MALAYSIAN MEDICAL ASSOCIATION

MMA
Handbook of Medical Ethics
2023 Edition

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PREFACE

The Malaysian Medical Association and Medical Ethics

A formal code of ethics may provide the doctor with a standard that is required of a medical practitioner. However, problems will always arise in the course of his professional work on which he may need specific guidance. These may occur, for example, in the context of a doctor-patient relationship, when in contact with the general public, setting up of a practice, relationship with colleagues, dealings with official bodies and in numerous other ways.

One of the most important functions of the Malaysian Medical Association MMA) is to advise and assist its members on ethical problems. The Code of Ethics of the Malaysian Medical Association (Code) sets guidelines for the proper conduct of the medical practitioner practicing in Malaysia. The Code is not, and cannot be, exhaustive. Its statements are general in nature, to be interpreted and applied in particular situations. Besides the Code of Ethics other materials related to medical ethics have been added, hence the document is now renamed as the Malaysian Medical Association Handbook of Medical Ethics (2023)

The conduct of the medical practitioner should always be conducive to the fulfilment of the patient's best interests and towards responsible professional performance complying with the prevailing medical evidence and standards.

All medical practitioners should study the Code to make decisions, which are in the best interest of the patient. Any member of the MMA who has an ethical issue or doubt in the manner in which he should conduct himself concerning a professional matter is urged to seek advice from the Ethics Committee of the MMA.

All medical practitioners should also be conversant with the Code of Professional Conduct and other ethical guidelines issued by the MMC and the Guidelines on Public Information by Private Hospitals, Clinics, Radiological Clinics and Medical Laboratories.
(Appendix I).

In this Handbook of Medical Ethics, 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", "clinic" 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.

ACKNOWLEDGEMENT

The following members of the MMA Ethics Committee (2022-2023) contributed significantly to the revision of the Code of Ethics of the Malaysian Medical Association.

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Datuk Dr. Thirunavukarasu *(*the Honorary General Secretary and the ex-officio)

Ms. Natasha Nagarajan of MMA Secretariat very ably and with diligence provided the extensive secretarial assistance required to complete the revision.

The revision of the MMA Code of Ethics required study of several codes of medical ethics from other sources and are acknowledged in the reference section.

THE PHYSICIAN'S PLEDGE

AS A MEMBER OF THE MEDICAL PROFESSION:

I SOLEMNLY PLEDGE to dedicate my life to the service of humanity;

THE HEALTH AND WELL-BEING OF MY PATIENT will be my first consideration;

I WILL RESPECT the autonomy and dignity of my patient;

I WILL MAINTAIN the utmost respect for human life;

I WILL NOT PERMIT considerations of age, disease or disability, creed, ethnic origin, gender, nationality, political affiliation, race, sexual orientation, social standing or any other factor to intervene between my duty and my patient;

I WILL RESPECT the secrets that are confided in me, even after the patient has died;

I WILL PRACTISE my profession with conscience and dignity and in accordance with good medical practice;

I WILL FOSTER the honour and noble traditions of the medical profession;

I WILL GIVE to my teachers, colleagues, and students the respect and gratitude that is their due;

I WILL SHARE my medical knowledge for the benefit of the patient and the advancement of healthcare;

I WILL ATTEND TO my own health, well-being, and abilities in order to provide care of the highest standard;

I WILL NOT USE my medical knowledge to violate human rights and civil liberties, even under threat;

I MAKE THESE PROMISES solemnly, freely, and upon my honour.

Adopted by the 2nd General Assembly of the World Medical Association, Geneva, Switzerland, September 1948

and amended by the 22nd World Medical Assembly, Sydney, Australia, August 1968

and the 35th World Medical Assembly, Venice, Italy, October 1983

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SECTION 1

1.0. GOOD MEDICAL PRACTICE

1.1. Preamble.

1.1.1. The medical profession since time immemorial has conducted itself with a high level of ethical behaviour that has earned the trust that patients have in medical practitioners today.

1.1.2. Medical ethics is defined as a civil code of behaviour considered correct by members of the profession for the good of both the patient and profession. This trust goes beyond written words and leads the public at large to expect the medical professional to have not only a high standard of medical ability and skill but also impeccable behaviour.

1.1.3. The need for a patient's trust in his medical profession is the basis for ethical codes from many centuries ago as manifested in the traditions of all the major civilizations. In recent times, national, regional and world associations of medical practitioners as well as other health care professionals have revised existing codes of ethics and formulated new ones to keep up with advances in medical knowledge, medical practice, and research as well as changes in society.

1.1.4. All doctors subscribe to the spirit of caring and confidentiality that regulates the doctor-patient relationship and these values continue to be accepted by all those who practice the art of medicine.

1.1.5. A new medical professional entering the profession of medicine joins a fraternity dedicated to the service of humanity. The medical professional will be expected to subordinate personal interests to the welfare of patients, and, together with fellow practitioners, seek to raise the standard of health in the community where one practices. A new medical professional inherits traditions of professional behaviour which form the basis of one's own conduct and must be passed on untarnished to the successors.

1.1.6. Malaysia is a multiracial, multireligious, and culturally diverse nation with "belief in God" being the first tenet of the country's guiding principles (Rukunegara). There are many core values running through the ethical beliefs of the various communities in Malaysia, which are worthy of emulation. Some of these values are extracted here for the guidance of our medical professional.

1.2. Summary of Duties of the Registered Medical Practitioners to the Patients.

1.2.1. Good medical practice and professional conduct refer to the ethical and professional standards of behaviour that are expected of medical professionals and other healthcare professionals in the delivery of medical care to their patients.

1.2.1.1. Clinical competence: medical professionals must have the necessary knowledge, skills, and experience to provide safe and effective care. One must always be cognisant of one's own limits of competence.

1.2.1.2. Communication: medical professionals must communicate effectively with patients, colleagues, and other healthcare professionals.

1.2.1.3. Confidentiality: medical professionals must maintain the confidentiality of patient information and respect patients' privacy rights including the right to have a chaperone present when being examined by a medical professional of the opposite sex.

1.2.1.4. Informed consent: medical professionals must obtain informed consent from patients before providing medical treatment or procedures. This also includes a written financial consent after providing written estimated charges and the basis for them before treatment is commenced or a report is provided.

1.2.1.5. Professionalism: medical professionals must act with integrity, honesty, and respect, in their interactions with patients, colleagues, society as a whole and avoid conflicts of interest, financial exploitation and be aware that personal conduct may affect one's own reputation and that of the profession.

1.2.1.6. Responsibility to patients: medical professionals must prioritize the well-being and safety of their patients and make decisions based on the best interests of the patient and should render help regardless of the financial ability, ethnic origin, or religious belief of the patient.

1.2.1.7. Maintaining medical records: Medical practitioners must keep accurate and complete medical records, in accordance with relevant regulations and guidelines.

1.2.1.8. Continuing education: medical professionals must engage in ongoing professional development to maintain and improve their knowledge and skills.

1.2.1.9. Responsibility to colleagues: medical professionals should refrain from criticizing another medical professional in the presence of patients or other healthcare personnel.

1.2.2. Notwithstanding the above, the medical professionals have a duty to report to the appropriate body of peers any unethical or unprofessional conduct by another medical professional.

1.2.3. Where a patient alleges misconduct by another medical professional, the patient must be fully informed about the appropriate steps to take to have that complaint investigated.

1.2.3. Medical professionals should adhere to these core values and seek guidance whenever in doubt.

1.3. Individual Responsibility.

1.3.1. Medical professionals have a strong individual responsibility to adhere to ethical codes in medicine in spite of numerous obstacles that one may encounter during the practice of medicine.

1.3.2. It is an important aspect of the individual responsibility of a medical professional that one's own exemplary behaviour is critical to maintaining the honour, dignity, and integrity of the profession as a whole.

1.3.3. In addition, the value of mutual goodwill in the fellowship of medicine cannot be over-emphasized.

SECTION 2

2.0. REGISTERED MEDICAL PRACTITIONERS AND THEIR PATIENTS

2.1. Consent for Medical Examination and Treatment.

2.1.1. In medical field consent is defined as the process by which a treating doctor explains the purpose, and potential risks of a medical or surgical intervention and the patient learns about and understands the intervention and then agrees to receive the treatment.

2.1.2. Such consent may be expressed or implied and may be verbal or in writing. The patient must possess sufficient mental capacity to make an informed decision.

2.1.3. Good communication between the doctor and patient is essential for consent it must be obtained in a language which the person understands and may require the help of an interpreter.

2.1.4. Except in a life-threatening emergency, where the need to save life is of paramount importance, the consent of the patient must be obtained before the proposed procedure, examination, surgery, or treatment is undertaken.

2.1.5. The primary purpose of the consent form is to provide evidence that the patient gave consent to the procedure in question. While a consent form is the most common method to signify consent, a patient's signature alone on the form consent is not sufficient.

2.1.6. The medical practitioner must inform the patient, in a manner that the patient can understand, about the condition, investigation options, treatment options, benefits, all material risks, possible adverse effects or complications, the residual effects, if any, and the likely result if treatment is not undertaken, to enable the patient to make his own decision whether to undergo the proposed procedure, examination, surgery, or treatment.

2.1.7. The patient must be at least 18 years old, not mentally incapacitated, able to have sufficient understanding and provides the consent on his own free will without undue influence.

2.1.8. There must be a witness, who may be another registered medical practitioner or a nurse who is not directly involved in the management of the patient nor related to the patient or the medical practitioner, to attest to the consenting process.

2.2. Duration of validity of Consent.

2.2.1. For an acceptable standard of care, the consent for an invasive procedure must be taken before the procedure is carried out.

2.2.2. The consent obtained in the above manner will remain valid if the patient's condition remains the same.

2.2.3. Should there be a change in the nature and clinical course, or the presentation of the illness for which the consent had initially been obtained, then a new consent must be obtained from the patient.

2.2.4. In instances when a patient from whom consent had been taken for a particular procedure, and the procedure is delayed or postponed, including and especially when an in-patient is discharged home, a new consent must be taken before undertaking the procedure, examination, surgery, or treatment.

2.3. Chronic conditions requiring periodic treatment.

2.3.1. Good standard of care requires that consent must be specific in time (contemporaneous) and procedure for any invasive treatment. This would apply in instances like patients requiring repeated de-sloughing, chemotherapy, or periodic blood transfusions.

2.4. Consent for photographs and audio-visual recordings.

2.4.1. Prior consent must be obtained if the practitioner is planning to take clinical photographs or to make audio-visual recordings before, during or after an invasive procedure.

2.4.2. There may be medico-legal reasons for taking photographs, or audio-visual recordings, as in cosmetic surgery or ablative surgery involving upper or lower limbs. Such photographs and audio-visual recordings rightfully belong to the patient, and if it is to be retained by the practitioner, further consent must be obtained. If such photographs or audio- visual recordings are requested by the patient to be taken away, it is advisable to keep copies of such material in the patient's records, for future requirements, like medical reports.

2.5. Who Can Take Consent.

2.5.1. Consent should be taken by a fully registered medical practitioner who will operate or perform the procedure on the patient.

2.5.2. In the event of the practitioner taking the consent and the practitioner performing the procedure being two different registered medical practitioners, the final responsibility and liability will rest on the practitioner who performs the procedure who should, before performing the procedure, confirm the nature of the information given to the patient by the other practitioner while taking the consent.

2.5.3. In many health facilities there are individuals who are not directly involved in patient care e.g. medical students, trainee nurses etc. They may be required to observe clinical procedures as their training process. The attending doctor should get patients consent before allowing them as observers.

2.6. Treating without consent.

2.6.1. Situations in which a practitioner may treat a patient without his/her consent. Such situations may arise when the following criteria are fulfilled:

2.6.1.1. Where immediate treatment is necessary to save a person's life, or to prevent serious injury to the person's immediate and long-term health, and the patient is unable to consent, and;

2.6.1.2. There are no next-of-kin or legal guardian available or contactable during the critical period, and;

2.6.1.3. No written advance medical directive by the patient has been given to the contrary.

2.6.2. In this situation, the treating practitioner and a second registered practitioner must reach a consensus. Both registered medical practitioners must co-sign the consent form, and the nature of the emergency and the consequences of delay must be documented.

2.7. Consent in minors.

2.7.1. Existing Laws related to consent in minors include:

2.7.1.1. Age of Majority Act 1971: a patient who is below 18 years of age is a minor and generally considered as not having the capacity to give valid consent to any medical procedure or surgery.

2.7.1.1.1. Guardianship of Infants Act 1961: the guardian of the person of an infant shall have the custody of the infant, and shall be responsible for his support, health, and education.

2.7.1.1.2. Law Reform (Marriage and Divorce) Act 1976: each parent has the responsibility for his/her child's welfare, unless there is an agreement, or a Court has made an order to the contrary. Parental responsibility is not affected by changes to relationships (i e if the parents separate).

2.8. Consent for those with Mental Disorders.

2.8.1. Consent for those with Mental Disorders shall be consistent with the provisions in the Mental Health Act 2001.

2.9. Professional Confidence.

2.9.1. Confidentiality refers to the legal or ethical duty to keep private the information gathered during a professional relationship. This doctrine of mutual trust underpins the pillars of a doctor patient relationship. The duty of confidentiality is one of the core duties in medical practice and is built on trust and confidence.

2.9.2. Professional confidence implies that a doctor shall not disclose voluntarily without the consent of the patient, preferably in writing, information that he has obtained during his professional relationship with the patient and may include what the practitioner may independently conclude or form an opinion about.

2.9.3. The duty of confidentiality continues to exist even after the death of the patient.

2.9.4. Where the medical condition of the patient is likely to pose a risk to others, the doctor should seek to persuade the patient to discontinue all such behaviour which puts others at risk, or to disclose the information to the parties at risk, or to consent to the doctor so doing.

2.9.5. If the patient refuses, the doctor may exercise discretion to breach confidentiality to protect other people.

2.9.6. A practitioner may release confidential information in strict accordance with the patient's consent, or the consent of a person authorized to act on the patient's behalf. Patient's consent for disclosure of information is part of good medical practice.

2.10. Breach of Confidentiality.

2.10.1. While confidentiality is an important element of the doctor-patient relationship, this is not absolute. The following are some situations where breaches of confidentiality may be ethically justified.

2.10.2. Disclosure in the patient's interest:

- Harm/injurious to himself.
- Incompetent, unconscious, etc.
- Treatment purposes with other staff.
- Where the patient may be a victim of neglect and abuse.

2.10.3. Disclosure in the public interest:

- Public interest includes matters which affects the life and even the liberty of members of the society:
- Disclosure in the interests of national security
- Disclosure to prevent harm to third party.
- Disclosure to prevent crime.

2.10.4. Disclosure required by Statute:

- Prevention and Control of Infectious Diseases Act 1988
- Poisons Act 1952
- Criminal Procedure Code
- Child Act 2001
- Sexual Offences Against Children Act, etc.

2.10.5. Disclosure compelled by a court order:

2.10.5.1. The doctor's usual course when asked in a court of law for medical information concerning a patient in the absence of that patient's consent is to resist on the ground of professional secrecy.

2.10.5.2. The presiding judge however may overrule this contention and direct the medical witness to supply the required information. The doctor has no alternative but to obey unless he is willing to accept imprisonment for contempt of court.

2.10.5.3. In the absence of a court order, a request for disclosure by a third party, without a patient's consent, (i.e.: a lawyer, a police officer, or an officer of a court) is not sufficient justification for disclosure.

2.10.6. Disclosure for training, research, audit purposes.

2.10.6.1. A breach of confidentiality under this category may be ethically justifiable if it is in accordance with the provisions in the MMC guidelines for Confidentiality.

2.11. Social Media.

2.11.1. Medical practitioners must avoid intentional or inadvertent sharing of patient’s confidential information in social media.

2.11.2. There is legal implication of violating patient’s right of privacy. Comments made online can be construed to be defamatory in nature. Informal, personal, and derogatory comments about patients or colleagues may trigger an action for defamation.

2.12. The Practitioner and Requests for Consultation.

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

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

2.13. The Dying Patient.

2.13.1. Where death is deemed to be imminent and where curative or life-prolonging treatment is futile, the physician has a duty to ensure that death occurs with dignity and comfort.

2.13.2. Such futile therapy can be ethically withheld or withdrawn, so as to allow natural death without active resuscitation.

2.13.3 One should always take into consideration any advance directives and the wishes of the patient, or if he is mentally incapacitated, his next of kin.

2.14. Medical Records.

2.14.1. Keeping good medical records are an indication of good practice. The doctor is encouraged to record all relevant details of his management of a patient.

2.14.2. Accurate, legible, comprehensive, and contemporaneous notes are advised.

2.14.3. Doctors have obligations relating to the storage, access, and use of health information available in the patients' records.

2.14.4. The doctor can be held responsible for any breaches of confidentiality of medical records.

2.14.5. Medical information can be released to a third party only when written consent has been given by the patient, or if the patient does not have mental capacity to do so, by his surrogate decision maker.

2.15. Electronic Medical Records.

2.15.1. Medical Practitioners who use electronic medical records to store patient information must ensure:

- That only authorised personnel have access to it.
- Regular monitoring of access to the medical records.
- Data security, information governance policy with protocols and procedures to ensure that patient information is documented, maintained, and disclosed, are in accordance with all the principles of Confidentiality.

2.16. Denial of Disclosure of Medical Record.

2.16.1. A medical practitioner may, on grounds other than the absence of written consent from a patient, or next of-kin, or legal guardian, deny disclosure of the contents of the Medical Record, if in his considered opinion, the contents if released may be liable to cause serious harm to the patient's mental or physical health or endanger his life.

2.16.2. The practitioner may also deny disclosure if the patient is deceased, unless a court order or consent from the administrator of the deceased's estate, is obtained.

2.17. Medical Reports.

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

2.17.2. A medical practitioner may be required to provide comprehensive medical reports when requested by patients, or legal guardians.

2.17.3. Specific consent by the patient is required if the request is made by the next of kin (unless the patient does not have capacity, or is deceased), an employer, or any other third party.

2.17.4. Any refusal or undue or unexplained delay in providing such report or withholding of such report on the grounds of non-payment of hospital charges or professional fees, is unethical and may have legal implications.

2.17.5. Fees may be charged for medical reports or expert opinion reports requested.

2.18. Medical Certificates.

2.18.1. Medical practitioners are constantly asked for certificates of various kinds, including issuing of medical sick certificate and should be continually on their guard against carelessness and inaccuracies in certifying.

2.18.2. The issuance of medical certificates should not be subjected to any form of pressure but should be carried out purely on medical grounds.

2.18.3. The practitioner should never certify a statement which he does not personally know to be a fact; he should never put hearsay information into a certificate, unless expressly so stated.

2.18.4. It must be stressed that the giving of medical certificates to patients without a medical examination is unethical and may lead to disciplinary action by the MMC.

2.18.5. The medical practitioner should exercise the most scrupulous care in issuing medical certificates especially in relation to any statement that a patient has been examined on a particular date.

2.18.6. The nature of the patient's illness should not be put on the certificate without the permission of the patient. The patient should be advised about the implication of revealing the diagnosis.

2.18.7. The practice of countersigning or endorsing another medical practitioner's certificate is unnecessary, unprofessional, and inappropriate.

2.18.8. Medical sick certificates are issued by practitioners for guidance on employment by the employer. The issuing of medical sick certificates without proper examination of patients, pre-signing of such certificates, failure to keep proper records in patient’s notes, back-dating for unacceptable reasons, or issuance of medical sick certificates for lengthy durations without interim examination even for chronic illnesses, and such related matters, is serious professional misconduct.

2.18.9. Backdating of medical sick certificates, which is defined as the issuance of a medical sick certificate on a date after the consultation or treatment, is allowed only under special circumstances when the practitioner has treated the patient and is aware of his medical condition, and the practitioner must accept responsibility for his actions in this respect.

2.18.10. The stating of the diagnosis of the illness on the medical sick certificate is permissible only with the consent of the patient.

2.18.11. Medical sick certificates should be signed by the practitioner and his name and MMC registration numbers stamped, with the date of issue clearly indicated.

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

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

2.19. Privileged Communication.

2.19.1. The Malaysian Medical Association considers that the exchange of medical information concerning patients should take place only between medical practitioners looking after the same patient.

2.19.2. The patient must be informed, and the consent obtained if the service of another medical practitioner is required.

2.19.3. Such exchange of medical information shall be regarded professionally as privileged communication and no prior consent of patient is necessary, provided such communication is made in the interest of the care of the patient.

2.20. Medical Research.

2.20.1. In any research on human beings, each potential subject must be adequately informed of the aims, methods, anticipated benefits and potential hazards of the study and the discomfort it may entail.

2.20.2. The subject of research should be informed that he or she is at liberty to abstain from participation in the study and that he or she is free to withdraw from the study at any time.

2.20.3. The practitioner should obtain the subject's informed consent in writing. In such circumstances, the practitioner should be conscious of differing obligations of the doctor-patient and researcher-subject relationship.

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

2.20.5. It is the duty of the practitioner to remain the protector of the life and health of that person on whom biomedical research is being carried out.

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

2.20.7. Children or young people should be involved in research only when research on adults cannot provide the same benefits.

2.20.8. Children or young people may participate if there is a potential benefit, and as long as the research does not go against their best interests or involves only minimal or low risk of harm. For example, research involving questionnaires or blood sampling.

2.20.9. If the children and young people object or appear to object in either words or actions, the research should not be conducted even if their parents' consent.

2.20.10. A practitioner shall use great caution in divulging discoveries or new techniques or treatment through non-professional channels.

2.20.11. A practitioner should not use any means to entice a patient into research with monetary benefits or other means.

2.21. Doctor and traditional medicine practice in healthcare services.

2.21.1. Traditional medicine is healthcare that lies for the most part outside the mainstream of conventional medicine.

2.21.2. There are many modalities of traditional medicine including herbal medicines.

2.21.3. Many patients resort to traditional medicines for a wide variety of conditions. It is also known that there are many patients who take both conventional and traditional medicine at the same time.

2.21.4. Coexistence of modern medicine and traditional and complementary medicine (T &CM) is in line with the World Health Organization's (WHO) vision and strategies. The Ministry of Health Malaysia (MOH) is guided by this vision for a comprehensive and integrated Malaysian healthcare system.

2.21.5. T&CM Units have been established in selected MOH hospitals throughout Malaysia by phases since 2007 to incorporate specific T&CM services into the national healthcare system.

2.21.6. T&CM services are provided to eligible patients who have obtained extension of care to T&CM services from Registered Medical Practitioners (RMPs).

2.21.7. They must be suitably indicated and are without contraindications to receive the prescribed T&CM service(s).

2.21.8. These services are offered based on practice guidelines and operating procedures developed by the T&CM Division (T&CMD), Ministry of Health of Malaysia.

2.21.9. These standards are established to ensure safe and quality services are consistently provided by T&CM practitioners working at the T&CM Units in MOH hospitals.

2.22. Telemedicine.

2.22.1. Telemedicine provides the tool or means to exchange medical information as part of the consultation with distant medical experts, be it foreign or local, during treatment of patients. It is a rapidly evolving area of medical practice.

2.22.2. However, most clinical applications of telemedicine have not been subjected to systematic comparative studies that assess their impact on the quality, accessibility, acceptability, and cost of healthcare.

2.22.3. The onus is on the medical practitioner to ensure that the principles of good ethical conduct are applied in telemedicine as well. These would include:

2.22.3.1. The doctor requesting the consultation should be responsible for the professional care of the patient.

2.22.3.2. Any consultation using this modality should be with the consent of the patient.

2.22.3.3. Ensuring confidentiality of patient information.

2.22.3.4. Ensuring that the appropriate choice of treatment is based on sound scientific evidence.

2.22.3.5. Guarding against self-laudatory activities as well as advertising.

2.22.3.6. Not associating with commercial concerns in such a way as to let it influence or appear to influence the treatment of patient.

2.22.3.7. The use of email should not diminish the quality-of-care patients receive.

2.22.4. Consultation and prescribing by email may seriously compromise standards of care where:

2.22.4.1. The patient is not previously known to the doctor.

2.22.4.2. There is little or no provision for appropriate monitoring of the patient or follow-up care.

2.22.4.3. The patient cannot be examined.

2.22.5. Doctors who wish to provide online services should consider carefully whether such a service will serve their patients' interests, and if necessary, seek advice from their professional association or medical indemnity providers.

2.23. Ethical and technical issues in teleconsultation.

2.23.1. Several ethical and technical issues may be encountered during teleconsultation that may include the following:

- Insufficient clinical information or inaccurate transfer of details to the opposite side
- Communication failure between doctor and patient due to technical breakdown
- Risk of confidentiality breach if the security measures fail
- Validity of verbal consent
- Inaccurate diagnosis

2.23.2. There are occasions whereby the doctor communicates with patients using electronic media e.g. email. While doing so the doctor must maintain the same ethical responsibilities as they do during physical consults.

2.23.3. The doctor must ensure the patient’s confidentiality is protected.

2.23.4. An informed consent should be taken from the patient or legal guardian prior to engaging with patient electronically.

2.24. Transplantation And Ethical Issues in Live Organ Donation.

2.24.1. Organ transplantation involves many ethical issues. Doctors practicing in this field must be aware of all the issues and ensure that they do not transgress any ethical principles.

2.24.2. The ethical issues of live organ donation are based on the four basic principles of biomedical ethics:

- respect for autonomy
- non-maleficence
- beneficence

- justice.

2.24.3. The donor, and/or their next of kin /guardian are entitled for a full disclosure of the intent of the organ transplant, the purpose of the procedure and, in the case of a living donor, the risks of the procedure.

2.24.4. The potential donor needs to make a free and informed decision on organ donation. Adequate information on all aspects of the surgery, short term and long-term complications must be provided to the donors.

2.24.5. Persons who are mentally incompetent to decide should not be allowed to donate.

2.24.6. Many institutions provide "donor advocates" who are physicians independent of the team looking after the recipients or the transplant team.

2.24.7. The potential donor should be assured that at any time he changes his mind on donating an organ, his wishes would be respected.

2.24.8. In cadaveric organ transplantation, it is important that the pronouncement of brain death is done using acceptable local criteria and persons performing tests to determine brain death are independent of the transplant team as well as the team looking after the recipient.

2.24.9. In living organ transplantation, a proper psychosocial assessment should be a routine practice to be conducted on both the donor and the recipient. They must be offered on-going counselling and appropriate support.

2.25. Intimate Examination.

2.25.1 When conducting an intimate examination, the doctor should observe the following:

- Inform the patient that an intimate examination needs to be done and explain the reason(s)why.
- Explain what the examination will involve.
- Ensure that the patient has agreed for an examination.
- Always have a chaperon present.

- Give the patient privacy to undress and dress.
- Keep the discussion relevant.
- Avoid unnecessary comments.

2.26. Chaperone.

2.26.1. A medical practitioner must ensure when consulting or examining a patient, particularly of the opposite sex to have the presence of a chaperone with visual and aural contact, within the consultation room or bedside.

2.26.2. This is for the protection of the practitioner and the patient, and to ensure that the patient is comfortable and not embarrassed by any appropriate physical examination.

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

2.27. Termination of Pregnancy (TOP).

2.27.1. Termination of pregnancy for the purpose of this document is confined to procedures to remove an embryo or foetus where the pregnancy is less than 22 weeks of gestation or if the gestation is unknown, where the foetus is estimated to be less than 500 gms.

2.27.2. The MMC regards induced non-therapeutic abortion as a serious professional misconduct and if proved to the satisfaction of the MMC, a practitioner is liable to disciplinary action. A criminal conviction in Malaysia or elsewhere for the termination of pregnancy affords grounds for disciplinary action.

2.27.3. In Malaysia, induced abortion is illegal under the Penal Code (Act 574). However, an exception clause has been added to Section 312 for.

"a medical practitioner registered under the Medical Act 1971 who terminates the pregnancy of a woman, if such medical practitioner is of the opinion, formed in good faith, that the continuance of the pregnancy would involve risk to the life of the pregnant woman, or injury

to the mental or physical health of the pregnant woman, greater than if the pregnancy were terminated.

2.28. Pre-Requisite for Termination of Pregnancy.

2.28.1. Patients can be seen at any private or public health institution, but the procedure should only be done in a setting with Gynaecologist (Specialist) support (this is also in accordance with the Private Healthcare Facilities & Services Act 1998).

2.28.1.1. This is to ensure that the procedure can be done properly and if complications should occur, these complications can be picked up quickly.

2.28.1.2. While by law, only one registered medical practitioner is required to assess if a termination of pregnancy is necessary, it is an accepted practice that in a Government Hospital setting, two doctors, one of whom is a specialist should concur that the termination of pregnancy is necessary and that continuation of the pregnancy would involve risk to the life of the pregnant woman, or injury to the mental or physical health of the woman, greater than if the pregnancy was terminated.

2.28.1.3. For mental health reasons, an opinion from a psychologist or psychiatrist though not needed may be advisable to weigh a balance between the mental health of the woman if the pregnancy is terminated or if it is not especially when there is severe depression or there is suicidal risk.

2.28.1.4. Obtaining a comprehensive history and examination including a general mental health assessment must be done to determine any coexisting health issues.

2.28.1.5. This assessment and examination must be adequately documented.

2.29. Consent for Termination of Pregnancy.

2.29.1. Written consent should be from the patient herself.

2.29.2. The patient should be encouraged to discuss this decision with her spouse, if this is applicable, and based on her cultural and religious norms prior to deciding and consenting to this procedure.

2.29.3 In a woman who is of unsound mind or who may be mentally challenged, consent should be obtained in accordance with the provisions in Section 77 of the Mental Health Act 2001 as a termination of pregnancy is a surgical procedure.

2.30. Abuse of Privileges Conferred by Law.

2.30.1. Prescribing of Drugs.

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

2.30.1.2. The MMC regards as serious professional misconduct the prescription or supply of drugs including drugs of dependence otherwise than in the course of bona fide treatment.

2.30.1.3. A practitioner may be convicted of offences against the laws which control drugs.

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

2.30.2 Dangerous Drugs.

2.30.2.1 The contravention by a registered practitioner of the provisions of the Dangerous Drugs Act 1952 and the Regulations made thereunder may be the subject of criminal proceedings, and any conviction resulting therefrom may be dealt with as such by the MMC in exercise of their powers under the Medical Act 1971.

2.30.2.2 Any contravention of the Act or Regulations, involving an abuse of the privileges conferred thereunder upon registered practitioners, whether such contravention has been the subject of criminal proceedings or not, will be subjected to disciplinary punishment by the MMC.

2.30.3. Sale of Poisons.

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

2.31. Abuse of Privileges.

2.31.1. Abuse of Trust.

2.31.1.1. Patients grant practitioners privileged access to their homes and confidences and some patients are liable to become emotionally dependent upon the practitioner.

2.31.1.2. Good medical practice depends upon maintenance of trust between practitioners and patients and their families, and the understanding by both that proper professional relationships will be strictly observed. In this situation practitioners must exercise great care and discretion in order not to damage this crucial relationship.

2.31.1.3. Any action by a practitioner which breaches this trust may raise the question of serious professional misconduct.

2.31.2. Abuse of Confidence.

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

2.31.3. Undue Influence.

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

2.31.4. Personal Relationships between Practitioners and Patients.

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

2.31.5. Practitioner's Inability or Fitness to Practice.

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

2.31.6. Medical Errors and Incident Reporting.

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

2.32 Conduct Derogatory to The Reputation of The Medical Profession.

2.32.1. Personal Behaviour.

2.32.1.1 The public reputation of the medical profession requires that every member should observe proper standards of personal behaviour, not only in his professional activities but at all times.

2.32.1.2. A conviction of a practitioner for a criminal offence may lead to disciplinary proceedings even if the offence is not directly connected with the practitioner's profession.

2.32.2. Personal Misuse or Abuse of Alcohol or Drugs.

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

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

2.32.3. Dishonesty and Improper Financial Transactions.

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

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

2.32.3.3. A practitioner must not prescribe or dispense drugs or appliances for improper motives.

2.32.3.4. A practitioner's motivation may be regarded as improper if he has prescribed a drug or appliance purely for his financial benefit or if he has prescribed a product manufactured or marketed by an organisation from which he has accepted an improper inducement.

2.32.4. Professional Fee, fee splitting or kick-back arrangement.

2.32.4.1. Reasonable charges can be made for services provided and it is in the best interest of the practitioner to discuss this with the patient prior to investigation or treatment.
The medical practitioner should abide by the prescribed Schedules of Fee.

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

2.32.4.3. Fee sharing, where two or more practitioners are in partnership or where one practitioner is an assistant to or acting for the other, is ethically permissible.

2.32.5. Indecency and Violence

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

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

2.32.6. Plagiarism.

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

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

2.33. A Colleague's Incompetence to Practice.

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

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

2.34. Respect for Human Life

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

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

2.34.3. The practitioner must not provide any premises, instruments, substances, or knowledge to facilitate the practice of torture or other forms of cruel, inhuman, or degrading treatment or to diminish the ability of the victim to resist such treatment.

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

SECTION 3

3.0. REGISTERED MEDICAL PRACTICIONER AND COLLEAGUES

3.1. Examination in Consultation.

3.1.1. Modern medicine cannot be practiced by a doctor in isolation. He is in continual contact with his colleagues for many purposes. He may need to have a patient examined by another practitioner; it may be necessary for a patient to be examined by a medical officer representing a third party, or if the patient is in industrial employment, a medical officer at his place of work may have a continuing interest in his health.

3.1.2. Whenever two registered medical practitioners are simultaneously managing a patient, each is expected to observe the ethical rules of conduct.

3.1.3. The custom of consultation is very old and through the years, the profession has evolved a code of conduct that should be followed meticulously. Failure to observe the established procedure may lead to difficulties or unpleasantness between registered medical practitioners.

3.1.4. A practitioner consulted is a practitioner who, with the acquiescence of the practitioner already in attendance, examines a patient under this practitioner's care and, either at a meeting of the two practitioners or by correspondence, cooperates in the formulation of diagnosis, prognosis, and treatment of the case. The term "consultation" means such a co-operation between practitioners. In domiciliary consultations, it is desirable that both practitioners should meet and in other circumstances similar arrangements should obtain wherever practicable.

3.1.5. It is the duty of an attending practitioner to propose a consultation where indicated, or to acquiesce in any reasonable request for consultation expressed by the patient or his next-of-kin. Registered medical practitioner must ensure the patient, or his next-of-kin if he does not have capacity, is informed clearly the need, when necessary, before bringing in another practitioner especially in private practice.

3.1.6. The attending practitioner should nominate the practitioner to be consulted and should advise accordingly, but he should not unreasonably refuse to meet a registered medical practitioner selected by the patient or the patient's representatives, although he is entitled, if such is his opinion, to urge that the practitioner has not the qualifications or the experience demanded by the requirements of the case.

3.1.7. The arrangements for consultation should be made or initiated by the attending practitioner. The attending practitioner should acquaint his patient of the approximate expenses, which may be involved in specialist consultation.

3.1.8. In cases where the consultant and the attending practitioner meet and personally examine the patient together, the following procedure is generally adopted and should be observed, unless in any instance there is substantial reason for departing from it.

3.1.8.1. All parties meeting in consultation should be punctual, and if the attending practitioner fails to keep the appointment, the practitioner consulted, after a reasonable time, may examine the patient, and should communicate his conclusions to the attending practitioner in writing and in a sealed envelope.

3.1.8.2. The diagnosis, prognosis and treatment should be discussed by the practitioner consulted and the attending practitioner in private.

3.1.8.3. The opinion on the case and the treatment as agreed should be communicated to the patient or the patient's representatives, where practicable, by the practitioner consulted in the presence of the attending practitioner.

3.1.8.4. It is the duty of the attending practitioner loyally to carry out the measures agreed at, or after, the consultation. He should refrain from making any radical alteration in these measures except upon urgent grounds or after adequate trial.

3.1.9. If for any reason the practitioner consulted and the attending practitioner cannot examine the patient together, the attending practitioner should send to the practitioner consulted a brief history of the case. After examining the patient, the practitioner consulted should forward his opinion, together with any advice as to treatment, in a sealed envelope addressed to the attending practitioner. He should exercise great discretion as to the information he gives to the patient or patient's representatives and, in particular, he should not disclose to the patient any details of any medications, which he has advised. In cases where the attending practitioner accepts the opinion and advice of the practitioner consulted, he should carry out the measures which have been agreed between them; however, if the attending practitioner finds he disagrees with the opinion and advice of the practitioner consulted, he should by suitable means communicate his disagreement to the practitioner consulted.

3.1.10. Should the practitioner consulted and the attending practitioner hold divergent views, either on the diagnosis or on the treatment of the case, and should the attending practitioner be unwilling to pursue the course of action advised by the practitioner consulted, this difference of opinion should be communicated to the patient or his representatives by the practitioner consulted and the attending practitioner jointly, and the patient or his representatives should then be advised either to choose one or other of the suggested alternatives or to obtain further professional advice.

3.1.11. In the following circumstances, it is especially desirable that the attending practitioner should endeavour to secure consultation with a colleague.

3.1.11.1. When the propriety has to be considered of performing an operation or of adopting some course of treatment which may involve considerable risk to the life of the patient or may

permanently prejudice his activities or capacities and particularly when the condition which it is sought to relieve by the treatment is not itself dangerous to life.

3.1.11.2. When any procedure likely to result in death of a foetus or of an unborn child is contemplated, especially if labour has not commenced.

3.1.11.3. When continued administration of any drug of addiction is deemed desirable for the relief of symptoms of addiction.

3.1.11.4. When there is reason to suspect that the patient:

- Has been subjected to an illegal operation; or
- Is the victim of criminal poisoning or criminal assault.

3.1.12. Arrangements for any future consultation or additional investigation should be affected only with the fore knowledge and cooperation of the attending practitioner.

3.1.13. The practitioner consulted should not attempt to secure for himself the care of a patient seen in consultation. It is his duty to avoid any word or action, which might disturb the confidence of the patient in the attending practitioner. The practitioner consulted should not communicate with the patient or the patient's representatives after the consultation except with the consent of the attending practitioner.

3.1.14. The attending practitioner should carefully avoid any remark disparaging the skill or judgement of the practitioner consulted.

3.1.15. Except by mutual consent, the practitioner consulted shall not supersede the attending practitioner during the illness with which the consultation was concerned (see also next Section).

3.1.16. The consultant is normally obliged to consult the referring practitioner before other consultants are called in.

3.2. Acceptance of Patient.

3.2.1. When a doctor in practice is planning to be away on other business or on vacation, he should formally appoint another doctor who will agree to look after his patients during his absence.

3.2.2. The examination of another doctor's patient may occasionally result in the patient being attracted to the examiner's own practice. Members are advised that the wilful enticement of patients from a fellow practitioner, or the employment of touts, or agents to attract patient to one's practice, are most unethical.

3.2.3. When a practitioner is called to attend a patient, whose regular medical attendant is temporarily unavailable, the practitioner should render whatever treatment may for the time be required and should subsequently notify the patient's regular doctor of the steps he has taken in the treatment of the patient.

3.3. Examining Medical Officers.

3.3.1. It often happens that a doctor's patient has to be examined for some particular purpose by a medical officer representing an interested third party. These examinations may occur in connection with life assurance or superannuation, entry into certain employment, litigation or requests from the police. The following Code of Medical Ethics governing special situations is approved. It does not apply to examinations performed under statutory requirements. Paragraphs 19, 20, 21 and 22 do not apply to pre-employment examinations, or to those connected with superannuation, Employees Provident Fund, SOCSO or with proposals for life or sickness assistance.

3.3.2. To this code, an examining medical officer is a practitioner undertaking the examination of a patient of another practitioner at the request of a third party with the exception of examinations under statutory requirements.

3.3.3. An examining practitioner must be satisfied that the individual to be examined consents, personally or through his legal representative, to submit to medical examination, and understands the reason for it.

3.3.4. When the individual to be examined is under medical care, the examining practitioner shall cause the attending practitioner to be given such notice of the time, place and purpose of his examination as will enable the attending practitioner to be present should he or the patient so

desire. (Preferably such notice should be sent to the attending practitioner through the post, or by telephone, but in certain circumstances a communication might properly be conveyed by the patient).

3.3.5. Exceptions to this are:

i When circumstances justify a surprise visit.

ii When circumstances necessitate a visit within a period, which does not afford time for notification.

3.3.6. Where the examining practitioner has acted under (i) or (ii), he shall promptly inform the attending practitioner of the fact of his visit and the reason for his action.

3.3.7. If the attending registered medical practitioners fails to attend at the time arranged, the examining registered medical practitioners shall be at liberty to proceed with the examination.

3.3.8. An examining registered medical practitioners must avoid any word or action which might disturb the confidence of the patient in the attending practitioner and must not without the consent of the attending practitioner, do anything which involves interference with the treatment of the patient.

3.3.9. An examining practitioner shall confine himself strictly to such investigation and examination as is necessary for the purpose of submitting an adequate report.

3.3.10. Any proposal or suggestion, which an examining practitioner may wish to put forward regarding treatment, shall be first discussed with the attending practitioner either personally or by correspondence.

3.3.11. When during an examination there come to light material clinical findings, of which the attending practitioner is believed to be unaware, the examining practitioner shall, with the consent of the patient inform the attending practitioner of the relevant details.

3.3.12. An examining practitioner shall not utilize his position to influence the person examined to choose him as his own registered medical practitioner.

3.3.13. When the terms of contract with his employing body interfere with the free application of this code, an examining officer shall make an honest endeavour to obtain the necessary amendment of his contract himself.

3.4. Registered Medical Practitioner in Relationship with Third Party Payers.

3.4.1. Many commercial firms, estates, mines and industries engage company registered medical practitioners to supervise the health and welfare of the employees and the environmental conditions of their work. The position of the company registered medical practitioners is such that without constant care, a conflict of loyalties is liable to arise, for, while he holds his appointment from the management, the object of his duties is the welfare of the workers, individually and collectively, and in the course of his duties, he will come into contact with the family registered medical practitioners of individual workers. As a registered medical practitioner, his paramount concern must be for the patient, and his behaviour should be guided by the customary ethical rules of his profession. To assist him in his special duties, the following set of rules are recommended.

3.4.2. Subject to statutory requirements, these rules shall, where existing ethical rules or custom fail to cover the circumstances, govern the professional relationship of industrial medical officers with their medical colleagues in other branches of medical practice, with those employees under their professional care, and with management's. The rules apply not only to whole-time officers, but also to those employed part-time or in any other capacity.

3.4.2.1. When a company registered medical practitioner renders advice or treatment to an employee at the place of employment, and when in the employee's own interests, he deems it advisable, he shall inform the employee's own registered medical practitioner of the material facts with the consent of the employee.

3.4.2.2. When a company registered medical practitioner finds on examination that an employee is unfit for work, he shall advise the employee to consult his own registered medical practitioner or he may, in an emergency, send him direct to hospital.

3.4.2.3. If an employee is under the care of his own registered medical practitioner of a hospital, and if at the place of employment there are special facilities and equipment for continuing

treatment, the company registered medical practitioner may arrange for such treatment with the approval of the registered medical practitioner or hospital concerned.

3.4.3. When in the course of an examination of an employee for superannuation purposes, retirement or special duty, material clinical findings come to light, the company registered medical practitioner should, with the consent of the person examined, inform his registered medical practitioner of the relevant details.

3.4.4. Except in an emergency, a company registered medical practitioner shall not undertake any treatment that is normally the responsibility of the employee's own registered medical practitioner, unless it be with his agreement.

3.4.5. A part-time company registered medical practitioner shall not utilize his position to influence an employee to choose him as his medical attendant.

3.4.6. A company registered medical practitioner shall not, except in an emergency, or where a prior understanding with local practitioners exists, send any employee direct to hospital. When he considers that attendance at hospital is necessary or advisable, he shall refer the employee to his own registered medical practitioner, to whom he may suggest to this effect. When, in an emergency, a company registered medical practitioner sends an employee to hospital, he shall inform the relatives (if the patient is likely to be detained) and also the employer's own registered medical practitioner, where known.

3.4.7. When a company registered medical practitioners is asked by his management to report on the condition of an employee who is absent from work for health reasons and under the care of his own doctor, the company doctor, before examining the patient, shall first communicate with the employee's doctor, informing him of the time of his intended examination.

3.4.8. A company registered medical practitioners should whenever possible, respond to an invitation for consultation with an employee's own doctor.

3.4.9. A company registered medical practitioners shall not carry out any personal preventive measure which is purely experimental without the consent of the employee, and, where desirable, the consent of the employee's own doctor.

3.4.9.1. The personal medical records of employees maintained by a company doctor for his professional use are confidential documents. Access to them must not be allowed to any other person except with the consent of the employee concerned.

3.4.9.2. A company registered medical practitioner shall at all times be responsible for the safe custody of his records. On the termination of his appointment, he shall hand over his records only to the company doctor who shall succeed him in the appointment.

3.4.9.3. If there is no successor to his appointment, the company registered medical practitioner retains his responsibility for the safe custody of his records or for their destruction.

3.4.10. A company registered medical practitioner shall not disclose his knowledge of industrial processes acquired by virtue of his appointment except with the permission of his management or when so required in courts of law.

3.4.11. When a company registered medical practitioner has examined an applicant for employment and as a result of the examination, employment is subsequently refused, the company registered medical practitioner should disclose his decision to the applicant and, when authorized, may disclose the findings to the patient's registered medical practitioner.

3.4.12. When a company registered medical practitioner addresses a communication to the employee's own doctor and receives no reply within a reasonable time, he shall be at liberty to assume that the employee's own registered medical practitioner takes no exception to the contents of his communication. It is important in the employee's interest that no opportunity of useful co-operation between the employee's registered medical practitioner and the company registered medical practitioners should be neglected. Such co-operation may be of particular value when an employee is under treatment for an occupational disease of which the company doctor has special experience.

3.4.13. Company registered medical practitioners should not make statements as to liability in the case of accidents at the place of work except when so required in courts of law.

3.4.14. In Malaysia, the role of a company registered medical practitioner differs considerably from that in other parts of the world. The custom has evolved whereby medical officers visiting estates, mines, factories, etc., are called upon, not only to advise the management on general

health matters, but also to treat the employees in a general practitioner's capacity. In view of the fact that many employees cannot afford to consult a private practitioner, it is not unethical for this practice to continue.

3.4.15. If, however, the patient is already under treatment from another registered medical practitioner, it is recommended that the company doctor does not treat the patient without consulting the patient's own doctor, and that any clinical findings which come to light during routine medical examination be communicated to the patient's own registered medical practitioner.

3.5. Panel Registered Medical Practitioners.

3.5.1. Registered medical practitioners in solo or group practice are often appointed on the panel of companies or corporate bodies to provide healthcare for the employees. The contractual agreements of such registered medical practitioners with the employers often stipulate certain conditions, which the doctor may accept as long as such conditions do not affect his ethical conduct.

3.6. The registered medical practitioners and the Managed Care Organisation.

3.6.1. A Managed Care Organisation is defined as any organization or body contracted or arranged, or intended to contract or arrange, to provide specified types and/or quality and/or quantity of healthcare within a specified financing system through one or a combination of the following mechanisms:

3.6.1.1. Delivering or giving healthcare to consumers through own or a third-party healthcare provider(s) in accordance with contractual agreements between all parties concerned.

3.6.1.2. Managing healthcare funds of payers (employers and/or financiers) to provide healthcare to employees (or enrolees) in accordance with contractual agreements between all parties concerned.

3.6.1.3. Any other types of healthcare delivery arrangements, which the Minister of Health may, from time to time, by notification in the Gazette declare to be a managed care organization.

3.6.2. For operational purposes, the term Managed Care Organisation includes all varieties and hybrids of healthcare management organisation where third parties (including private healthcare facilities and medical practitioners) are involved in an administrative control capacity in the delivery of healthcare by registered medical practitioners.

3.6.3. The MMA, however, asserts that the registered medical practitioners, whether in solo or group practice, directly (without third party managers or financiers) providing healthcare to employees of corporate bodies (or individual enrolees), through the panel contractual system, should not be considered a managed care organization, in the context of the above definition and its specific implications.

3.6.4. Registered medical practitioners participating in providing patient care with MCOs should abide by the following guidelines:

3.6.4.1. It is the medical practitioner's responsibility to ensure that, in his association with MCOs, his clinical practice does not violate the Code of Professional Conduct of the MMC and the Code of Medical Ethics of the MMA.

3.6.4.2. Irrespective of whichever healthcare system the medical practitioner practices, he must place the interest of the patient first. In this context:

- He should not enter into any contractual agreement that poses a conflict of interest between his professional practice and the provision of care for his patient.

- He should not participate in schemes that encourage or require him to practice below his professional standard or beyond his clinical capability.

3.6.4.3. Good clinical practice should be the basis of care rather than enticement with financial incentive or financial disincentive.

3.6.4.4. Registered medical practitioners should avoid actions/commitments which endanger doctor /patient relationship, and which allow for breach of confidentiality.

3.6.4.5. Registered medical practitioners should not allow themselves to commit either directly or indirectly advertising in any form as a marketing strategy of managed care organisation.

3.7. Fee Splitting and/or any Form of Incentive as an Inducement for Referring a Patient.

3.7.1. Fee splitting or any form of kickback arrangement as an inducement to refer a patient to another practitioner or facility is unethical. The premise for referral must be quality of care and the best interest of the patient. Violation of this will be considered as infamous conduct in a professional respect.

SECTION 4

4.0. RELATIONSHIP OF REGISTERED MEDICAL PRACTIONERS WITH OTHER PROFESSIONALS

4.1. Dental Surgeon, Nurses, and Other Healthcare Professionals.

4.1.1. The doctor is frequently in contact with other health professionals and members of other professions, e.g., nurses, dentists, pharmacists, and the clergy. These relationships give rise to ethical challenges. Some illustrations of how the doctor should conduct himself in such inter-professional relationships are mentioned below.

4.2. Consultations.

4.2.1. When a patient, in the opinion of his medical attendant needs dental treatment, the patient should be referred with consent in all but exceptional circumstances to his own dental surgeon. In the event of the patient having no regular dentist, there is no objection to a doctor recommending a dental surgeon of his own choice.

4.2.2. When on behalf of one of his patients a doctor wishes to consult a dental surgeon, the doctor should communicate in the first instance with the patient's own dental surgeon. In the event of the patient having no regular dentist, there is no objection to the doctor consulting the dental surgeon of his own choice.

4.2.3. A patient's medical practitioner when approached by a dental surgeon about the patient, whom he has knowledge of some medical disorders and needing a major dental procedure, the medical practitioner is obliged to accept the referral in the best interest of the patient.

4.3. Ministers of Religion.

4.3.1. Registered medical practitioners should co-operate with the clergy of the patient in the care of the patient, when religious involvement may be conducive to his patient's recovery as long it does not interfere with the professional medical management.

4.4. Pharmacists.

4.4.1. Collusion between registered medical practitioners and pharmaceutical chemists for any type of financial gain is reprehensible. A doctor should not arrange with a chemist for the payment of a commission on business transacted, nor should he hold a financial interest in a chemist's shop related to his practice. Professional cards should not be handed to chemists for distribution.

4.5. Nurses and other Healthcare Professionals.

4.5.1. Recognising that patient care involves a multi-disciplinary approach, it is desirable that registered medical practitioners work closely with nurses and other healthcare professionals in the delivery of patient care.

4.5.2 Mutual understanding and respect for each other's responsibilities and capabilities will enhance the working relationship between nurses, other healthcare professionals and registered medical practitioners.

SECTION 5

5.0. RELATIONSHIP OF REGISTERED MEDICAL PRACTICIONERS WITH PHARMACEUTICAL INDUSTRIES AND MEDICAL DEVICES INDUSTRIES

5.1. Pharmaceutical Services Products and Medical Equipment.

5.1.1. The relationship between a registered medical practitioner with the pharmaceutical industry and medical industries which design, manufacture and market medical instruments, prosthesis,

machines, implants etc must be on a strictly professional manner without compromising the treatment to a patient.

5.1.2. The medical practitioner is expected to prescribe treatment based on his clinical judgement without any influence by pharmaceutical companies or medical industries.

5.1.3. It is unethical for a medical practitioner to accept gifts in any form, money, trips or equipment for their personal use from these industries.

5.1.4 A medical practitioner should disclose his interest if in his professional opinion feel that either any pharmaceutical product or medical equipment which he has direct and personal financial interest in would serve his patient's best interest. This does not apply to the acquisition of shares in a public company marketing pharmaceutical product.

5.1.5 To avoid abuse by manufacturers, registered medical practitioners should refrain from writing testimonials on commercial products unless a legally enforceable guarantee is obtained that the testimonial will not be published without consent.

5.2. Commercial Enterprises.

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

5.2.2. A general ethical principle is that a practitioner should not associate himself with commerce in such a way as to let it influence, or appear to influence, his attitude towards the treatment of his patients.

5.2.3. Where the registered medical practitioner has a financial interest, he has an ethical duty to disclose his interest to the patient. The MMA disapproves of the direct association of a medical practitioner with:

5.2.3.1. Any commercial enterprise engaged in the manufacture or sale of any substance which claims to prevent or treat a disease especially if it is of undisclosed nature or composition which appears to influence/encourage the practice of self-diagnosis or self-medication to the public.

5.2.3.2. Any system or method of treatment which is not under medical control, and which is advertised in the public press.

5.2.3.3. Any facility or service to which the registered medical practitioner refers patients for diagnostic tests, for procedures or for inpatient cases in which the practitioner has a financial interest.

5.2.3.4. Any discussion, which could lead to the purchase by a public authority of goods, or services in which the registered medical practitioner, or a member of the immediate family, has a direct or indirect pecuniary interest.

5.3. Reprints and Publications.

5.3.1. Issues of Reprints or Abstracts: To establish authenticity for reports on its products and to support the promotion of the product in an ethical manner, the Ethics Committee suggests that the name and full credentials of the medical practitioner to be added to the reprint or the abstract of the article.

5.3.2. The Position of the registered medical practitioner: When names of medical practitioners are associated with advertising and marketing of proprietary products, the medical practitioner being the author can be accused of unethical conduct and also exposes the medical practitioner to the risk of firms utilising the medical practitioner’s name to enhance their business.

5.3.3. Reasonable Quotations: A medical practitioner may quote or use excerpts from any publication in his own publications provided it falls within the fair use exemption which would include not-for-profit/educational use. The medical practitioner should always refer to the publisher’s guidelines for authors to avert any ethical or legal action.

5.3.4. It is not considered unethical if registered medical practitioners' names appear in a bibliography of published works.

5.4. Nursing Homes and Medical Institutions.

5.4.1. Institutions providing medical advice or treatment may publish this information in the medical press, or in other publications primarily intended for the medical profession. Such information

may include the names and qualifications of the resident and attending medical officers. However, there should be no laudatory statement of the form of treatment given.

5.4.2. A registered medical practitioner who is associated with an institution for the treatment of patients by physical therapy and electrical methods must adhere strictly to the following conditions:

5.4.2.1. That the institution is not in any way advertised to the lay public with the name and other professional details of the practitioner.

5.4.2.2. That the treatment of all patients is under the direct control of a registered medical practitioner who accepts full responsibility for their treatment.

5.4.2.3. That the relationship between the medical officer of the institution and private practitioners conforms to the usual ethical procedure between consultant and practitioner.

5.4.2.4. If a medical practitioner has a financial interest in any institution to which he refers a patient, he must disclose this fact to the patient.

SECTION 6

6.0. ADVERTISING AND CANVASSING

6.1. Modern life brings the doctor into contact with the public in numerous ways, both directly and indirectly, and raises for him problems of conduct unknown to his predecessors.

6.2. Advertising" in connection with the medical profession must be taken in its broadest sense to include all those ways by which a person is made publicly known, either by himself or by others, without objection on his part, in a manner which can fairly be regarded as for the purpose of obtaining patients or promoting his own professional advantage, or as appearing to be for these purposes. (MMC Guideline on Dissemination of Information by the Medical Profession)

6.2.1. The medical profession in this country has long accepted the convention that registered medical practitioners should refrain from self-advertisement. (MMC Code of Professional Conduct)

6.2.2. The practices of touting or canvassing for patients are also considered to fall under the definition of advertising and are unethical.

6.2.3. Self-advertisement is not only incompatible with the principles which should govern relations between members of a profession but could be a source of danger to the public. A practitioner successful at achieving publicity may not be the most appropriate doctor for a patient to consult. In extreme cases advertising may raise illusory hopes of a cure.

6.2.4. The arrangement whereby the Malaysian Medical Association, or any other recognized professional body, which has been granted approval by the Honourable Minister of Health to publish announcements of opening of new clinics or change of address of clinics, will be allowed. The guidelines for advertisement in lay press must be in compliance with those given in the Advertising Guidelines for Healthcare Facilities and Services of the Medicine Advertisement Board of the Ministry of Health Malaysia. (Appendix I).

6.2.5. Members are required to exercise their utmost caution when disseminating medical information be it through radio, television, print, electronic media as well as social media and adhere to the guidelines provided in this Code of Ethics as well the MMC Code of Professional Conduct.

6.2.6. The MMC also places emphasis on this issue and have published guidelines related to advertising. (Appendix I)

6.2.7. Members need to be familiar with the provisions contained in these MMC guidelines as well as the provisions in the Medicines (Advertisement and Sales) Act 1956 which will impact their practice.

SECTION 7

7.0. SETTING UP PRACTICE

7.1. There is an ethical obligation on a doctor not to damage the practice of a colleague with whom he has recently been engaged professionally.

7.1.1. A RMP who has acted as an assistant to or locum tenens for that principal or as a member of a partnership should preferably not set up in practice in opposition to his former principal or partner in the area of practice of that principal or partner. While this course of action taken by a doctor may not be contrary to the law, yet may be considered undesirable by his colleagues.

7.2. Notices.

7.2.1. A practitioner commencing practice is allowed to announce this in the press through the MMA and as specified under Section 6.2.4, 6.2.5,6.2.6 & 6.2.7 and as provided in the Section 4(a) of the Medicines (Advertisement & Sales) Act 1956.

7.2.2. From time to time, it may happen that a doctor, whether in general or consultant practice, wishes to make some formal announcement about his practice to his patients or his colleagues. A general practitioner, for example, may need to notify his patients of a change of address or of surgery or consulting hours, or perhaps he may be changing to consultant practice. In any such case, the notification should be sent as a circular letter, under cover, to the patients of the practice, that is, to those who are on its books and are not known to have transferred themselves to another doctor. There is no objection to a suitable notice being placed in the waiting room.

7.2.3. A practitioner who wishes to draw the attention of his colleagues in the profession to the fact that he has recently commenced or intends to practice any particular branch of medical or surgical work, or to acquaint his colleagues of the services he proposes to make available, may do so in any or all of the following ways:

7.2.3.1. By calling upon practitioners already established in the area and giving a personal explanation of his arrangements and plans.

7.2.3.2. By sending a sealed postal notification to those practitioners who may be expected to be interested, provided such a communication contains no laudatory allusion to himself or his work.

7.2.3.3. By communications on professional subjects presented to the local branch of the MMA or to other medical organizations; and

7.2.3.4. By sending reprints of his published work to those practitioners who may be expected to be interested.

7.2.3.5. By publication in the Berita MMA/MJM within guidelines set by the Ethics Committee.

7.3. Premise.

7.3.1. In selecting the premises for his surgery, a doctor should preserve the dignity of his profession and bear in mind certain ethical considerations.

7.3.2. The sharing of the premise by medical practitioners and non-medical practitioners is unethical.

7.4. Nameplates.

7.4.1. Nameplates shall be plain and shall not exceed 930.25 sq. cm (1 sq. ft) in area.

7.4.2. The nameplate may bear the following:

7.4.2.1. The medical practitioner's name, his approved registrable qualifications, and titles.

7.4.3. There is no objection to the inclusion of phrases such as "Surgeon", "Psychiatrist", by a practitioner who is solely engaged in the practice of that specialty.

7.4.4. For every additional practitioner, an additional nameplate conforming to the above-mentioned standards may be exhibited.

7.4.5. Nameplates of practitioners who do not practice in the clinic should not be exhibited.

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

7.4.7. A separate signboard to indicate consultation hours not exceeding 930.25-sq. cm (1 sq. ft) is permitted.

7.5. The Practitioner and his Practice.

7.5.1. There is an ethical obligation on a practitioner not to damage the practice of a colleague or employer with whom he has been in professional association.

7.5.2. Actions such as procuring medical records of patients previously treated by him from his previous clinic, inducing such patients to transfer to his new clinic, or any other similar actions may be deemed unethical.

7.5.3. In employing locum tenants, the practitioner must ensure that the person is fully registered with the MMC and has a valid Annual Practising Certificate.

7.6. Signboards.

7.6.1. The use of a large signboard to indicate a private medical practice is considered unethical in many parts of the world. However, as the custom is already prevalent in Malaysia, and as a signboard does help patients to find a doctor, it is recommended that their use should continue, provided:

7.6.1.1. There shall not be more than two signboards to indicate the identity of the practice.

7.6.1.2. Signboards may be illuminated in a style appropriate for a medical practice.

7.6.1.3. The total size of the signboard or signboards, if there are two, shall not exceed 3.0 sq. meters.

7.6.1.4. Where signs are painted on walls, the perimeter of the lettering should not enclose an area more than those specified in 7.6.1.3.

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

7.6.1.6. The use of the word "Pharmacy" being a contravention of the Pharmacy Act, its use is illegal unless the premise is in fact a Dispensing Pharmaceutical Chemists Shop.

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

7.7. 24 Hours Clinic.

7.7.1. No additional signboards are permitted.

7.7.2. Notification of the availability of 24-hour service should be on the nameplate pertaining to consultation hours or on the existing clinic signboards.

7.7.3. Qualified and registered practitioners should be always available and his availability should be within a reasonable period of time, not exceeding thirty (30) minutes.

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

7.7.5. If an emergency arises, requiring the practitioner to be called away, the clinic should do one of the following:

7.7.5.1. Not to accept any new patients until the practitioner is back in the clinic.

7.7.5.2. Inform intending patients that the practitioner is not available.

7.8. Maternity Home.

7.8.1. Since maternity homes provide 24 hours services, the above regulations in respect of 24-hour clinic would also apply to maternity homes.

7.9. Medical Directories/ Yellow Pages.

7.9.1. Registered medical practitioners are sometimes uncertain about the form of entry they should allow in medical directories. The entry form should appear in the ordinary small type. No special type or special entry should be permitted.

7.9.2. There is no objection on ethical grounds to the listing of professional telephones in the Yellow Pages of the Telephone Directory, provided they conform to the following provisions:

7.9.2.1. Name and address of clinic and telephone number/s are allowed.

7.9.2.2. Address, telephone numbers of registered medical practitioners' practices and residence are allowed.

7.9.2.3. Names, addresses and telephone numbers of branch practices are allowed.

7.9.2.4. Emergency answering-service telephone number/s and pager numbers are allowed.

7.9.2.5. All entries in the Yellow Pages must be classified only under the heading "Medical Practitioners - Registered".

7.9.2.6. No entry pertaining to clinics in the Yellow Pages must be classified under other headings, e.g. clinics, registered medical practitioners, opticians, contact lens practitioners, etc.

7.9.2.7. Entry pertaining to clinic hours is permitted.

- All entries should appear in ordinary small type. No bold types, special display, boxed entries shall be permitted for a doctor or his practice.
- All entries listed under "Registered Medical Practitioners" should be confined to registered medical practitioners registered with the MMC and should not include homeopathy practitioners, dental practitioners, traditional medicine practitioners, etc.

7.10. Local Directories.

7.10.1. It is permissible for a doctor's name to be included in a handbook of local information, purporting to contain a list of all local medical practitioners, provided the list is open to the whole of the profession in the area and publication of names is not dependent on the payment of a fee.

7.11. Professional Calling Cards.

7.11.1. Calling card should only contain the name of the practitioner, registrable professional qualifications, state and national awards, home, practice and email address(es), telephone, and facsimile numbers. It would be unethical to use calling cards to solicit patients.

7.12. Letterheads.

7.12.1. The letterhead may contain the name of the clinic, address(es), telephone and fax numbers, email address and the names of the registered medical practitioners practicing in that clinic with their registrable qualifications, state and national awards and clinic hours.

7.13. Banners.

7.13.1. A temporary banner to announce the opening of a new clinic/hospital may be allowed for the purpose of public information. The size should conform to that allowed for a signboard. It should not be displayed for a period longer than one (1) calendar month prior to the date for opening. The banner is only permitted to be displayed at the entrance of the premise. It should only contain the date of opening and the name of the clinic/hospital. Any other information is unethical.

7.14. Telehealth.

7.14.1. Doctor can only have virtual consultation with a person who is already his/her patient. This can be seen as a continuation of care.

7.14.2. Under such special circumstances, the practice of telemedicine virtual consultation is still subjected to ethical considerations whereby the rights of patients are protected.

7.14.3. In providing medical care using telecommunications technologies, physicians are advised that they must:

- possess adequate training and competency to manage patients through telemedicine.
- follow all ethical and legal requirements such as to obtain valid informed consent from the patient.
- ensure that the physician's identity, place of practice and registration status are made known to the patient, and the identity of the patient is confirmed at each consultation.
- ensure that the identities of all other participants involved in the telemedicine encounter are disclosed to and approved by the patient and documented in the patient record.
- ensure that both the physician-site and the patient-site are using appropriate technology that complies with legal requirements regarding privacy and security and accreditation standards where required.

7.14.4. Due considerations must be given to the safety and maintaining a high standard of patient care:

- consider whether the telemedicine medium affords adequate assessment of the presenting problem, and if it does not, arrange for a timely in-person assessment.
- explain the appropriateness, limitations, and privacy issues related to telemedicine to the patient.
- provide an appropriate medical assessment based on the current symptoms or condition, history, medications and limited examination possible.
- create and maintain medical records of the consultation, in accordance with professional and legal requirements.
- ensure patients have enduring access to their medical records and that medical records are available to other health care professionals for the provision of ongoing patient care.

SECTION 8

8.0. THE ETHICS COMMITTEE OF MMA

8.1. Role And Objectives of Ethics Committee of MMA.

- To promote ethical conduct and provide counsel and advice for medical practitioners.
- To offer advice and counsel to medical practitioners involved in activities that may be construed or are a breach of ethics.
- To educate medical practitioners and the medical community on desirable ethical conduct.
- To deliberate and where possible resolve amicably disputes involving issues on ethics. To advise MMC on the ethical implications of issues, which it may be, required to take a position.

8.2. Disputes between Registered Medical Practitioners.

8.2.1. From time to time, registered medical practitioners working together in a practice or in the same locality find themselves at variance with one another. Friction may arise in many ways and often quite unnecessarily. For instance, clashes of personality and temperament between registered medical practitioners in neighbouring practices may magnify trifling differences into angry quarrels; the hasty acceptance from patients of rumours or uncorroborated reports of another doctor's utterances or actions may lead the practitioner to make unjust accusations against a colleague.

8.2.2. If animosities are allowed to fester, they not only embitter local practice but also damage the reputation of the profession in the eyes of the public. It is important, therefore, that disputes should be resolved quickly within the profession itself; and whenever possible, amicably.

8.2.3. Most of these disputes concern relationships not governed by law but by the traditions of the profession and harmony can be best restored by reference to some medical person or authority with extensive knowledge and experience of medical ethics and customs.

8.2.4. To provide the profession with an adjudicating body, the Association, through the Ethics Committee, has devised "ethical machinery" based on the experience of many years. The procedure should not be regarded as a judicial trial but as a service attempting reconciliation through impartial adjudication.

8.2.5. The machinery consists of the Ethics Committee itself, which is a standing committee of the MMA Council with detailed uniform rules of procedure for the investigation of complaints.

8.2.6. Briefly, the complainant must write to the respondent (stating the complaint in terms sufficiently specific to enable the respondent to reply) and intimating that he contemplates the initiation of a complaint through the ethical machinery of the Association.

8.2.7. A copy of the letter of complaint, together with any reply, must be submitted to the Honorary Secretary of the appropriate branch of the Association. The Honorary Secretary must then send the correspondence to the Head Office and obtain instructions on the steps to be taken in dealing with the matter and must take no other action whatsoever in connection with the

complaint except that prescribed in the advice and instructions he receives from the Head Office.

8.2.8. The Association will not accept responsibility for any consequence in ethical proceedings not so referred.

8.2.9. Alternatively, the letter of complaint, together with any reply received from the respondent, can be submitted to the Honorary General Secretary of the Association directly.

8.3. Disputes between a Doctor and His Patient.

8.3.1. Where a dispute arises between a doctor and his patient and a complaint is brought to the Ethics Committee, the doctor should respond to queries of the Ethics Committee as soon as possible, as provided in the Rules of the Ethics Committee (see MMA Constitution).

APPENDIX I

REFERENCES

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19. Traditional And Complementary Medicine Act 2016 https://hq.moh.gov.my/tcm/en/upload/aktaBI2016.pdf
20. 0–18 years: Guidance for all doctors General Medical Council https://www.gmc-uk.org/-/media/documents/gmc-guidance-for-doctors---0-18-years---english-20200211_pdf-48903188.pdf

APPENDIX II

RELEVANT DECLARATIONS

1. DECLARATIONS BY PROFESSIONAL MEDICAL ASSOCIATIONS

a. THE WORLD MEDICAL ASSOCIATION

- Declaration of Geneva
- Twelve Principles of Provision of Health Care in any National Health Care System
- International Code of Medical Ethics
- Regulations in Time of Armed Conflict
- Declaration of Helsinki
- (Recommendations Guiding Physicians in Biomedical Research Involving Human Subjects)
- Recommendations Concerning Medical Care in Rural Areas
- Statement on Family Planning
- Declaration of Sydney Statement on Death
- Declaration of Oslo Statement on Therapeutic Abortion
- Statement on the Use of Computers in Medicine
- Declaration of Tokyo (Guidelines for Medical Doctors Concerning Torture and Other Cruel, Inhumane or Degrading Treatment or Punishment in relation to Detention and Imprisonment)
- Statement on the Use and Misuse of Psychotropic Drugs
- Declaration of Sao Paulo Statement on Pollution
- Resolution on Physician Participation in Capital Punishment
- Declaration on Principles of Health Care for Sports Medicine
- Declaration of Venice on Terminal Illness
- Recommendations Concerning Boxing
- Statement on Medical Manpower I
- Statement on Medical Manpower II
- Statement on Child Abuse and Neglect
- Statement on Freedom to Attend Medical Meetings
- Statement on Medical Manpower III
- Declaration on Human Rights and Individual Freedom of Medical Practitioners
- Statement on Live Organ Trade
- Declaration on Physician Independence and Professional Freedom
- Declaration on Madrid on Professional Autonomy and Self-Regulation
- Declaration on Rancho Mirage on Medical Education
- Statement on In-Vitro Fertilization and Embryo Transplantation
- Declaration on Euthanasia
- Declaration on Human Organ Transplantation
- World Medical Association Interim Statement on AIDS

- Statement on Genetic Counselling and Genetic Engineering
- Statement of Policy on Infant Health
- Statement on Access to Health Care
- Statement on the Professional Responsibility of Physicians in Treating AIDS Patients
- Statement on Academic Sanctions or Boycotts
- Resolution on Medical Group Practice World Medical Association Resolution
- Statement on Health Hazards of Tobacco Products
- Declaration on the Role of Physicians in Environmental and Demographic Issues
- Statement on Animal Use in Biomedical Research
- Statement on Generic Drug Substitution
- Statement on Foetal Tissue Transplantation
- Statement on Persistent Vegetative State
- Statement of Policy on the Care of Patients with Severe Chronic Pain in Terminal Illness
- Statement on Tobacco Manufacture, Import, Export, Sale and Advertising
- Declaration of Hong Kong on the Abuse of the Elderly
- Declaration of Chemical and Biological Weapons
- Resolution on Human Rights
- Resolution on Therapeutic Substitution
- Statement on Traffic Injury
- Declaration on Injury Control
- Statement on Adolescent Suicide
- Declaration of Malta on Hunger Strikers
- Declaration of WMA Fifth World Conference on Medical Education
- Resolution to Prohibit Smoking on International Flights
- Declaration on the Human Genome Project
- Statement on Physician-Assisted Suicide
- Statement on Home Medical Monitoring
- Telemedicine and Medical Ethics
- Resolution of the Council of the World Medical Association
- Statement on Noise Pollution
- Statement on Medical Malpractice
- Statement on Alcohol and Road Safety
- Statement on Issues Raised by the HIV Epidemic
- Statement on Body Searches of Prisoners
- Statement on Patient Advocacy and Confidentiality

- Statement on Safety in the Workplace
- Statement on Condemnation of Female Genital Mutilation
- Statement on the Right of a Woman to Contraception
- Resolution on Rededication to the Principles of the World Medical Association Ethical Standards
- Resolution on the Refugee Problem Around the World
- Resolution on Physician's Conduct Concerning Human Organ Transplantation
- Statement on Medical Ethics in the Event of Disasters

b. WORLD PSYCHIATRY ASSOCIATION

- WPA Statement and Viewpoints on the Rights and Legal Safeguards of the Mentally Ill
- Declaration of Hawaii/II
- Declaration on the Participation of Psychiatrists in the Death Penalty

c. ACOEM - CODE OF ETHICAL CONDUCT

This Code establishes standards of professional ethical conduct with which each member of the American College of Occupational and Environmental Medicine (ACOEM) is expected to comply. These standards are intended to guide occupational and environmental medicine physicians in their relationship with the individuals they serve employers and workers' representatives, colleagues in the health professions, the public and all levels of government including the judiciary.

2. DECLARATIONS BY UNITED NATIONS

- Principles of Medical Ethics
- The Protection of Persons with Mental Illness and the Improvement of Mental Health Care
- Principles for the Protection of Persons with Mental Illness and for the Improvement of Mental Health Care

3. DECLARATIONS BY COUNCIL OF EUROPE

- Recommendation 818 (1977) on the Situation of the Mentally Ill

APPENDIX III

PERSPECTIVES IN MEDICAL ETHICS

Medical ethics may vary among different cultural groups due to diverse beliefs, values, and societal norms. However, the fundamental principles of professional behaviour have remained unaltered through the

recorded history of medicine in different societies. Here are some descriptions of medical ethics among some cultural groups:

Western Medical Ethics

Medical ethics from the time of Hippocrates to the current time in the West provides insight into the evolution of ethical principles and practices in healthcare. An overview of the major shifts is presented here:

1. Hippocratic Era (circa 460-370 BCE): The Hippocratic Oath is the most widely known of Greek medical texts. It is attributed to the ancient Greek physician Hippocrates and laid the foundation for medical ethics. It emphasized the principles of beneficence, non-maleficence, and patient confidentiality. Physicians pledged to use their knowledge and skills for the benefit of patients and to avoid causing harm. Confidentiality was valued to build trust between doctors and patients.

Hippocratic Oath

I swear by Apollo the physician, and Asclepius, and Hygieia and Panacea and all the gods and goddesses as my witnesses, that, according to my ability and judgement, I will keep this Oath and this contract:

To hold him who taught me this art equally dear to me as my parents, to be a partner in life with him, and to fulfil his needs when required; to look upon his offspring as equals to my own siblings, and to teach them this art, if they shall wish to learn it, without fee or contract; and that by the set rules, lectures, and every other mode of instruction, I will impart a knowledge of the art to my own sons, and those of my teachers, and to students bound by this contract and having sworn this Oath to the law of medicine, but to no others.

I will use those dietary regimens which will benefit my patients according to my greatest ability and judgement, and I will do no harm or injustice to them.

I will not give a lethal drug to anyone if I am asked, nor will I advise such a plan; and similarly I will not give a woman a pessary to cause an abortion.

In purity and according to divine law will I carry out my life and my art.

I will not use the knife, even upon those suffering from stones, but I will leave this to those who are trained in this craft.

Into whatever homes I go, I will enter them for the benefit of the sick, avoiding any voluntary act of impropriety or corruption, including the seduction of women or men, whether they are free men or slaves.

Whatever I see or hear in the lives of my patients, whether in connection with my professional practice or not, which ought not to be spoken of outside, I will keep secret, as considering all such things to be private.

So long as I maintain this Oath faithfully and without corruption, may it be granted to me to partake of life fully and the practice of my art, gaining the respect of all men for all time. However, should I transgress this Oath and violate it, may the opposite be my fate.

Translated by Michael North, National Library of Medicine, 2002. https://www.nlm.nih.gov/hmd/greek/greek_oath.html

2. Middle Ages and Renaissance (5th to 16th centuries): During this period, medical ethics was heavily influenced by religious and moral doctrines. Christian ethics became prominent, and physicians were often guided by religious principles in their practices. The sanctity of life and the duty to care for the sick were key ethical considerations.
3. Enlightenment (17th to 18th centuries): The Enlightenment era brought about significant changes in medical ethics. There was a shift towards secularization and a growing emphasis on reason and individual rights. Physicians began to focus more on empirical evidence and scientific methods, leading to the emergence of modern medical ethics.
4. 19th Century: The 19th century saw the formalization of medical ethics as a field of study. Medical schools started incorporating ethics into their curriculum. The concept of "informed consent" began to gain importance, emphasizing the patient's right to be informed about their medical treatment and make autonomous decisions.
5. 20th Century: The 20th century marked a significant transformation in medical ethics. The Nuremberg Code (1947) and the Declaration of Helsinki (1964) were instrumental in establishing ethical principles for human experimentation, emphasizing the importance of informed consent, risk-benefit assessment, and protection of research subjects.
6. Late 20th Century to Current Time: With advances in medical technology, ethical challenges have become more complex. Bioethics emerged as a distinct discipline, encompassing issues such as end-of-life care, genetic testing, organ transplantation, and reproductive technologies. Ethical debates around issues like abortion, physician-assisted suicide, and healthcare resource allocation continue to shape medical ethics.

In the current time, Western medical ethics is heavily influenced by the principles of autonomy, beneficence, non-maleficence, and justice. The patient's right to self-determination and informed consent is highly regarded, and healthcare professionals are expected to act in the best interest of their patients while adhering to ethical guidelines and standards. Additionally, cultural competence and sensitivity are increasingly recognized as essential components of ethical healthcare delivery in a diverse society. As medical knowledge and societal values continue to evolve, medical ethics will undoubtedly face new challenges and adapt to meet the needs of patients and healthcare systems.

Islamic Culture and Professional Ethics

Islamic medical ethics are guided by Sharia law, emphasizing the preservation of life and the principle of beneficence. Islamic ethics prioritize the concept of "maslaha," which means the greater public good. Family involvement and respect for authority figures are considered important and desirable.

Tracking the changes in medical ethics within Islamic cultures from the advent of Islam in the 7th century to the current time reveals a dynamic interplay of religious principles, cultural traditions, and contemporary medical advancements. However, it is important to note that Islamic cultures are diverse, and medical ethics can vary across different regions and historical periods. Here is a general overview:

1. Early Islamic Era (7th to 11th centuries): During the early Islamic period, medical ethics were influenced by Islamic teachings and the principles found in the Quran and Hadith (sayings and actions of the Prophet Muhammad). Islamic scholars, such as Al-Razi and Ibn Sina (Avicenna), emphasized the importance of preserving life, compassion for the sick, and the obligation of physicians to act ethically in their practice.
2. Medieval Islamic Medicine (11th to 15th centuries): Islamic medical ethics continued to develop and integrate with various cultural and intellectual traditions. Medical scholars like Ibn Rushd (Averroes) further explored the relationship between medicine and ethics within the context of Islamic jurisprudence (Fiqh).
3. Colonial and Post-Colonial Period (19th to mid-20th centuries): With the advent of colonialism, Islamic medical ethics faced challenges and changes due to interactions with Western medicine and ethics. Colonial powers sometimes imposed Western medical practices and ethics, which led to cultural clashes and shifts in traditional approaches to healthcare.
4. Modern Islamic Bioethics (mid-20th century to current time): In the mid-20th century, there was a resurgence of interest in Islamic bioethics, responding to new medical technologies and ethical dilemmas. Islamic scholars and institutions began engaging with contemporary bioethical issues, such as organ transplantation, assisted reproductive technologies, and end-of-life care, while drawing on Islamic principles and jurisprudential sources.
5. Integration of Islamic Ethics with Global Bioethics: In recent decades, efforts have been made to integrate Islamic medical ethics with global bioethics discourse. Islamic scholars and bioethicists participate in international discussions, seeking common ground while addressing issues specific to Islamic cultures.
6. Diverse Ethical Perspectives within Islamic Cultures: It is important to recognize the diversity within Islamic cultures, as different regions and communities may interpret Islamic teachings differently. This diversity can lead to variations in ethical perspectives, particularly in addressing contentious bioethical issues.

Key Islamic ethical principles that continue to influence medical ethics within Islamic cultures include:

(a) Sanctity of Life: Emphasizing the value and preservation of life, and the obligation to avoid causing harm.

(b) Autonomy and Informed Consent: Acknowledging the right of patients to make informed decisions about their healthcare.

(c) Beneficence and Non-Maleficence: Encouraging acts of kindness and good, while avoiding harm to patients.

(d) Religious Obligations: Considering religious beliefs and practices in healthcare decision-making.

Islamic medical ethics continue to evolve in response to the changing healthcare landscape and advancements in medical technology while staying rooted in the principles of Islamic teachings and cultural traditions.

In an effort to counter the secular nature of the modern version of Hippocratic Oath the Islamic Association of North America in 1977 adopted the "Oath of a Muslim Physician", which is a composite drawn from the historical and contemporary writings of Muslim Physicians.

THE OATH OF A MUSLIM PHYSICIAN

Praise be to Allah (God), the Teacher, the Unique, Majesty of the heavens, the Exalted, the Glorious, Glory be to Him, the Eternal Being Who created the Universe and all the creatures within, and the only Being Who containeth the infinity and the eternity. We serve no other god besides Thee and regard idolatry as an abominable injustice.

Give us the strength to be truthful, honest, modest, merciful, and objective.
Give us the fortitude to admit our mistakes, to amend our ways and to forgive the wrongs of others.
Give us the wisdom to comfort and counsel all towards peace and harmony.
Give us the understanding that ours is a profession sacred that deals with your most precious gifts of life and intellect.
Therefore, make us worthy of this favoured station with honour, dignity and piety so that we may devote our lives in serving mankind, poor or rich, literate or illiterate, Muslim or non-Muslim, black or white with patience and tolerance with virtue and reverence, with knowledge and vigilance, with Thy love in our hearts and compassion for Thy servants, Thy most precious creation.
Hereby we take this oath in Thy name, the Creator of all the Heavens and the earth and follow Thy counsel as Thou hast revealed to Prophet Mohammad (pbuh).
"Whoever killeth a human being, not in lieu of another human being nor because of mischief on earth, it is as if he hath killed all mankind. And if he saveth a human life, he hath saved the life of all mankind." (Qur'an v/35)

Source: https://fimaweb.net/the-oath-of-a-muslim-physician/

Indian Medical Ethics

Tracking the changes in medical ethics from ancient times to the present in Indian culture reveals a rich tapestry of ethical principles shaped by various religious, philosophical, and cultural traditions. Indian medical ethics have evolved over millennia, reflecting the country's diverse history and cultural influences. Here is an overview of these changes:

1. Ancient Indian Medicine (circa 1500 BCE to 500 CE): Ancient Indian medicine was heavily influenced by the Vedic tradition, which included the practice of Ayurveda. Ayurveda emphasized the holistic approach to health, focusing on maintaining balance and harmony among the body, mind, and spirit. Ethics in this era were rooted in Dharma (righteousness) and the moral responsibilities of physicians to their patients. The Oath of Initiation from the 7th Century BC text Charaka Samhita predated the Hippocratic Oath by two centuries. This Oath bears testimony to the high level of professional ethics in ancient India *(Source: Cross Cultural Perspectives in Medical Ethics: Robert MVeatch, 1989 2nd Edition)*

2. Classical Period (500 CE to 1500 CE): During this period, Indian medical ethics continued to be guided by the principles of Ayurveda. Physicians were expected to practice compassion, non-harm (ahimsa), and truthfulness in their interactions with patients. Hindu, Buddhist, and Jain ethics also played significant roles in shaping medical practices.
3. Medieval and Colonial Era (1500 CE to 1947): With the advent of Islamic and European influences through invasions and colonization, Indian medical ethics encountered new challenges and changes. Islamic medical ethics brought concepts of beneficence and compassion, while Western medical ethics introduced concepts of autonomy and informed consent. These influences interacted with traditional Indian ethics, leading to a diverse ethical landscape.
4. Modern Indian Medicine (1947 to the present): After India gained independence in 1947, the country's medical ethics experienced further transformation. The establishment of medical schools and institutions led to a formalization of medical ethics education. Indian bioethics emerged as a distinct field, addressing contemporary ethical challenges posed by medical advancements, globalization, and cultural diversity.
5. Integration of Western Bioethics with Indian Perspectives: In the latter half of the 20th century, there was a growing recognition of the need to integrate Western bioethical principles with Indian cultural and philosophical perspectives. Scholars sought to harmonize principles like autonomy, justice, and non-maleficence with traditional Indian ethics and religious teachings.
6. Contemporary Indian Medical Ethics: Today, Indian medical ethics continue to evolve, shaped by global bioethical discourse and the country's unique cultural and religious diversity. Ethical

considerations in areas such as reproductive technologies, end-of-life care, organ transplantation, and genetic research are ongoing subjects of debate and exploration within the Indian context.

Key ethical principles that have persisted in Indian medical ethics across history include:

(a) Ahimsa (non-harm): Avoiding harm to others and promoting compassion and non-violence.

(b) Dharma (righteousness): Upholding moral responsibilities and duties towards patients and society.

(c) Satyam (truthfulness): Practicing honesty and truthfulness in medical practice and communication.

Indian medical ethics continue to be a dynamic field, drawing from ancient wisdom, cultural traditions, and global bioethics, as India navigates the challenges and opportunities presented by advances in healthcare and ethical dilemmas in the modern world.

Chinese Medical Ethics

Tracking the changes in medical ethics from ancient times to the present in Chinese culture reveals a long and dynamic evolution of ethical principles and medical practices. Chinese medical ethics have been influenced by Confucianism, Taoism, Buddhism, and other philosophical and cultural traditions. Here is an overview of the key changes:

1. Ancient Chinese Medicine (circa 1000 BCE to 221 BCE): During this period, Chinese medicine was heavily influenced by Taoism and naturalistic principles. Ethical values centred on the harmony between humans and nature, with a focus on the balance of Yin and Yang and the Five Elements. Physicians were expected to act with compassion and respect for life while adhering to the principles of non-maleficence and beneficence.
2. Confucian Ethics and Imperial Medicine (221 BCE to 1912 CE): The rise of Confucianism during the Han Dynasty (206 BCE to 220 CE) had a profound impact on Chinese culture and medical ethics. Confucian ethics emphasized filial piety, respect for authority, and loyalty. Physicians were regarded as highly respected professionals, and medical ethics were deeply entwined with social and moral values. Medical practitioners were expected to show benevolence and serve the community.
3. Integration of Buddhist Ethics (1st century CE onward): With the spread of Buddhism in China, Buddhist ethical principles, such as compassion and altruism, further influenced medical ethics. Buddhist monasteries played a role in healthcare, providing care to the sick and needy, and Buddhist principles of non-harming and mindfulness became important in medical practice.
4. Colonial and Modern Era (19th century to 1949): During the colonial era and the early 20th century, China experienced external influences from Western medicine and ethics due to colonization and globalization. Western bioethical principles, such as autonomy, informed consent, and individual rights, began to interact with traditional Chinese medical ethics.

5. People's Republic of China (1949 to present): After the founding of the People's Republic of China, the Chinese government sought to modernize healthcare and medicine, incorporating Western medical practices and ethics. This period saw the establishment of modern medical institutions and the development of a unified code of medical ethics.
6. Contemporary Chinese Medical Ethics: In the present time, Chinese medical ethics continue to evolve and adapt to global advancements in healthcare and ethical dilemmas. Ethical considerations related to medical research, organ transplantation, end-of-life care, and reproductive technologies have become prominent topics of discussion and regulation in China.

Key ethical principles consisting of Five Commandments and Ten Requirements that have persisted in Chinese medical ethics across history include:

(a) Compassion and Benevolence: Demonstrating kindness and care for patients and the community with equal treatment of all and care not for financial reward.

(b) Emphasis on exemplary personal behaviour, availability to patients and adherence to accepted medical formulary.

(c) Non-Maleficence: Avoiding harm and providing treatment with minimal risks.

(d) Filial Piety and Respect for Elders: Valuing the elderly and showing respect for authority figures, including medical professionals.

(e) Respect for privacy of patients especially of the women who must be attended to only in the presence of an attendant.

Ref.: Chen Shih-Kung - An Orthodox Manual of Surgery, circa 1613

Source: Cross-Cultural Perspective in Medical Ethics: Robert M Veatch, 1989, 2nd Edition

It is important to recognize that Chinese medical ethics are influenced by a rich tapestry of philosophical and cultural traditions, and the country's diverse history continues to shape ethical practices in contemporary healthcare.

Indigenous Cultures

Indigenous communities have their own unique systems of medical ethics, often deeply rooted in spiritual and traditional practices. The interconnectedness of nature, community, and individual health plays a significant role. Decision-making may involve the consultation of elders, healers, and spiritual leaders to align medical choices with cultural beliefs and practices.