia, Mezzanine Floor, Wisma OCM, Jalan Hang Jebat, 50150 Kuala Lumpur.

The doctor is also expected to help the athletes and players to achieve a relaxed but focused attitude towards their sports, by techniques which do not use banned substances.

He is also expected to ensure that the athletes and players under his medical care are free from the banned substances as determined by the International Olympic Council, so that the athletes and players do not test positive and face disqualification from the events or games, much to the embarrassment of the individual, the team and the nation.

11. CONCLUSION

The doctor in employment has the assurance of a stable income, but this is sometimes at the cost of some degree of professional and ethical laxity. Ethical conflicts between the doctor's management of the employee and the conditions laid down by his employer may place him in a quandary. Without exception, the doctor's primary objective should be to provide ethical health care for his patients, and to protect his professional rights and the rights of patients.

In these times of complex issues confronting the medical profession, when time-honoured values and principles are being constantly challenged, the doctor with conscience, who holds these principles closest to his heart and therefore to his trusting patients, will probably be poorer in the pocket but, in the final analysis, richer as a caring human being.

REFERENCE

1. The Employment Ordinance, 1955

2. The Medical Act, 1971

3. The Code of Professional Conduct, Malaysian Medical Council

4. The Government Orders 1999

5. Medicine Betrayed (1992): Publication of British Medical Association

6. Guideline on Good Medical Practice, MMC, 2001

7. Guidelines on Confidentiality: MMC Publication 2001

8. World Medical Association The Declaration of Tokyo (1975)

9. Guideline on Medical Records and Medical Reports: MMC 2006

10. Private Healthcare Facilities and Service Act, 1998 and Regulations, 2006

11. World Anti-Doping Code (WADA) 2004

12. Industrial Relations Act, 1967

13. Guide on Counselling of HIV Infection and AIDS. Ministry of Health, 1995

APPENDIX I :
DECLARATION OF TOKYO,

Guidelines for Medical Doctors concerning on torture and other cruel, inhuman or degrading treatment or punishment in relation to Detention and Inprisonment

Preamble

It is the privilege of the medical doctor to practise medicine in the service of humanity, to preserve and restore bodily and mental health without distinction as to persons, to comfort and to ease the suffering of his or her patients. The utmost respect for human life is to be maintained even under threat, and no use made of any medical knowledge contrary to the laws of humanity.

For the purpose of this Declaration, torture is defined as the deliberate, systematic or wanton infliction of physical or mental suffering by one or more persons acting alone or on the orders of any authority, to force another person to yield information, to make a confession, or for any other reason.

Declaration

1. The doctor shall not countenance, condone or participate in the practice of torture or other forms of cruel, inhuman or degrading procedures, whatever the offence of which the victim of such procedures is suspected, accused or guilty, and whatever the victim's beliefs or motives, and in all situations, including armed conflict and civil strife.

Adopted by The 29th World Medical Assembly, Tokyo, Japan, October 1975

2. The doctor shall not provide any premises, instruments, substance or knowledge to facilitate the practice of torture or other forms of cruel, inhuman or degrading treatment or to diminish the ability of the victim to resist such treatment.

3. The doctor shall not be present during any procedure during which torture or other forms of cruel, inhuman or degrading treatment is used or threatened.

4. A doctor must have complete clinical independence in deciding upon the care of a person for whom he or she is medically responsible. The doctor's fundamental role is to alleviate the distress of his or her fellow men, and no motive whether personal, collective or political shall prevail against this higher purpose.

5. Where a prisoner refuses nourishment and is considered by the doctor as capable of forming an unimpaired and rational judgement concerning the consequences of such a voluntary refusal of nourishment, he or she shall not be fed artificially. The decision as to the capacity of the prisoner to form such a judgement should be confirmed by at least one other independent doctor. The consequences of the refusal of nourishment shall be explained by the doctor to the prisoner.

6. The World Medical Association will support, and should encourage the international community, the national medical associations and fellow doctors to support, the doctor and his or her family in the face of threat or reprisals resulting from a refusal to condone the use of torture or other forms of cruel, inhuman or degrading treatment.

APPENDIX II :
ADDRESSES

Suhakam:
The Human Rights Commision of Malaysia,
Level 29, Menara Tun Razak,
Jalan Raja Laut,
50350 Kuala Lumpur.

Phone: 603-26125600
Fax: 603-26125620
E-mail: admin@suhakam.org.my ; humanrights@suhakam.org.my
Website : http://www.suhakam.org.my/en/index.asp

World Medical Association:
The World Medical Association
13, ch. du Levant
CIB - Bâtiment A
01210 Ferney-Voltaire
France

Phone: +33 4 50 40 75 75
Fax: +33 4 50 40 59 37
E-mail: wma@wma.net
Website : http://www.wma.net/e/

United Nations:
Office of the UN High Commissioner for Human Right
UN office at Geneva
8 - 14 avenue dela Paix
1211 Geneva 10, Switzeland

or local UN representative at the office

Amnesty International:

International Secretariat
1 Easton Street
London WCIX 8DJ
United Kingdom

The initial draft of this Guideline on the *Ethical Implications of Doctors in Conflict Situations* was prepared by Dr. Abdul Hamid Abdul Kadir, MBBS (S'pore) FRCSEd., MChOrth (Liverpool), Dr. Raja Malek bin Raja Jallaludin MBBS (Mal) and Ms. Sharon Kaur Gurmukh LLB (Hons) (Cardiff), MA (Medical Law & Ethics) (London)

The members of the Ethics Committee of the Malaysian Medical Council, instrumental in preparing this Guideline, are:

Chairman :

Dr. Abdul Hamid Abdul Kadir, Dato
MBBS (S'pore), FRCSEd., MChOrth (Liverpool)

Members :

Professor Emeritus Datuk Dr. Alexius Delilkan
MBBS (S'pore), FRCA (England), FANZCA (Australia), FAMM

Prof. Dr. Mohd Nizam Isa
PhD (Australia)

Dato' Dr. Mohd Rani Jusoh
MBBS (Mal), FRCP (Edinburgh), FRCP (Ireland)

Dr. Raja Malek bin Raja Jallaludin
MBBS (Mal)

Dr. Ravindran Jegasothy
MBBS (Mal), FRCOG (London), FAMM

Dr. Choy Yew Seng
MBBS (Mal), M.Paed (Mal), MRCP (Paed)(Edin)

Ms. Sharon Kaur Gurmukh
LLB (Hons)(Cardiff), MA (Medical Law & Ethics)(London)