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**THE MALAYSIAN MEDICAL PROFESSIONALS:
SERVING THE PUBLIC INTERESTS?**

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The Malaysian Medical Professionals: Serving the Public Interests?

Introduction

Freidson (1970a,1970b, 1988a, 1988b) suggests that the deal between professions and the state is that the professions will ensure safe and competent services and in exchange have the exclusive right to provide certain services. Other authors have suggested that professions use their powers to further their professional interests rather than the interests they are presumed to serve i.e those of the general public (Stigler 1971; Posner 1974; Peltzman 1976; Hancher 1990).

This paper presents a case study¹ of the professional regulation of doctors. It examines the performance of the regulatory institutions of the medical profession in Malaysia. The aim of this study is to assess the degree to which regulation achieves the government's objectives of ensuring quality of health care services, and is seen to do so. It poses the question: Do the regulatory institutions of the Malaysia medical profession act to achieve the objectives of the government terms of the quality of health services?

To assess performance of the regulatory institutions of the medical professions the indicators used are in terms of the regulatory process and the outcome of regulation. The regulatory process will examine the composition of the decision-making body; the process for identifying bad practices as well as the process for reviewing complaints and imposing sanctions for bad behaviour; and the extent of the balance of protection between professional and public interest.

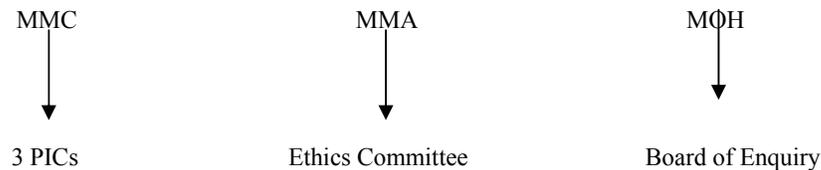
¹ The findings of this case study are mainly drawn from a review of documentary sources and interviews with key informants and other interviewees. The author conducted a series of interviews with the personnel of Ministry of Health (MOH), the Malaysian Medical Council (MMC), the Malaysian Medical Association (MMA), and with officials of the NGOs such as the Federation of Malaysian Consumers' Association (FOMCA), Citizen's Health Initiatives (CHI), Malaysia Trades Union Congress (MTUC), Institute of Islamic Understanding (IKIM), advocates and solicitors, members of the Preliminary Investigations Committee (PIC) of the MMC, the Medico-legal Society of Malaysia, doctors both from the public and private sector, managers of six private hospitals, fellow academician and some members of the general public. In all, a total of 105 respondents were interviewed.

In terms of outcome, it will look at the number of cases that were heard relative to the number of doctors; the number of people who were punished for bad behaviour; the types of punishments and whether or not they are likely to be a deterrence.

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 other entities involved in the regulation of the Malaysian health sector.²

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. The aim is to assess the degree to which they can be seen to represent specific stakeholder groups, in particular, representation for the general public.

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 1 below:

Table 1
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
<i>Total members</i>	24

² From the definition and identification of forms of organisation of regulation in the health sector, as well as the procedural legitimacy of agencies, the author has derived a way of categorising the entities involved. For further discussion of the different categories of entities, please see ‘Medical Regulation in Malaysia: Towards an Effective Regulatory Regime’ (Nik Rosnah 2002).

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 1). There are 11 nominees elected from among members representing the registered practitioners. There is no representation of advocacy groups or representative of other stakeholders. Neither is there a representation of the general public or the users.

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.

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.

How does the system of the MMC and the MMA actually works?

This section explores the regulatory process and strategies of the regulatory bodies.

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

Licensing and establishing standards

The power of the MMC lies in its control of the registers for licensing medical professionals. It decides what qualifications are necessary for registration/licensing. The MMC may remove persons from the register temporarily or permanently if they are found to be unfit to perform their professional duty. It MMC published a statement on Medical Ethics in 1975 which was later replaced by a Code of Professional Conduct in 1987. All newly registered practitioners are given a copy on registration. The code outlines minimum standards. Breaches of these standards are referred to as ‘infamous

conduct in professional respect' or 'serious professional misconduct.' The contents of the MMC's Code of Professional Conduct will be discussed in the following section. According to key informant at the MMC, the MMC's Code of Professional Conduct is similar to that of the UK General Medical Council.

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).

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. 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.

'Infamous Conduct'

The Medical Act 1971 confers disciplinary jurisdiction on the MMC. One of the grounds upon which the MMC may take disciplinary action is that a practitioner has been found guilty of 'infamous conduct in a professional respect'. The MMC may order that the name be struck off from the Register; suspend from the Register for such period as it thinks fit; reprimand; or any such order as above but with a suspension of the order, for a period not exceeding two years (s.30 Medical Act 1971).

The MMC's Code of Professional Conduct contains the following definition of 'infamous conduct.':

'If a medical man in the pursuit of his profession has done something with regard to it which will be reasonably regarded as disgrace or dishonourable by his professional brethren of good repute and competency, then it is open to the General Medical Council, if that be shown, to say that he has been guilty of infamous conduct in professional respect' (Lord Justice Lopez 1894).

'infamous conduct in a professional respect means no more than serious misconduct judged according to the rules, written or unwritten, governing the profession' (Lord Justice Scrutton 1930) (cited from Code of Professional Conduct, MMC1987:9).

It can be observed that the standard was set in the nineteenth century and that it is based on the opinions of the professionals. That the 'infamous conduct' is judged according to "the rules, written or unwritten, governing the profession" is linked to a certain view of the profession.

The Code of Professional Conduct has three main sections: (i) the disciplinary jurisdiction of the Council, (ii) forms of infamous conduct which may lead to disciplinary proceedings and (iii) the disciplinary procedure of the MMC. The Code of

Professional Conduct outlines the outer limits of conduct beyond which a practitioner is guilty of serious professional misconduct, grouped under four main headings:

- (a) Neglect or disregard of professional responsibilities.
- (b) Abuse of professional privileges and skills.
- (c) Conduct derogatory to the reputation of the medical profession.
- (d) Advertising, canvassing and related professional offences.

One of the forms of ‘infamous conduct’ under group (a) above in which the MMC may institute disciplinary proceeding is “when a practitioner appears seriously to have disregarded or neglected his professional duties to his patients”(Code of Professional Conduct) (MMC 1987: 11). The public is entitled to expect that a registered medical practitioner will provide and maintain a good standard of medical care which includes among others, conscientious assessment of a patient’s condition, sufficiently thorough attention, examination and where necessary, diagnostic investigation, competent and considerate management (ibid).

While some forms of ‘infamous conduct’ are quite clearly for the interest of the public, some are of more interest to the profession such as improper financial transaction, improper demand for fees, advertising and canvassing for purpose of obtaining patients, etc., as in group (d) above. This links to the definition of the ‘infamous conduct’ given on the previous page.

The definition and application of the term ‘infamous conduct’ and ‘ethics’ is of crucial importance to distinguish conduct that is primarily of importance to the public and conduct that is primarily of importance to the professionals. 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.

The author began with the assumption that ‘infamous conduct’ includes matters of malpractice. However, according to a key informant³ at the MMC, the MMC deals with complaints of ethics and professional behaviour, not cases of malpractice or negligence.

The “Council is not ordinarily concerned with **errors in diagnosis or treatment, or with the kind of matters which give rise to action in the civil courts for negligence**,⁴ unless the practitioner’s conduct in the case has involved such a disregard of his professional responsibility to his patients or such a neglect of his professional duties as to raise a question of infamous conduct in a professional respect.”(Code of Professional Conduct, MMC 1987:12).

This reliance on the concept of ‘professional responsibility’ and ‘professional duties’ provides a demarcation line which divides the responsibilities of the medical professionals into two categories: a. to the profession and b. to the civil courts.

Review of the System

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. 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. According to some doctors⁵ and a CEO⁶ of a private hospital interviewed, practitioners can continue to practise incompetently as long as they are not caught. This opinion is confirmed in the author’s interview with key informants in the MMC⁷ and MOH⁸ who said that the only way the MMC may know about breaches in the standard of competence is when there is a complaint. And even if there is, according to the solicitors⁹ interviewed, the performance has to be proved to be grossly incompetent before the MMC will apply sanctions against the accused.

Although MMC’s powers lies in its control of the register of professionals, there is no separate specialist register, albeit the question of a separate specialist register among the

³ C2

⁴ Embolden is mine

⁵ P1,P2, and P15.

⁶ P11

⁷ C2.

⁸ M7

⁹ S1 and S2

professionals has been discussed since 1980s (MMA 1980). In 1992, an Ad hoc Committee on Specialist Register drafted a Bill which was sent to the Attorney General's Chamber for approval (MMC Annual Report 1993: 18-19). However, until now, only the basic medical qualification is the essential requirement. Some doctors¹⁰ in the private sector who were interviewed expressed concern that, there are cases of individual practitioners who have undergone training in the UK and on coming back to their practice, claim to be specialists in their subspecialty and if no one complains, they become a 'specialist' as there is no direct inspection made by the MMC.

Complaints

The channels for complaints are the MMC and the MMA. The MMC which caters for both the public and private sectors; the government which caters for complaints on doctors in the public hospitals and clinics; and the courts of law. 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.

Channels for complaints by colleagues and peers

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: 7). 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.

In the ten years beginning 1987/88, 43.5% of complaints were on issues the author 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 on advertising, whilst among issues of public interests, the largest number of complaints was on clarification/advice (Table 2).

¹⁰ P1, P6 and P15.

Table 2: Complaints Received by the MMA Ethics Committee 1987-1997

Complaint/Year	87/88	88/89	89/90	90/91	91/92	92/93	93/94	94/95	95/96	96/97	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.

Note: The original data includes the number of carbon copies and anonymous letters of complaints to the MMA but as these are doubtful as to whether they could be regarded as complaints, the author have chosen to disregard them in this data.

Channels for complaints by the public

According to a key informant of the MMC¹¹, the MMC relies on reports or complaints received from the public. On reviewing the MMC's annual report of 1993 and 1995, there is a small section noting that anybody wishing to lodge a complaint is advised to submit in writing to the President of the MMC, giving particulars such as the name of the practitioner, the place of practice, nature and details of complaint and documents or evidence in support of the complaint. However, these annual reports are distributed to a restricted circle, that is amongst the doctors. There were also no guidelines on the kinds of offences that patients can complain. From interviews, the MMC receives complaints from many sources, written complaints to MMC, by telephone, through newspapers or through hospitals. Interviews with PIC members also reveal that they receive complaints through various means. These 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.

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. 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.

While the MMC has a policy of looking into professional misconduct, which relates only to issues of ethics and conduct and not on issues of malpractices or negligence, this is not made clear to the general public. Many interviewees who were not in the medical profession, were not aware of the distinction between issues of ethical conduct and issues of malpractice or negligence, what constitutes malpractices or negligence or that the only channel for complaints on malpractices or negligence is through the court.

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

¹¹ C2.

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.¹²

The nature of complaints

The PICs receive about 8-10 complaints per month. The complaints are of a various nature ranging from overcharging, breach of advertisement, conduct of doctors and business competition. Table 3 shows the number of complaints received between 1986-1994 with an analysis of the complaints. According to two members of the PIC, a significant number of complaints received by the PICs were from the medical professionals themselves, with some referred by the Ethics Committee of the MMA.

Most complaints from medical professionals were related to advertisements. According to two members of the PIC¹³, complaints relating principally to personal behaviour of doctors which could raise serious professional misconduct were lesser in comparison to complaints pertaining to advertisement. Regulation of advertisement deters quacks from advertising, however, it is also important to the medical professionals in reducing competition. This sentiment seem to be raised by many interviewees from the advocacy groups and also from among doctors interviewed. Table 3 below indicates the number and nature of complaints received by the MMC.

Table 3: Complaints Received by the MMC

Nature of complaints	1986	1987	1988	1989	1990	1991	1992	1993	1994	Total
Primarily of professional interests										
Advertising	17	8	6	7	7	3	2	3	7	60
Association with unregistered and / or unqualified persons	3	5	1	2	1	1	3	3	2	21
False claim/ medical reports (including selling of M.Cs)	0	3	1	3	0	0	0	4	3	14
Total	20	16	8	12	8	4	5	10	12	95
Primarily of public interests										

¹² Interview information with key informants of MOH.

¹³ H1 and P21.

Abuse of relationship with patients / relatives	1	0	2	0	0	0	1	0	2	6
Prescribing drugs without care and control inclusive of poison item	1	5	4	0	0	0	0	0	2	12
Neglect/disregard of professional responsibilities	4	3	0	7	8	7	14	4	4	51
Convicted by court	0	2	0	0	0	1	1	1	1	6
Incompetence to Practise	-	-	-	-	-	-	-	7	4	11
Standard of care/management	-	-	-	-	-	-	-	5	3	8
Total	6	10	6	7	8	8	16	17	16	94
Others	3	4	1	10	7	7	9	10	6	57
Total	29	30	15	29	23	19	30	37	34	246

Source: Malaysian Medical Council Annual Reports 1993 and 1994

Between 1986-1994, a total of 246 complaints were received. The number of complaints increased by 17.2 per cent whereas the number of doctors with Annual Practising Certificates increased from 5,394 in 1987 to 8,831 in 1994, an increase of 63.7 per cent (MOH 1987, 1994). The number of complaints did not increase proportionately. There was an average of 27 complaints per year or about 2 complaints per month. The complaints decrease from 1 complaint for 186 practising doctors in 1986 to 1 complaint for 260 practising doctors in 1994, which indicates a lack of robust complaints.

Out of the total of 246 complaints received by the MMC, 95 or 38.6 per cent were primarily of professional interests, 94 or 38.2 per cent were primarily of public interests and 57 or 23.2 per cent were obscure cases with unclear subject. Out of a total of 95 complaints that were primarily of professional interests, 60 or 24.4 % of it pertained to advertising. On the other hand, out of a total of 94 complaints that are primarily of public interests, only 11 complaints or 4.5 % pertained to incompetence to practice. This gives the impression that significant resources in terms of time and manpower have been allocated for issues of professional interests rather than for issues of public interest.

Outcome of the complaints

a. At the MMC : According to an informant at the MMC¹⁴, the PICs hold around 80 meetings per year to investigate complaints. The cases included new or repeat hearings. In 1993 the PICs held 40 meetings (MMC 1993: 15). In 1994 the PICs had 51 meetings and inquired into 33 cases, of which 14 were new cases. So over the years it can be seen that the PICs held their meetings in increasing numbers. A review of records on disciplinary cases attended by the PICs show that in spite of efforts made by the PICs, there is a backlog of cases accrued from as early as 1986, which were not cleared.

As shown in the Tables 4 and 5 below, outcomes of these complaints were, at best, patchy. In 1993, the PICs considered 23 cases, summarily dismissed 10 and referred 9 to the MMC. In 1994, 33 cases were considered out of which, 8 were summarily dismissed and 15 were referred to the MMC (Table 4). Between 1993-1994, from a total of 18 cases that were summarily dismissed, 13 cases were related to medical incompetence or neglect of professional responsibilities. The cases were summarily dismissed on the grounds that those complaints were not ethical matters (MMC Annual Reports 1993 and 1994). The complainants were advised that they could pursue the matter before other forums such as the civil court (MMC 1994:22)

Table 4: Inquiries Made by the PIC in 1993 and 1994

<u>No. of cases/Year</u>	<u>1993</u>	<u>1994</u>
No of meetings	40	51
Total cases inquired	23	33
Cases summarily dismissed	10	8
Cases referred to MMC	9	15

Source: MMC Annual Reports 1993 and 1994

Between 1986-1994, 4 cases were found guilty. Out of those found guilty, 3 were reprimanded and 1 practitioner was struck off the register. The practitioner who was struck off the register was found guilty of improper conduct by maintaining improper association and having a sexual relationship with his patient. Of the 3 reprimanded cases, 1 was found guilty of making false entries in the logbooks, 1 was found guilty of

¹⁴ C2.

false entry in patient's bed head ticket and another was guilty of conviction by court (MMC 1993, 1994). Between 1995-1999 no cases have been found guilty (Table 8).

Table 5: Cases Brought to the Malaysian Medical Council between 1995-1999

Year	Total cases brought in the year	Summary dismissal	Pending cases	Found guilty and punished
1995	41	22	19	-
1996	22	7	15	-
1997	26	4	22	-
1998	46	8	38	-
1999*	19	1	18	-

*Figures up to September 1999

Source: Malaysian Medical Council (personal communications).

b. In the public sector (MOH): In the public sector, according to the key informant, the states are supposed to send complaints report to the Medico-legal Unit of MOH stating the number of complaints they received every month. However, these are not adhered to fully as some states do not send in their reports. From the interview, it emerged that not all complaints are acted upon or brought to the Board of Inquiry.

The Medico-legal Unit, MOH handles disciplinary cases as well as cases from the public hospitals that are taken to court. These are cases in the public sector filed in the court against the government hospitals or MOH or actual doctors in the government hospitals that render treatment to the patient. The total number of these medico-legal cases was not made available. From an informant at the MOH, as at September 1999, there were 96 cases pending. From 1993-1997 there were 67 medico-legal cases that were settled as in Table 6 below. On average, 13 cases were settled per year.

Table 6: Forms of settlement on Medico-legal Cases of the Public Hospitals 1993-1997

Forms of Settlement	No. of cases
Court Order	35
Agreement without liability	18
Annulled cases	7
Cases withdrawn	5
Cases settled outside court without summon	2
Total cases	67

Source: Medical Practice Division, MOH (personal communication)

The compensation made to these medico-legal cases were as shown in Table 7 below. Apart from cases that were taken to court, there were also cases that were obviously of medical negligence which were settled outside the court. Out of these cases, so far none of the medical practitioners have been struck off the Register.

Table 7: Compensation Paid on Medico-legal Cases 1993-1997

Year	No. of cases compensated	Total compensation (in M'sian Ringgit)
1993	3	221,294
1994	15	834,854
1995	10	265,603
1996	20	1,029,321
1997	7	727,990
Total	55	3,079,062

Source: Medical Practice Division, MOH

c. The court: The total number cases of malpractices that have been filed against hospitals or actual doctors both in the public and private sectors that were brought to court was not made available. Over a period of 20 years from 1980-2000, a total of 410 cases of medical negligent have been settled by the court (refer Table 8).

Table 8: Cases of Malpractice in the Country Settled 1980-2000

Years	No. of cases	Amount settled (Malaysian Ringgit)
1980-1984	69	Not available
1985-1989	120	266,598.48
1990-1994	111	1442,969.50
1995-2000	110	928,605.95
Total	410	2,638,173.80

Source: Attorney-General's Office (personal communication).

From Table 8 above, between 1980-2000, the total compensation ordered by the court was RM2,638,174 for 410 cases. On average, the amount of compensation was RM6,434.57 for each cases of malpractice. In relation to the Malaysian mean monthly gross household income of RM1,563 (Malaysia 1993:60), this amount is comparatively low to support a family in a situation whose head of the household unit is incapacitated

due to medical malpractice. In relation to a private doctor's average monthly take home pay of RM31,000.00,¹⁵ the amount is negligible as a deterrent for malpractices.

A review of the conduct and processing of complaints

This section reviews the process of complaints and the conduct system in the MMC and the public sector.

Review of the system

The author review the processing of complaints in the MMC and the government through its court.

a. In the MMC: According to a member of the PIC¹⁶ it is rare for cases to be overturned by the MMC. The author's interview with a key informant¹⁷ 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 [s.26 (7) 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 [s.31(1) Medical Act 1971]. Ranjan¹⁸ 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 MOH¹⁹, 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

¹⁵ Computation is based on the doctors' remuneration at Lam Wah Ee Hospital. See Tan C.S Dato' Dr. (1997) 'Prospects For a Nob-Profit Sector in Health Care: The Experience of Lam Wah Ee Hospital', paper prepared for the National Conference on Privatisation & health care Financing in Malaysia: Emerging Issues and Concerns, Penang, Malaysia 5-6 April, 1997

¹⁶ P21.

¹⁷ C2.

¹⁸ Advocates and Solicitor, P.S Ranjan & Co - personal interview.

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 (1988b) observation that doctors give the benefit of the doubt to each other to an extent not done in other professions.

b. The court: There are also cases of complaints on medical negligence from the public and the private sector that are brought to court.²⁰ 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.²¹ 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. Not all of the medical negligence cases from his hospitals are settled out of court. A manager of one private hospital²² preferred to settle in court, as the case will take a long time to get settled and in the meantime, the practice will continue as per normal.

According to an advocate and solicitor²³, 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 foreseeable 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 which 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

¹⁹ M7.

²⁰ Interview information from S1, P11 and M7.

²¹ This was confirmed by managers of some private hospitals (P4, P9 and P11) that the author visited and the advocates and solicitors who deal with medico-legal cases.

²² P11

²³ S1

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.” (paragraph 2.22 The Code of Professional Conduct of the MMC 1987).

According to informants²⁴ from the 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. And 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,²⁵ in particular, 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 is an “excellent cooperation between the Society, the MMA, the Bar Council and also the Malaysian Dental Association in the past year” (Medico-legal Society 2000:1).

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

²⁴ S1 and L2

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.

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.²⁶ This is confirmed in an 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 which are not registered as official medicines and not prescribed by hospitals can be taken to the tribunal (Consumer Protection Act 1999). An informant at the MOH commented that this was rather strange as the omission on protection matters concerning medical profession meant that consumers are not effectively protected.

A key informant²⁸ from the public sector as well as some doctors²⁹ 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

²⁵ In the Joint Meeting of the Medico-Legal Society in 1999, the three professional bodies, the medical, dental and the Bar Council have agreed upon some guidelines referring to medico-legal cases (the respective reports of the MMA, MDA, the Bar Council and Medico-legal Society).

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 was to re-examine ways to make the charter an operational document (SunValley October 21, 2000).

²⁸ R1

department meet to review complicated cases, deaths or unusual cases.³⁰ The aim is for the doctors to learn from each other and improve the quality of service. According to informants³¹ at some private hospitals, medical audit is rarely done. If there is any, it is voluntarily undertaken by the doctors. From interviews with doctors in the private sector³², occasionally some doctors in the private sector do attend conferences overseas, with some being funded by pharmaceutical companies.

A former senior official³³ of the government who is now in private practice said:

“in the private sector nobody governs the medical professionals except by peer expectation. In the public sector, they 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.”

Concluding remarks

The main findings are summarised Table 9 below.

²⁹ P1, P6 and D2

³⁰ Interview information from key informants, U10, R1, P6, H1, H2 and H4.

³¹ Informants P4, P11 and P15.

³² Informants P1, P8, P9 and P15

³³ P1.

Table 9: Summary of the Main Findings

Issue	Remarks
Who regulate the profession	MMC, MMA and MOH
Membership of the regulatory bodies Composition	<p>MMC:</p> <ul style="list-style-type: none"> • Largely representative of medical practitioners and medical organisation (20 out of 24 members). • No representation of advocacy groups, other stakeholders or lay members. • Almost exclusively male with only 2 female nominees from faculties of medicine • Older members and mostly specialists • Mostly residents of Selangor <p>Out of 24 members, 11 are elected members from the medical professionals – unlikely to risk popularity with the doctors by whom they are elected.</p> <p>MMA: Mainly medical professionals. No other representatives being co-opted in any of their committees</p>
Membership of disciplinary committees	<p>PIC of MMC:</p> <ul style="list-style-type: none"> • 17 members, all are senior doctors, mostly specialists • No lay member • All are residents of Selangor <p>Board of Inquiry (Government): 4 members, all are doctors . No lay members</p> <p>Ethics Committee (MMA): 9 members, all are doctors. No lay members</p>
Regulatory procedures and processes Identification of competent practitioners	<p>Through:</p> <ul style="list-style-type: none"> • Licensing • Establish Code of Professional Conduct – concern with issues of ethical behaviour, not on malpractices/negligent • No support for maintaining competent skills

	<ul style="list-style-type: none"> No direct inspection, relies on complaints
Channels for complaints	<p>For colleagues and peers: MMA.</p> <ul style="list-style-type: none"> 44% of complaints on issues of professional interests, mostly on advertising 56% of complaints on issues of public interest, mostly on clarification/advice. <p>For the public: MMC, court and Board of Inquiry (for complaints on doctors in the public hospitals)</p> <ul style="list-style-type: none"> 39% of complaints to MMC were issues of professional interests, of which mostly on advertising 38% were issues of public interest, mostly pertained to incompetence to practice Complaints did not increase proportionately to no. of doctor: 1986 – 1 complaint to 186 doctors. 1994 – 1 complaint to 260 doctors No proper channel established No established information to the public
Outcome of the complaints	<p>MMC (between 1986-1999) : 4 found guilty of which 3 were reprimanded, 1 struck off register.</p> <p>MOH (between 1993-1997): 67 cases settled by court, 55 compensated.</p> <p>Court (Between 1980-2000): Over a period of 20 years, 410 cases of malpractice settled. On average, compensation was RM6,434.57 for each cases.</p>
Review of system	<p>MMC:</p> <ul style="list-style-type: none"> Small panel of PIC, not representative of users No right to dissenting opinion <p>Court:</p> <ul style="list-style-type: none"> Takes up to 7 years for a cases to be settled Difficult for patients to establish malpractices Inadequate laws for patients to review medical records to prepare themselves for trial No institutional support for aggrieved patients

Referring back to the question – “Do the regulatory institutions of the Malaysia medical profession act to achieve the objectives of the government in terms of quality of health services?,” the conclusion is “no, they do not.”

From the summary of findings as in Table 9, it is difficult to prove the degree of regulatory capture in the regulatory process. However, circumstantial evidence strongly suggests that the profession comes first. This is evidenced in the composition of the decision-making bodies which are largely representative of medical practitioners and medical organisations. 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 predominance of the medical profession in the key regulatory institutions raised concerns on the objectivity of these institutions and the rational judgment of cases brought to their committees. It also suggests that the viewpoints of the doctors and their interests have an important influence. This suggestion seems to be reinforced by the procedures and processes of the MMC. 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. There is lack of proper machinery to deal with poorly performing doctors except through the court of law. Cases of medical negligence or malpractices are excessively difficult to prove and take a very long time to settle. The inadequate laws to access medical records exacerbate this problem.

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.

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