GUIDELINE OF

THE MALAYSIAN MEDICAL COUNCIL

ETHICAL IMPLICATIONS OF DOCTORS IN SITUATIONS OF PROFESSIONAL PRACTICE CONFLICT

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1. INTRODUCTION

Registered Medical Practitioners (RMPs) in Malaysia may practice in Government Institutions through the Ministry of Health, Ministry of Higher Education, Ministry of Home Affairs, Ministry of Human Resource, Ministry of Youth and Sports, or the Malaysian Armed Forces. RMPs in the private sector, may be in solo practice, group practice, private hospitals, private universities, corporate organizations, non-governmental Organizations (NGO), nursing homes or in charitable organizations. RMPs in government may with prior approval also practice in private clinics and hospitals as provided for in the government circulars.

The employment of RMPs in these Organizations may be permanent (pensionable) or contractual and will be subjected to the rules and regulations of the organizations and as specified in their contracts. The RMPs employed in Government service are governed by the rules of the Public Services Commission (Suruhanjaya Perkhidmatan Awam) and the circulars from the respective ministries released from time to time.

The RMPs serving the Malaysian Armed Forces maybe on a Regular Commission (Pensionable) or on a Short Service Commission (Contract) and will be subject to the Armed Forces Act 1972 and the various Orders of the Armed Forces Council.

Irrespective of their employment sector and employing organization, it must be noted that medical practitioners are required to be registered to practice in the country by virtue of the Medical Act 1971 (Act 50), and Medical Regulations 2017, and therefore are subject to the terms of the Act and the Regulations. RMPs are reminded to be knowledgeable of the contents of the Code of Professional Conduct, Good Medical Practice and Guidelines of the Malaysian Medical Council.

2. PRIVATE SECTOR

Safe and ethical practice is expected of all RMPs and at all times. The RMP's primary duty should be to his patient. In his employment in the private sector, conflicts can arise in various forms, either in direct reference to his terms of employment or in relation to his type of practice within the Institution. From the onset, it is important that the RMP realises that he is part of an organization and that there will be several stakeholders with varying priorities. The RMP however is obliged to abide by the Code of Conduct and the various Guidelines.

It is essential that the RMP understands the terms of employment as specified in the contract with the employer. It may be in his interest to seek legal opinion before accepting the contract. The Do's and Dont's as specified may need clarification, and the RMP must get an explanation if in doubt. Some institutions allow the RMP to practice in other private related or non-related institutions, some do not. Employment of additional RMPs in similar specialties may be a cause for concern. These are sources of potential conflict. Rules set by the Board of Management from time to time, with or without consultation may also be a source of discontent. Whatever the area of conflict, it is advisable that the RMP maintains a two-way communication, to ensure a healthy and safe work environment.

In areas where the RMP is a fully paid employee, he may be compelled to release confidential information to the management in terms of diagnosis and the type of treatment offered to the employee/patient. Extreme caution is required in such circumstances. It is important that the consent of the employee/patient is always obtained. This also applies in Government or Armed Forces services where the superior may wish to know the progress of the illness or limitations to duty or workplace of his employee.

It would be in the RMP's best interest to remember his professional responsibilities to his patient and at the same time balance his obligations to the organisation. This delicate balance may be best achieved through dialogue and diplomacy.

3. PRIVATE HOSPITALS

RMPs may be engaged to practice in Private Hospitals in one of the following models:

a. Full time salaried employment
b. Full time as Independent Provider
c. Full time and salaried for an initial specified period, then moving on to be an Independent Provider.
d. Visiting Rights

Generally, RMPs have no financial involvement in the ownership of the hospitals. They may obtain practising rights, with rental of clinic space, usage of wards and surgical facilities, use of diagnostic and other services. They are required to abide by the prescribed Schedule of Fees in force at the time, the MMA Fees Schedule and the Fee Schedule of the Private Healthcare Facilities & Services Act 1998 (Act 586). The Board of Management may oftentimes issue Board decisions for compliance of RMPs, and these may have to be complied with as long as there are no conflicts with the Code of Professional Conduct and ~~other~~ guidelines issued by the MMC. If there are conflicts, these are best sorted out by the RMPs through the Medical and Dental Advisory Committee of the respective healthcare facility.

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 return of investment (ROI). Some of these conditions may pose ethical conflicts for the doctor.

Private hospitals enter into business arrangements with Managed Care organisations or Third-Party Administrators, 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 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 may set up their own chain of primary care clinics (preferred provider organisation or PPO) which would then refer the patients only to these hospitals. This arrangement should be explained to the employer and the employee (the patient), as it implies denial of freedom of choice of referral to a preferred doctor or hospital. Any conflict in this matter must be amicably sorted out by the parties concerned.

Medical Records and Medical Reports and Confidentiality

Matters related to these topics are clearly and comprehensively defined in the MMC guidelines on Confidentiality and Medical Records and Medical Reports. There may be areas of conflict and the RMP is advised to be familiar with these guidelines and the management of such conflicts.

Permission to Practise in Additional 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 may

be a measure to deny the freedom of doctors to practice where they want. There may be other reasons, such as premise restrictions, desire for exclusivity of highly skilled specialists, and so on, decisions made for business interest reasons. 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.

Fee Splitting

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

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

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

Fee splitting which implies that a practitioner makes an incentive payment to another practitioner for having referred a patient to him, is unethical practice. Fee sharing between two practitioners managing a patient, with the patient’s consent, 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.

Rights of Referral to Specialists Outside the Facility

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.

4. PUBLIC SECTOR

The Medical Act 1971 (Amendment 2012) requires all RMPs including those in Public Hospitals to possess Professional Indemnity Insurance coverage against medical errors and negligence.

Most ethical issues involving RMPs in Public government or corporatized) institutions, including university teaching hospitals and armed forces hospitals are generally handled administratively within the organisation. However, there is an increasing number of professional ethical issues being referred to the Malaysian Medical Council from such public healthcare institutions, which then are subjected to disciplinary inquiry procedures.

When patients, families or next-of-kins resort to legal action against the RMP and the healthcare institution, it becomes a matter for the courts, with some suits being 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 complaint is lodged against a practitioner individually or personally, it is within his right to inform the facility and seek a combined assistance and advice from a professional indemnity organization.

Settlement out of court or through a process of mediation or arbitration is less emotionally draining, more speedily resolved, economical, and subject to less public scrutiny, since it usually includes a non-disclosure agreement where the the parties involved are bound not to reveal the details of the case.

It is accepted that such settlement is not an admission of guilt. Be that as it may, the public health care 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 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 with impending threat of legal action 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 corporatized hospitals) must give priority to ethical principles above personal publicity and departmental interest when making statements related to patients or their management or treatment 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 action.

Limited Private Practice and Locum Services

The RMPs in public health care employment are now allowed to provide service in private hospitals, private medical schools or in private clinics. The approval of the relevant authorities is required. The additional places of practice need to be stated in the Annual Practicing Certificate, and also covered by professional indemnity.

Government specialists or medical officers who opt to undertake approved limited private practice besides their primary place of practice should ensure that adequate clinical and treatment facilities are available in their other places of practice, so that the standard of care provided is of comparable standard.

5. OCCUPATIONAL HEALTH

The Occupational Physician or the Occupational Health Doctor may be employed by an industry, hospital, university or self-employed at a clinic. He is expected to act as an impartial advisor and healthcare provider on matters of health of all those employed in the organization. Other tasks involve return-to-work programmes and disability assessment.

Among his duties, he is expected to inspect working and living conditions of the employees. There may be instances when the occupational physician has to decide that a particular working environment may create or exacerbate existing health problems of certain employees or applicants seeking employment. His tasks involve managing and preventing work-related diseases, accidents, and injuries. In addition, he is required to notify the respective regulatory bodies when a mandatory notifiable disease is suspected. The occupational physician'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.

In the case of refusal or of unwillingness to take adequate steps to remove an undue risk or to remedy a situation which presents evidence of danger to health or safety, the occupational physician must make, as rapidly as possible, his concerns clear, in writing, to the appropriate senior management executive. The involved workers and their representatives in the establishment should be informed and the relevant authority should be contacted, whenever necessary; in the event of any conflict with the prescribed Occupational Safety and Health rules of the Ministry of Human Resource. Workers should not be dismissed from employment when detected to be inflicted with treatable infectious or communicable diseases, such as tuberculosis or HIV. It is prudent 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 establishment with appropriate precautions.

Commercial Secrets

Occupational Physicians are obliged not to reveal industrial or commercial secrets of which they may become aware in the course of their activities. However, they must not withhold information which is necessary to protect the safety and health of workers or of the community.

Pre-employment Medical Examination for Foreign Workers

Pre-employment medical examination conducted on foreign workers includes compulsory testing for HIV, besides sexually transmitted disease and drug dependence. It is the government policy to repatriate foreign persons with positive test results to their country of origin for further treatment. There are ethical questions raised by the enforcement of such policy as they are deemed to be discriminatory in nature. The argument extended is that these diseases are related to personal behavioural and lifestyle 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.

Pre-employment Medical Examination for Local Workers

Occupational medicine practitioners are often engaged by corporate bodies to conduct pre- employment, pre-placement, periodic or fitness to return-to-work medical examinations on prospective employees to comply with the Occupational Safety and Health Act (OSHA 1994). It is incumbent upon the doctor to obtain consent from the employee before conducting physical examination and drawing blood for investigations. The medical examination or surveillance must be carried out with the non-coerced informed consent of the workers. The potentially positive and negative consequences of participation in screening and health surveillance programmes should be discussed as part of the consent process.

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] 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, or forthcoming, from the employee, the doctor must inform the employer and exert his right not to conduct the examination or investigations.

Occupational Physicians should recognize the guidelines that every employer should adopt appropriate measures to prevent the spread of HIV infection and ensure that HIV positive employees are not discriminated. This will also apply to situations in which there is declared an infectious disease pandemic or endemic.

Biological Monitoring and Investigations

Biological tests and other investigations must be chosen for their validity and relevance for protection of the health of the worker concerned, with due regard to their sensitivity, their specificity and their predictive value. Occupational health professionals must not use screening tests or investigations which are unreliable, or which do not have a sufficient predictive value in relation to the requirements of the work assignment.

Contribution to Scientific Knowledge

Occupational health professionals must report objectively to the scientific community as well as to the public health and labour authorities on new or suspected occupational hazards.

Medical Confidentiality

Individual medical data and the results of medical investigations must be recorded in confidential medical files which must be kept secured under the responsibility of the occupational physician or other recognised occupational health practitioners. The information contained in these files must only be used for occupational health purposes and not be shared with the employer for non-health related reasons.

Impartiality

The occupational physician functions at the interface between the employer (management) and the employee (non-management or trade union). He must not take sides with either the management or the trade union in the discharge of his duties. This may appear obvious, but a conflict of interest may arise, as the physician is often paid either by the management with contractual stipulations or the employee.

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.

6. 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 health and welfare of the public and ride the consequences armed with only their own irrefutable social conscience.

7. POLICE AND PRISONS SECTORS

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 submit 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 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 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.”

8. ARMED FORCES SERVICES

RMPs serving in the Malaysia Armed Forces (MAF) are commissioned as Military Officers or Civilian Medical Officers or a Civilian Medical Specialist. As military officers, they will be subjected to the Armed Forces Act 1971 and have to abide by the Directives of the Armed Forces Councils. As Commissioned Military Officers they are subjected to Military Law and can be tried in a Military Court by an authorized Military Commander or reprimanded administratively by their Commanders for disciplinary and administrative offences. Military Medical Officers can also be seconded to work under the United Nation Peace Keeping Forces or in an International Combined Task Forces but these Military Officers will continue to be subjected to existing Malaysian Armed Forces Acts and the Armed Forces Council Directives and Malaysian Laws.

Civilian Medical Officers and Civilian Medical Specialist too are subject to the Commanding Officer’s Directives and Standard Operating Procedures while working in

any military health facility in camps or in the field. Often these procedures are to ensure Operational Security and Safety in such locations.

The role of the RMP in Malaysia Armed Forces is to promote and maintain health, prevent and mitigates health risk provide care during injuries and illness to soldiers and advise the commanders of the state of health of the Malaysia Armed Force in times of peace and armed conflicts. RMP are also expected to provide care for dependents of armed forces including family members and Armed Forces Veterans.

In times of armed conflict, RMP are often exposed personally to risk either due to enemy actions, Commanders Intents or their own acts of bravado. Given the danger and risks during any armed conflict, the safety and security of soldiers under the RMP's care must be his utmost priority.

In an armed conflict the RMP will be expected to provide care to refugees, internally displaced persons (IDPs) including detainees and prisoners of war (POW) as stipulated in their commanders' directives or orders. In delivering care RMP must uphold the principles of humanitarian law in armed conflicts, protecting and serving the health need of the patients under his care and protecting their safety and personal dignity at all times. The RMP also must be ready to assess the ability of local health care workers including detained enemy soldiers (individual protected by the Humanitarian Law of Armed Conflicts or International Humanitarian Law) and assist International Organization like UNHCR, International Confederation of Red Cross (ICRC) in delivering their duties in any armed conflict situations.

9. MANAGED CARE ORGANISATIONS (MCOs) & THIRD PARTY ADMINISTRATIONS (TPAs)

The MCO is defined in the Private Healthcare and Services Act 1998 (Act 586) as any organisation or body with whom a private healthcare facility or service provider has an arrangement or contract to provide healthcare services within an agreed finance system. RMPs who are contracted with these MCOs or TPAs are subjected to pre-arranged

conditions of professional service to employees of their corporate clients. The RMPs are paid an agreed fixed Professional Fee for each doctor-patient contact.
Potential conflicts may arise as the clinical management and nature of billing by the RMP is subject to audit by the MCO/TPA.

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.
e. The pre-payment scheme imposes on the RMP to provide professional care within the financial limits provided by the employer. He needs to obtain prior approval to exceed the ceiling with adequate justification.

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. RMPs are advised to only associate themselves with MCOs/TPAs that are licensed under the Private Healthcare Facilities and Services Act 1998.

The nature and stipulations of contacts between the licensee or the holder of registration of managed care organization and the licensee or the holder of registration of a private healthcare facility or service are laid out in the Private Healthcare Facilities and Services1998.

10. INVOLVEMENT IN SPORTS ORGANISATIONS

A doctor will be involved in sports organisations in a number of roles. In the first instance he may be part of the organising committee of sports events in which case he will be involved with putting in place the medical services to ensure that athletes are provided timely medical attention for injuries and illnesses that may occur both in and out of the competition during the games period.

The doctor could also be one of the doctors on duty at the games village or during competitions at the venues. In these roles he plays the part of host and it is behoven on him to treat all concerned with only medical bias in mind not nationality, sport or nation. At these events doctors are also involved in ensuring that the medical related components of the rules governing the games are put in place and adhered to the rules, guidelines and practices enunciated by the international agencies responsible for sport. These include the International Olympic Committee, The International, Regional and National Federations for each individual sport as well as the umbrella agencies such as WADA, the World Anti-Doping Agency. One of these that takes centre stage these days are the Anti-Doping Measures put in place to ensure a level playing field for all the participants.

The use of banned performance enhancing substances by athletes and sportspersons is not only a contravention of the ethics of sports but could also endanger the wellbeing of the concerned athlete. 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 could sometimes plead with sports medicine doctors to obtain such banned performance enhancing substances particularly when they are faced with performance threatening injuries or illnesses. 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, without breaking any rules that could disqualify the athlete. 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.

The Anti-Doping Program is governed by the WADA Code which gained international acceptance through the Copenhagen Resolution 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.

Nationally the responsible agencies are the National Anti-Doping Agency, ADAMAS which comes under the purview of the Ministry of Youth and Sports as well as the Olympic Council of Malaysia, , the OCM which has clear enunciations in their rules as per 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, *mutatis mutandis*, to all persons and competitions under the Olympic Council of Malaysia's jurisdiction.

Doctors are often part of the team and can be in situations where he has to make decisions regarding the ability of an athlete to start, continue or to stop play for medically associated reasons. He could be under pressure to put the team's interest first but the decision he makes should be in the medical interests of the athlete in the first instance.

11. FEMALE CIRCUMCISION

Female circumcision (in similar terms as female genital mutilation, cutting, clitoridectomy, hoodectomy in the English language, and sunna, halayays, tahur, megrez and khitan in the Arabic language) when performed has no health or hygiene benefits. There is no scientific evidence supporting this as a medical procedure, unlike that in male circumcision.

The Medical Profession believes in its principle of ‘’Primum non nocere”, and where there is no benefit or doubtful benefit, such procedures should not be performed. Complications arising from female circumcision, such as bleeding and infection, and psychological harm have been reported. From an ethical and medical and health viewpoint, performing female circumcision should be prohibited.

12. TREATING THE LGBTIQA+ COMMUNITY

The WHO Constitution (1946) states “The enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being without distinction of race, religion, political belief, economic or social condition.” Out of the 17 Sustainable Development Goals that were set by United Nations General Assembly in 2015 which are targeted to be achieved in 2030, Goal No 3 states “Good Health and Well Being” which is to ensure healthy lives and promote wellbeing for all at all ages.

The doctor by profession should have a fiduciary responsibility to the patient’s best interest. An ethical area of conflict occurs when the patient practices a lifestyle that is antithetical to the doctor’s personal, moral and religious perceptions.

The LGBTIQA+ community often makes treating doctors uncomfortable as it clashes with their beliefs. The acronym LGBTIQA+ refers collectively to people who are lesbian, gay, bisexual, transgender, intersex and /or queer/questioning, asexual and other terms such as non-binary and pansexual. Patients who come under the LGBTIQA+ umbrella often

find themselves marginalised. This creates barriers to access appropriate health care and supportive services. The barriers not only cause their physical health to suffer, but this population is also at risk disproportionately for developing mental health issues as a result of the discrimination.

Doctors who treat the LGBTIQA+ community often find themselves caught in a dilemma between their beliefs and their professional duties when executing care to their patients. The doctor faces an ethical conflict which could compromise the care given to the patient resulting in widening of the health disparity involving this community. Here, the doctor must be guided by the principle that his primary responsibility is to provide nonjudgmental and unbiased care which is in the best interest of the patient regardless of the patient's choice of lifestyle.

The general principles of medical ethics apply here as well. The principles for working with the LGBTIQA+ patients are no different than working with the heterosexual patients. Doctors need to realise this community experiences the same health problems as others and not everything is centred around their gender. A doctor who feels that his principles and beliefs may compromise his professional capacity to treat the patient can refrain from treating this patient. In this situation the doctor can refer the patient to another doctor who is neutral in his perception to the LGBTIQA+ community.

WHO Human Rights and Health (29 December 2017) envisages that "the right to health includes both freedom and entitlements".

Freedoms include the right to control one's health and body (for example, sexual and reproductive rights) and to be free from interference (for example, free from torture and non-consensual medical treatment and experimentation).

Entitlements include the right to a system of health protection that gives everyone an equal opportunity to enjoy the highest attainable level of health.

13. THE GOOD SAMARITAN

Away from their workplace, doctors are frequently faced with situations that may demand their expertise in medical emergencies. It must be considered a professional responsibility for doctors to assist in such situations to the best of their clinical ability; not doing so may not be ethically or morally right. However, the doctor must take into account the circumstances and the environment where the emergency occurred, and ensure it is safe for him to provide the medical assistance.

Emergencies occurring during air travel are common. The advantage here is that some emergency equipment and lifesaving drugs will be available on board. Nevertheless, doctors may sometimes be asked to advice the captain of the airline on whether to continue the flight to its destination or to return or land at another airport. These are difficult judgements that may have to be made and the doctor has to justify whatever decisions he makes in the interest of the patient. Incidents may also happen in areas like roadside or malls where no emergency equipment maybe available in close vicinity. The doctor is however obliged to provide what he could do best, even if it means only summoning an ambulance.

Litigations against a Good Samaritan generally does not happen. It would anyway be wise to keep some notes of the event, for future need.

In any emergency, the Good Samaritan must offer assistance, being aware of his own safety, competence and the availability of other options of assistance and care.

14. CONCLUSION

RMPs are advised at all times and circumstances to abide by the MMC Code of Professional Conduct and various Guidelines on Safe and Ethical Practice, and by various other professional organisations. Their primary responsibility is the wellbeing of their patients, and all other interests should be secondary. The RMP has his rights and privileges, the patient has his/her rights, the Organization where he practices has also its

rules and regulations. A balance is desired in the delivery of healthcare without jeopardizing the doctor-patient trust and maintaining a healthy and happy working environment.

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NOTE

1. **The following are the members of the drafting committee for this guideline:**

Mej. Jen. (B) Dato' Pahlawan Dr. R Mohandas (Chairman)
MBBS (Madras Medical College)
Masters in Health Planning – University of New South Wales
Diploma in Industrial Health Royal College of Physicians and Surgeons of England and Society of Apothecaries
Diploma in Tropical Medicine and Hygiene from Mahidol University

Professor Dr. Jayakumar Gurusamy
MBBS (Manipal, Ind), M. Med (Occup Med) S'pore, FRCP (Ire), FFOM (Ire)
FAMM, FAOEMM
Post Grad Diploma Bioethics, Human Rights, & Health Law, Cert Med Edu (AMEE)

Dr. Gayathri K. Kumarasuriar
M.B.B.S (Manipal, India), MRCPsych (RCPsych, U.K.), (AM) D.R.M (UPM)
PCertHyp,PDHyp,PDCBH (I.C.C.H.P, U.K.)
Post Graduate Diploma in Bioethics,Human Rights and Health Law, Cert Med Edu (AMEE)

Lt Gen Dato' Dr Pahlawan (Dr) Md Amin Bin Muslan
M.B.B.S (UM)
Master of Medicine (Occupational Medicine)

Tan Sri Dato Dr Mani Jegathesan
Advisor to the Commonwealth Games Federation
Chairman of the Medical and Anti-Doping Commission of Olympics of Asia

Dr S. Kamalanathan
MBBS (JN Medical College, Belgaum, India)

Dr. K. Jeyaratnam
MBBS (Mysore) FRCS (Edin), FICS
General Surgeon

Dr. M. Bala Tharmalingam @Dr Bala
(MBBS), Bangalore, India (1993)
Masters in Healthcare Administration (MSc), USA (2004)
Masters in (Yoga) – Tamil Nadu Physical Education and Sports University in Chennai, India (2014)
PhD in Medical Education, Texila American University (2016)

Prof. Dato' Dr. Abdul Hamid
MBBS (S'pore) FRCS Ed MChOrth (Liverpool)
Orthopaedic Surgeon

2. This guideline was first published on 14 November 2006.

3. This is the 2nd edition of the guideline which was approved by the Ethics Committee on 27th August 2025 and adopted by the Malaysian Medical Council on 25th November 2025.

4. This document will be due for review in 5 years, or earlier as necessary.