

Good Medical Practice

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FOREWORD

This Booklet serves as a guide to the medical practitioners to meet the standard of care and professionalism set out by the Malaysian Medical Council. It contains the moral and professional obligations expected of the medical practitioners of this country.

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

I therefore, urge all medical practitioners to adhere to the guidelines laid down in this booklet, at all times. Useful contributions from the medical fraternity may be incorporated in future revision of these guidelines.

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January, 2001

THE TEN GOLDEN RULES OF GOOD MEDICAL PRACTICE

1. Practice with Kindness, Ethics and Honesty.
2. Upgrade Professional Knowledge and Clinical Skills.
3. Maintain good Patient Records.
4. Maintain good Communication with Patients and Relatives.
5. Maintain Doctor-Patient Confidentiality.
6. Allow Second Opinion and Referral to Colleagues.
7. Maintain good Working Relationship with Colleagues.
8. Be conscious of Cost of Healthcare.
9. Avoid Publicity, Self-promotion and Abuse of Position.
10. Be a Partner in promoting Global Health.

1. PREAMBLE

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

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

This booklet cannot cover all forms of professional practice and therefore is not exhaustive. The practitioner must therefore be always prepared to explain and justify his actions and decisions whenever there is question or doubt raised about his practice.

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

The guidelines laid out in this booklet on Good Medical Practice are intended to be positive in approach, and to convey to doctors what they should do.

These Guidelines have been prepared with the Malaysian doctor in mind, though clearly the professional code which governs the form and manner of medical practice are universal in concept, international in acceptance and global in implementation.

2. THE DOCTOR AND THE PRACTICE

2.1 The Doctor The Person

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

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

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

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

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

2.2 *The Place of Practice*

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

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

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

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

It is acceptable to display certificates or scrolls of recognised medical degrees and diplomas in the consultation room so that the patient is fully aware of the credentials of the doctor.

Clinical equipment should be in good working order and clean and neatly arranged.

An untidy and cluttered consultation room may indicate a very busy doctor, but on the other hand may mean to the patient that the doctor is not systematic and methodical. A sink and clean hand-towel within reach will reflect a hygienic practice.

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

2.3 *Calling Card*

The doctor's calling card should limit the information therein contained to name, registrable qualifications, address and contact numbers. Some cards are also used as appointment cards. Calling cards should never be distributed to members of the public for purpose of touting or advertising, or be left on counters for convenient pick up by anyone.

2.4 *Medical Records and Reports*

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

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

Similarly notes and records relating to operations and invasive procedures should be written clearly, with attention to indications, findings, relevant details, difficulties encountered and the measure taken.

Notes once made out should not be erased or altered, or new words inserted after a lapse of time, as these may indicate defensive action by the doctor in the event of unexpected eventualities in the course of the patient management.

For patients who are at high risk, particularly those who are aged and medically compromised, the possible risk of surgery and anesthetics need to be explained to the patient or next-of-kin, and recorded in the notes.

It is well to remember that while the clinical notes and records physically reside with the doctor and to the hospital, the information therein contained belongs, morally and ethically to the patient and to regulatory authorities. These documents may be demanded by the patient or his appointed officers for various purposes, ranging from need to seek second opinion, to seek further treatment elsewhere, or for litigation.

Doctors are obliged to provide comprehensive Medical Reports when requested by patients or by the next-of-kin, in the case of children and minors, or by the employer with the patient's consent. Any refusal or undue delay in providing such reports is unethical.

2.5 *Records of Dangerous and Controlled Drugs*

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

Doctors are required by legislation to maintain proper records of the prescription of dangerous and controlled drugs, and a stock inventory. Failure to comply is a serious offense.

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

2.6 *Publicity*

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

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

Publicity seeking behaviour of even a handful of doctors would reflect adversely on their inadequate moral and professional upbringing and bring disrepute to the profession as a whole.

Voluntary public service projects by doctors, providing advice on illness and healthcare to the people in rural and remote areas are laudable. However it is poor taste to exploit the situation by allowing photographs of them examining such members of the public, to appear with news coverage of their activities in the media. Even more deplorable is to identify themselves by their name and place of practice.

2.7 *Medical Cover*

The doctor going off duty must ensure that suitable arrangements are made for the patient's continued care.

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

In the case of hospital patients, the doctor going on leave must ensure effective handover procedures by communicating clearly through proper documented notes with a colleagues to continue management in his absence. The colleague covering him must agree, and the patient or the next-of-kin must also be made aware of this arrangement. Messages left on the pager or answering machines are considered discourteous.

The doctor standing in should have the qualifications, experience, knowledge and the skills to perform the duties for which he will be responsible. He is directly accountable for the care of the patients while on duty.

2.8 *Relationship With Pharmaceutical & Equipment Firms*

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

The doctor may offered fully paid trips, travel grants and hospitality to attend conferences, or some equally attractive inducement, promoting a single new pharmaceutical product. Although these may have educational value, the doctor must carefully evaluate the motives, expectations and the hidden agenda of such firms, and the ultimate payback expected. Discretion in dealing with such matters will help to preserve the credibility and impartially of the medical profession.

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

3. *THE DOCTOR AND THE PATIENT*

3.1 *Doctor – Patient Relationship*

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

The relationship paves the way for frank discussion in which the patient's needs and preferences and the doctors clinical expertise are shared to select the best treatment option.

For the patient, the first encounter with the doctor is an experience with vast implications for future relationship. The patient who seeks medical help is an anxious frame of mind. The courage that he has to muster to attend a clinic is immense, and the experience of stepping into the doctor's consultation room can be unnerving. **By that one crucial act, the patient, with the sole and simple hope of finding a solution to his health problem, makes many bold personal sacrifices.** He surrenders his individuality and privacy to the doctor, literally lays bare his soul, exposing his innermost secrets and personal problems to the doctor who, in truth and essence, is a total stranger. The doctor's only claim to this privilege is his education and training as a compassionate healer.

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

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

The patient, on the other hand, takes the doctor's work for granted. He rarely cares for the doctor's sentiments at that point in time. Whether the doctor has been stretched to his physical and mental limits during his work, or whether he has had any rest or a square meal, are of no concern to the patient. Submerged in his own misery, the patient's all consuming concern is for an immediate solution to his own problem.

3.1.1 **The doctor is at all times expected to practise good medicine, exhibit the norms of good clinical practice and present himself as follows:**

Be attentive and a good listener, attaching importance to even the most trivial of the patient's complaints, making the patient feel that he is the most important person in that consultation room, and his problem are indeed most significant. Only then can the patient feel relaxed and at ease with the doctor.

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

Be gentle and concerned when examining the patient, making the patient feel relaxed through every step of the physical assessment, periodically pausing to explain

the need for a particular step. The physical examination of the patient is to be carried out, without exception, in the presence of a chaperon.

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

- 3.1.2 Give the relevant **options when discussing treatment**, and the limitations and possible complications.

In the course of consultation, the following are some aspects of good medical practice:

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

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

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

Cultivate a **friendly and amicable relationship**, which will give the patient confidence and trust in his doctor.

Avoid being business-like. Give time for the patient to settle down in the consultation room and to measure out the doctor who is an untested stranger. A few casual questions like “Where are you working?”, “How old are you?”, “Have you been waiting too long?” go a long way to establish a friendly atmosphere and convivial beginning.

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

Avoid patronising your patients. Be firm but pleasant in your discussions without being condescending. Avoid developing private and personal relationship with your patient, and discourage any attempt by a patient to become personally and privately involved with you.

In private practice, trying to satisfy a patient’s demands may sometimes be considered necessary from a financial angle, in the mistaken belief that a “customer is always right”. In such instances, the doctor’s approach must be based on the principals of good medical practice, and these should not be sacrificed for pecuniary reasons. The doctor must take as his duty to educate and

correct a patient's erroneous or mistaken concepts of medical treatment and healthcare.

Should there be a reason to disagree with a patient's opinion or impression to treatment option, be positive in presenting your views without belittling the patient or making him feel inadequate and ignorant. Tact and dignified diplomacy are the keys to a successful and longlasting doctor-patient relationship.

A person may come to clinic requesting a sick certificate, feigning an illness. The doctor must evaluate such a request in the light of the previous experience with the person/patient involved, and act judiciously and tactfully.

Never issue prescription or medical sick certificate without examining the patient first and making relevant notes in the patient records. Never pre-sign sick certificates or prescription pads as these may be misused by unauthorised persons in your absence. Never take advantage of a patient's predicament or plight to further your own interest or ambitions.

3.2 *Doctor – Patient Confidentiality*

Medical confidentiality is a traditional principle and an integral requirement of doctor-patient relationship. Central to this principle is the preservation of the dignity, privacy and integrity of the patient. When a third party seeks medical information, such request should only be entertained on the explicit written consent of the patient or the next-of-kin.

It is well to remember that there is a wide difference between what is interesting to the public (and therefore newsworthy) and what is of public health interest. In any event, the patient's protection is an overriding consideration, and must be weighed carefully before allowing any form of disclosure.

Legal or statutory requirements sometimes override the limits of patient-doctor confidentiality, and the doctor is often required by law to disclose information regarding illness and treatment. The patient should then be made aware of this public duty.

Doctors who use clinical patient materials in medical publications or at medical conferences must at all times avoid revealing personal details of the patients in the study. Photographs when used should not revealed identifying facial or physical features.

When discussing patient data at in-house hospital mortality and morbidity meetings, direct reference to patient's name, identity and personal details should be avoided.

In the final analysis, good medical practice dictates that the doctor must exert all in his powers to preserve patient confidentiality. The information that the doctor has come to possess is, in the first place, through the patient's voluntary revelations and consent to submit to physical examination and diagnostic investigate procedures. It is the patient's belief that such information will be kept private and used solely for his benefit.

3.3 *Chaperon*

A doctor must always examine a patient, whether female or male, or a child, with a chaperon being physically present in the consultation room, with visual and aural contact throughout the proceedings.

A relative or friend of the patient is not a reliable chaperon, as he or she may not fully appreciate the nature of the physical examination performed by the doctor and may even testify against the doctor in the event of allegations of misconduct or physical abuse. Similarly, a relative of the doctor (wife, daughter, etc), who is not an impartial observer, would be prejudicial as a chaperon.

These requires are designed to allow the doctor to proceed with clear, unhampered clinical examination of the patient, as he deems appropriate for the purpose of arriving at a proper diagnosis, without later having to defend his actions.

3.4 *Prescribing*

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

A few simple questions on the above matters will give the patient the confidence that the doctor is concerned about the current medication, so that adverse reactions are avoided; neither will be receiving duplicate medications already given by another doctor.

It is good medical practice to inform the patient the purpose of the medications, and potential adverse reactions that may some times arise. The name of the medicine, preferably both the generic and trade, should be clearly labeled.

Some patients carry little pocket notebooks in which they keep a record of medicines they are taking regularly, and the doctor should enter new prescriptions therein. This is for the safety of the patient is he should develop adverse reactions and also to assist the next physician handling the situation so that he may give appropriate, specific emergency treatment or antidote.

Medications should be prescribed in most circumstances, for an appropriate convenient duration, particularly for diseases that may need close periodic monitoring.

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

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

Patients should be warned against self medication or purchasing controlled medication without prescription.

3.5 *Treatment*

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

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

3.6 *Second opinion*

The second request by a patient for a second opinion should be handled with due sensitivity and tact. It is good medical practice to accede to such a request, and the doctor must give full co-operation for the patient to obtain such opinion. He must make available all relevant information and investigation results to the colleague, in good faith without attempting to influence the decision of the colleague.

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

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

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

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

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

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

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

3.7 *Consent*

The doctor often assumes that a patient who walks into his consultation room gives implied consent for all subsequent procedures. It must be remembered that "implied consent" per se is merely an impression and would not protect the doctor in the event of any litigation.

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

Any invasive procedure, however simple, should be undertaken only with consent from the patient, preferably documented, or in the case of a minor, from the parent or guardian.

On the whole, when patients are given clear and candid explanations, they rarely refuse an investigation or procedure.

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

3.8 Professional Fees

Doctors are usually uncomfortable discussing fees and charges with their parents before treatment –embarrassing because it implies that treatment is for a price, and seems to go against the principles of medical care. It may also have negative effects in that the patient who is unable to meet the charges might shop around for “cheaper” or improper care.

Doctors do appreciate that the patients who seeks treatment, do so out of dire necessity – for saving a limb, pain-relief, cure from disease, and so on. It is not like purchasing a luxury consumer item, which can be delayed or postponed. Doctors who discuss professional charges with their patients are therefore under various constraints and should keep this in mind.

There are of course many factors that the doctor has to consider when determining his professional fees. He must not charge unreasonably. He must be fully conscious at all times about the finer aspects of medical economics and its effect on the public seeking medical treatment in these days of escalating healthcare cost.

It is good medical practice for the doctor to make available to the patient an estimate of his professional charges and the hospital charges prior to commencing treatment. The patient must also be warned that should there be a need for intensive care after surgery, the charges may escalate.

In the case of emergencies, medical ethics and humane considerations dictate that doctors render emergency or life saving treatment to patients irrespective of their ability to pay. Subsequent management to the patient will depend on the ability of the patient to meet the charges. To deny treatment to patients requiring emergency or in life threatening situations, because of inability to pay a deposit, is considered unprofessional and unethical.

In private hospital practice, when the expenses begin to exceed initial estimates for patients who unexpectedly require intensive or long-term care, this must be immediately brought to the attention of the patient or the next of kin. If there is

inability to meet the rising bill, the doctor must make all efforts to transfer the patient to a public or less expensive private hospital and personally make the necessary arrangements to facilitate such a transfer. The colleague or hospital must accept this transfer in good faith and without making disparaging remarks later.

3.9 *Universal Precautions*

Patients, who have been discovered during preliminary investigations to have serious communicable diseases, like AIDS or hepatitis, should nonetheless be treated by doctors, practicing accepted universal precautions. To refuse to care for such patients or to refer them away is considered unethical.

3.10 *Relatives and Friends*

Unknown to the doctor coming in contact for the first time with a patient, there is a whole retinue of relatives and friends in the background. These people do not normally appear on day-one but descend soon after surgery or other major treatment, or when the patient turns critically ill. They then have a barrage of queries: why did it happen, what went wrong, what is next, will the patient survive, and so on.

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

In the event of unforeseen eventualities in the course of patient management, it is this pleasant and cordial line of communication and dialogue that will most often see the doctor through the crisis.

4. *THE DOCTOR AS A TEAM PLAYER*

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

The doctor must always treat his colleagues fairly. The doctor must allow his views of a colleague's lifestyle, culture, beliefs, race, colour, gender, sexuality, or age to prejudice his relationship with him.

The doctor must treat his nursing and ancillary staff with respect and understanding, listen and act sympathetically to legitimate work or service grouses. The doctor must obtain their services as part of a team, and help to create a working environment that is pleasant and harmonious.

Healthcare is increasingly provided by multi-disciplinary teams. A doctor is expected to work constructively within teams and to respect the skills and contributions of colleagues and other healthcare staff.

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

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

When faced with such situation, it is good practice to contact the first doctor in confidence and seek “the other side of the story”. This will help you to appreciate the problem faced by him and the course of action to take.

It is good medical practice for a doctor to maintain cordial working relationship with his colleagues. This may take some effort, especially in an urban situation, with large number of doctors in practice in the same location, but it is a move that has immense benefits.

When a doctor refers a patient to another doctor for special investigation or treatment, it is unethical to request for kickbacks, gifts or favours in return.

A doctor must avoid looking at colleagues in his area of practice as competitors or rivals. It is more useful for doctors to project the image of a team, with common practice guidelines, so that patients will appreciate this and avoid clinic hopping.

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

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

5. *THE DOCTOR AND THE EMPLOYER*

There is an increasing presence and influence of Managed Care Organisations (MCOs) or Healthcare Managements Organisations (HMOs) in the country in recent years. Panel doctors serving corporate bodies have come increasingly under scrutiny and pressure to act as primary care doctors, taking cost controlling risks, or in the other words, to act as gate-keepers, on a prepaid fee system. This requires that the doctor operate according to schedules and manuals drawn by MCOs or HMOs.

It is good medical practice for the doctor to remember his primary professional responsibility to patients when operating under such stringent financial constraints and controlled patient care, which may be imposed by MCOs or HMOs. It is important to preserve good doctor – patient relationship and confidentiality in whatever adverse practice environment, and to remember at all times that doctors exist because there are patients who need individual care, and the doctor's primary concern is for their health and welfare.

The doctor should not feel pressurised and yield to unfair administrative actions by employers, particularly when employees are to be terminated from service, or penalised, for treatable illness with no permanent or long-term disabilities. In such circumstances, the doctor, in the interests of the patient, should seek independent opinion from colleagues to support his findings and views if he finds himself compromised, and being used as a tool by employers to enforce their own unfair, unilateral decisions.

6. *THE DOCTOR IN SOLO PRACTICE*

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

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

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

7. *THE DOCTOR IN INSTITUTIONAL AND PUBLIC PRACTICE*

The public practicing in an institutional facility has to constantly keep in mind the escalating cost of healthcare provision and delivery. High-tech innovations tend to be expensive, and doctors must evaluate the need for such procedures before ordering them from their patients.

It is good medical practice for the doctor to remember, that health resources generally are costly, precious and finite. As such, it is his unwritten duty as a guardian of such health resources, to preserve and ensure sustained high quality. He must also keep in mind that he is in a position to safeguard the global environment by helping to dispose clinical wastes and toxic by-products of the drugs and chemicals used in medical practice in a manner that is least harmful.

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

In hospitals with wards with classes, the doctor must remember that the “class” refers to the comfort facilities in the rooms and not to the standard or level of medical care. Treatment should not be varied according to the patient’s ability to pay.

This attitude must also be impressed upon the nursing and allied professional staff.

Patients newly admitted to the ward should be seen as soon as possible, examined and treatment commenced without undue delay. Patients need to be attended to regularly, and rounds conducted at least once a day, and more frequently in ill patient. The doctor may not realise it, but to the patient, the most refreshing and important event for the day is the visit by the doctor, his gentle touch and a few caring words.

8. *THE DOCTOR IN DILEMMA*

A patient who complains about his treatment has a right to expect a prompt and appropriate response. The doctor has a professional responsibility to deal with complaints constructively and honestly.

The patient’s complaint must not prejudice his further treatment.

If a patient has suffered serious harm for whatever reason, the doctor should act immediately to put matters right. The patient must receive a proper explanation and the short and long term effects. When appropriate the doctor should offer an apology.

If a patient has died, the doctor should explain, to the best of his knowledge, the reasons for, and the circumstances of, the death to the next-of-kin.

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

In the doctor's own interest and those of his patients, he must obtain adequate insurance or professional indemnity cover for any part of his work not covered by his employer's indemnity scheme. In the event of any impending criminal or ethical proceedings against him, the doctor should, as soon as possible, in writing, inform the firm providing such insurance or indemnity cover, to obtain appropriate and early legal advice.

9. GENERAL

A. The International Code of Medical Ethics (Excerpts)

“At a time of being admitted as a member of the Medical Profession:

I solemnly pledge myself to consecrate my life to the service of humanity;

I will practice my profession with conscience and dignity;

The health of my patient will be my first consideration;

I will maintain by all means in my power, the honour and noble traditions of the medical profession;

I will not permit considerations of religions, nationality, race, party politics or social standing to intervene between my duty and patients;

I will maintain the utmost respect for human life from its beginning even under threat, and I will not use my medical knowledge contrary to the laws of humanity.”

B. The Declaration of Geneva (Excerpts)

I solemnly pledge myself to consecrate my life to the service of humanity.

I will practice my profession with conscience and dignity. The health of my patient will be my first consideration.

I will respect the secrets which are confided in me.