GUIDELINE FOR MANAGING DOCTORS WITH PSYCHOLOGICAL PROBLEMS AND DISORDERS IN THE MINISTRY OF HEALTH

MINISTRY OF HEALTH MALAYSIA

2017

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MESSAGE FROM THE DIRECTOR-GENERAL OF HEALTH

There is an important link between healthy doctors and a sustainable health care system. This understanding has spurred the movement for 'physician health' programs all over the world. Clinicians have unique requirements that cannot be met by programs intended for the general staff. Studies have repeatedly shown high levels of stress occurring in higher proportions in doctors and medical students as compared to the general working population i.e. approximately 28 per cent vs. 18 per cent respectively. One of the explanations is that stress in doctors is a product of the interaction between the demanding nature of their work and their obsessive, conscientious and committed personalities. Without proper assessment and management, these difficulties may persist or escalate into mental health issues, substance misuse and disruptive behaviour.

Doctors, in general, are reluctant to seek advice because of the worries related to confidentiality and stigma associated with mental illness. However, the issues of efficiency and competency is of utmost importance here in view of the nature of mental illnesses.

In view of that, I would like to commend the effort made by the Psychiatric Services in producing this guideline. This is a timely input to benchmark and standardize psychiatric practices; and also gives an understanding to other clinicians who are supervising a medical colleague who has such problems.

Datuk Dr. Noor Hisham bin Abdullah
Director-General of Health
Ministry of Health, Malaysia

MESSAGE FROM THE DEPUTY DIRECTOR-GENERAL OF HEALTH

A doctor with psychological problems and disorders often faces unique barriers to obtain help and is reluctant to seek medical advice through the usual routes and mechanisms. There are professional risks involved in the acknowledgement of ill health, in particular psychological illness and substance misuse. Concern about the response of colleagues, their fitness to practise, or losing the respect of patients are all reasons given for doctors ignoring their own ill health. Doctors in training, in particular, may feel vulnerable about their career prospects. This stigma attached to ill health reinforces the perception that ill health is akin to inadequate performance and unacceptable conduct.

The consequences of this include delay in getting treatment, self-prescription, and working through illness. The evidence suggests that self-prescribing and prescribing for the family is prevalent among all groups of doctors, including medical students. In view of that, the medical fraternity must not view this phenomenon as being the responsibility of psychiatrists only. The fraternity needs to be able to recognise and refer colleagues who are unwell, so that prompt treatment can be initiated. The fraternity also needs to work as a team to facilitate a colleague's return to work, and to advise the necessary agencies if the efforts are unsuccessful or if there are disciplinary issues.

Hopefully, this will contribute to the efforts of the Ministry of Health in creating a healthy working environment; which is "a practice setting that maximizes the health and well-being of healthcare providers, quality patient outcomes, and organizational and system performance" (Healthy Work Environments Best Practice Guidelines Project).

Datuk Dr. Jeyaindran Tan Sri Sinnadurai
Deputy Director-General of Health (Medical)
Ministry of Health, Malaysia

FOREWORD BY DIRECTOR OF MEDICAL DEVELOPMENT DIVISION

Psychiatric and mental health services in Malaysia have been evolving since the turn of the century; particularly in the fields of neuropsychiatry, psychopharmacology and recovery-oriented psychiatry. As it becomes evidence-based, the psychiatric fraternity also needs to maintain its 'mindfulness' while helping patients to move on with their lives. Various patient groups will present different sets of challenges to their treating psychiatrists: and ironically, one of the most technically-challenging groups of patients would be our own medical colleagues.

Treating a registered medical practitioner requires not only clinical expertise, but also knowledge of ethical, legal and human resource/ administrative aspects. And if the client-doctors are undergoing training e.g. during housemanship or Masters training, then training aspects need to be factored in also. Without this armamentarium of knowledge and skill, the psychiatrist might not be able to balance between compassion and duty to the public; thus resulting in prolonged medical leave without any clear exit pathway for doctors with psychological problems and disorders. There is a need to balance the management of the client-doctors and the safety and well-being of patients that they treat.

This guideline is designed to assist psychiatrists in the various roles that they play in the management of doctors with psychological problems and disorders – either as the treating psychiatrist, a senior colleague or an expert assessor participating in the Medical Review Panel. It is also to guide other medical professionals who come into contact with colleagues who have psychological issues, about how to refer and support them. It is more of a clinical and practical document, with due recognition of the main policy documents provided by the Malaysian Medical Council (MMC) and the Medical Development Division of the Ministry of Health Malaysia. With more uniform practice and documentation, it is hoped that the psychiatric fraternity can assist the MMC and MOH in ensuring that medical practitioners with psychological problems and disorders are able to fulfil professional and personal responsibilities and consequently able to practice medicine with reasonable skill and safety to patients.

This document is the result of the work by the Psychiatry Services, Ministry of Health and includes valuable inputs from individuals, organizations and professional bodies before being formally adopted.

Dato' Dr. Hj. Azman bin Abu Bakar
Director
Medical Development Division
Ministry of Health

GUIDELINE FOR MANAGING DOCTORS WITH PSYCHOLOGICAL PROBLEMS AND DISORDERS

1.0 INTRODUCTION

The medical profession is at times so challenging and highly stressful that doctors and medical students can become mentally ill. Already at higher risk than the general population and other professionals, their distress may manifest in suicide, depression, anxiety disorders, substance use and self-prescribing. In Australia, the key finding of the National Mental Health Survey of Doctors and Medical Students 2013 is that doctors reported substantially higher rates of psychological distress and attempted suicide compared to both the general population and other professionals. The study found that medical graduates are most vulnerable during the transition from university to hospital, a period referred to as housemanship. The stresses they experienced include the need to balance work and personal responsibilities (26.8%), too much to do at work (25.0%), responsibility at work (20.8%), long working hours (19.5%) and fear of making mistakes (18.7%).

In Malaysia, under the Medical Act 1971, medical graduates need to complete their housemanship training before they are eligible for full registration with the Malaysian Medical Council (MMC) in order to qualify to practice. A Ministry of Health Malaysia (MOH) study of housemen in 28 MOH hospitals (Berita MMA 2009) showed that 67.8% of trainees found housemanship highly stressful, with 53% contemplating quitting. The highest stress level was related to working hours and workload, with 34% never having time for social or recreational activities. The study, conducted by the Institute of Health Management, showed that 21.8% needed counselling and 5.8% needed more specific treatment. Another study (ASEAN Journal of Psychiatry, Vol. 12 (1) 2011) identified that work related stress could arise from poor communication skills and from being overly worried about making mistakes.

Inevitably, stress could lead to psychological problems and disorders that may impact the ability of doctors and housemen to deliver the best possible medical care to their patients. In the United Kingdom, a Department of Health report published by the General Medical Council (GMC) in July, 2013 showed that doctors with mental illness may have impaired judgment causing them to hide or deny their problems. They may also wait too long to ask for help or try to treat themselves by self-diagnosis, self-referral and self-prescribing. Such actions may result from worry over the stigma associated with the mentally ill and the shame of admitting that they are ill. This is further evidenced in the Australian study, where about 40% of doctors in the survey viewed colleagues with mental health disorders as less competent, 48% felt these doctors were less likely to be appointed and 59% felt that being a patient causes embarrassment for a doctor. Thus, the combined forces of stigma, shame and secrecy make it particularly difficult for individuals, organisations and policymakers to address mental ill health in doctors.

To address the problem of reluctance to seek help, the GMC commissioned the British Medical Association (BMA) to form the Doctors for Doctors support service for colleagues facing a fitness to practice case. They provide confidential emotional support via an advice call-in service and a counselling service manned by volunteer doctors. The GMC, in collaboration with the Medical Schools Council, also drew up guidelines for medical schools to provide support services for medical students with mental health conditions. In an effort to bring about change, the GMC also commissioned a report on good practices in medical schools that urged clearer policies on mental health and careers in medicine, and the need to provide protection for students.

In Malaysia, the number of new house officers has increased tremendously over the years: there were 780 new house officers in 2001; as compared to 3,564 new house officers in 2011 (MOH 2013). There is a possibility that there could be more doctors and house officers with psychological problems and disorders than before. Interestingly, the study by University Sains Malaysia (ASEAN Journal of Psychiatry,

Vol. 12 (1) 2001) found that distressed house officers' coping strategies were more emotion-focused by to religion, acceptance and self-distraction. However, self-distraction was found to be maladaptive and could delay recovery while better coping strategies should include positive reinterpretation, active coping and planning. The study also recommended the need to de-stigmatise mental illness and to dispel misconceptions that doctors with psychological disorders or problems have impaired ability.

Doctors who seek treatment for psychological problems and disorders deserve to be treated as any other patient. However, as practising doctors, there are aspects related to patient safety which need to be looked at. They might appear to be physically well when in fact they have a psychiatric disorder. They would punch in and out of work, receive their salaries and allowances but are unable to function as doctors. Technically, they should be given medical leave and proper administrative measures instituted.

There is need for an administrative guideline on how best to manage and support distressed doctors, referred to as client-doctors in this document, in need of psychological management. For these client-doctors, poor performance is not an inevitable consequence of psychological problems and disorders. Even those with serious mental illness, if they are provided with appropriate help and are given support at work, can continue to practise successfully. This Guideline for Managing Doctors with Psychological Problems and Disorders will provide medical professionals, hospital and state health authorities a clear course of action in providing support for the treatment and recovery of mentally distressed doctors. In tandem with that, State Health Departments should conduct regular workshops for psychiatrists and other medical professionals in their respective states regarding these matters.

2.0 ACCESS TO PSYCHIATRIC SERVICES

2.1 Self –referral

2.2 Referral by

a) Hospital Director

b) Heads of department (HOD)

c) Consultants, specialists, medical officers, counsellors

2.3 General Considerations

a) i. The client-doctor should be managed by a psychiatrist in the hospital where he/ she is working. If the hospital has no psychiatrist, the client-doctor should be referred to the nearest hospital with a psychiatrist

ii. If the client-doctor is in a health clinic or mental institution, he should be referred to the nearest hospital with a psychiatrist

b) The client-doctor should be informed and written consent obtained if a medical report be requested by any third party, including the MMC

c) The client-doctor must register as a patient to enable them to receive treatment

3.0 PRINCIPLES OF ASSESSMENT

Doctors with psychological problems and disorders are in distress and should be treated as patients. The client-doctors may not be able to make objective judgments about treatment, illness severity and impact, risk or ability to work. Assessment of the client-doctor is aimed at making the appropriate diagnosis and providing correct treatment.

3.1 Person to conduct assessment

Assessment for psychological problems and disorders should only be done by a psychiatrist. Clinical psychologist and/or other specialists can aid or assist if necessary.

3.2 Information to be given to client doctor

The client doctor shall be informed of section 3.3 of the MMC's Code of Professional Conduct, 1986[refer Appendix 1: Code of Professional Conduct (CPC) of the Malaysian Medical Council]. Because of this requirement, the psychiatrist has to notify a senior colleague if the client-doctor is significantly severely impaired (refer Appendix 2: Template for Memo to Hospital Director).

3.3 Information to be gathered from client-doctor

a) Events leading to referral
b) Frequency of symptoms
c) Impact of symptoms
d) Situational cues that trigger symptoms
e) Usual coping mechanisms and social support
f) Suicide risk potential
g) Medication history
h) Illicit drug use information
i) Disciplinary aspects e.g. absences from work without reason or without medical leave

Proper documentation of assessments is very important

3.4 Diagnosis

In general, client-doctors can be divided into 3 categories:

a) Having psychiatric illness
b) Having vague diagnostic entities e.g. stress-related not amounting to a disorder
c) Attitude or personality issues

The treating psychiatrist should make the best possible diagnosis based on International Classification of Diseases (ICD) or Diagnostic and Statistical Manual (DSM) classification wherever possible.

3.5 Formulation

Formulation should be done to include predisposing, precipitating, perpetuating, prognostic and protective factors. It offers an understanding of the client-doctor's functioning in relation to his* work.

*The term 'his' is used throughout this document to refer to the male and female gender

4.0 PRINCIPLES OF TREATMENT

There are 2 aspects to consider when managing doctors with psychological problems and disorders. As patients, they have the right to be treated as any other patient. As practising doctors, aspects related to safety of the patients being treated by the client-doctors also need to be taken into account.

4.1 Engagement

a) The client-doctor should be engaged and made comfortable to receive the treatment. The psychiatrist should explain the tentative plan of management and what is expected from the client-doctor, including his commitment to the treatment plan.

b) The client-doctor may have many issues related to work, personal or family life (besides the clinical psychiatric problem) and probably decisions will need to be made. If relevant to the case, issues of absenteeism and poor work performance prior to the consultation should be discussed. The treating psychiatrist should advise client-doctors to allow sufficient time for recovery before making important life decisions e.g. quitting.

4.2 Goal setting

It is important to set clear goal(s) of the psychiatric consultation on the first visit. The client-doctor may have a set of unrealistic objectives from the consultation. A common goal shared by both client-doctor and psychiatrist will ensure a strong commitment to treatment and a positive outcome.

4.3 Commitment

The client-doctor should be told that a commitment to consultations (4.2 above) and the management plan is expected. Compliance to follow-up should be emphasized, as defaulting on appointments may contribute towards a negative outcome, and later affect his career.

4.4 Challenges

a) The client-doctor is expected to attend clinic appointment as scheduled. If for any reason he is unable to come for the appointment, it is his duty to inform the psychiatrist and arrange for another appointment. If the client-doctor fails to come for appointment after repeated reminders and is not contactable, the psychiatrist may:

   i) Inform the Head of Department (HOD) / Hospital Director of the client-doctor of his non-attendance

   ii) Consider to inform family members

b) If the client-doctor is able to work, he should be informed that it is his responsibility to maintain good work attendance and work performance. If he has problems related to work, the issue should be discussed by the client-doctor with the clinical supervisor or HOD.

c) The treating psychiatrist should not hesitate to consult a senior psychiatrist.

4.5 Medical Leave

Medical leave is given, if after assessment, the client-doctor is found to be temporarily mentally unfit to work (Refer 5.1 for details on medical leave).

Scenario : A house officer who is not able to work / practise

The house officer is physically well, with no history of physical (medical) illness. He clocks in and out from the hospital every day and gets his monthly salary. However, he is not able to perform his duties as a practising doctor due to psychiatric illness. This client-doctor should be properly assessed and treated by a psychiatrist and issued with medical leave if he is unable to practise in a safe manner. He should only be allowed to manage patients when he is deemed to be able to practise safely by the treating psychiatrist.

4.6 Discharge

The psychiatrist should prepare the client-doctor for the eventual termination from the follow-up.

The expected outcomes at the end of treatment include the following: -

a) The client-doctor is well and is then discharged.

b) The client-doctor defaulted treatment and is lost to follow-up. He may be technically discharged. However, if the client-doctor is suffering from a serious psychiatric disorder, efforts should be made to trace the client-doctor and advise him to continue follow-up. If he still fails to come for follow-up, his HOD should be informed of his default.

c) The client-doctor is transferred out to another hospital. If he needs continuation of treatment, then he may be referred to another psychiatrist in that hospital.

d) The client-doctor requests to change psychiatrists. A referral letter should be provided by the treating psychiatrist.

4.7 Medical report

Anytime during the course of treatment, or even after being discharged from follow-up, a medical report may be requested by the client-doctor or a third party e.g. MMC.

a) A medical report is only released following a written request and written consent from the client-doctor.

b) The client-doctor has the right to see the content of the medical report, on request, before being released to the requesting party.

c) If the client-doctor refuses to give consent for the medical report, the psychiatrist should reply to the requesting party informing about the refusal to release the report.

d) The medical report should be made using the MOH Medical Report Format (Appendix 3: MOH Medical Report Format). The content should be comprehensive and address the purpose of requesting the medical report, including the client-doctor's ability to practice safely, issues of insight and judgment. Other relevant recommendations may be included such as prescribed work place condition or specific risk factor.

e) The assessment and recommendations by the psychiatrist do not address issues of competency of the client-doctor due to lack of skill, knowledge and training. Competency should be assessed by the clinical supervisor.

FLOWCHART FOR MANAGEMENT OF DOCTORS WITH PSYCHOLOGICAL PROBLEMS AND DISORDERS

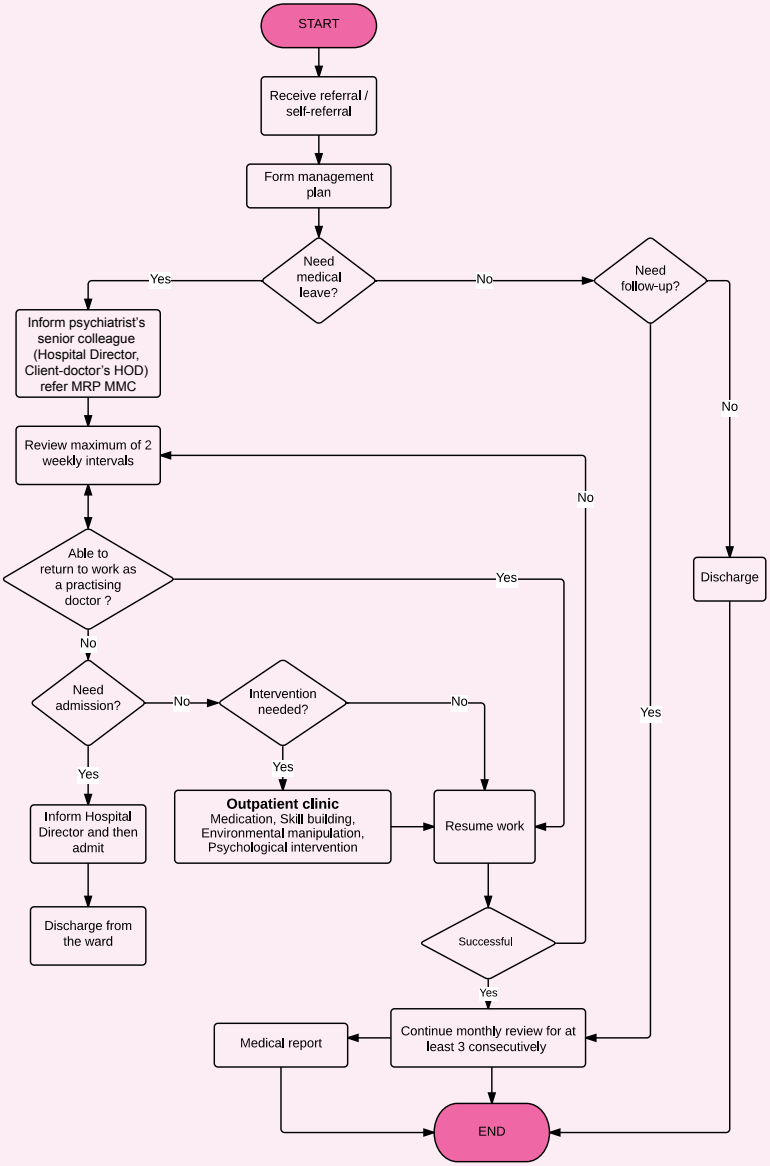

Figure 1: Flowchart for management of doctors with psychological problems and disorders

5.0 ETHICAL CONSIDERATIONS AND CONFIDENTIALITY

Medical practitioners are governed by the existing codes, guidelines and circulars. The following are excerpts from some relevant documents.

5.1 Doctor-Patient Relationship

In relation to section 3.3 of the Code of Professional Conduct of the Malaysian Medical Council [Appendix 1: Code of Professional Conduct (CPC) of the Malaysian Medical Council], the treating psychiatrist, upon determining the degree of impairment that may pose a risk to the client-doctor's ability to manage patients, shall inform the senior colleague of the client-doctor. A template for notifying the Hospital Director is available in Appendix 2 (Template for Memo to Hospital Director).

a) At present, all medical certificates are submitted to the Hospital Director's office, as such, the office is informed if a medical certificate is issued.

b) Any client-doctor who requires medical leave is deemed "unable to carry out his duties as a medical practitioner by reason of his mental condition" during the period of the medical leave. The client-doctor is therefore referred to a senior colleague (Hospital Director) as per CPC Section 3.3 and the senior colleague (Hospital Director) has to "act appropriately". This usually means that the client-doctor's case will be discussed at the hospital-level committee and forwarded to the MMC for review when and if appropriate.

c) Fitness to practice is determined by the MMC.

5.2 Common Ethical Issues

Several important and challenging ethical issues are discussed below, following a consultation with MMC in April 2013. The treating psychiatrist should be aware of these ethical issues and exercise the necessary caution. The following questions on ethical issues have been clarified by the MMC as follows:

a) The relationship between psychiatrist and a patient who is a medical practitioner (henceforth referred to as the client-doctor) should be a doctor-patient relationship. The psychiatrist and client-doctor cannot be treated as a colleague-colleague relationship as such a relationship is superseded once the colleague seeks consultation/management as a patient.

b) If it is a doctor-patient relationship, and the psychiatrist who reports a client-doctor who is unable to practice safely, the MMC will not initiate ethical proceedings. The Whistle Blower Act provides legal protection to informants but has yet to be tested. The vital consideration for reporting is the safety and proper standard of care of the patients treated/managed by a person (a client-doctor who is a registered medical practitioner) who is licensed to practise. The psychiatrist who reports such a practitioner owes an ethical and moral obligation to the patients and to the profession. This is supported by the MMC, and the psychiatrist is protected.

c) All cases of medical practitioners with psychological problems (the client-doctor) need to be reported to the Hospital Director if the client-doctor compromises patient care. The question of whether it is minor or not does not arise, and the best person to make a decision in this respect would be a third "neutral" person who has the authority to decide. All cases which compromise patient care must be reported to the Hospital Director (if in a government or teaching hospital), and to the Person-in-Charge (if in a private health care facility and services), and then to the MMC if considered appropriate.

d) Depending on the "medical certificate" or "sick certificate" issued by the psychiatrist to the client-doctor, the type of medical condition (and its effect on patient care) and the frequency with which such certificates are given, a report to the MMC can be triggered. These factors have to be taken into account when deciding on the question of such a "trigger".

e) For doctors in government service, the medical certificate will be submitted to the Hospital Director who will then "take appropriate action". In the case of the practitioner working in a private health care facility or service, the medical certificate should be submitted to the Person-in-Charge. In the case of an independent general/family practitioner, the matter should be reported to the State Health Director for appropriate action.

f) The MMC has the right to seek explanations if the impaired doctor has not been reported to the Council and may question psychiatrists who do not report on client-doctors who sought treatment for a psychological problem. Reporting to MMC will depend on the severity of the problem and the standard of care of the patients by the client-doctor. Please see (d) above.

5.3 Consent for Medical Records and Medical Reports

MMC Guideline 002 / 2006 on Medical Records and Medical Reports

It is stated in Section 1.16: Disclosure to Third Party Payers and Managed Care Organisations (MCOs) that:

"Medical Records of patients belong intellectually to practitioner and ethically to patient. Release of information from medical record should only be made by informed consent of employee/ patient."

Section 1.12 of the same guideline states :

"It is important to appreciate the confidential nature of the Medical Records and though the practitioner and the healthcare facilities and services have rights of ownership, they should still obtain consent from the patient or next-of-kin before any release of information from the medical records to any third person"

MMC respects the right of the patient to give their consent before any release of information. As such, any reports must be made with the explicit written consent of the client-doctor. This would include any requests from the government or private sector, even MMC. Appendix 4 (Content of Medical Report to Malaysian Medical Council) lists the items that should be included in a medical report.

If the client-doctor does not give consent for the release of the medical report, the administration may take whatever administrative measures available to ensure the client-doctor complies with the request as stated in the Director-General of Health Circular 16/2010. The psychiatrist may consult the MMC, and after having done so, decide whether it is appropriate to disclose the client-doctor's condition to the MMC, in the interest of the public.

Director General of Health Circulars 16 and 17/2010 on the processes of issuing a medical report

a) Requests for medical reports should be referred to the Director of the State Health Department, Director of Hospital Kuala Lumpur or the directors of the respective medical institutions

b) Original consent forms signed by the patient or next-of-kin should accompany any requests for medical reports

c) The Royal Malaysian Police, courts, or agencies which are empowered by law to obtain the medical report of a particular patient are exempted from the need for a written consent.

d) Information on treatment or other investigations carried out on a patient shall only be released in the form of a medical report; and not in its original form.

5.4 MMC Guideline 001/2010 on Managing Impaired Registered Medical Practitioners

The Role of the Malaysian Medical Council in Determination of Impairment

Being the registering and licensing authority, the MMC is empowered by the Medical Act, 1971, to assess impaired registered medical practitioners and to decide on their further management and fitness to practise. In all matters dealing with impaired registered medical practitioners, including practitioners refusing to attend Medical Review Panel/ Fitness to Practice Committee, relevant sections of the Act and Regulations 1974 shall apply.

The MMC has given the following definitions for medical practitioners; which are distinct concepts but do overlap occasionally:

a) Impaired practitioner: One who is unable to fulfil professional or personal responsibilities and consequently is unable to practice medicine with reasonable skill and safety to patients because of physical or mental illness, including deterioration through the aging process or loss of motor skill, or excessive substance use or abuse.

b) Incompetent practitioner: One who is ignorant or lacks appropriate skills but is not ill.

c) Unethical practitioner: One who knowingly and willingly violates fundamental norms of conduct towards others, especially his/ her patients.

The Process of Determination of Impairment

When a notification or complaint is received about an impaired registered medical practitioner, the MMC shall convene a committee (the Fitness to Practice Committee/ Medical Review Panel) to review the evidence to ensure that the complaint is without prejudice, relevant, complete and valid. After assessment by an independent relevant specialist or panel, there are basic considerations in managing impaired registered medical practitioners, i.e.:

a) Whether the practitioner is suffering from an illness or condition which has seriously impaired or may seriously impair his ability to practise ;

b) Whether he needs support during treatment and rehabilitation, and

c) Whether his illness or condition may result in the community being put at risk should he be allowed to continue practising as part of his rehabilitation programme as determined by the Council during treatment.

The registered medical practitioner involved shall be informed of the decision of the Council and the Committee shall arrange an interview with the registered medical practitioner and an assessment of his condition be made. The impairment of a registered medical practitioner will not be decided solely on his medical condition. The important aspects of his assessment will include:

a) Compliance to treatment and follow-upb) Physical and cognitive impairment.

c) Remission of symptoms with treatment.

d) Insight into his condition.

e) Skill specifically in relation to his professional practice.

After due investigation and interview the Committee shall determine if the registered medical practitioner's fitness to practice is found to be impaired and shall inform the Council accordingly. The Council shall, if it agrees with the findings of the Committee, and if there is sufficient evidence of impairment, determine if it is necessary to temporarily suspend, restrict the registered medical practitioner's right to practice by stipulating conditions, remove his name from the Register, or make any other recommendations as the Council may deem fit.

The registered medical practitioner, if not already under follow-up, should subsequently be referred to a relevant specialist (e.g. a psychiatrist, neurologist, or others) to treat his condition.

6.0 ADMINISTRATIVE ASPECTS

6.1 Medical leave

Medical leave is given when, after assessment, the client-doctor is found to be temporarily mentally unfit to work. It is also to facilitate the client-doctor's recovery and to ensure that he is not a danger to his patients.

Under the Government General Order (GO) or 'Perintah Am Kerajaan', all MOH doctors are accorded the same amount of medical leave as any other civil servant. In cases where a client-doctor needs extended medical leave, the following applies :

a) Less than 90 days per calendar year - approval from HOD or Hospital Director

b) Additional 90 days - approval from Secretary-General, MOH

c) More than 180 days - the respective institution/hospital has to form a Medical Board

d) If the client-doctor has taken at least 45 days of medical leave a year for 3 consecutive years, the hospital/institution may also form a Medical Board. Please refer to Pekeliling KPK Bil 18/2010 on Medical Board for details.

The treating psychiatrist is advised to keep a record of MCs issued or have a contact person in the Administrative Office who will assist in keeping track of the MCs issued to the respectiveclient-doctors.

Each medical leave issued to the client-doctor should not exceed the duration of 2 weeks to ensure regular assessment by the treating psychiatrist

For House Officers (HO):

i) They are entitled to 8-10 days of annual leave in each posting. Any leave (annual leave plus other leaves such as MC, etc.) beyond 10 days will affect the training duration. Total annual leave is 25 days.

ii) They should be informed that all medical leave, including medical leave issued by psychiatrist, may be forwarded to the MMC by the Hospital. All client-doctors should be informed of the implication of obtaining MCs from psychiatrists i.e. it might trigger a report to the MMC.

6.2 Frequency of review

Review

a) When the client-doctor is unwell and in need of medical leave, he should preferably be reviewed at an interval of no longer than 2 weeks until he improves and is able to return to work. A shorter interval of review is preferable if the client doctor is acutely ill.

b) When he has recovered and no longer requires medical leave, a longer period of review is acceptable.

c) In the case of HOs, following a successful return to the housemanship training, suggested follow-up reviews by the psychiatrist include:

i. Monthly for 3 consecutive months accordingly, then,

ii. Continue to follow-up the HO until completion of housemanship training and the confirmation of full registration by MMC.

Client-Doctor in Crisis

In cases of acute crisis, the client-doctor is advised to:

a) Be seen in the emergency department by the Psychiatric Medical Officer (MO) on call on that day. The MO should subsequently consult the treating psychiatrist on the next course of action including to arrange that the client-doctor be seen by the treating psychiatrist; or,

b) Make their own effort to contact the treating psychiatrist and make arrangements to be seen at the earliest appropriate instant; or

c) Get medical leave from any doctor, where applicable, instead of going absent without official leave. The client-doctor should make an appointment to see the psychiatrist at the earliest possible date. The maximum allowed amount of leave obtained from the private sector is 14 days. All leave obtained from the private sector should be endorsed.

6.3 Reassignment to non-clinical posts

The client-doctor, as a practicing doctor, should be able to provide proper, safe care to patients. If a client-doctor is physically fit, able to come to work regularly and clocks in and out as required but is mentally ill, medical leave should be issued to ensure patient safety. However, if no medical leave is given, the doctor should be relocated to a posting which is not related to patient care.

As client-doctors impaired by psychiatric illness: :

a) Housemen are required to complete their training, then only can they be reassigned to non-clinical posts

b) For medical officers and specialists, since they are confirmed in service, they may be relocated to areas that do not involve patient care

6.4 Cessation of registration with Malaysian Medical Council and psychiatric admission

Sect 24(1)(a) of the Medical Act 1971 states the following :

(1) Where

(a) the Registrar is satisfied that any person who is registered under this Act is admitted to or confined in a mental hospital under the provisions of the law;

(b) any person who is registered under this Act has been certified by a medical review panel, which shall consist of not less than three medical practitioners appointed by the Council, to be unfit to perform his professional duty by reason of his mental or physical condition;

he shall thereupon cease to be so registered, and an endorsement shall accordingly be made against his name in the Register.

6.5 Performance reports and attendance records

a) If referred by HOD or Hospital Director, this information on client-doctors' performance reports and attendance record should be made available to the treating psychiatrist even without the client-doctor's consent, as this information belongs to the Hospital.

b) If self-referred; the client-doctor should be made aware that these records will be requested by the treating psychiatrist from the relevant units.

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APPENDIX 1: CODE OF PROFESSIONAL CONDUCT (CPC) OF THE MALAYSIAN MEDICAL COUNCIL (1986)

Section 3.3 : Incompetence to practice

"Where a practitioner becomes aware of a colleague's incompetence to practice, whether by reason of taking drugs or by physical or mental incapacity, then it is the ethical responsibility of the practitioner to draw this to the attention of a senior colleague who is in a position to act appropriately"

Source : Code of Professional Conduct, Malaysian Medical Council. 1986

APPENDIX 2: MEMO TO HOSPITAL DIRECTOR STANDARD TEMPLATE

HOSPITAL .....
JABATAN PSIKIATRI DAN KESIHATAN MENTAL
MEMO ANTARA JABATAN

Ruj. Kami : _____ Tarikh : .....

Ruj. Tuan : .....

Perkara	:	**NOTA MAKLUMAN BAGI KEPERLUAN "CODE OF PROFESSIONAL CONDUCT (1986) SECTION 3.3 UNTUK PEGAWAI PERUBATAN** **NAMA PEGAWAI:.....** **NO PENDAFTARAN DENGAN MAJLIS PERUBATAN MALAYSIA: .....**
Kepada	:	Tuan/ Puan Pengarah [Nama Hospital]
Daripada	:	[Nama Pakar Psikiatri]
Salinan	:	[Nama Ketua Jabatan di mana Pegawai Perubatan tersebut ditempatkan] Fail

Tuan/ Puan,

Adalah dengan hormatnya saya merujuk perkara di atas.

2. Dengan ini saya mengesahkan bahawa saya telah memeriksa Pegawai Perubatan penama di atas pada tarikh .....Penilaian saya mendapati bahawa beliau:

☐ Menghidapi gejala-gejala penyakit yang boleh menganggu kemampuan beliau untuk mengamal. Dengan ini saya telah memberikan beliau cuti sakit mulai tarikh_____; nombor sijil sakit _____

☐ Tidak lagi mengalami gejala penyakit dan mampu untuk mengamal dengan selamat. Beliau boleh mula bertugas mulai tarikh _____

3. Sekiranya pihak tuan/ puan memerlukan laporan lengkap tentang pegawai ini, mohon hubungi saya di nombor telefon atau email yang tertera di bawah.

4. Di atas perhatian dan tindakan selanjutnya daripada pihak tuan/ puan saya dahului dengan ucapan terima kasih.

"BERKHIDMAT UNTUK NEGARA"

Saya Yang Menurut Perintah

.....

(Nama Pakar Psikiari yang Merawat)
[No. Pendaftaran Majlis Perubatan Malaysia]
[No.Telefon serta email]

APPENDIX 3

APPENDIX 3: MOH MEDICAL REPORT FORMAT

Laporan Perubatan (Medical Report)
Kementerian Kesihatan Malaysia

Butiran Pesakit *(Patient Particulars)*:

Nama pesakit *(Name of patient)*: .....

No K/P *(I/C No)*: Baru *(New)* ..... Lama *(Old)* .....

No Passport *(Passport No)*: ..... MRN: .....

Umur *(Age)*: ..... Jantina *(Sex)*: ☐ Lelaki *(Male)* ☐ Perempuan *(Female)*

Tarikh masuk wad atau menerima rawatan buat kali pertama *(Date of admission or receiving treatment for the first time)*: .....

Tempat menerima rawatan *(Place where patient received treatment)*:

☐ Jabatan Kecemasan *(Emergency Department)*
☐ Klinik Pakar *(Specialist Clinic)* ☐ Wad *(Ward)* .....

Tarikh discaj dari wad atau meninggal dunia *(Date of discharge or death)*: .....

Disiplin *(Discipline)*: Psikiatri dan Kesihatan Mental *(Psychiatry and Mental Health)*

Sejarah *(History)*:

(Including presenting complaints, History of presenting complaints, Past medical history, Family history, Social history and occupational history, Review of systems, Medical records reviewed)

Pemeriksaan Fisikal *(Physical Examination)*:

(Including general assessment, Eye, ENT, Oral cavity, Respiratory System, Cardiovascular System, Abdomen, Genitourinary, Central Nervous System, Musculoskeletal, Mental Health Status and Others)

Diagnosis *(Diagnosis)*:

Rawatan *(Treatment)*:

Rumusan prosedur yang dijalankan ke atas pesakit *(Summary of procedures carried out on patient)*:

APPENDIX 3

Preskripsi ubat-ubat yang diberikan kepada pesakit *(Drugs and other medicaments prescribed to patient)*:

Perkembangan keadaan pesakit sepanjang di bawah penjagaan doktor termasuk rawatan susulan *(Progress of patient while under the care of the doctor including follow up)*:

Keadaan pesakit ketika berjumpa kali terakhir dengan doktor

(Condition of the patient last seen by the doctor): Tarikh *(Date)*: .....

Cuti sakit/sekolah *(Medical certificate/school leave)*: Dari *(From)* ..... hingga *(to)* .....

Surat kerja ringan yang diberikan *(Light duty given)*: Dari *(From)* ..... hingga *(to)* .....

Laporan disediakan oleh *(Report prepared by)*:

Nama *(Name)*: .....

No K/P *(I/C No)*: ..... Jawatan *(Designation)*: .....

Kelulusan *(Qualification)*: ..... Jabatan *(Department)*: .....

Tandatangan *(Signature)*: ..... Tarikh *(Date)*: ..... Masa *(Time)*: .....

Cop rasmi Hospital *(Official Hospital Stamp)*

APPENDIX 4: MEDICAL REPORT TO MALAYSIAN MEDICAL COUNCIL

Medical report by a treating psychiatrist to Malaysian Medical Council (MMC) will be used in the assessment of a client-doctor's fitness to practice. The result of assessment will influence the decision to allow a client-doctor to practice or otherwise. In the case of house officers, the result of assessment will impact on the decision to give full registration as a medical practitioner. (See also section 3.6 Medical Report and section 4.3 MMC Guidelines)

In the Medical report to MMC:

a. Use standard Ministry of Health Medical Report Format (see Appendix 3)

b. Include summary of case, including events that trigger referral to psychiatrist, work history, history of admission, and history of treatment from previous psychiatrist and previous assessment by MRP of MMC.

c. Progress of the client-doctor

d. State the psychiatrist's opinion about the outcome of treatment

e. State the prognostic factors, both positive and negative

f. Conclusion is helpful, especially if the case is complicated and the report is fairly long

g. If the client-doctor is well and most probably is safe to practice, it is acceptable to state your opinion. It will help the MRP members during the meeting.

However if the client-doctor is not well and in your opinion is not safe to practice, this must be clearly stated. It is advisable not to comment on the client-doctor's fitness to practice. The MMC will make the appropriate decision on fitness to practice and inform the client-doctor.

APPENDIX 5 : HOUSEMANSHIP TRAINING PROGRAMME

Structure and Length of Training

a) Generally, a house officer (HO) will undertake four-monthly postings in Medicine, Paediatrics, Surgery, Orthopaedic, Obstetrics & Gynaecology and Emergency Medicine / Anaesthesia / Psychiatry / Family Health.

b) Generally, the minimum length of housemanship training is 24 months (with 6 basic disciplines for 4 months in each posting).

c) The total duration of each discipline should not exceed 12 months.

d) The total duration of housemanship training should not exceed 5 years (as per Suruhanjaya Perkhidmatan Awam (SPA) requirement i.e. : 1-3 years + extension 2 years).

e) There should not be a gap of more than 4 months between postings. Otherwise the HO may need to repeat the entire housemanship training. Any postings completed before the gap is not counted. However, Director-General of Health may reconsider if it is due to health reasons.

Placement of Postings

a) HOs not allowed to move to another posting till completed / passed existing posting.

b) HOs are not allowed to move to another training hospital either to complete or repeat similar discipline. The only consideration is for HOs who had failed their second end-posting assessment.

c) In exceptional circumstances, HOs may be allowed to continue housemanship training in another training hospital and consideration could only be made with the approval from the Director General of Health.

d) Transfer to another discipline before successfully completing the current posting is also not allowed.

Source : Buku Panduan Program Pegawai Perubatan Siswazah Kementerian kesihatan Malaysia, Edisi 2012

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