Medical Regulation in Malaysia: Towards an Effective Regulatory Regime

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Abstract

This paper assesses the functioning of the regulatory system of the Malaysian medical profession. It demonstrates that the regulatory bodies of the medical profession do not reflect the interest of the users adequately. Their composition mostly represents the medical practitioners and medical organizations and their regulatory processes do not provide clear channels through which users can voice complaints.

Introduction

Throughout the world, medical regulation is a key healthcare issue. However, in many developing countries it is not satisfactorily addressed. While there has been some research on health sector regulation in industrialized countries, little has been written about developing countries (Kumaranayake 1997). Soderlund and Tangcharoensathien (2000) note, that in most countries, there are "paper" regulations in the form of legislative efforts made to regulate private health care provision, but often there is insufficient impetus to implement these regulations at the point of health care delivery. The same observation is made by Hongoro and Kumaranayake (2000), in their study on Zimbabwe. From their study, Hongoro and Kumaranayake (2000) conclude that the key problem in enforcing existing regulations include the weaknesses of the main regulatory body, the Health Professionals Council (HPC) and insufficient resources.

In poorer countries regulatory capture is prevalent as government has little capacity. (Soderlund and Tangcharoensathien 2000). The private sector expansion therefore occurs in a policy vacuum with no measures taken to ensure adequate quality (Mills et al. 2001). To understand why this is so it is necessary to look in detail at an actual case. The focus of this analysis is Malaysia. Since emerging out of the economic recession in the mid-eighties, Malaysia has experienced robust economic growth. The private health sector was encouraged as part of a more general acceptance of a market-oriented health policy.

Since independence in 1957, the Malaysian health system has been able to deliver health care to communities throughout the country. The government provides the major health and health related facilities, financed from public revenue. Twenty-five years after independence, Malaysia had attained a health standard that was almost at par with those of the developed countries . The system has been described as egalitarian in character with its focus on primary health care and accessibility assured in geographic and financial terms (Meerman 1979; and Balasubramaniam 1996).

In the mid 1980's, the Malaysian government initiated a program of economic liberalization and deregulation relating to the concept of 'Malaysia Incorporated' that included a comprehensive privatization policy (Economic Planning Unit (EPU) 1985, 1991). With government encouragement in the 1980's, there has been a steady rise in the number of private hospitals and private clinics. The unprecedented growth of the private medical sector in recent years has wide ranging implications for the Malaysian health care system and the overall healthcare costs (EPU 1996). It has been reported that private health care affects the distribution which resulted in unequitable medical and health resources and in poorer quality of care (ibid).

The problems experienced in Malaysia are certainly not unique (see Bhat 1996; and Bloom 2000). It is well-known that leaving health care to market forces does not necessarily lead to an effective and efficient health care system (Rosenthal and Newbrander 1996).

This study explores the regulatory institutions of the Malaysian medical professionals. It examines the stated objectives of the regulatory agency; the composition of the decision-making body; as well as the regulatory process of the regulatory institutions of the medical profession. It looks at the process for identifying bad practices and the extent of the balance of protection between professional and public interest. The aim is to assess the degree to which the state-sanctioned regulatory bodies act in the public interest in ensuring quality of health care services.

This study first briefly reviews the literature on regulation and the actors in regulation. It then examines the key debates/ issues of regulation in the health sector. Then it examines the regulatory institutions of the Malaysian health care system by looking closely at the

membership of the regulatory bodies of the medical professionals, the process and the conduct system of the regulatory institutions to assess the degree to which the regulatory agencies effectively regulate the medical professionals. It finally discusses the recommendations for transformation of the regulatory institutions and the initial process of implementing these changes.

What is Regulation?

Much of the early literature on the economics of regulation focused on the regulation of public utilities (Spulber 1989; and Price 1994). Empirical studies of regulation examined the control of prices and entry in industries such as utilities, communications, transportation and finance. Kahn (1970, 3) defines regulation as "direct governmental prescription of major aspects of … structure and economic performance … control of price, price fixing, prescription of quality and conditions of service and the imposition of an obligation to serve…" He observes that "[T]the essence of regulation is the explicit replacement of competition with government orders as the principal institutional device for assuring good performance. The regulatory agency determines specifically who shall be permitted to serve…" (1970, 20).

Maynard (1982) defines regulation as government's "action to manipulate prices, quantities (and distribution), and quality of products." Whilst Manning (1989, 49) defines it as "attempts to govern markets in order to make market participants observe specified standards." These definitions accord with Kumaranayake et al. (2000) who assert that regulation is the imposition on standards on quality, distribution and competitive prices.

Analysis of regulation in medical sociology has largely focussed on the concepts of institutions and occupations of services. Freidson (1970) defines professional regulation as "the observability of performance to colleagues and structural vulnerability of the practitioner to control by colleagues". However, he also notes that while observability and dependence are necessary conditions for effective control, they are not sufficient. Willingness to exercise supervision and exert influence over performance is also needed, but evidence suggests that in practice there is little influence over performance.

Effective regulation establishes a situation in which the outcome

that is socially optimal also generates most profit for the firm, such that the firm chooses it voluntarily. Some of the objectives of regulation include protection of consumers; encouragement of efficiency and innovation; and promotion of competition (Price 1994).

Regulation aims to enforce "responsible" conduct on business enterprises, non-profit organizations, and even agencies of government and is recognizable by three characteristic elements: (1) a body of governmentally adopted rules or standards prescribing "responsible" behaviour; (2) a cadre of enforcement agents and auditors to monitor, and thereby to deter deviations from these rules or standards; and (3) a schedule of sanctions to be applied to persons or organisations who deviate from the rules and standards to an unacceptable degree (Bardach 1989).

Formal regulatory policies have elements of control, which include non-coercive forms of actions such as mediation, conciliation and use of publicity to induce compliance with policy; inspection (of premises, products or records); the power to grant or deny contracts; taxation as an important policy instrument because it not only provides revenue but also encourages certain types of behaviours; and imposing sanctions on violators (Anderson 1994).

Who are the Actors in Regulation?

From the literature three categories of actors can be identified: the first category is the core regulatory agencies. According to Majone (1997: 160), "the agencies are created by democratically enacted statutes which define the agencies' legal authority and objectives; that the regulators are appointed by elected officials; that regulatory decision-making follows formal rules which often require public participation." In the case of independent regulatory institutions such as the state-sanctioned regulatory bodies, the criteria of legitimacy are: "policy consistency; the expertise and problem-solving skills of the regulators; their ability to protect diffuse interest; professionalism and most important, a clear definition of the objectives of the agency …" (ibid: 161). Majone asserts that regulation depends so heavily on scientific knowledge that expertise has always been an important source of legitimization of regulatory agencies. Hence, regulatory agency with expert knowledge enjoys greater power than the administrator (ibid, 157).

The second category of actor is based upon enforced self-regulation (Ayres and Braithwaite 1992; and Grabosky 1995) which entails the requirement that the organization develops its own compliance programme. While the third category is based on the conferment of public status on organized interest groups. By presenting information to deliberative forums, interest groups can contribute to balanced, objective decision-making or perspectives which might not, in the ordinary course of events, be drawn to the attention of decision-makers (Grabosky 1995).

Key Debates/ Issues of Regulation in the Health Sector

It is useful to view the regulatory structure on the three-tiered principal-agent hierarchy in which the government and the firm are respectively the ultimate principal and agent (Stigler 1971; and Laffont and Tirole 1991). Given that the state aims for equitable health service provision, and the private providers are profit-driven, it can be anticipated that there would be a divergence of objectives. Therefore the government has to specify incentives to align the motivations of the agents as closely as possible with the principal's objectives. Beyond these areas, specifying efficient contracts becomes much more problematic (Mackintosh and Roy 1999; and Mills et al. 2001).

A well-known hazard of regulation is that regulatory agencies may be 'captured' by those they are meant to regulate (Stigler 1971; and Laffont and Tirole 1991). Given the uncertainty and asymmetric information in a principal-agent framework, there is little incentive for the agents to perform in a manner that maximizes the benefits to the principals (the state). This theory's main proposition is that agents wish to maximize their own welfare rather than that of their principals. Collusion between regulator and the firm is likely to prevent the government from achieving its objectives.

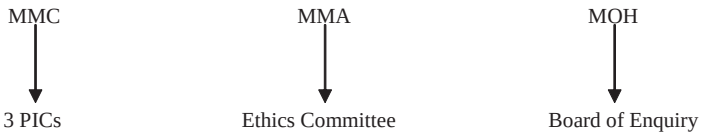
Bennett (1997) asserts that regulatory capture consists of two linked phenomena: first, the interests reflected in the activity of regulators do not adequately represent all those affected by the activity, and second, this inadequacy is due to the difficulty on the part of those authorities in committing themselves to reflecting the interests in question. This argument concurs well with Grabosky (1995) who argue that a balanced decision-making requires a balance of interest representation.

The discussion thus far has focused on the theoretical aspects of regulation. We will now move to analyze the Malaysian case in detail.[1]

Regulatory Institutions of the Malaysian Health Care System

Currently the regulatory framework for the Malaysian medical professionals are provided for by three main bodies: the Malaysian Medical Council (MMC), the Malaysian Medical Association (MMA) and the government through its Ministry of Health (MOH). All the main regulatory bodies have their own disciplinary committees as summarised below in Figure 1.

Figure 1.
The Disciplinary Committees of Each Regulatory Bodies.



1. The MMC: The functions of the MMC are to register medical practitioners intending to practise in the country and to ensure that medical practice is of reasonable and acceptable standards(MMC 1994). In exercising its powers to protect the public from malpractices and negligence, and in disciplining those who fail to come up to expectations, the MMC establishes Preliminary Investigation Committees (PICs) to make preliminary investigations into complaints or information touching on disciplinary matters (Medical Regulations 1974).

2. The MMA: The MMA is a representative body of the medical profession and it had an established Ethics Committee. One of the functions of the Ethics Committee of the MMA is to consider complaints by its members or members of the public. The Constitution of the MMA empowers it to expel its members in accordance with the procedure prescribed by its Code of Ethics and Rules of the Ethics Committee (MMA 1997).

3. The MOH: Doctors in the public sector are regulated under three tiers of regulatory structure: the state level, the ministerial level, that is the MOH and ultimately the Public Service Department. They are

also subject to regulations by the MMC and, if they are members of the MMA, regulations of the MMA. The MOH establishes the Board of Inquiry Committee to look into ethical and disciplinary matters of the doctors in the public service. The Board of Inquiry is usually conducted at the state level. The MOH does not play a role in regulating the medical professionals in the private sector.

Apart from these three bodies, there are many entities involved in the regulation of the health sector. From the definition and identification of forms of organisation of regulation in the health sector, as well as the procedural legitimacy of agencies, this study derived a way of categorising the entities involved. First, there are core regulatory bodies recognised in laws. These are the state-sanctioned bodies with powers granted by Parliament, and agents of direct government regulation. The second category is the self-regulated professional representative bodies which combine protecting self-interest with wider advocacy and the third category is the variety of other representatives and stakeholder bodies. The three categories of entities is summarised as in Table 1 below:

Table 1.
Categories of Entities Involved in Regulating Malaysia's Health Sector.

Core Regulatory Bodies	**Professional Representative Bodies**	**Advocacy Groups or Stakeholders Representatives**
a. state-sanctioned bodies: • Malaysian Medical Council • Malaysian Optical Council • Malaysian Dental Council • Nursing Board Malaysia • Midwives Board Malaysia • Medical Assistants Board *b. Direct state regulation:* • MOH (ministerial level and state level).	• Malaysian Medical Association • Malaysian Dental Association • Academy of Medicine • Federation of Private Medical Practitioners Association Malaysia • Muslim Doctors Association. • Specialist Muslim Doctors Association • Obstetrical and Gynaecological Society of Malaysia • Society of Pathologists Malaysia • Paediatric Association Malaysia • Malaysian Society of Anaesthesiologists • Malaysian Psychiatric Association • Medico-legal Society of Malaysia.	• Federation of Malaysian Consumers Association (FOMCA) • Malaysian Trades Union Congress (MTUC) • Aliran • Citizen's Health Initiatives (CHI) • Medical Faculties

The Core Institutions of Government

Apart from the government, the MMC coincides with the definition of a core regulatory body of the medical profession, as it is provided with a legal framework and governed by the Medical Act 1971 and Medical Regulations 1974. These Acts placed the MMC as the custodian of the medical profession (MMC 19932).[2]

Professional Self-regulatory Bodies

The second category of institution is the professional representative bodies, which combine protecting self-interest with wider advocacy. The MMA, being a professional organization registered under the Societies Act 1966 and governed by its Constitutions and Bye-laws, comes under this category. Its stated objectives is to promote the interest of the profession of medicine and to help sustain the professional standards of medical ethics (MMA 1997). Linking this to definition of the regulatory body, the MMA as a professional representative body bestowed with self-regulatory power, is rightly part of the regulatory structure of the medical profession.[3]

Another body is the Medico-legal Society of Malaysia whose objective is to sustain and foster interdisciplinary coperation between the medical and legal professions (Medico-legal Society of Malaysia undated). The Medico-legal Society is a mixed body of professionals and its members comprises those from the medical and legal professions and other associated professions who are actively engaged in medico-legal work (ibid).

Advocacy Groups

The third category consists of other non-governmental organizational bodies, which are also involved indirectly in the health sector. They are not regulatory bodies. However, they are monitoring and they are advocacy groups or representatives of stakeholders. One example is the Federation of Malaysian Consumers' Association (FOMCA). FOMCA represents the Malaysian consumers and it strives for unity by promoting social justice and human dignity. Another body is the Malaysian Trades Union Congress (MTUC), which represents the Malaysian workers.[4] In the context of health issues, MTUC upholds its belief that health care for the workers and their families is a basic

necessity and that it should be affordable to all especially the poor.[5] On August 22, 1999 MTUC declared an emergency resolution that the government should not privatise or corporatise government hospitals.[6] The MTUC is recognised by the government as the representative of workers and is consulted by the government on major changes in labour laws through the National Joint Labour Advisory Council.

Another group is the *Aliran*. In the recent years it has become increasingly concerned with the direction of healthcare reforms. In 1997 it proposed the Citizen's Health Initiative (CHI), a health movement group composed of healthcare professionals and individuals concerned with the direction of impending health care reforms (Aliran Monthly 1997) and launched the Citizen's Health Manifesto (Aliran Monthly April 1998).

Other such bodies are the university medical faculties, which are governed by the Constitution, Acts and Regulations of the university. Their stated objective is to ensure that aspects of medical education and the conduct of examinations are satisfactorily met. They play a significant role in the determination of entry qualifications, class size, curriculum, and dissemination of knowledge to train doctors.

All the bodies above represented public interest as well as sectional interest. However, besides those bodies such as FOMCA, MTUC and CHI in the third group, no one body particularly in the first and second groups (Table 1) is seriously acting on behalf of consumers.

In terms of regulating the health sector, certain groups seem to be more dominant than others. It can be said that the regulatory bodies in the first group (refer Table 1) have more influence than those in the second group, as these regulatory bodies are either sanctioned by the state or through direct state legislation. The regulatory bodies in the second and third groups are groups that combine public interest and advocacy interest groups which are, as termed by Majone (1999) "independent regulatory institutions". Benson (1994) identified two basic types of resources that are central to the political economy of organizational networks: money and authority. Authority refers to the legitimation of activities, the right and responsibility to carry out programmes of a certain kind. The legitimated claims are termed domains. Among the professional representatives and the advocacy groups, for example, the MMA possesses the expertise and professional knowledge in health care, placing it as the 'authority' in its domain, i.e the

health care. And because of its expertise and professional knowledge, the MMA is often consulted by the government on major changes in health care. The MMA has its opinions and often presents policy statements and proposals on healthcare reform. Policy statements by the MMA on fees and its proposal on healthcare reforms such as the National Health Scheme are accepted by the government.[7] These in turn, give the MMA a political influence over the policy-makers. Members from the MMA can be members of the MMC, but not from the third group (refer Table 1). Complaints from the MMA often go to the MMC. The MMA often speaks on behalf of all doctors and is accepted as the 'voice of doctors'. On January 1 1999, the membership of MMA was 6306 out of a total of 11,565 registered medical practitioners, or about 54 per cent (MMA1999a).

The MMA is financially strong.[8] It is self-funded and owns properties. Many of its members are also from the influential elite of the society (see MMA 1999). Besides the financial resources, the MMA also has the necessary manpower to carry out its tasks - MMA's secretariat is staffed by 25 people of which 4 are medical practitioners, in comparison to the MMC's secretariat, which is staffed by 7 people including 2 medical officers. It also has a number of committees on special topics pertaining to health that are of national and international concern.

The MMA defines the fee schedule, which most private hospitals and private practitioners use. It is highly autonomous – it names representatives to sit on various Government boards and the Ministry of Health such as the Atomic Energy Licensing Board as well as bodies of non-governmental organizations. The MMA is often consulted by government agencies on issues pertaining to health such as the Health Dialogue Council 1998, Budget Council 1999 (MMA 1999a). Given these resources and political influence, the MMA is placed in a more influential position than other regulatory bodies in the second and the third group. In conclusion, the MMA is a large, well-financed body with an effective interest group and powerful leadership. As this study will show, although the MMA is a pressure group representing doctors' interest, it plays an important role in regulating doctors.

Most of the bodies in the third group are also self-funded and possess their own budget and financial resources. However, in terms of authority, these bodies do not have the expertise and knowledge in

health care and health care is not the centrality of their functions. In health care matters, they do not have the political influence enjoyed by those in the second group such as the MMA. Therefore, it can be said that in regulating the health sector, the third group that seriously acts on behalf of the consumers such as FOMCA, MTUC and CHI does not have significant influence relative to that of the MMA.

Within the main regulatory institutions, some doctors express concern that the MMC seems to be privileging the MMA. As a circumstantial pointer, it is worth noting that despite the powers vested in the MMC as well as its functions stated in the Medical Act 1971, it is not actually an independent body. It is financed by the state with its budget held by the Medical Division of the MOH. According to the key informant of the MMC, it does not have its own financial resources. Its activities are managed by its secretariat, which is run by two officers and five support staff, all paid by the MOH. Being funded by the state, in a way is good for the public interest as it ensures that the MMC is answerable to the public. However, the problem is that if the government does not put in more funds, the MMC would not be able to investigate. At the present time, besides the Preliminary Investigation Committees, the MMC does not have sufficient resources nor the necessary manpower to carry out its task. One can argue therefore, that the MMC has to depend on the MMA, for the expertise, knowledge and manpower to regulate the health sector.

Membership of the Regulatory Bodies of the Medical Professionals

This section looks at the membership of the main decision-making bodies in regulating the medical professionals in the private sector, in terms of the composition, gender and selection process.

Composition of MMC

Under the Medical Act 1971, the Director-General of Health is the President of the MMC. The members of the MMC are drawn from three main sources: nomination by universities, election by registered medical practitioners from West Malaysia and Sabah and Sarawak, and appointed members from the public services. The membership is for three years (Medical Act 1971). In 1999 there were 24 members. The membership is summarised in Table 2 below:

Table 2.
Membership of the MMC in 1999

The Director-General of Health as President	1
Nominated from Faculties of Medicine	9 (3 each from University of Malaya, Science University of Malaysia and National University Malaysia)
Elected by registered medical practitioners:	11 (9 in West Malaysia, 1 in Sabah and 1 in Sarawak)
Appointed from the public services	3
Total members	24

Out of the 24 members, a total of 20 represent the stakeholders of the medical profession and medical organisation and three members representing the public services (Table 2). There is no representation of advocacy groups or representative of other stakeholders. Neither is there a representation of the general public or the users.

All 9 members representing the medical faculties are professors, and the 11 elected medical practitioners are senior doctors, both in their age and in their level of hierarchy. The 3 representatives of the public sector are of senior positions in the MOH. Some doctors interviewed raise concerns that the members are not representative of the medical profession. In terms of geographical representation, 19 of its members are residents of Selangor[9], whilst 5 are residents outside Selangor. Among these 5 members, 1 is from Sabah and 1 from Sarawak, whilst 3 are from Kelantan where the medical faculty of University of Science Malaysia is situated. This shows an imbalance in terms of geographical representation relative to population for although Selangor was the most populous state with 2.43 million people, other states such as Johor and Perak were also close behind with population of 2.19 million and 2.00 million people respectively (Seventh Malaysia Plan) (1996-2000) (Malaysia 1996).

From 1993 through to 1999, the membership of the MMC consisted solely of doctors. There have not been any 'lay' or non-medical members. Even the 3 appointed members from the public services were doctors. The composition of the MMC suggests that the viewpoints of doctors and their interests have an important influence.

During the same, the members of the MMC were mostly male with only two female member nominees of the university medical faculties. This is a reflection of a masculine construction in the health care sector and the patriarchal nature of the society. Despite the government's stated commitment in the Sixth Malaysia Plan (1991-1995)

(Malaysia 1991) to ensure 'equitable sharing in the acquisition of resources and information as well as access to opportunities and benefits of development for both men and women' and of 'integrating women in all sector of national development', Ng (1999) observes, gender subordination still continues in various forms at both the personal and structural levels, both of which are conditioned by the sociocultural trends in the society. The under representation of women in the composition of MMC confirms this observation.

Selection Process

There are 11 nominees elected from among members representing the registered practitioners (Medical Regulations 1974). An interviewee of FOMCA opines that in carrying out their duties, the elected members are unlikely to risk their popularity with the doctors from among whom they are elected. As for the three public sector appointees, according to a key informant of the MMC, they are usually chosen by the Director-General and appointed by the Minister.

Composition of the MMA

Membership of the MMA consists of 7 categories namely: ordinary, life, honorary, overseas, associate, student and exempt membership (MMA 1997). In all of the seven categories, the membership is open to medical practitioners, with the exception of student membership which are open to registered medical students who are Malaysian citizens. No lay members or representatives of advocacy groups or other stakeholders are co-opted into any of these committees.

Membership of the Disciplinary Committees of the MMC, the MMA and the MOH

a. The Preliminary Investigations Committees (PICs) of the MMC: All the members of the PICs are appointed by the President of the MMC from among the medical practitioners (Medical Regulations 1974). All complaints to the MMC are considered first by the PIC. It holds a formal inquiry to establish whether there is a prima facie case of professional misconduct which would then be referred to the MMC (Medical Regulations 1974). Much depends on the way complaints are dealt with by the PICs. Their membership strongly influences the regulating process.

The membership of the PICs is for 3 years. There are three PICs consisting of not less than three and not more than six members each (Medical Regulations 1974). All of its members are doctors. Between 1993-1999, all PIC members were in senior positions and most were specialists. There were two female members out of the 17 members. All of the members reside in Selangor. The PICs have an even narrower mix of people than the MMC.

A number of informants from among the NGOs and academics raised concerns that the PIC is not large enough to reflect a wide range of opinions and to allow differences of opinion. This is further exacerbated by the fact that these committees do not include lay members, thus making it difficult for the small group to disagree. A proposal was recently brought to the MMC to have lay members of PIC. According to a key informant at the MMC, this proposal was influenced by recent developments in the UK. However, there is no clear indication as to whether the proposal to have lay members in the PIC has materialised.

b. The Ethics Committee of the MMA: The Ethics Committee has nine members, elected from among the registered members of the medical professionals (MMA1997). There are no lay members or representatives of advocacy groups or other stakeholders co-opted into this committee.

c. The MOH Board of Enquiry: There are at least three members on the Board of Enquiry. The membership comprises of two specialists in the relevant specialty, one of which chairs the Board, another member from other specialty and any other co-opted member it deems necessary.

The Established Procedures and Conduct System of the Main Regulatory Bodies

This section looks at the process and the conduct system of the main regulatory bodies. To know whether or not the system is seen to protect the interest of the public, the public perception of the regulatory bodies is also gauged as their perception could reflect the public confidence in the regulatory process.

The Established Procedures

The MMC and the MMA identifies competent practitioners through various means.

1. Licensing and Establishing Standards:

The power of the MMC lies in its control of the registers for licensing medical professionals. The MMC may remove persons from the register temporarily or permanently if they are found to be unfit to perform their professional duty. It published a statement on Medical Ethics in 1975, which was later replaced by a Code of Professional Conduct in 1987 (MMC 1987), which is similar to that of the UK General Medical Council. The code outlines minimum standards. Breaches of these standards are referred to as 'infamous conduct in professional respect' or 'serious professional misconduct.'

The MMA too produced its own Ethical Code in 1998, similar to the MMC's Code of Professional Conduct. It includes brief guidelines on good medical practice; relationship of doctors with other professionals, relationship with commercial undertakings; advertising and canvassing, and setting up practice (MMA 1999b).

2. Disciplinary Inquiries:

Disciplinary inquiries are usually made following complaints. The MMC caters complaints for both the public and private sectors; the government caters for complaints on doctors in the public hospitals and clinics; and the courts of law.

Through the PICs, the MMC holds a tribunal or a kind of court to inquire into complaints about medical professionals. One of the PICs is specially assigned to look into matters pertaining to advertisements, whilst the other two look into matters of ethics and conduct. The conduct of disciplinary inquiries is governed by the Medical Regulations 1974 and guided by the Code of Professional Conduct. The PICs can summarily dismiss an allegation if it is found to be unsustainable (Medical Regulations 1974). If a PIC finds there are grounds to support a charge it may recommend an inquiry by the MMC.

The MMA also considers complaints about professional conduct of individuals upon receiving a report from a member or non-member of the Association, or a member of the public. The Ethics Committee

of the MMA is empowered to investigate, and take action as it deems fit on complaints about breach of ethics by the registered members of the Association (MMA1997). Following investigation, it may decide that (a) the case be dismissed; (b) the doctor has committed an error of judgment but the conduct does not call for censure; (c) that the doctor be censured; (d) a recommendation to MMA for expulsion from its membership or (e) complaint be made to the Malaysian Medical Council. According to the President of the MMA, if a case is found, the Ethics committee will act as a complainant by filing a report to the MMC for further action.

Complaints about doctors in public hospitals and clinics are dealt by the Board of Inquiry at state level. Following investigations by the Board of Inquiry a report is sent to the ministerial level: the Medico-legal Unit for complaints on doctors in public hospitals and the Public Health Division of the MOH for complaints against the government's health clinics. At the ministerial level, the report of the findings is then submitted to the Disciplinary Board for its action.

Review of the System

This section reviews the instances of regulation in action.

Mechanism to Regulate Clinical Competence

Several interviewees[10] pointed out that beyond issuing the Code of Professional Conduct (by the MMC) and Ethical Code (by the MMA), there is little mechanism to regulate the clinical competence of practising doctors particularly in the private sector. An informant at the MMC[11] confirmed that there are no specific guidelines to define the minimum benchmark of acceptable standard of competence.

A key informant[12] from the public sector as well as some doctors[13] interviewed point out that the MMC has no mechanism to ensure that doctors keep up with developments in their area and for ensuring improvements for doctors who slacken in their performance. In the public sector, the Government address this issue by sending government doctors overseas for training and to conferences. Some public hospitals and teaching hospitals have adopted medical audit, whereby doctors of the specialty or department meet to review complicated cases, deaths or unusual cases.[14] The aim is for the doctors to learn

from each other and improve the quality of service. According to informants[15] at some private hospitals, medical audit is rarely done.

The MMC's primary mode of regulating the profession is by maintaining the register of qualified medical practitioners such that the public may be able to distinguish to whom they may safely go for advice and treatment.[16] However, the MMC has not established an inspectorate to carry out its responsibilities by ensuring, for example, that those registered with MMC are practising in accordance with the conditions on their licensing certificates and that they practise competently. Some doctors[17] and a CEO[18] of a private hospital interviewed, opined that practitioners can continue to practise incompetently as long as they are not caught. This opinion is confirmed in interviews with key informants in the MMC[19] and MOH[20] who said that the only way the MMC may know about breaches in the standard of competence is when there is a complaint.

Channels for Complaints

Since the regulatory bodies rely on complaints, specific channels are needed for doctors and members of the public to be heard. The processing of complaints is reviewed in the MMC, MMA and the government through its court.

Channels for Complaints by Colleagues and Peers

The report *The Handling of Complaints Against Doctors* (Allen et al. 1996) is a useful tool in assigning complaints to two categories: (a) complaints that are primarily of professional interest: unacceptable behaviour but not principally detrimental to medical treatment of patients, and (b) complaints which concerned primarily to public interest: the personal behaviour of doctors towards patients which either led to criminal convictions or raised issues of serious professional misconduct that relate principally to the medical treatment of patients.

In the MMA, in the ten years beginning 1987/88, 43.5% of complaints it received were on issues categorized as primarily of professional interest, whilst 56.5% were on issues of public interest. Among the issues of professional interests, the largest number of complaints was regarding advertising, whilst among issues of public interests, the largest number of complaints was on clarification/advice (Table 3).

Table 3.
Complaints Received by the MMA Ethics Committee 1987-1997

Complaint/ Year	87/8	88/9	89/90	90/1	91/2	92/3	93/4	94/5	95/6	96/7	Total
Primarily of professional interest											
Advertising	39	24	14	17	15	6	11	8	8	16	158
Exorbitant charges	2	2	6	9	9	5	4	10	6	12	65
Medical Certificate	2	2	2	2	1	5	7	5	6	4	36
Total	43	28	22	28	25	16	22	23	20	32	259 (43.5%)
Primarily of public interests											
Unsatisfactory treatment	15	14	8	12	17	5	1	4	9	4	89
Alleged negligence	-	-	10	4	4	6	15	6	4	8	57
Clarification/ advice	15	12	8	13	10	11	19	10	11	16	125
Unprofessional conduct	-	-	3	-	14	4	6	6	4	4	41
Refusal to label drugs	-	-	-	2	1	-	2	1	-	-	6
Refusal to give medical report	-	-	-	1	-	2	3	-	3	5	14
Refusal to make house call	-	-	-	-	-	2	-	-	3	-	5
Total	30	26	29	32	46	30	46	27	34	37	337 (56.5%)
Grand Total	**73**	**54**	**51**	**60**	**71**	**46**	**68**	**50**	**54**	**69**	**596 (100%)**
Cases referred to MMC	11	7	10	5	-	1	-	-	2	1	37

Source: Adapted from the MMA Annual Reports.

Channels for Complaints by the Public

The MMC receives complaints from many sources including written complaints to the MMC, by telephone, through newspapers or through hospitals.[21] Interviews with PIC members also reveal that they receive complaints through various means. This seem to confirm that there is no proper, established channel for complaints and no information made public as to whom complaints should be addressed, how and on what reasons.

A review of statistics of cases summarily dismissed by the PIC in 1993 shows that out of 10 cases summarily dismissed, 5 were because the complainant withdrew his complaint, or no official complaint made,

or complainants could not be contacted (MMC 1993). This suggests that the general public needs to be informed of the procedures for complaints.

In conducting investigations, an interview with the key informant at the MMC confirms that the MMC usually goes by the decisions of the PIC. Therefore the first hearing of a case before the PIC is crucial. However, besides the panel of the PIC being small and not representative of the users, the decision is by a majority (Medical Regulation 1974), with no right to a dissenting opinion. Once a majority is secured further discussion is not necessary.

Any person who is aggrieved by the decision of the MMC may appeal to the High Court (Medical Act 1971). Ranjan (1998) argues, it would be extremely difficult to set aside the findings or decision of the tribunal unless it can be shown that there is a substantial error of law or procedure or the findings are inconsistent with the evidence. So it can be said that the standard of proceeding of the PIC of the MMC is high because its potential decision goes straight to the High Court.

In the course of interview with an informant at the MOH[22], it emerged that in the public sector, there are cases where while there is inquiry pending, the medical professionals resign from the post in the government and join the private sector and thus no inquiry is made into the case. And no mention of it is made to the MMC as according to the informant, the MOH has no authority on private cases. This seems to support Freidson's (1988) observation that doctors give the benefit of the doubt to each other to an extent not done in other professions.

The Court

There are also cases of complaints on medical negligence from the public and the private sector that are brought to court. Information on the number of private cases settled out of court or private cases brought to court was not obtainable. According to key informants, cases brought to the civil court can take up to seven years to be settled. And many private practitioners and private hospitals usually settle their cases out of court to avoid bad publicity. This was confirmed by managers of some private hospitals[23] and the advocates and solicitors[24] who deal with medico-legal cases. An out of court settlement is not made public and colleagues do not get to know of the offence and hence they do not stop referring patients.

According to Ranjan,[25] an advocate and solicitor, it can be very difficult to establish medical negligence: First, the courts recognise that there are differences of opinion in the medical profession, and so long as the actions taken are in accordance with the standard of an informed body of medical opinion, the doctor cannot be held negligent. Second, for the plaintiff to succeed, it must be shown that the injury was forseeable at the time that the breach of duty was committed. This would depend on the state of medical knowledge of the patient at the time of the incident in question. The frequent problem is that many patients would already have been suffering from some pre-existing ailment at the time of being seen or treated by the doctor. As such it would be difficult to say if the injury that was the subject of the complaint was caused by the doctor's action. Ranjan (1998) observes, in Malaysia, patients often face difficulties as there is inadequate law relating to disclosure of and access to their medical records for them to obtain a complete clinical picture of their case and to obtain expert opinion before their case goes to court or trial. This situation is exacerbated by the doctor's ethical and legal duty of confidentiality:

> A practitioner may not improperly disclose information which he obtains in confidence from or about a patient. (The Code of Professional Conduct of the MMC 1987, paragraph 2.22).

According to Ranjan and an informant of another advocates and solicitors firms dealing with litigation cases, medico-legal cases in Malaysia are on the rise but there is no official statistic on it. The majority of the claims are filed against doctors in the private sector. There is an average of 13-15 per cent claims filed against the government annually. According to the interviewees this percentage is low which could also mean that there is a reasonable standard of care in the government. The majority of the claims appear to be in the private sector.

Institutional Support/Channels of Consultation

According to the President of Medico-Legal Society, a joint meeting of principal office bearers of the MMA, the Malaysian Dental Association (MDA), the Bar Council and the Medico-legal Society was reactivated in October 1998, which provide a channel of consultation between doctors, dentists and lawyers. The joint meeting meets once in six months to discuss matters affecting doctors, dentists and lawyers, in particu-

lar, problems that doctors face when they are required to attend court as witnesses. It was also noted that lawyers also faced problems in obtaining the services of doctors to obtain a medical opinion and/or to attend court as witness as "most doctors were not prepared to come forward to give medical evidence against another doctor" (Medico-legal Society 1999, 10-11).

There are no organizations in Malaysia specifically concerned with patients' problems or victims of malpractices such as the Victims of Medical Accidents in Britain. The aggrieved parties also have not attempted to work as a group to pursue justice from the regulatory institutions of the medical profession or health institutions. Individual victims most often go through newspapers to tell their woes in the hope that it gives bad publicity for the institution concern. There is no institutional support or channel for patients who need to utilise the legal system to consult on their cases except to rely on their counsel.

According to interviewees,[26] the Patients Charter, which states the right to redress of grievances, has not been effective and lacks 'teeth' as it lacks the backing of the relevant machinery. This is confirmed in the interview with the President of FOMCA, that the Patients' Charter is not effective because of the absence of a platform to address health matters. Although the Patients Charter was embraced by consumer representatives five years ago, it has been reported in the media that the charter still has not seen formal implementation.[27]

In October 1999 the Ministry of Domestic Trade and Consumer Affairs enforced the Consumer Protection Act 1999. The Act aimed to protect consumers especially the low-income group, via a tribunal comprising people from legal fraternity appointed by the Ministry of Trade (Sunday Star August 29, 1999). Under the Act, the tribunal would conduct civil claims of RM 10,000 and below and would handle all cases, but not those linked to the medical profession. However, cases concerning medicines that are not registered as official medicines and not prescribed by hospitals can be taken to the tribunal (Consumer Protection Act 1999). An informant[28] at the MOH commented that this was rather strange as the omission on protection against matters concerning medical profession meant that the consumers are not effectively protected as this leaves the consumer having to consult his counsel and no one else.

Public Perception

The perception of the public is based on interviews with key or elite informants, reports in the newspaper and public opinion in the media and speeches of senior officials.

Some academics expressed concerns that some members of the MMC are also members of committees of the MMA. It was felt that, in exercising their powers in the capacity as public officials, they might render support to their own colleagues. The author was not able to confirm on this. The Consumers' Association of Penang too brought this matter up in the media.[29] The case in point related to this issue was a complaint with allegations against a surgeon for medical negligence which was brought up to the MMC about three years ago. The complainant through the media[30], highlighted the issue that the case affecting her mother who passed away was not fairly heard by the PIC for reasons of bias – the chairman of the PIC was the Vice-President of the Medico-legal Society and that the Defence Counsel for the surgeon was the President of the Medico-legal Society. Interview with the key informant of the MMC however, reveals that for the MMC the fact that the presiding Chairman of the PIC and the Defending Counsel of the accused surgeon who were both respectively the Vice-President and President of the Medico-legal Society, has no bearing on the case.

There has also been concern expressed among the advocacy groups, doctors and some members of the academicians that there is no proper machinery to deal with consistently poor performance of doctors except through the court of law, as cases of medical negligence or malpractices, which are excessively difficult to prove and take a very long time to settle.

A former senior official of the government who is now in private practice said:

> In the public sector, they (the medical professionals) are governed by quality assurance measures and indicators and there is also mechanism to recognize institutions that are outliers. But this is not happening in the private sector. Currently there is no controlling inspection in the private sector.

Concerns have been raised by many interviewees from the advocacy groups, FOMCA, MTUC and CHI that there is not a single representation from the advocacy groups in the MMC. The Secretary-General of

the MTUC view that their representation is important, as it would help to produce a fair perspective as most often medical professionals close ranks when patients challenge their doctors. He cited cases of botched operations which go undetected or were quietly compensated outside the court. According to him "it is only when it concerns a high profile person that an inquiry is made, not by the MMC but by the hospital concerned, more to safeguard the interest of their business than anything else."[31] This view is shared by the President of FOMCA who summed up his concern that " there is a club culture among them [the doctors]."

The President of FOMCA view that their representation could help voice some of the complaints and grievances of consumers on some of the doctors' treatment of patients. He cited cases of doctors treating patients while under the influence of alcohol. However, in a newspaper report, Dr. Krishnan, the then President of the MMA was reported as saying that there are enough laws to protect patient's rights, and enough channels for the public to take remedial action against doctors such as complaining to the MMC, the MOH or the MMA He was responding to a statement by FOMCA that the Consumer Protection Bill must include patients' rights to 'adequate protection.' (*The Star*, August 30, 1997).

There were interviewees who felt that in general the Malaysian medical profession is well-regulated. One of the interviewees refers to the low percentage of litigation cases as compared to other countries such as the US, as testimony that the medical professionals in the country are conducting themselves well.

Conclusion

In summary, there is no representation of advocacy groups or other stakeholders and no representative of the users in any of the key regulatory institutions of the medical professionals – the MMC, the MMA and the public sector. The MMC is largely representative of stakeholder groups in the medical profession. In the MMA the members are mainly doctors and the composition of its Council and executives committees are also doctors. In the disciplinary committees, the PICs of the MMC, the Ethics Committee of the MMA, as well as the Board of Inquiry of the MOH, there are also no representatives of other advo-

cacy groups or stakeholders, no lay members and no representative of the users or the general public.

From the findings it is difficult prove the degree of regulatory capture in the regulatory process. However, circumstantial evidence strongly suggests that the profession comes first, as evidenced in the composition of the decision-making bodies which are largely representative of medical practitioners and medical organisations. This does not necessarily mean that these regulatory bodies always act in the interests of the narrow interest group but it suggests the possibility that they may reflect particular points of view and may be seen to do so.

The findings also show that the regulatory process is not seen to safeguard the interests of the general public: channels of consultation for patients were not clearly articulated and the measures for the expression of the public interest are weak – there is no information established. The channels for complaints to be heard are much clearer for doctors than for the general public. The passive regulatory nature of the MMC which relies on complaints and only reacting to those reported to it, severely reduces the number of offences brought before the MMC. This is further compounded by the lack of an inspectorate to detect offences.

Except for those in the public sector, there is a lack of institutional support for the medical professionals to keep in line with the best evidence and maintaining their competent skills. The law courts take a long time to settle litigation cases. Many people are not able to determine what constitutes malpractice. This problem is exacerbated by the inadequate laws to access medical records.

The composition of the key regulatory bodies as well as the regulatory processes do not show that they provide sufficient safeguards to protect the interests of the public. Indeed, in the perception of the public, it is not seen to be doing so.

The reasons for this could be due to several factors. One of these is the low budget of the MMC which limits its capacity and restricts its regulatory activities and functions. Another reason is the influence of the MMA. It has the resources – expertise, manpower, finance not just to self-regulate but also to have political influence over the policy-makers. The third reason is the political influence of the medical professionals themselves who possess the expert knowledge and are considered the elite of the society.

The findings suggest a number of ways to improve the functioning of the current regulatory environment. The dominance of the medical profession in the regulatory bodies contributes to the general perception that they act for the narrow interest groups. The government needs to institute a fair representation of interest groups in the professional regulatory bodies to ensure that their decisions are in the interests of both the professionals and the users. A fair representation of interest groups can provide a counterbalancing force against any intervention or dominance of any one group interest. Consumers, for example, can play a significant role in promoting regulatory effectiveness, but the role needs to be developed within the context of the current regulatory framework.

The findings also suggest that the MMC would have to have a sufficient ability and capacity to manage. It requires trained staff and monetary resources, and also openness and autonomy as it is faced with many well-informed professionals and well-financed professional association with an effective interest group and powerful leadership.

The findings also suggest that one important reason for the malfunctioning of the regulatory agencies was the lack of a formal system with established information for members of the public to lodge complaints. Adequate laws relating to disclosure and access of medical records are needed so that plaintiffs and defendants can obtain complete clinical information on their cases.

Notes

1. The findings of this study are mainly drawn from a review of documentary sources and a series of interviews conducted with the personnel of MOH, Malaysian Medical Council MMC and the Malaysian Medical Association MMA, officials of the NGOs such as Federation of Malaysian Consumers' Association FOMCA, Citizen's Health Initiatives CHI, Malaysia Trades Union Congress MTUC, Institute of Islamic Understanding IKIM, advocates and solicitors, some members of the Preliminary Investigations Committee PIC of the MMC, Medico-legal Society of Malaysia, doctors both from the public and private sector, managers of some private hospitals, fellow academician and some members of the general public. As some matters and opinions raised are sensitive, most of the key informants wished to remain anonymous.

2. Parallel to the Malaysian Medical Council are the Malaysian Optical and Dental Councils, Nursing Board, Midwives Board Malaysia and Medical Assistants Board responsible for the professional practice and registration of these categories of health workers. This discussion restricts to the medical profession.

3. Under the same category is the Academy of Medicine, the Federation of Private Medical Practitioners Association Malaysia FPMPAM, Muslim Doctors and Specialist Muslim Doctors Associations, Obstetrical and Gynaecological Society Malaysia, Society of Pathologists Malaysia, Paediatric Association Malaysia, Malaysian Society of Anaesthesiologists, Malaysian Psychiatric Association. The stated objectives of these bodies pertain to the various specialism of the medical profession.
4. The MTUC is a unionised workforce of about 800,000 members, forming about 10% of the total 8.2 million workforce in the country Malaysian Trades Union Congress: Report of the General Council 1997-1998 p.64.
5. It called for the government to undertake the health insurance scheme as a social service to the population and not be privatised. It also called for the government to monitor the quality of healthcare and control exorbitant charges by private hospitals MTUC Report of the General Council 1997-1998:24-25.
6. Malayan Nurses Union: Emergency Resolution.
7. See, for example, *The Star,* November 16, 1996 "Scheme will not lead to higher medical bills";*The Sun* September 11, 2000 "Healthcare restructuring needs support".
8. In 1997 and 1998, it had an income of RM2million per year. For both years, the surplus before tax were RM500,000 for each year MMA 1999.
9. There are 13 states in Malaysia. They are: Perlis, Kedah, Perak, Negeri Sembilan, Selangor, Pahang, Johor, Terengganu and Kelantan, Penang, Melaka, Sabah and Sarawak.
10. U4, P1, P6 and P15,
11. C2.
12. R1
13. P1, P6 and D2
14. Interview information from key informants, U10, R1, P6 , H1, H2 and H4.
15. Iinformants P4, P11 and P15.
16. Interview information with key informant at MMC, C2
17. P1, P2, and P15.
18. P11
19. C2.
20. M7
21. Interview information with key informant of the Malaysian Medical Council C2.
22. M7.
23. P4, P9 and P11,
24. S1 and S2
25. Personal interview.
26. U2 and U4.
27. On October 2000, consumers representatives which includes FOMCA, Consumers International Regional Office for Asia and the Pacific CI ROAP organised a National Consumer Seminar. One of the agenda items was to re-examine ways to make the charter an operational document SunValley, October 21, 2000.
28. M7.
29. *The Star,* "CAP highlights medical errors", April 3, 2001; and *The Star,* "Learn from mistakes, MMA", April 10, 2001.
30. *The Sun,* April 9, 2001

31. The informant was commenting on a case that occurred a few years ago in which a high profile person died on the operating table at one of the private hospitals. An inquiry was made on this case.

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