CODE OF ETHICS AND PROFESSIONAL CONDUCT

Revised Edition | April, 2022

Protecting the Public and Guiding the Medical, Dental, Paramedical and Allied Health Professions

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FOREWORD

The Medical Council of Malawi (the Council) is pleased to issue this ***revised*** edition of *The Code of Ethics and Professional Conduct,* which shall be observed*, mutatis mutandis,* by all medical practitioners, dentists, paramedical and allied health professionals practicing in Malawi. The first edition was published in 1990, the second edition in 2006 and the current in 2022. The Code of Ethics and Professional Conduct (the Code) is promulgated by the Council in fulfillment of its functions as outlined in, and in the exercise of the powers vested in the Council by, Part IV, (Sections 10, 11, and 12) of the Medical Practitioners and Dentists Act, Chapter 36:01 of the Laws of Malawi. This Code shall be used in collaboration with other established laws, policies and procedures approved for use in Malawi and should not be interpreted as opposing those in existence. This Code has included emerging issues, ethical dilemmas which Practitioners may encounter during their practice, and offences applicable to Practitioners and health facilities for wrong doing.

This Code should guide medical doctors (including specialists), dentists, paramedical and allied health professionals which include laboratory, audiology, optometry, public health, environmental health, radiography, psychologists, physiotherapists and other rehabilitative disciplines, biomedical engineers, clinical nutritionists, dieticians and others. This Code, though not exhaustive, has covered major ethical areas of consideration to be adhered to by health professionals registrable by the Council. In situations in which practitioners are faced with ethical and professional ambiguity, the Council advises practitioners to seek advice from their seniors or more experienced colleagues, relevant professional bodies and associations (see appendix of associations). The Council, is available to offer guidance, and may be contacted through its Registrar at P.O. Box 30787, Lilongwe 3. The Council will determine the appropriate conduct to have been followed in matters of ethical and professional concern, which have not been covered in this Code. Any decision made by the Council is final.
Practitioners may express their views, to the Council on any matters covered in this Code for further consideration.

All aggrieved parties are encouraged to appeal to the Council Board in writing through the Board Chairperson, or the Registrar.

Professor John E. Chisi
Board Chairperson

Dr. Davie Zolowere
Registrar/Chief Executive Officer

ACKNOWLEDGEMENTS

The development and review of this Code of Ethics and Professional Conduct is the result of team work and dedication of various individuals, institutions and organisations. The Medical Council of Malawi would like to acknowledge the contributions made by these various groups aiming to protect patients, clients and the public, to guide health care professionals regulated by the Council, to guide employers, management of health institutions and facilities, and training institutions involved in teaching health professionals.

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Lastly, the Council sends special thanks to all employees of the Council for their contribution to the development of this Code.

LIST OF ABBREVIATIONS AND ACRONYMS

CH	Central Hospital
CHAM	Christian Health Association of Malawi
CPD	Continuous Professional Development
DHSS	Director of Health and Social Services
GOM	Government of Malawi
HIV	Human Immunodeficiency Virus
IHAM	Islamic Health Association of Malawi
MOH	Ministry of Health
NMCM	Nurses and Midwives Council of Malawi
NGO	Non-Governmental Organizations
PMRA	Pharmacy and Medicines Regulatory Authority
SDMs	Substitute Decision-Makers

DEFINITION OF TERMS

In this Code of Ethics and Professional Conduct, unless otherwise specified, the following list of terms are defined as below:

"Adverse event" is an undesired harmful effect resulting from treatment, medication *or other health* intervention, such as surgery.

"Advertising" includes all those methods by which a practitioner is made known to the public either by himself or by others without his objection, in a manner which can be fairly regarded as having for its purpose the obtaining of patients or the promotion in other ways of the practitioner's individual professional advantage.

"Certification" includes any act whether concerned with medical certificates or documents, which must statutorily be signed by a medical practitioner, or another person so authorized.

"Child" is a minor or a person who is not yet old enough to have *the rights of an adult, as they* are yet to attain the age of majority and are under the age of full legal responsibility. The age of majority according to the Section 23(6) of the Malawi constitution is 18 years.

"Code of ethics and professional conduct" a set of ethical guidelines, principles and best practices to understand the difference between right and wrong, and apply the knowledge to inform practice.

"Council" means the Medical Council of Malawi established under the Medical Practitioners and Dentists Act, Chapter 36:01 of the Laws of Malawi.

"Disaster" is an occurrence disrupting the normal conditions of existence and causing a level of suffering that exceeds the capacity of adjustment of the affected community. It can be caused by natural, man-made or technological hazards. The hazards can be geophysical, hydrological, climatological, meteorological or biological.

"Ethics" are the moral standards and principles by which entities (individual practitioners, employers or institutions) govern their behaviors and decision-making.

"Emergency" is a situation that poses an immediate risk to health and life, requiring extra ordinary measures in order to avert a disaster.

“Medical Research” is a research that has its focus on health related issues/ problems with a view to identify solutions or new trends in managing health problems.

“Informed consent” is a principle in medical ethics and medical law that a client or patient should have sufficient information before making their own free decisions about their medical care. The practitioner educates a patient or client about the risks, benefits, side effects and alternatives of a given procedure or intervention. The patient must be competent to make a voluntary decision about whether to undergo the procedure or intervention.

“Immediate dependants” mean spouse, children and parents.
“Intimate examination/procedure” is a physical examination or procedure for medical purposes that includes examination of the breasts, genitalia, pelvic or rectum of a patient or client. Such examinations may cause stress or embarrassment in patients and clients.

” Oath“ is a solemn promise, often invoking a divine witness, regarding one’s future action or behaviour. In this document the oaths are statements of the moral principles and values that govern the conduct the profession.

“Pandemic” is an epidemic that has spread across a large region affecting a substantial number of individuals, causing suffering and death.

“Public Announcements” means a publication on the website, or other reasonable methods to provide public notice or a statement made to the public or to the media whether newspaper, radio, television, social media to give information concerning health services.

“Practitioner” refers to a medical-clinical, dental, optometry, laboratory, public health or preventive, paramedical, or a person in the allied health profession, who are regulated by the Medical Council.

“Private practice facility” refers to a clinic, hospital, laboratory, imaging and radiology, mental health and addiction treatment centre, dialysis facilities, physiotherapy, orthopedics-rehabilitation centres, disability homes and mortuaries being operated for financial gain or as a business.

INTRODUCTION / PREAMBLE

Ethical codes of conduct and standards are the moral frameworks that individual practitioners, health institutions and organizations use to guide decision-making and differentiate between right and wrong practice in health service provision. Common ethical practices for practitioners include, telling the truth, taking responsibility for one's actions, practicing according to evidence-guidelines and policies, fulfilling professional obligations, following the law, providing evidence- based information, acting in the best interests of clients and patients, and maximizing clients and patients' safety.
In keeping with its aim to protect patients, practitioners, and the general public, the Medical Council of Malawi has set forth this Code of Ethics and Professional Conduct to guide the education, and practice of practitioners.

This Code is divided into eight (8) sections. The first section covers general issues relating to practitioner's duties and obligations to the public. The second section deals with issues of practitioners' relationship with colleagues and professional associations. The third section covers matters in relation to practitioners in private practice. The fourth section discusses advertising at length as this is an important area in medical ethics and professional conduct. The fifth section outlines emerging issues such as use of social media, adverse events, telemedicine and e-health, practicing during pandemics, emergencies and disasters, Continuous Professional Development (CPD), safeguarding, practitioners' connections with commercial enterprises, professional fees and issuance of medical reports. The sixth section covers ethical dilemmas encountered by practitioners in their practice. The seventh section outlines types of actions which may constitute professional misconduct and may result in disciplinary action being taken by the Council. The eighth section deals with penalties and fines for misconducts.

1.1. Purpose

The purpose of this Code of Ethics and Professional Conduct is to clearly outline expectations of all practitioners eligible to practice in Malawi. It sets out the principles that characterizes good practice and makes explicit the standards of ethical and professional conduct expected by their professional peers, patients, clients, and the public. It is addressed to practitioners and is also intended to let the public know what they can expect from a practitioner. The application of the Code will vary according to individual circumstances, however, the principles should not be compromised.

1.2. Intended users of the Code of Ethics and Professional Conduct

This Code is intended for all practitioners and students who provide various health services as they provide care to those who need it. It is also intended to guide the public, policy makers, employers, and recipients of health services to be informed of what is expected of medical ethical responsibilities.

1.3. Oaths

Oaths remind practitioners of their obligations to their patients, clients and the public. The Oaths sworn by practitioners registered by the Council during graduation include the Hippocratic, Public Health Professionals, Optometry, and Dieticians Oaths for medical, public health, optometry and dieticians respectively. The administration of the Oath shall only be by an individual who themselves have made the same oath which they can administer to others. No person who has never sworn the oath should administer the Oath on behalf of the Council.

1.3.1 The Hippocratic Oath

The Hippocratic Oath is an oath of ethics historically taken by physicians. It requires a new medical practitioner to swear, to uphold specific ethical standards. The oath is the earliest expression of medical ethics, establishing several principles of medical ethics which remain of paramount importance. Practitioners registered by the Council are expected to practice according to the principles in the Hippocratic Oath or any Oath relevant to their profession.

“Hippocratic Oath: Modern Version

I SWEAR to fulfill, to the best of my ability and judgment, this covenant:

I WILL RESPECT the hard-won scientific gains of those physicians in whose steps I walk, and gladly share such knowledge as is mine with those who are to follow.

I WILL APPLY, for the benefit of the sick, all measures [that] are required, avoiding those twin traps of overtreatment and therapeutic nihilism.

I WILL REMEMBER that there is art to medicine as well as science, and that warmth, sympathy, and understanding may outweigh the surgeon’s knife or the chemist’s drug.

I WILL NOT BE ASHAMED to say “I know not,” nor will I fail to call in my colleagues when the skills of another are needed for a patient’s recovery.

I WILL RESPECT THE PRIVACY of my patients, for their problems are not disclosed to me that the world may know. Most especially must I tread with care in matters of life and death. If it is given me to save a life, all thanks. Above all, I must not play God.I WILL REMEMBER that I do not treat a fever chart, a cancerous growth, but a sick human being, whose illness may affect the person’s family and economic stability. My responsibility includes these related problems, if I am to care adequately for the sick.

I WILL PREVENT DISEASE whenever I can, for prevention is preferable to cure.

I WILL REMEMBER that I remain a member of society, with special obligations to all my fellow human beings, those sound of mind and body as well as the infirm.

IF I DO NOT VIOLATE THIS OATH, may I enjoy life and art, respected while I live and remembered with affection thereafter. May I always act so as to preserve the finest traditions of my calling and may I long experience the joy of healing those who seek my help.

So, help me God.

Source: Adapted from Louis Lasagna, Academic Dean School of Medicine, Tufts University, who wrote in 1964.”
https://www.pbs.org/wgbh/nova/doctors/oath_modern.html

1.3.2 The Public Health Professional's Oath

As a public health professional, I hold sacred my duty to protect and promote the health of the public. I believe that working for the public's health is more than a job, it is a calling to public service. Success in this calling requires integrity, clarity of purpose and, above all, the trust of the public.

Whenever threats to trust in my profession arise, I will counter them with bold actions and clear statements of my professional ethical responsibilities.

I do hereby swear and affirm to my colleagues and to the public I serve that I commit myself to the following professional obligations.

In my work as a public health professional:

I WILL STRIVE to understand the fundamental causes of disease and good health and work both to prevent disease and promote good health.

I WILL RESPECT INDIVIDUAL RIGHT while promoting the health of the public.

I WILL WORK TO PROTECT AND EMPOWER disenfranchised persons to ensure that basic resources and conditions for health are available to all.

I WILL SEEK OUT INFORMATION and use the best available evidence to guide my work.

I WILL WORK WITH THE PUBLIC to ensure that my work is timely, open to review, and responsive to the public's needs, values, and priorities.

I WILL ANTICIPATE AND RESPECT diverse values, beliefs, and cultures.

I WILL PROMOTE PUBLIC HEALTH in ways that most protect and enhance both the physical and social environments.

I WILL ALWAYS RESPECT and strive to protect confidential information.

I WILL MAINTAIN AND IMPROVE my own competence and effectiveness.

I WILL PROMOTE THE EDUCATION of students of public health, other public health professionals, and the public in general, and work to ensure the competence of my colleagues.

I WILL RESPECT THE COLLABORATIVE NATURE of public health, working with all health professionals who labor to protect and promote health.

I WILL RESPECTFULLY CHALLENGE DECISIONS that are contrary to supporting and protecting the public's health.

In all that I do I WILL PUT THE HEALTH OF THE PUBLIC FIRST, even when doing so may threaten my own interest or those of my employer.

In dedication to these high goals, on my honor, and with a clear understanding of these obligations that I as a public health professional have accepted, I do, this day, commit myself.

Source: University of Georgia, Ethics Forum, University of Georgia Public Health. The Oath of Public Health Professionals.
http://www.epimonitor.net/Public_Health_Professionals_Oath.htm_

1.3.3 The Optometry Oath

With full deliberation I freely and solemnly pledge that:

I AFFIRM that the health of my patient will be my first consideration.
I WILL practice the art and science of optometry faithfully and conscientiously, and to the fullest scope of my competence.
I WILL uphold and honorably promote by example and action the highest standards, ethics and ideals of my chosen profession and the honor of the degree, Practitioner/Doctor of Optometry, which has been granted me.
I WILL provide professional care for those who seek my services, with concern, with compassion and with due regard for their human rights and dignity.
I WILL place the treatment of those who seek my care above personal gain and strive to see that none shall lack for proper care.
I WILL hold as privileged and inviolable all information entrusted to me in confidence by my patients.
I WILL advise my patients fully and honestly of all which may serve to restore, maintain or enhance their vision and general health.
I WILL strive continuously to broaden my knowledge and skills so that my patients may benefit from all new and efficacious means to enhance the care of human vision.
I WILL share information cordially and unselfishly with my fellow optometrists and other professionals for the benefit of patients and the advancement of human knowledge and welfare.
I WILL do my utmost to serve my community, my country and humankind as a citizen as well as an optometrist.

I HEREBY commit myself to be steadfast in the performance of this my solemn oath and obligation.

Source: American Optometry Association, 2020, https://documents.aoa.org/about-the-aoa/ethics-and-values/the-optometric-oath

1.3.4 Professional Oath for Dietitians:

As a professional dietitian I pledge to practice the art and science of dietetics to the best of my abilities:

to maintain integrity and empathy in my professional practice;
to strive for objectivity of judgment in such matters as confidentiality and conflict of interest;
to maintain a high standard of personal competence through continuing education and an ongoing critical evaluation of professional experience;
to work co-operatively with colleagues, other professionals, and laypersons;
to protect members of society against the unethical or incompetent behaviour of colleagues or other fellow health professionals;
to ensure that our publics are informed of the nature of any nutritional treatment or advice and its possible effects;
to obtain informed consent for our invasive or experimental procedures.

I further pledge to promote excellence in the dietetic profession:

to support others in the pursuit of professional goals;
to support the training and education of future members of the profession;
to support the advancement and dissemination of nutritional and related knowledge and skills;
to involve myself in activities that promote a vital and progressive profession.

Source: Code of Ethics for the Dietetic Profession in Canada.
http://ethics-t.iit.edu/ecodes/node/4290

1.3.5 The Medical Laboratory Professionals Oath

As a Medical Laboratory Professional, I have a responsibility to contribute from my sphere of professional competence to the general well-being of society as a Practitioner of an autonomous profession. I serve as a patient advocate. My expertise is applied to improving patient healthcare outcomes by removing barriers to laboratory access and promoting equitable distribution of healthcare resources.

As a Medical Laboratory Professional, I will adhere to relevant laws and regulations pertaining to the practice of Clinical Laboratory Science and actively seeks to change laws and regulations that do not meet the high standards of care and practice.

My full and solemn pledge is as follows:

As a Medical Laboratory Professional, I pledge to uphold my duty to Patients, the Profession and Society and:

I WILL place patients' welfare above my own needs and desires.

I WILL ensure that each patient receives care that is safe, effective, efficient, timely, equitable and patient-centered.

I WILL maintain the dignity and respect for my profession.

I WILL promote the advancement of my profession.

I WILL ensure collegial relationships within the clinical laboratory and with other patient care providers.

I WILL improve access to laboratory services.

I WILL promote equitable distribution of healthcare resources.

I WILL comply with laws and regulations and protecting patients from others' incompetent or illegal practice

I WILL change conditions where necessary to advance the best interests of patients.

Source: American Society for Clinical Laboratory Science. Code of Ethics. https://www.ascls.org/about-us/code-of-ethics Accessed, July 2019.

Section

1

General duties of the practitioner to the public

Every practitioner shall:

1.1 Respect all aspects of human life, and shall do all that can reasonably be done to safeguard and improve the quality of human life, and shall not do anything which may cause suffering or terminate life. Delegate duties only to other practitioners who have the necessary qualifications, competence (knowledge, skills, attitude), and judgment to ensure clients and patients safety.

1.2 Give such advice and treatment as is necessary within own expertise, experience and or competence to reduce or eliminate the suffering of patients.

1.3 Treat patients, clients or any persons accompanying or visiting a patient with due courtesy and respect for their inherent dignity.

1.4 Respect patients' or client's confidentiality. The practitioner shall not divulge any information relayed to him/her by the patient or anyone acting on behalf of a patient in the course of the patient or client/ practitioner relationship to a third party;

Provided that a practitioner may, however, be required to reveal confidential information on patients in courts of law where the judicial ruling will prevail.

1.5 Not to discriminate against any person on the basis of age, race, colour, gender, sexual orientation, language, religion, political or other opinion, nationality, ethnic, cultural or social standing, disability, property, birth status, or other status.

1.6 Must provide truthful information about his/her qualifications, training or professional affiliations. He/she must not use them to mislead or deceive patients or the public as to his/her competence in a field of practice or ability to provide treatment.

1.7 Gather Informed Consent for services, interventions or procedures

Ensure informed consent is gathered before: providing any health-related service, conducting a physical examination, taking any samples from the patient/client, providing treatment, or conducting counselling, education or providing preventive services including health and nutrition related advice. Informed consent is both an ethical and legal obligation of practitioners registered by the council and originates from the patient's right to direct what happens to their body. Informed consent can be verbal or written depending on the service to be offered.

However, verbal informed consent should always be documented by the practitioner as part of client/patient notes. Informed consent requires that the decision maker, has capacity to make the decision, is adequately informed (is given all relevant information that a reasonable person would require to decide), and the resultant decision must be voluntary and free of coercion. All invasive surgical procedures (except in specific emergencies and where such requirements have a high likelihood of loss of life) should have written or witnessed informed consent, completely filled and copies filed appropriately for easy retrieval. Informed consent is more than just signing a consent form.

Informed consent as a minimum should include: (1) describing the proposed intervention or procedure, (2) emphasizing the patient's or client's role in decision-making, (3) discussing alternatives to the proposed intervention, (4) discussing the risks of the proposed intervention including side effects, as well as benefits (5) eliciting the patient's understanding of points 1-4, (6) obtaining the verbal or written consent to proceed with intervention or procedure. Informed consent can be withdrawn whenever the patient/client wishes to do so even during an intervention of procedure.

In the case of persons who may be unable to give informed consent including minors, unconscious or psychiatric patients, the most senior practitioner in consultation with the parent or guardian may give consent for the procedure or treatment, and such consent should where possible be witnessed by a second practitioner. In the event of differing opinion between the parent or guardian and the practitioner, the practitioner's stand shall prevail in the best interest of the concerned patient or client. Specific guidance for each group is given below;

1.7.1 Informed Consent for adults

A practitioner can obtain an informed consent from any competent adult as long as the information from 1.1-1.6 above is fully met.

1.7.2 Consent for children and minors

Generally, a child cannot provide informed consent. However, the Government of Malawi (GoM) established Acts, Policies and Strategies (for example the HIV Act, the Youth Friendly Health Services strategy) specific to services which may allow clients or patients less than 18 years of age to consent for treatment or procedures, in those scenarios the policies, acts or strategies shall guide Practitioners. For interventions involving children or minors the power to consent can be delegated to substitute decision-makers (SDMs) for example parents or guardians. This is called "informed consent on behalf of the minor."

Even with SDMs available, the child should be reasonably involved in decision making about their intervention or treatment appropriate with their age. Therefore, treatment should not be forced on children or minors because SDMs have consented on their behalf. Matured minors may provide informed consent for themselves. Examples of matured minors include minors who are (1) under 18 and married, (2) are mothers of children (married or not).

In circumstances dictated by law (above 18 years of age or according to ages outlines in MoH policies and guidelines), health providers will operate and be guided by the presumption that the child is mature and can consent to their treatment, service or care, but where the health provider is concerned that the child may not appreciate the full circumstances of the treatment they are about to receive, the health provider would perform a maturity/capacity test to determine whether the child needs further assistance to make decisions regarding the treatment, health service or care. Where the Practitioner is reasonably sure the benefits of an intervention outweighs the risks, and the child is mature enough and understands the information and there is no guardian/parent the intervention maybe be provided. However, there should be adequate documentation of the considerations made. Some cases may require consultation with senior Practitioners, professional associations, legal counsel or the Council to make decisions on whether or not to proceed with an intervention.

1.7.3 Informed consent for mentally challenged patients

SDMs for example legal guardian, or parent may provide permission on behalf of mentally challenged patient including psychiatry patients if the patient is unable to understand and make decisions. The practitioner and the substitute decision maker should provide a decision in the best interest of the patient.

1.7.4 Exceptions to informed consent

Exceptions for informed consent may include (1) when the patient is incapacitated. However, when relatives or guardians are available for the incapacitated patient, they should be involved in making decisions for treatment. When there are no guardians or relatives for the incapacitated patient and the practitioners are reasonably sure the benefits of an intervention outweigh the risks, an intervention can be conducted. (2) life-threatening emergencies with inadequate time to obtain consent, and (3) voluntary waived consent.

In all cases where the patient or client is not able to give informed consent, the consent is deferred to substitute decision makers only until when the patient or client is able to consent. When the patient has recovered to a reasonable condition where they are able to make an informed decision, consenting should be reverted back to the patient or client.

1.8. Emergency Calls

Practitioners have a duty to attend to emergency calls to save lives.

1.8.1 When several practitioners are called to attend an emergency or an accident, the first to arrive shall be considered to be in charge. However, he should withdraw in favour of any other practitioner preferred by the patient or a member of his family, if the patient is incapacitated, or the practitioner who is well conversant with the nature of the injury should take over.

1.8.2 In an event of an accident, or sudden illness any qualified practitioner shall assume the responsibility to assist the victim. It is unprofessional and unethical to ignore such an eventuality where one's medical know-how would have made the difference between saving a life and the demise thereof.

1.9. Accurate documentation of clients or patients notes

Medical or health care documentation is information that is recorded about a patient or client care. The primary purpose of health care documentation is to facilitate safe, high-quality and continuous care. Health care documents can be paper-based or electronic. Details of the health care provided should always be documented. Practitioners have a duty to communicate effectively in medical notes to provide accurate, informative, concise and auditable records of the care they deliver to patients or clients. The notes should be written professionally, be identifiable, readable and offer practical recommendations regarding patient or client care. Confirm the patient's details are correct on every document written on.

1.10. Practitioners with serious mental or physical impairment

A practitioner shall not provide treatment or care to clients while suffering from a serious physical or mental impairment, disability, condition or disorder (including an addiction to alcohol or a drug, whether or not prescribed) that places or is likely to place patients or clients at risk of harm.

Practitioners suffering from a mental or physical impairment that could place patients or clients at risk, must seek advice from other practitioners to determine whether, or in what ways, he/she should modify his/her practice, or discontinue the practice temporarily or permanently if necessary. It is the duty of every practitioner to look out for other Practitioners to ensure they are safe, and fit to offer services.

Practitioners are encouraged to seek for advice from other practitioners, professional associations, or the Council for guidance if unclear on whether to practice or not based on their condition. More information is in the fitness to practice sub-section under emerging issues.

Section 2

Practitioners relationship with colleagues and professional associations

2.1. Sharing of Knowledge and Skills with Colleagues

Practitioners shall share developments in the medical field with their colleagues, and do all they can to promote medical knowledge, education and research. They shall, however, avoid any action, which may be regarded as self-praise, and shall not condemn their colleagues or use derogatory language about them.

2.2. Charging of Fees to another Practitioner

In view of the bond of fellowship that exists amongst all members of the Profession, no matter where they qualify or practice, it is advisable not to charge fees directly/consultation fees for attending to another practitioner or his/her immediate dependants. This practice should be extended to nurses. There may be some exceptions to the uniform implementation of this advice. The Council expects practitioners to exercise discretion in this matter.

2.3. Requesting Advice from another Practitioner

A practitioner may formally request, with the patients'/clients' or their guardians' consent, whenever possible, the opinion and advice of another practitioner who may or may not be a specialist. Such consultation should end when all the necessary visits are made, and a written report of the consulted practitioners opinion or treatment is made to the referring practitioner. The on-going care of the patient remains the responsibility of the referring practitioner and not the consulted practitioner.

2.4. The Duties of Practitioners Regarding Consultations

2.4.1 It is the duty of the attending practitioner to accept the opportunity of a second opinion in any illness that is serious, obscure or difficult, or when consultation is desired by the patient or by persons authorized to act on the patient's behalf. While the practitioner may choose the consultant he/she prefers, he/she shall not deny the patient the opportunity to be seen by a consultant of his/her choice although he/she may advise the patient accordingly, if the preferred, consultant does not have the qualifications or experience which the existing situation demands.

2.4.2 It is particularly advisable that the attending practitioner shall, whenever desirable and possible, secure consultation with a colleague when performing an operation or adopting a course of treatment which may entail considerable risk to life, particularly when the condition which is intended to be relieved by the treatment is in itself dangerous to life;

2.4.3 The practitioner shall be expected to report to appropriate authorities when there are grounds for suspecting that the patient has been subjected to an illegal procedure or is the victim of criminal poisoning.

2.4.4 Consultation shall be done in the best interest of the patient. The attending practitioner shall give the consultant a brief written history of the case before the consultant examines the patient. The consultant shall record his/her opinion whether on the hospital records and/or by a sealed letter addressed to the attending practitioner. The joint decision shall be communicated to the patient. If agreement as to diagnosis and treatment is not possible, a further opinion shall be sought and the patient and/or a member of his/her family shall be informed of this by the attending practitioner and the necessity for such action shall be explained.

2.5. Patients referred to Practitioners in Hospital and Feedback

When a patient has been sent either for out-patient examination and treatment or admission to a hospital under the consultant's care, it is the duty of the consultant to report findings and discuss them with the attending practitioner so that the latter may have all possible advantage from the consultation. At the conclusion of the examination and treatment by the consultant the patient shall be referred to the attending practitioner with an adequate report for continued care.

2.6. A Practitioner as a Visitor

When a practitioner socially meets the patient of another practitioner, or visits him/her when ill, he/she must be careful not to be drawn into interference through suggestions or opinions. A practitioner's suggestions or opinions should only be expressed in consultation with the attending practitioners, and that such consultations shall be done in the best interests of the patient.

2.7. Differences between Practitioners

Professional differences between practitioners, which after adequate discussion cannot be settled, shall be referred to senior or more experienced practitioners. If the issue is not resolved by the seniors, it can be referred to the Registrar of the Council provided that where the complaint is on unprofessional conduct of a colleague, such complaint shall be referred in writing to the Registrar.

2.8. Medical Witnesses

Medical witnesses are expected to be motivated by a desire to assist courts in arriving at just decisions and not merely to further the interests of the party on whose behalf they have been summoned.

2.9. Succeeding another Practitioner

When one practitioner takes over total care for management of a patient, he/she shall make no adverse comments about the treatment already given.

2.10. Providing temporary cover for other Practitioners

A practitioner providing temporary cover for other practitioners shall act in such a manner that he/she shall not jeopardize the welfare of patients, and patients' confidentiality shall be respected at all times.

2.11. Relationship of Practitioners with Hospitals

Mutual understanding and cooperation between the medical profession and hospital management are most essential. Membership in an honorary attending staff capacity carries with it certain general responsibilities such as teaching and enlarging medical knowledge. Such a position should be held as a trust for the good of the medical profession. All members should make their contribution to the work required for the maintenance of high quality of care.

2.12. Relationship of Practitioners with other health professionals regulated by different Authorities

The primary duty of health professionals is to the patient, putting the patient's welfare above their own needs and ensuring that each patient receives the highest standard of care according to current standards. It is therefore, imperative that practitioners consult all relevant professionals related to patient or client care while they discharge their noble duty of serving patients, clients and the public.

In the course of serving patients and clients, practitioners shall collaborate with other health professionals regulated by other Regulatory Bodies. This teamwork, shall be guided by the principle of ensuring high quality health care provision at all times. Some of the professionals to be collaborated with shall include Nurses and Pharmacists.

2.12.1 The services provided by the nursing profession in the care of patients and prevention of illnesses are essential and complementary to the work of the medical profession. Therefore, it is the duty of Practitioners, to support and, where necessary, consult nurses so that both professions while remaining true to their respective code of ethics will cooperate as a harmonious team so that optimum service is provided to patients and clients.

2.12.2 With good consultation with pharmacists the practitioner, shall ensure that the prescribed medicines and supplies are available. If the specific prescribed medicines and supplies are not available, the practitioner shall prescribe the best alternative or provide proper referral to where such can be sourced.

2.12.3 For purposes of enhancing the professional relationship between the practitioners and the other professionals, practitioners shall familiarise themselves with the provisions of the Nurses and Midwives Act, and the Pharmacy Medicines and Regulatory Authority Act in order to appreciate the provisions and practices of the professions.

2.13. Relationship of Practitioners with Professional Associations or Societies

Practitioners must subscribe and associate themselves with their local, national and international associations or societies to promote their own and the general advancement in medical science and art.

2.14. Relationship of Practitioners with Practitioners in Training

2.14.1 It is unethical to delegate any work to another practitioner or nurse unless he/she is suitably qualified and experienced to undertake that work.

2.14.2 Registration on the interns' register carries the same prescribing authority as full registration within the hospital in which the intern is employed.

2.14.3 Registered practitioners in training are responsible to their consultant or general practitioner supervisors. If they believe that the general advice they have been given is inapplicable to a particular situation or is not in the best interest of individual patients, they shall seek further specific clarification. If necessary, they shall ask the consultants or general practitioners to take back their delegated authority and to take over management of the patients' illness personally since the primary responsibility of junior practitioners in training posts is to patients. They shall therefore, decline to do anything which they believe is not in the patients' best interest.

2.15. The Practitioners relationship with the Council

The Council is a legally constituted body which was established to serve the interest of the general public and of practitioners in the country. The Council expects maximum cooperation from its registrable Practitioners. It is a legal requirement that all practitioners be registered with the Medical Council of Malawi and that their registration shall be renewed annually. Practitioners shall abide by all directives of the Council. Any acts or omissions, which can be interpreted as amounting to contempt of the Council, shall be avoided at all times. Offenders shall be liable to penalties as determined by the Council from time to time.

2.16. Relationship of the Practitioners with the Public

Practitioners shall conduct themselves in the community in a manner that upholds the integrity, dignity and ideals of their profession. They shall not allow themselves to be influenced by such factors as religion, socioeconomic considerations, race, or politics in the conduct of their professional practice. They shall also endeavor to do all in their power to promote the general well-being of the community in which they live. Furthermore, all Practitioners are expected to abide by the laws of Malawi.

Section

Practitioners in private practice

3.1. Setting up a Private Practice

3.1.1. Practitioners may set up a private practice facility (clinic, hospital, laboratory, imaging and radiology, mental health and addiction treatment centre, dialysis facilities, physiotherapy, orthopedics-rehabilitation centres, disability homes and mortuaries) by purchasing the goodwill of an existing private practice, by entering into an established partnership, or by individually setting up the practice". It is unethical for Practitioners who intend to set up new private practice facility to borrow equipment and supplies from other existing registered clinics only to pass initial inspection.

Provided that Practitioners shall, in setting up their practices, not do damage to the practices of colleagues, particularly those with whom they have recently been engaged in professional associations.

Practitioners setting up private practice facility shall abide to regulations, standards and good practice guidelines. The facility shall be managed by a Practitioner who satisfies the minimum qualifications and experience as per regulations. Services offered in private practice shall only be according to the scope of practice of the Practitioner involved in private practice.

3.1.2. Except for specialists in Pediatrics, Surgery, Medicine and Obstetrics/Gynaecology, specialists in diagnostic fields including Radiology, Pathology, Anatomy and Hematology who want to start up general private practice shall be required to undergo at least a total of 6 weeks orientation split among the departments of Pediatrics, Surgery, Medicine and Obstetrics/ Gynaecology at a Central Hospital prescribed by Medical Council of Malawi.

3.1.3. If a Practitioner has been out of active practice for a continuous period of at least 3 years he/she shall be required to undergo an orientation at a Central Hospital prescribed by Medical Council of Malawi. The orientation period shall be a total of 6 weeks in the relevant departments consistent with their registration profession.

3.1.4. For those allied specialists in private practice and already doing general practice, they shall be expected to attend CPD sessions relevant to their practice.

3.1.5. For those Practitioners who have applied for specialist licenses, holders of such licenses shall restrict their practice to the conditions set out in their licenses.

3.1.6. Where a Practitioner is employed, for example by the MoH, the Kamuzu University of Health Sciences, Central Hospitals, District Hospitals or facilities under the Director of Health and Social Services (DHSS), Christian Health Association of Malawi (CHAM), Islamic Health Association of Malawi (IHAM), Non-governmental organizations (NGO), and the Practitioner wants to operate a private practice, below is the guidance;

i. The employer shall write a letter of authority allowing the Practitioner to operate or open private practice. Where the employer does not accept dual practice, the council shall not provide private practice license.

ii. This letter shall be presented to the council by the Practitioner including other key requirements as stipulated in the Council regulations.

iii. The Council shall review if the requirements have been met in line with regulations.

iv. The employer/proprietor has a responsibility to ensure
- (1) employment discipline
- (2) clients are attended to- the Practitioner does not abdicate their responsibility to be available to patients at their premise to ensure patients are not neglected for selfish financial gain as a consequence of the Practitioner practicing at multiple premises-
- (3) proper handover of patients to subsequent Practitioners to ensure continued care
- (4) report any observed neglect of patients and clients at their premise to the council.

v. The Council expects employers, and management of institutions for Practitioners involved in private practice (primary employment and private practice), to report on misconduct of Practitioners at their primary facility.

vi. All private facilities are expected to report data to respective government offices (for example DHSS) to inform the District Information Health System and government system for planning.

vii. Failure of employers to report on neglect of patient and client care by their employees who engage in private practice shall constitute institutional negligence and therefore a disciplinary issue for the employer/institution.

viii. Practitioners neglecting patients at their primary employment may result in harm to clients and therefore shall constitute a misconduct culminating in a disciplinary action by the Council.

ix. The private practice license maybe withdrawn by the Council.

3.2. Naming of private clinics and hospitals

In selecting a name for a private practice facility, or a collective title for a group or partnership, Practitioners shall;

3.2.1 Avoid the use of a name which could be interpreted as implying that the services provided in that facility or by that partnership have received some official recognition not extended to other local Practitioners.

3.2.2 Avoid the use of fancy names, which may be misleading, a name shall be deemed as misleading if:

- it contains a material misrepresentation of fact or law or omits a fact necessary to make the statement considered as a whole not materially misleading, is likely to create an unjustified expectation about results the Practitioner can achieve or states or implies that the Practitioner can achieve results by means that violates the rules of professional conduct or other law; or compares the Practitioners services with other Practitioner's services, unless comparison can be factually substantiated.

3.2.3 The Council shall in the exercise of its discretion deny use of a name deemed unacceptable. The use of terms such as "clinic" "centre" or "surgery" is acceptable.

3.3. Informing the Public about Private Practices

3.3.1 Practitioners commencing practices in particular specialties, or changing their area of practice may make public announcements after obtaining prior clearance of the announcements from the Council. They may also notify their colleagues of their availability for private consultations by sending sealed letters to those Practitioners whom they might normally expect to be interested. They may include their home addresses and telephone numbers of the consulting premises where appointments can be arranged.

3.3.2 Practitioners who may need to notify their patients or clients of new practice, a change of address, or of clinic hours, may send sealed circular letters to the patients of the practice, they may also make public announcements after prior clearance by the Council.

3.3.3 The format for letters announcing changes of practice arrangements or changes of specialist practice shall include the following information:

- The name of the Practitioner;
- Medical qualifications;
- Title of the main specialty in the case of a specialist;
- Brief details of the new clinic address
- Consulting hours and
- Services being offered

3.3.4 The drafts of the announcements made under (i-vi) above, shall be submitted to the Council for clearance before they are circulated to the public.

3.4. Group Practices and Ethics

3.4.1 Whatever is right and becoming in a Practitioner is equally right for any association of Practitioners in clinics or other groups, and whatever is obligatory upon the individual is equally obligatory upon the group.

3.4.2 It is undesirable and not in keeping with the principles of the profession for Practitioners to practice in partnership with anyone not duly registered to practice in the health field.

Section

4

Advertising

The rationale for the Health Profession refraining from advertisement or self-promotion is that the health care professional who is most successful at getting publicity may not necessarily be the most appropriate one to treat a patient. Patients and their relatives are vulnerable to persuasive influences such as unprofessional advertising.

4.1 Practice shall not be gathered by any kind of solicitation, direct or indirect. The best advertisement of a Practitioner is a well-merited reputation for ability and integrity in his/her profession.

4.2 Where a Practitioner takes over the practice of another Practitioner it is proper to notify all Practitioners in the area of the change. It would not be unethical for the Practitioner whose practice is being taken over to notify his/her former patients of the take-over.

4.3 A Practitioner shall not procure, sanction, be associated with or acquiesce in notices which commend his/her own or any Practitioner's skill, knowledge, services and qualifications, or which downgrade those of others.

4.4 Practitioners shall not boast of cures or indulge in self-praise to attract patients.

4.5 There shall be a clear differentiation between advertisement or self-promotion and legitimate factual announcement of a service being provided without self-aggrandisement or downgrading others.

4.6. Practitioners Relationship with Organizations that advertise their services to the Public

If a Practitioner owns or holds shares in an organization which advertises diagnostic or clinical services to the public, he/she shall: -

4.6.1 Not permit his/her own name to be used in advertisements to the lay public;
4.6.2 Ensure that advertisements are factual and do not advertise the Practitioner's qualities.
4.6.3 Ensure that the advertisement by the organization are vetted by the council before going to the public.

4.7. Practitioners in Relationship with Organizations which advertise to the Medical Professions, but not to the Public

Practitioners who have a relationship with organizations which advertise to the medical profession but not to the public shall ensure that such advertisements are factual, and do not make un-favourable comparisons with other organizations.

4.8. Public References to Practitioners by Companies or Organizations

A Practitioner shall take steps to avoid the publication of reports, notices or notepaper issued by a company or organisation and drawing attention to professional attainments of a Practitioner in their employment. Companies and Organizations shall inform rather than use Practitioners experience or qualifications to praise the Practitioners in order to get more clients or patients at the expense of other institutions. Companies, Organizations and Practitioners shall crosscheck the contents of their notices, magazines with the Council.

4.9. Questions of Advertising arising from Articles, or Books, Broadcasting or Television Appearances by Practitioners

Practitioners who write to magazines or journals addressed to the public, articles or columns which offer advice on common medical conditions or problems, or who are involved in television or radio programmes dealing with such matters, shall not use language, which might be construed as advertisement or self-promotion or denigrating other Practitioners.

4.10. Notice Boards, Door Plates and Signposts

Advertising may arise from notices or announcements displayed, circulated or made public by a Practitioner in connection with his/her own practice if such notices or announcements materially exceed the limits customarily observed by the profession in Malawi. It is important that the public be informed of the location of a Practitioner's premises, but in choosing the wording and size of a sign, the Practitioner shall abide by the following criteria:

4.10.1 A signpost or doorplate shall not be ostentatious.

4.10.2 It is acceptable for the information on the Practitioner's plate to be repeated in a second language if necessary;

4.10.3 A plate shall not carry more than the Practitioner's names, qualifications, services offered, and consulting hours;

4.10.4 The Geneva Convention prohibits the use of the Red Cross or similar sign. Clinics or surgeries shall not use the Red Cross. A green cross or other sign may be used to symbolize such a facility.

4.10.5 No notices or signposts shall be too large, or repeated more frequently than is necessary to indicate to patients the location of the premises;

4.10.6 No notices or signposts shall be used to draw public attention to the services of one practice at the expense of others.

4.11. Directories and Lists of Practitioners

An entry of Practitioners' names in a telephone directory shall appear in the standard typeface. The Practitioner shall neither request nor allow any entry in a special typeface or any description other than his/her qualifications or, in the case of a specialist, his/her specialty. It is permissible for a Practitioner's name to be included in a handbook of local information, provided that the list is open to the whole profession in the area and that the publication of the names is not dependent on the payment of a fee.

4.12. Canvassing

Canvassing for the purpose of obtaining patients, whether done directly or through an agent, and association with or employment by persons or organisations which canvass is unethical. It is also unethical to talk in a derogatory manner about the professional skills, knowledge, qualification or services of another Practitioner.

4.13. Communication with the Public on Medical Subjects

All opinions on medical subjects which are communicated to the public by any medium be it a public meeting, the press, radio or television shall represent what is the generally accepted opinion of the medical profession, and or proven by scientific evidence.

Section

5

Emerging Issues

5.1. Use of Social Media for patients and client information

Social media provides a platform for building social and professional relationships for healthcare professionals through YouTube, LinkedIn, Twitter, Facebook, WhatsApp and blogs among others. Morality, ethical and legal principles ought to guide the professional disclosure of the patient information both online and offline. Failure to uphold ethical standards on social media exposes patients to embarrassment and psychological harm. In addition, breaching confidentiality erodes the patients trust and undermines Practitioner-patient/client relationship therefore; Practitioners ought to think carefully before accepting friend requests from their patients or sending friend requests to them because of the risk of blurring professional and personal lives.

Practitioners shall:

5.1.1. Refrain from taking any pictures and videos (including treatment and laboratory data) from patients and clients.

5.1.2. Sharing of the patients' pictures and videos on social media shall constitute invasion of privacy, and where absolutely necessary, clearance shall be sought from the council prior.

5.1.3. Where the pictures/videos are required for professional purpose from a patient or client, a signed informed consent from the patients or clients shall be gathered.

5.1.3.1. The written informed consent shall be filed appropriately for easy retrieval if requested by the council.

5.1.3.2. The taken pictures or videos shall not include features that would identify the client, for example the client/patient face.

5.1.3.3. Sharing of pictures/videos shall be limited to the team/ individuals involved in direct management of the patient or client. Pictures shall not be shared to individuals that will not have impact in the care of the patient/client.

5.1.4. Communicating on work interaction groups like WhatsApp to share information, pictures of patients/clients when requesting second opinion permeates into telemedicine and poses ethical and legal challenges on privacy, confidentiality, storage, security and ownership of the shared information. Therefore, the Practitioner shall seek guidance from the council.

5.1.5. Making negative and defamatory comments on social media about colleagues, patients and clients can be viewed as bullying and unprofessional, rather Practitioners shall address issues of concern directly with the relevant individuals.

5.1.6. Practitioners who violate the patients' and clients' right to privacy and confidentiality and who are deemed to bring the profession into disrepute may be subjected to Councils' disciplinary hearing or may be sued for invasion of privacy by the healthcare user.

5.2. Telemedicine and E-health

Telemedicine and E-health is the application of technologies for the transfer of clinical radiological/pathological/laboratory/medical information through the use of internet and other technologies. Telemedicine and e-health has ethical and legal issues for example scope of practice, patient consent, privacy technology issues, equitable access to technology and professional regulation.

In provision of telemedicine or e-health, the following must be taken into consideration:

5.2.1 All Practitioners involved in Telemedicine and E-health locally or internationally to serve Malawians shall be registered and be in good standing with the council.

5.2.2 Any device, software or service used for the purpose of e-health should be secure and fit for the purpose and must preserve the quality of the information being transmitted.

5.2.3 If the Practitioner offers services to the patient or client, he/she is responsible for gathering and assessing the information used to form the diagnosis, irrespective of its source. If he/she receives a referral, which does not contain the information required to make the diagnosis to make a fair assessment, Council expects that Practitioner will request the relevant information or return the referral to the sender with a request for more information.

5.2.4 The council expects that the services or treatment the Practitioner provide to the patient through telemedicine or e-health meets the required standards of care in a face-to-face consultation. The standards include patient selection, consent, assessment, diagnosis, treatment, privacy and confidentiality, and follow-up.

5.2.5 The Practitioner should consider whether a physical examination would add critical information before providing treatment to a patient or before referring the patient to another health care Practitioner for services including diagnostic imaging and pathology testing

5.2.6 If Practitioner receives reports from e-health providers, ensure that the above standards are followed and he/she must notify that e-health provider, their management if you have concerns about the quality of care being provided.

5.2.7 More guidance is available in the Telemedicine minimum standards available at the council.

5.3. Safeguarding

Safeguarding is fundamental to provision of safe and high-quality health care. Safeguarding is about protecting the health, wellbeing and human rights of individuals, which allow them to live free from harm, abuse and neglect.

Patients, clients and Practitioners should be protected from all types of abuse, including physical, sexual, psychological or emotional, discriminatory abuse, organisational or institutional abuse, and modern slavery. The abuse of patients and clients is an important cause of harm to patients. Due to the nature of health care, clients and patients are at an increased risk of abuse. Some patients and clients are at increased risk of abuse due to age, gender, illnesses like mental ill-health, or substance abuse.
Legally and ethically, Practitioners have a duty of care to protect colleagues, patients and clients, act on concerns about abuse, and shall be alert to the possibility of undisclosed abuse when working with those at risk of harm. A patient or client interaction with a Practitioner, may be the only opportunity that an individual living in an abusive environment has to discuss these concerns. Therefore, Practitioners should take any allegation of abuse seriously, make enquiries and share concerns if abuse is suspected.

Practitioners, health facilities, teaching institutions and the Council shall work together to prevent and stop both the risks and experience of abuse or neglect, while at the same time making sure that patients and clients wellbeing is promoted including, where appropriate, having regard to their views, wishes, feelings and beliefs in deciding on any action. Practitioners must recognize that patients and clients sometimes have complex interpersonal relationships and may be ambivalent, unclear or unrealistic about their personal circumstances.
Practitioners have a duty of care, an obligation to avoid acts or omissions, which could be reasonably foreseen to injure, harm or cause distress to patients and clients. Practitioners shall anticipate risks clients and patients, take care to prevent them coming to harm.

Practitioners shall;

5.3.1. Treat patients and clients as individuals, respect their dignity, rights to privacy and confidentiality, and rights to make their own decisions.

5.3.2. Take prompt action if client safety, dignity or comfort is being compromised by themselves or colleagues:
- Report or raise concerns if patients/clients or even other Practitioners do not receive adequate care.

5.3.3. If dealing with a child, minor or person with disability, assess their capacity to consent consistent with outlined consent procedures.

5.3.4. Give client/patient privacy to undress/dress and keep clients/patients covered whilst conducting a physical examination, procedure or treating them as much as possible to maintain their dignity.

5.3.5. Before conducting an intimate examination, procedure or intervention:
- Explain why the examination/procedure is necessary and give the client/patient an opportunity to ask questions.
- Explain what the examination/procedure will involve in a way the client/patient can understand, so that they have a clear idea of what to expect, including any pain or discomfort.
- Get and document the client's informed consent.

5.3.6. Before, during or after examination or treatment:
- Stop if the client has so requested.
- Do not make personal comments regarding the client.

5.3.7. With consent from the client, ensure a chaperone/sentinel, (second staff member or client relative) is present for all intimate examinations/ procedures, especially where the Practitioner is of a different gender to the client. The chaperone/sentinel protects both the patient/client and Practitioner. The chaperone reassures the client and protects the Practitioner should any complaints or serious concerns arise.
- Chaperones/sentinel may still be required in some intimate examinations/procedures between Practitioner and clients/ patients of the same gender.
- A chaperone should never be forced on patients. If the client refuses a chaperone, the procedure may continue, but the refusal should be documented in the client records.
- If the Practitioner does not wish to proceed in the absence of the chaperone, this should be explained with reasons to the client/patient.
- Record the name of the chaperone/sentinel in the client record.

5.3.8. Maintain trust through being open, acting with integrity, and treat all clients and patients fairly and equitably.

5.4. Medical errors

A medical error is a preventable adverse event resulting either from human error or due to negligence. The council expects all Practitioners to adhere to good clinical practice, guidelines and policies to minimise the risk of medical errors. The council expects health facility owners, proprietors, and employers to provide adequate resources for provision of high-quality services.

Practitioners are expected to;

5.4.1. Identify medical errors quickly and timely to minimise harm.

5.4.2. Rectify the error as soon as possible and ensure the effect of the error are minimised as practically possible.

5.4.3. Refer for further care if required and accompanying the patient is encouraged. Failure to refer a patient with an adverse event in an effort to conceal the error is negligence, may worsen the patient health hence a disciplinary issue.

5.4.4. Adequate and complete documentation of the events that caused the medical error and further treatment being sought.

5.4.5. Acknowledge the medical error happened, communicate to the patient/client and guardian honestly and promptly about the cause of the adverse event, and apologise if appropriate to do so.

5.4.6. Report the adverse event to the relevant authority, where appropriate. The primary Practitioner has a duty to follow up the client.

5.4.7. Take careful measures when explaining the cause to the client in order to not imply there was element of negligence, if the suspected causal services were provided by a different Practitioner. The Practitioner can inform the initial Practitioner of the medical errors, or direct the client back to the previous Practitioner if not satisfied with the cause of the adverse event, or seek clarity from the council.

5.4.8. It is only the mandate of the Council to conclude whether there was negligence or not after the case is reported and investigated.

5.5. Issuance of Medical Reports, Forms and Certificates

Practitioners are relied upon to issue medical reports, forms and certificates for a variety of purposes (such as insurance forms, employment forms, and court cases) on the assumption that the truth of the report can be accepted without question. A Practitioner shall exercise care in issuing these documents, and shall not include in them statements that he/she has not taken appropriate steps to verify. These reports may be used for legal purposes.

According to Section 12 of the International Code of Medical Ethics of the World Medical Association, “A doctor owes to his/her patient the absolute secrecy on all which has been confided to him/her or which he/she knows because of the confidence entrusted to him/her.” In all forms and certificates where, medical reports are to be filled in by Practitioners there shall be included a declaration to be signed by the patient or a responsible relative or guardian stating that consent is given to the Practitioner to supply the information requested. It is also strongly recommended that these forms and/or declarations be supplied in duplicate to permit the Practitioner to retain a copy.

All medical reports, forms and certificates filled by a Practitioner must (1) be legible, (2) clearly bare the full name, address, qualifications, the usual signature, area of specialization, registration number of the Practitioner, (3) the official stamp with a date.
The reports should include (1) name of the patient, (2) date and time of examination or treatment, (3) description of condition or illness in layman’s language having gathered informed consent from the patient/client (the employer does not have the right to know the diagnosis but can query the patients fitness to practice), (4) whether the patient/client is totally indisposed of duty or whether they are able to perform less strenuous duties in the work environment, (5) the exact period of recommended sick leave if applicable, (6) date of issue of the report or certificate.

Only Practitioners in good standing with the council must complete medical forms, reports and certificates. Practitioners shall only write the reports in line with their registration and expertise.

5.6. Access to medical records and disclosure of medical information

Consistent with the access to information bill, patients and clients shall have the right to request and receive copies of their medical records.

Information shall not be disclosed to third parties, except subject to limitations. Provided that in the following circumstances, the confidential information may be disclosed to a third party:

- Where there is a valid expressed consent from the patient or his/her legal adviser or guardian, provided that information may be given to a relative or appropriate person if in the circumstances of the case in question it is reasonably undesirable on medical grounds to seek the patient's consent.
- As a statutory obligation.
- Where the information may be required by law, for instance at the instruction of the court.
- In the interest of the public, where public interest persuades a Practitioner that his duty to the community overrides that to his patients; and only to relevant authorities or public.
- With the written consent of a parent or guardian of a child.
- In the interest of the patient, information may be disclosed to other health care provider or health facility for continued care.
- In the interests of research and medical education, information may be divulged, but identifiable information shall not be revealed.
- For the purpose of medical insurance provided patients and clients gave prior informed consent to access the information.
- In the case of the deceased patient, with the written consent of the next of kin or the executor of the deceased estate

5.7. Connections with commercial enterprises

5.7.1. A Practitioner shall not associate himself/herself with commerce in such a way as to let it influence, or appear to influence, his attitude towards the treatment of his patients.

5.7.2. A Practitioner shall refrain from writing a testimonial on a commercial medical product unless he receives a legally enforceable consent from the council.

5.7.3. There ***shall*** be no direct association of a Practitioner with any commercial enterprise engaged in the manufacture or sale of any substance which is claimed to be of value in the prevention or treatment of disease, and which is recommended to the public in such a fashion as to be calculated to encourage the practice of self-diagnosis and self-medication or is of undisclosed nature or composition.

5.7.4. A Practitioner shall not be associated with any system or method of treatment, which is not informed by principles of good clinical practice, scientific evidence, or regulated by the council.

5.8. Professional Fees

5.8.1. The only basis on which a fee may be charged to a patient or on which any Practitioner may receive money, is that of work actually done for the patient, and such patient must receive a receipt from the Practitioner concerned.

5.8.2. In case where in the opinion of the attending Practitioner the services of one or more consultants are required, each consultant shall render his account and submit his/her receipt individually.

5.8.3. Each Practitioner shall send his/her account to the patient individually. If, however, a surgeon has a regular assistant at operations he/she may pay him/her directly. When the assistant has referred the patient to the operating surgeon the assistant shall send a statement of his/her fee directly to the patient.

5.8.4. If fees are collected by an organised clinic, medical group, medical partnership or Practitioner employing regular assistants, each such organisation is in effect regarded as an individual who acts in that capacity. The same principle applies when the clinic and hospital are combined and operate under the same ownership.

5.8.5. When a third person or organisation enters into a financial arrangement between patients and Practitioners, the Practitioners should render an individual account to the third person or organisation concerned. If more than one Practitioner is carrying out professional services, a statement to the patient by a third person or organisation should show the amount paid to each Practitioner.

5.8.6. In places where those with special training or qualifications are not available, dispensing of such commodities may be undertaken in accordance with the Pharmacy and, Medicines Regulatory Authority Act.

5.8.7. A Practitioner's receipt to the patient shall show clearly and separately his/her professional fee and the charge for the commodities dispensed.

5.8.8. Practitioners shall not have proprietary interest in preparations or appliances, which they may recommend to patients.

5.8.9. Where Practitioners, a medical group or a clinic of surgery, own and occupy an office building, it should not be considered unethical for them to rent space to businesses or individuals under the following provisions:

5.8.9.1. That the rent charged is the normal or going rent for that similar space;

5.8.9.2. That there is neither real nor implied endorsement of the

business carried on by the tenant; and

5.8.9.3. That other than normal rent, there be no profit of any kind, direct or hidden, derived from the tenant concerned.

5.9. Medical Research

All medical research shall be conducted in the best interest of the patient and must be conducted ethically following the national and international research guidelines and policies e.g. World Medical Association (WMA) declaration of Helsinki). All medical research done in Malawi shall undergo an independent scientific and ethical review by recognized national bodies like the National Health Sciences Research Committee. Practitioners conducting Medical research must be registered with the Council. In the case of clinical trials where drugs are involved, permission for approval shall be sought from the Pharmacy and Medicines Regulatory Authority. All institutions where medical research is to be conducted are mandated to enforce this regulation. Practitioners involved in medical research must be in good standing with the council.

5.10. Practicing during pandemics, emergencies and disasters

Pandemics, emergencies and disasters can dramatically disrupt healthcare service provision and regulation of practice. The experiences with the COVID19 pandemic have revealed that the ability to regulate health service provision to ensure patient safety in the context of a pandemic and emergencies can be challenging. Moreover, disasters can cause widespread environmental and material loss, human life loss and suffering which exceeds the ability of the affected community to cope.

A pandemic can have serious health and socioeconomic consequences as a result of unprecedented disease burden stretching the health system, fear among Practitioners and the public, travel restrictions and resource constraints. The extra disease burden pandemics bring could further complicate health service provision making adherence to standards difficult, predisposing patients and the population to preventable suffering from which health services are intended to protect them. Patient's rights maybe violated whilst accessing healthcare either intentionally or unintentionally.

Travel restrictions may limit visit to health facilities, institutions and Practitioners for inspections or supervisions potentially culminating in significant negative impact on quality of services provided. Fear may lead Practitioners to neglect their duties to clients, patients and the public. Moreover, some Practitioners may refuse to offer health service provision risking clients, patients and the public. In addition, employers and hospital management may fail to procure and provide adequate supplies and equipment (for example inadequate personal protective equipment)

predisposing Practitioners to increased occupational risks.

Therefore, during pandemics, emergencies and disasters the Council, employers, hospital management and Practitioners still have a duty to safeguard safe service provision for clients, patients and the general public. There will be need to develop creative approaches to sustain acceptable standards of health care.

During pandemics, emergencies and disasters the Council shall:

- Inspect and license facilities ability to offer services for specific facilities in order to protect patients, clients and the public.
- Monitor adherence to standards for health service provision using face to face or remote approaches where appropriate.
- Monitor availability of resources for continued service provision and hold employers accountable for providing conducive environment that protects Practitioners.
- Support the rapid development and dissemination of guidance on practice (standards or protocols for preventing, testing, diagnosis and treatment) for Practitioners to be well informed.
- Support efforts on adherence to experimental treatments, which should be expedited or procedurally approved to inform both curative and preventive health service provision.
- Support efforts for provision of health care services for Practitioners to be health and provide services.
- Fast track or adapt registration/licensure policies to accommodate students and recently retired Practitioners in the workforce to provide temporal relief if the workforce is over-stretched.
- Investigate complaints, conduct disciplinary hearings and meetings to address reported complaints as required by law.

Employers and hospital management shall:

- Rapidly disseminate guidelines and practices which may be evolving as informed by lessons learnt from the pandemic, emergencies and disasters.
- Develop adaptive strategies to ensure adherence to standards of care.
- Provide adequate resources for Practitioners.

Practitioners shall:

- Still practice in line with expected ethics and professional standards.
- Practice according to best known evidence-based medicine and good clinical practice.
- Avoid informing the public non-evidence-based remedies which may result in harm.
- Participate in prevention, preparedness and response efforts to pandemics, emergencies and disasters.

5.11. Practitioners fitness to practice

Fitness to practice is the ability to meet professional standards, character, professional competence and health. According to the Health and Care Professions Council (HCPC), someone is fit to practice if they have the "skills, knowledge, character and health to practice their profession safely and effectively". Therefore, all Practitioners registered by the Council must have the skills, knowledge, character and health to practice their profession safely and effectively. The conduct of a professional outside of their working environment may involve fitness to practice where it could affect the protection of the public or undermine public confidence in the profession.

If a Practitioner's fitness to practice is impaired or negatively affected it means there are concerns about their ability to practice safely and effectively. This may mean that they should not practice at all, or that they should be limited in what they are allowed to do.

In most cases, health conditions and disabilities do not affect a Practitioners fitness to practice, as long as the Practitioner:

- Demonstrates appropriate insight.
- Seeks appropriate medical advice; and
- Complies with treatment.

The types of cases that question a Practitioner's fitness to practice may include (1) Misconduct or unprofessional behavior– behaviour that falls short of what can reasonably be expected of a professional, (2) Lack of competence – lack of knowledge, skill and judgment, usually repeated and over a period of time and (3) Physical or mental health – usually a long-term, untreated or unacknowledged condition. Reporting concerns of fitness to practice provides an opportunity to put things right and is generally the most effective method of preventing further harm. This fitness to practice guidance aims to protect both the Practitioner's health and the public from accessing health services from Practitioners who are unfit. Our focus is on current impairment; whether a Practitioner may continue to present a risk.

Employers have a duty:

- To ensure that Practitioners are fit to practice.
- To protect patients, clients, service users and members of the public.
- To safeguard public confidence in the profession.
- To comply with the requirements of professional/regulatory bodies as well as employment and labor laws.
- To ensure that Practitioners are not offered employment to directly serve clients, patients and the public if they are not fit to practice.

- Adjust, where possible, to allow a practitioner to fulfil the core competencies of their practice and enable them to work in a safe and appropriate environment in line with labour laws.
- To make reasonable adjustments for disabled practitioners.
- Report and consult the Council if there are concerns about a practitioners' fitness to practice professionally.

Practitioners have a duty to ensure:

- They are competent therefore are not unsafe for practice
- Avoid unprofessional behavior, including: lack of respect, poor attitude, laziness, inappropriate use of mobile phone, poor time keeping, failure to engage with investigations into unprofessional behaviour; poor self-management, lack of personal accountability and dishonesty.
- To seek for advice or consultations from the Council for guidance if unclear on whether or not to practice based on their condition.
- Report to relevant authorities if they themselves feel unfit to practice or they observe other practitioners are unfit to practice.

The Council has a duty:

- To ensure that only practitioners that are fit to practice are registered and licensed.
- To conduct investigations, hearings and address any appeals from Practitioners and employers concerning fitness to practice.
- Ensure processes are carried out as quickly as possible, consistent with fairness and professionalism, and provide feedback.

When a decision of lack of fitness to practice has been made, clear communication should be made to the Practitioner or their delegated decision maker. This include:

- Practitioners understand any allegations and/ or concerns, and how they relate to the relevant professional standards and fitness to practice;
- Reasons should be given for decisions reached about the Practitioners health or behaviour, and what to do about it;
- All relevant professional associations and bodies, regulators and ministries should be informed.
- The Council shall be a possible route of appeal on fitness to practice for Practitioners;

5.12. Continuous Professional Development

Continuing Professional Development (CPD) are a set of educational activities which serve to maintain, develop, or increase the competency and professional performance and relationships that a Practitioner uses to provide services for patients, the public, or the profession. Competency is a combination of knowledge, skills and attitude not only qualifications. CPD

aims to develop and maintain professional competencies of Practitioners through on going learning throughout the Practitioner's practice for client safety. The council requires Practitioners to meet minimum requirements for CPD. Achieving CPD points is a perquisite for annual practicing license renewal. The council through its CPD committee will approve CPD providers that maybe hospitals, organisations, training or research institutions, or professional associations. CPDs may be conducted face to face, or remotely using multiple platforms.

The Practitioner shall:

1) Keep his/her knowledge, skills and practice up to date.
2) Plan and regularly review CPD activities to ensure they are relevant to his/her scope of practice.
3) Affiliate themselves with approved CPD providers to keep CPD activities on-going and accumulate the required minimum CPD points as stated in the Council-CPD regulations/policy.
4) Ensure that his/her practice meets the reasonably expected professional standards.

The employer shall:

1) Ensure that employees' CPD activities are compliant with the Council's requirements.
2) Provide a conductive environment and resources for CPD activities within their facilities or organizations.
3) If they qualify as a CPD provider, apply to the Council to be recognised and accredited.
4) Include CPD compliance as part of job descriptions, and performance appraisals.

More guidance on CPD regulations and processes are available at the Council premises, or can be accessed through the Council website.

Section

Ethical Dilemmas

Ethics are standards and principles by which Practitioners govern their behaviors, decision-making and actions. When these standards and principles conflict with each other in a decision-making situation, an ethical dilemma may occur. The ethical dilemma takes place in a decision-making context where any of the available options requires the Practitioner to violate or compromise on ethical standards. Genuine ethical dilemmas, must be differentiated from merely apparent dilemmas or resolvable conflicts. An ethical dilemma may be epistemic or ontological, self-imposed or world imposed, obligation or prohibition, and single-agent or multi-agent.

6.1. Characteristics of ethical dilemmas

Ethical dilemmas can be characterised by the following three elements:

1. The Practitioner must be faced with a choice or the need to decide.
2. The Practitioner must have more than one course of action available.
3. The Practitioner recognises that the available courses of action may require them to compromise on some ethical standards of the profession. Ethical dilemmas may perplex Practitioners as strong reasons for a course of action may be balanced by equally powerful countervailing arguments.

6.2. Four steps approach to address ethical dilemmas.

Common sense, clinical experience and integrity and good intentions alone may not guarantee that Practitioners will know how to respond appropriately to such dilemmas. Some ethical dilemmas are complex and may require consultations with other Practitioners, Council, legal counsel, bioethicist or a bioethics committee, or professional associations.

When faced with ethical dilemmas, Practitioners should ensure respect for persons, autonomy, non-maleficence, beneficence, human rights, integrity, truthfulness, confidentiality, compassion, tolerance, justice and good professional competence.

Respect for persons: the recognition of a person as autonomous, unique, and free individual.

Autonomy: Determine the wishes of the client or patient to protect their autonomy.

Justice: Follow the due process to determine limits on healthcare and treat patients or clients alike.

Beneficence: Seek the clients or patient's best interest and assess what counts as goods to be pursued

Non-maleficence: Determine what counts as harms and avoid it.

Practitioners should ensure the four steps approach is used to addressing ethical dilemmas in health practice. The four steps include:

1. Identify or formulate the dilemma or specific problem being considered.
2. Gather relevant information about the issue at hand. The information may include clinical, personal and social, the medical situation, status of the patient, views of the health care team and pragmatic issues that complicate the case. Authoritative sources of information like policies, guidelines, professional associations, other Practitioners, can provide alternative options of actions.
3. Evaluate the available options of solutions and options. This can support the Practitioner clarify the ethical issues further. Every identified intervention/solution should be assessed considering its consequences, values-duties and rights which weigh heaviest, the Practitioners individual view concerning the correct option and its weaknesses, how the Practitioner would have wanted to be treated if they were in the position of the client or patient in a similar circumstance, and the Practitioners consideration of how the client/patient would have wanted to be treated in the circumstance if they knew all the information.
4. Sharing and discussing the most appropriate proposed intervention with those it will affect, most especially the client or patient. Alternatives should also be explained and the decision should be implemented with sensitivity bearing in mind those whom it may affect.

6.3. Examples of ethical dilemmas.

Practitioners may experience many ethical dilemmas. Examples include, euthanasia, execution, withholding or withdrawing life sustaining treatment, and refusal of life sustaining treatment, provision of extraordinary treatment, whether to accept gifts from clients or patients, conflict of interest in medical settings.

Euthanasia, also called mercy killing is the practice of intentionally ending life to relieve pain and suffering. Death penalty also called execution is a state-sanctioned practice of killing a person as a punishment for a crime. The death penalty is currently not being practiced in Malawi but theoretically, Practitioners maybe required by the state to offer execution services.

Withholding and withdrawing life sustaining treatment, provision of extraordinary treatment to patients, whether to accept gifts from clients or patients, conflict of interest in medical settings and refusal of life sustaining treatment are explained from the following page as they are the most commonly experienced ethical dilemmas.

1. Withholding and withdrawing life sustaining treatment

Ethics, professional codes, public policies and laws indicate do no harm in health care. The dilemma concerning withholding or withdrawing life sustaining treatment is dependent on the principle of non–maleficence. The debate center on omission and commission distinction between withholding (not starting) and withdrawing (stopping). Many professionals and family members feel justified in withholding treatments they never started, but not in withdrawing treatments already initiated such as decisions whether to stop a ventilator-respirator, stopping IV fluids or NGT tube feeding and hydration, stopping antibiotics to fight infections. However, often the moral burden of proof is heavier when the decision is to withhold rather than to withdraw treatments. When faced with this situation, Practitioners shall follow the four steps explained.

2. Refusal of life sustaining treatment

Refusal of life sustaining treatment is where a patient or guardians, by accepting life sustaining treatment would ideally return to the state of health but refuses to get such care resulting in a continuing compromised health status risking death or impairment. For example, Jehovah Witness who may refuse to accept blood transfusion on religious reasons. The principle of respect of personal autonomy requires the recognition of the right of the competent adult Jehovah's Witness to refuse the life sustaining blood transfusion.

However, Practitioners are required to act in the best interest of the patient and protection of the children rights to life. Practitioners should ensure all options of encouraging the patients or guardians to accept the care have been exhausted (including counselling), if acceptable alternatives are available and indicated offer these, consultation of senior Practitioners and other key stakeholders. Where competent adults have insisted on treatment refusal, the steps taken by the Practitioner should be documented comprehensively and have the adult and their witness consent for the refusal. For children, Practitioners should act in the best interest of the child, legal and security agents maybe involved in implementing care.

3. Provision of extraordinary treatment

The general standard of care is the acceptable and or documented treatment in line with good clinical practice, guidelines and standards based on documented evidence. As a principle, Practitioners should give the standard car, which is often simple, natural, inexpensive, or routine. In professional practice, extraordinary treatment is unusual and unfamiliar among Practitioners.

For extraordinary treatment, Practitioners should assess whether the treatment is beneficial or burdensome and should point to a quality of life criterion that requires balancing risks and benefits. Only Practitioners specialized or experienced in the specific field maybe justified to offer the extraordinary care, and a team-based approach is encouraged to decide whether or not the treatment should be offered.

4. Whether to or not accept gifts from clients or patients

Gifts maybe offered to Practitioners to thank Practitioners for services offered to patients or clients. However, there are problems associated with gifts such expectations for personal treatment, changes in doctor-patient relationship, impairment of judgment, and erosion of the public trust. While the value of some gifts may be acceptable, others may be too significant to affect professionalism. Sometimes, the clients or patient may later request special treatment such as personal favors, inappropriate medical care and unethical actions such filling a fake medical report.

The approach to handling gifts may include:

- appreciating that gifts could be problematic
- getting advice from colleagues or professional associations whether the specific gift could be acceptable
- accepting the gift graciously
- not letting the gifts affect professional judgment
- consider sharing the gift with others.

Institutions may consider developing a gift register and having Practitioners declare gifts that have been offered or accepted.

5. Conflict of interest in health practice

Practitioners are expected to act in the best interest of their patients or clients. A conflict of interest exists when a person entrusted with the interests of a client, or the public violates that trust by promoting his/her own interest or the interest of the third parties. Conflict of interest maybe problematic in the health care because of the following reasons: patient's outcome may be compromised, the integrity of judgment may be violated, and trust in the health profession may be undermined. Practitioners shall serve patients' best interests by preventing and avoiding conflicts of interest. The Practitioner and the hospital can manage conflict of interest by re-affirming that the patient's interests are paramount, disclose conflict of interests, and take precautions to protect conflict of interests.

Section

7

Actions which may constitute offences, malpractices and misconducts resulting in disciplinary action

Below are examples of actions or omissions which may constitute offenses, malpractices, or misconducts. The Council may decide on case by case basis whether the action or omission not listed here constitutes misconduct in line with principles of ethics and professional conduct. Therefore, the list is not exhaustive.

7.1. Unlawful or unethical Termination of Pregnancy

Termination of pregnancy in Malawi is regulated in accordance with the Penal Code Section 149 – 151 as read with Section 243 and is limited to circumstances where it is necessary to save the life of the pregnant woman. Practitioners found guilty of conducting, procuring or attempting to procure abortions for a purpose other than saving the life of the woman are liable to severe penalties under the Penal Code (Cap: 7:01). The Ministry of Health provides policies and guidelines in line with the Laws of Malawi. Practitioners are encouraged to refer to the policies and guidelines for guidance on conditions that may endanger lives of the pregnant women, consistent with the profession. In cases of illegal termination of pregnancies, the penalty shall be suspension or erasure from a register.

7.2. Issuance of False Reports, Forms and Certificates

Members of the public, or institutions may require reports, forms or certificates from Practitioners. The reports should be developed, signed and issued by a duly qualified and registered Practitioner on the presumption that the truth of such statements can be accepted without question. Reasonable care should be taken in completing such documents. Practitioners must be meticulous in making sure that the certificates they issue are accurate in their statements of fact. They must resist all requests to issue false certificates as issuing false certificates is a disciplinary issue.

7.3. Unethical Prescribing and Use of Drugs

Practitioners are expected to be fully conversant with the provisions of the regulatory Acts relevant to their profession such as the Pharmacy and Medicines Regulatory Authority Act. The Council urges all Practitioners to study these Acts, and in case of doubt, to seek advice from the Chairperson or Registrar of the Council. Practitioners must always be mindful of their privileged positions in relation to dangerous drugs as well as the scheduled ones and should avoid their unethical use including prescribing to addicted patients. They should be conversant with side effects and interactions of all drugs. Practitioners shall take all reasonable steps to communicate the side effects and interactions of drugs to their patient/ client. No drugs, which have expired according to manufacturers' specifications, shall be dispensed to patients.A Practitioner in private practice being found prescribing drugs from the public facilities is a disciplinary issue.

7.4. Patents

A Practitioner ***shall*** not make use of, or recommend any remedy, the principal ingredients of which are not disclosed to the profession.

7.5. Association with Improper Systems or Methods of Treatment

It is unethical for a Practitioner to be associated with any system or method of treatment, which is not *evidence – based* and or consistent with good clinical practice. This includes promotion and use of non-scientific evidence based nutritional supplements or products.

7.6. Managing patients without Informed Consent

All Practitioners should ensure that as far as possible informed consent is obtained before any procedure is carried out on a clients and patient. Failure to gather consent is a disciplinary issue.

7.7. Abuse of Professional Confidence

A Practitioner shall not disclose to a third-party information, which he/she obtained in confidence from a patient in the course of the professional relationship between the patient and the Practitioner. A Practitioner shall always be prepared to justify his/her action whenever he/she disclosed confidential information. If the disclosure is/was done contravening the principles set in the Code, and the relevant laws in Malawi, it shall be a professional misconduct.

7.8. Abuse of Relationships between Practitioners and Patients or clients

Abuses of the Practitioner and patient or client relationship may include:

7.8.1. Having sexual activity or maintaining improper emotional or sexual relationships with the patient in the course of the Practitioner/patient relationship; and

7.8.2. Abuse of clients and patients including, verbal and physical abuse.

7.8.3. Abuse of financial opportunities which may occur as a result of:

- Improperly obtaining money from patients, or from medical insurance schemes, improperly sanctioning payments or financial claims under insurance schemes, workmen's compensation schemes, civil suit cases or any other authorities
- In the case of a treatment which involves more than one specialist in the same discipline only the original Practitioner shall charge the approved fees for the treatment which he will then share with the additional Practitioner; or in the case of a treatment involving more than one specialist in different disciplines only the original specialist shall send the bill for the approved fees indicating the appropriate proportions for the additional specialists, depending on their individual contributions to that treatment,
- Improper prescription of drugs or appliances in which a Practitioner has a financial interest;
- Practitioners should not take advantage of patients' dependence on them to get disproportionate benefits for their services.

7.9. Disregard of Personal Responsibilities to Patients and clients for their Care and Treatment

7.9.1. **Negligence in Diagnosis or Treatment**

The Council has a duty to protect the public by ensuring that Practitioners do not relinquish their personal responsibilities for their patients, for example by: -

7.9.1.1. Failing to be present at their usual places of work without notifying patients or making alternative arrangements for patients to be attended to;

7.9.1.2. Failing to visit their patients when called upon to do so without making alternative arrangements. Practitioners shall make every effort to attend to persons whom they have accepted as patients speedily;

7.9.1.3. Unskillful or careless treatment of a complaint which has been properly diagnosed;

7.9.1.4. Failing to warn patients of the dangers of certain treatments;

7.9.1.5. Gross and/or prolonged neglect of duties;

7.9.1.6. Attempting to carry out procedures for which the Practitioner has no adequate training or experience leading to more suffering for the patient. Exceptions may occur in case of emergency, if the Practitioner can show that he acted to save life, there being no competent Practitioner available in the area for him to consult with.

7.9.1.7. Refusal or inadequate pre-referral care, Refusal or failure to offer care, deliberate inadequate, or delay pre-referral care

7.10. Associating with Unregistered Persons

It is a professional misconduct for a duly qualified and registered Practitioner or facility/employer to be associated professionally with a person who is not duly qualified and or registered to practice medicine.

7.11. Conduct Derogatory to the Reputation of the Profession

Undesirable modes of personal behavior may arise from abuse of alcohol, breaches of the Pharmacy and Medicines Regulatory Authority Act, or other offences committed by the use of drugs. Practitioners shall not serve or treat patients and clients under the influence of alcohol or drugs, unlawful substances or while intoxicated.

The commission of offences of false pretense, forgery, misdemeanors fraud, indecent behaviour, assault or felonies, which reflect adversely on the profession's standing in the public eye, should be avoided.

The Council takes a serious view of assaults or indecent acts in the course of a Practitioners' duties. The Council may take disciplinary action where a Practitioner has been convicted for any offence in a court of law.

7.12. Improper Attempts to Profit (Advertising, Canvassing and Related Professional Offences)

These offences may be committed at the expense of professional colleagues by canvassing for patients, or advertising. Practitioners should avoid doing anything, which may be interpreted as an attempt to attract patients to them or to undermine the reputation of colleagues.

7.13. Conducting private practice but neglecting responsibilities at the primary facility of employment.

If a Practitioner abdicates their responsibility and absences themselves from their patients at their primary facility of employment for selfish financial gain from private practice, it becomes a misconduct. This may lead to withdrawal of the private practice certificate, and both the employer and Practitioner maybe disciplined.

Section

8

Fines and Penalties for offences, malpractices and misconducts

Fines and penalties may be imposed by the Council through the Board of Directors as a consequence of unprofessional conduct, and has been found guilty of improper or disgraceful conduct after an inquiry by the committee under Chapter 47 of the Medical Practitioners and Dentists Act No 17 of 1987 and consistent with this Code of Ethics and Professional Conduct.

Fines and penalties may also be imposed by the Council Secretariat in the course of conducting its routine operations in line with set regulations and guidelines.

The fines and penalties for each offence, malpractice or misconduct will fall within the range of the minimum and maximum fines stipulated for each category, against a registered practitioner or a person who is legally required to be registered, or a health institution. The fines and penalties may range from warnings, monetary fines, suspension or closure of facility, or erasure from registers.

The fines and penalties are reviewed and approved by the board regularly and copies are available at the council premises, or through the Council website.

Below are some of the offences, malpractices or misconduct and applicable sections. The list is not exhaustive;

Table 1: List of cases of unprofessional conduct and relevant sections derived from.

Category of offences, malpractices or misconduct: Unprofessional conduct relating to:	Applicable Sections
1. (a)Unauthorized advertising.	Section 4 of the Code.
(b) Verbal abuse.	Sections 1.1, 1.2, 1.3 and 1.5 of the Code, Sections 5.3 and 7.8 of the Code.
(c) A registered practitioner practicing in private without private practice license.	Section 38 and Section 40 of the Medical Practitioners and Dentists Act.
(d)Defacing certificates, fake reports, submission of fake internship reports, or signing off intern reports before completion.	Sections 5.5 and Section 7.2 of the Code
(e) A practitioner issuing derogatory remarks on the reputation of colleagues.	Sections 2.1, 2.6 and 2.9 of the Code.
(f) Charging illegal fees and commission, and improperly obtaining money from patients	Section 5.8 and Section 7.8 of the Code
2. A practitioner practicing beyond the scope of own profession	Sections 1.2 and 7.9.1.6 of the Code.
3. Employing unregistered persons. 4. Partnering with unregistered practitioners. 5. Hosting unregistered practitioners including Interns, local and international students.	Section 30, 55(2) and Sections 56 - 59 of the Medical Practitioners and Dentists Act.
6. Practicing medicine without registration with the Council, including interns and students.	Section 59 of the Medical Practitioners and Dentists Act.
7. Running unregistered clinic, outreach or medical camps.	Section 38(4) of the Medical Practitioners and Dentists Act.

8. Improper conduct of registered Practitioners.	Section 7.11 of the Code.
9. Using Intern practitioners to operate in private practice.	Section 10.4 of the Internship guidelines. Section 38(6) of the Medical and Dentist Act.
10. Withholding or refusal to offer services during emergencies, or pandemics.	Section 5.3.2 and 5.10 of the Code.
11. Over-servicing of patients.	Sections 7.3 and 7.8.3 of the Code.
12. Administering addictive prescriptions to already addicted patients.	Section 7.3 of the Code.
13. Issuing improper prescription	Section 7.8 of the Code.
14. Exposing patients to danger or harm.	Sections 2.4.2, 7.3 and 7.9.1.4 of the Code.
15. Providing insufficient care to patient.	Section 7.9.1.4.
16. Providing treatment or conducting procedures without informed consent.	Sections 1.7 and 7.6 of the Code.
17. Sharing consultation rooms with unregistered practitioner or entity	Section 7.10 of the Code.
18. Incompetence regarding treatment of patients. 19. Negligence	Section 7.9, 7.9.1 (7.9.1.3) and 7.9.2. 5.9.1 of the Code.
20. Rude behavior towards patients.	Sections 1.1, 1.2, 1.3, Section 5.3, and 7.8of the Code.
21. Misuse and abuse of social media related to patient care.	Sections 5.1, Section 7.7 and Section 7.11 of the Code.
22. Practitioner engaging in fraud. 23. Practitioner giving or receiving kickbacks from patients.	Section 7.8 of the Code
24. Unprofessional conduct emanating from criminal conviction.	Section 49 of the Medical Practitioners and Dentists Act. Section 7.11 of the Code.

25. Engaging in unacceptable relationships with patients.	Section 5.3, Section 7.8 of the Code.
26. Engaging in undesirable practices or models of care, using non-evidence based practice. Non-recognized medicines and practices.	Section 7.5 of the Code.
27. Divulging confidential information about clients or patients.	Sections 1.4 and 2.10 of the Code.
28. Defeating or obstructing justice, or obstructing Council personnel to carry out their duties.	Section 55A (2) of the Medical and Dentist Act.
29. Canvassing for patients.	Sections 4.12 and 7.12 of the Code.
30. A registered Practitioner communicating false information that does not represent acceptable opinion of the profession.	Section 4.13 of the Code.
31. Registered person using unregistered title or qualification.	Section 67 of the Medical Practitioners and Dentists Act.
32. Impersonating a registered Practitioner, or posing as a Practitioner when one is not.	Section 66 of the Medical Practitioners and Dentists Act.
33. Licensed facility or Practitioner not adhering to set minimum standards, regulations, policies and or guidelines. For example, not adhering to infection prevention risking the patients to harm.	Section 55A (1) of the Medical Practitioners and Dentists Act.
34. Conducting private practice but neglecting responsibilities at the primary facility of employment.	Section 7.3 of the Code

APPENDIX

Table of professional associations, societies and unions in Malawi for Practitioners registered by the Council

	Name of professional association, society or union
	Association of Obstetricians and Gynecologists of Malawi
	Association of Dieticians in Malawi
	College of Physicians and Surgeons
	College of Physicians of Malawi
	Dental Association of Malawi
	Medical Association of Malawi
	Malawi Association of Medical Laboratory Scientists
	Malawi Environmental Health Association
	Malawi Optometry Association
	Medical Doctors Union of Malawi
	Society of Medical Doctors
	Physicians Assistants Union of Malawi
	Physiotherapy Association of Malawi
	Radiographers Association of Malawi

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