Malaysia

by
Kartina Aisha Choong
University of Central Lancashire, United Kingdom

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The Author

Dr Kartina Aisha Choong studied Law at the University of Cardiff before being called to the Bar of England and Wales in 1995 by the Honourable Society of Lincoln’s Inn, London. She holds Masters degrees in Health Care Ethics (1995) and Applied Social Research (1997) from the University of Manchester, and in Islamic Studies (2003) from the University of Leeds. Her PhD degree was obtained from the University of Manchester in 2001.

She currently holds a Senior Lectureship in Medical Law at the University of Central Lancashire where she is also the Course Leader for their LLM in Medical Law & Bioethics and LLM in Forensic & Legal Medicine. She has previously taught Law at the Universities of Reading, Durham and Leeds Metropolitan. Between 2002 and 2010, she served as a subject specialist for Medical Ethics and Religion for INTUTE: Arts and Humanities. She is a Fellow of the UK Higher Education Academy (FHEA).
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<th>Abbreviation</th>
<th>Full Form</th>
</tr>
</thead>
<tbody>
<tr>
<td>AIMST</td>
<td>Asian Institute of Medicine, Science and Technology University</td>
</tr>
<tr>
<td>AMM</td>
<td>Academy of Medicine of Malaysia</td>
</tr>
<tr>
<td>APHM</td>
<td>Association of Private Hospitals of Malaysia</td>
</tr>
<tr>
<td>ART</td>
<td>Assisted Reproductive Technology</td>
</tr>
<tr>
<td>AUCMS</td>
<td>Allianze University College of Medical Sciences</td>
</tr>
<tr>
<td>BUCM</td>
<td>Beijing University of Chinese Medicine</td>
</tr>
<tr>
<td>CGPA</td>
<td>Cumulative Grade Point Average</td>
</tr>
<tr>
<td>CMA</td>
<td>Commonwealth Medical Association</td>
</tr>
<tr>
<td>CMAAO</td>
<td>Confederation of Medical Associations in Asia and Oceania</td>
</tr>
<tr>
<td>CUCMS</td>
<td>Cyberjaya University College of Medical Sciences</td>
</tr>
<tr>
<td>DAP</td>
<td>Democratic Action Party</td>
</tr>
<tr>
<td>DSA</td>
<td>District Specific Approach</td>
</tr>
<tr>
<td>EPF</td>
<td>Employees’ Provident Fund</td>
</tr>
<tr>
<td>FOMCA</td>
<td>Federation of Malaysian Consumers Association</td>
</tr>
<tr>
<td>GCP</td>
<td>Malaysian Guideline for Good Clinical Practice</td>
</tr>
<tr>
<td>GIFT</td>
<td>Gamete Intra-Fallopian Transfer</td>
</tr>
<tr>
<td>HAS</td>
<td>Hospital Specific Approach</td>
</tr>
<tr>
<td>IMU</td>
<td>International Medical University</td>
</tr>
<tr>
<td>IPF</td>
<td>Indian Progressive Front</td>
</tr>
<tr>
<td>IRB/IEC</td>
<td>Institutional Review Board/Independent Ethics Committee</td>
</tr>
<tr>
<td>KJP</td>
<td>Kumpulan Perubatan (Johor) Healthcare</td>
</tr>
<tr>
<td>LDP</td>
<td>Liberal Democratic Party</td>
</tr>
<tr>
<td>LMS</td>
<td>Licentiate in Medicine and Surgery</td>
</tr>
<tr>
<td>MAEAN</td>
<td>Medical Association of South East Asian Nations</td>
</tr>
<tr>
<td>MBBS</td>
<td>Bachelor of Medicine and Bachelor of Surgery</td>
</tr>
<tr>
<td>MCA</td>
<td>Malaysian Chinese Association</td>
</tr>
<tr>
<td>MD</td>
<td>Doctor of Medicine</td>
</tr>
<tr>
<td>MDA</td>
<td>Malaysian Dental Association</td>
</tr>
<tr>
<td>MDC</td>
<td>Malaysian Dental Council</td>
</tr>
<tr>
<td>MHTC</td>
<td>Malaysia Healthcare Travel Council</td>
</tr>
<tr>
<td>MIC</td>
<td>Malaysian Indian Congress</td>
</tr>
<tr>
<td>MMA</td>
<td>Malaysian Medical Association</td>
</tr>
<tr>
<td>MMC</td>
<td>Malaysian Medical Council</td>
</tr>
<tr>
<td>MNB</td>
<td>Malaysian Nursing Board</td>
</tr>
</tbody>
</table>
List of Abbreviations

MOH  Ministry of Health
MPS  Malaysian Pharmaceutical Society
MQA  Malaysian Qualifications Agency
MREC Medical Research and Ethics Committee
MSQH Malaysian Society for Quality in Health
MSU Management and Science University
NHIS National Health Insurance Scheme
NIA National Indicator Approach
NSR National Specialist Register
NUCM Nanjing University of Chinese Medicine
NUS National University of Singapore
PAS Islamic Party of Malaysia
PBB Parti Pesaka Bumiputra Bersatu Rakyat Sarawak
PBRS Parti Bersatu Rakyat Sabah
PBS Parti Bersatu Sabah
PPP People’s Progressive Party
PRS Parti Rakyat Sarawak
PUGSOM Perdana University Graduate School of Medicine
QAP Quality Assurance Programme
SHUTCM Shanghai University of Traditional Chinese Medicine
SPDP Sarawak People’s Democratic Party
SUPP Sarawak United People’s Party
T & CM Traditional and Complementary Medicine
UCSI University College Sedaya International
UIAM Universiti Islam Antarabangsa Malaysia
UITM Universiti Teknologi MARA
UKM Universiti Kebangsaan Malaysia
UM Universiti Malaya
UMNO United Malay National Organization
UMS Universiti Malaysia Sarawak
UniKL RCMP Universiti Kuala Lumpur Royal College of Medicine Perak
UNIMAS Universiti Malaysia Sarawak
UniSZA Universiti Sultan Zainal Abidin
UPKO United Pasokmomogon Kadazandusun Organization
UPM Universiti Putra Malaysia
UPNM Universiti Pertahanan Nasional Malaysia
USIM Universiti Sains Islam Malaysia
USM Universiti Sains Malaysia
UTAC Unrelated Transplant Approval Committee
UTAR Universiti Tunku Abdul Rahman
WFME World Federation for Medical Education
WHO World Health Organization
WMA World Medical Association
General Introduction

Chapter 1. The General Background of the Country

§1. GEOGRAPHY AND CLIMATE

1. Malaysia is a relatively small country in the Southeast Asia region. It comprises two constituent parts: Peninsula Malaysia (Semenanjung Malaysia) and East Malaysia (Malaysia Timur).
   Peninsula Malaysia, which is also known as West Malaysia (Malaysia Barat), is located between the Straits of Melaka and the South China Sea. To its west, lies the Indonesian island of Sumatra; to its south, the Republic of Singapore; and to its north, Thailand with whom it shares a land border. It is home to eleven states namely Johor, Kedah, Kelantan, Melaka, Negeri Sembilan, Pahang, Perak, Perlis, Pulau Pinang, Selangor and Terengganu. It also houses two federal territories namely Kuala Lumpur and Putrajaya.
   East Malaysia is separated from Peninsula Malaysia by nearly 650 kilometres of the South China Sea. Located on the island of Borneo, it shares land borders with Brunei in the north and the Indonesian territory of Kalimantan in the south. It is home to the states of Sabah and Sarawak, and the federal territory of Labuan.
   Together, the two constituent parts occupy a total land mass of 330,803 square kilometres.¹

2. Malaysia’s climate is characterized by uniform temperature throughout the year, high humidity and heavy rainfall. Being near the equator, it enjoys abundant sunshine with an average temperature of 27°C. The wind flow over the country is generally light but consistent periodic changes in the wind flow pattern give rise to two monsoon wind seasons: the southwest monsoon (May to September); and the northeast monsoon (November to March). The northeast monsoon brings in more rainfall than the southwest monsoon and the areas most affected are the east coast of Peninsula Malaysia, western Sarawak and the northeast coast of Sabah where flooding usually occurs.²

¹. Department of Survey and Mapping, Malaysia.
². Malaysian Meteorological Department.
§2. Population

3. Malaysia has a population of approximately 28 million people and a population density of around 86 inhabitants per square kilometre.\(^3\) The estimated population distribution by states and federal territories as at the end of 2010 was as follows:\(^4\)

<table>
<thead>
<tr>
<th>State</th>
<th>Square Kilometres</th>
<th>Population</th>
</tr>
</thead>
<tbody>
<tr>
<td>Johor</td>
<td>19,210</td>
<td>3,305,900</td>
</tr>
<tr>
<td>Kedah</td>
<td>9,500</td>
<td>1,966,900</td>
</tr>
<tr>
<td>Kelantan</td>
<td>15,099</td>
<td>1,670,500</td>
</tr>
<tr>
<td>Kuala Lumpur</td>
<td>243</td>
<td>1,722,500</td>
</tr>
<tr>
<td>Labuan</td>
<td>91</td>
<td>95,500</td>
</tr>
<tr>
<td>Melaka</td>
<td>1,664</td>
<td>771,500</td>
</tr>
<tr>
<td>Negeri Sembilan</td>
<td>6,686</td>
<td>1,011,700</td>
</tr>
<tr>
<td>Pahang</td>
<td>36,137</td>
<td>1,534,800</td>
</tr>
<tr>
<td>Perak</td>
<td>21,035</td>
<td>2,460,800</td>
</tr>
<tr>
<td>Perlis</td>
<td>821</td>
<td>240,100</td>
</tr>
<tr>
<td>Pulau Pinang</td>
<td>1,048</td>
<td>1,596,900</td>
</tr>
<tr>
<td>Sabah</td>
<td>73,631</td>
<td>3,214,200</td>
</tr>
<tr>
<td>Sarawak</td>
<td>124,450</td>
<td>2,506,500</td>
</tr>
<tr>
<td>Selangor and Putrajaya</td>
<td>8,153</td>
<td>5,102,600</td>
</tr>
<tr>
<td>Terengganu</td>
<td>13,035</td>
<td>1,050,000</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>330,803</strong></td>
<td><strong>28,250,500</strong></td>
</tr>
</tbody>
</table>

As can be observed from the figures above, the population distribution is uneven. Although East Malaysia covers 60% of the total land of the country, around 80% (i.e., approximately 22.5 million) of people live in Peninsula Malaysia. The country’s capital, the federal territory of Kuala Lumpur, is the most densely populated constituency in Malaysia. With nearly 2 million people living within its geographical boundaries, the population density therein is 7,088 inhabitants per square kilometre.\(^5\)

4. Malaysia is embodied by a rich mixture of ethnolinguistic groups. They are officially classified as *Bumiputeras* and non-*Bumiputeras*.

*Bumiputera*, meaning ‘son of the soil’, is a status which is conferred on ethnic groups which resided in the region prior to the British colonization period.

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\(^3\) Department of Statistics, Malaysia.
(1824–1957). They are divided further into Malays (Melayu) and non-Malay ethnic groups like Kadazan/Dusun, Bajau, Murut, Iban, Bidayuh, Melanau and Orang Asli (aborigines). They claim to be and are officially recognized as the indigenous people of the land and are conferred rights and privileged status on a wide range of issues like land ownership, business, housing, entry into well-resourced boarding schools for secondary education, public scholarships for tertiary education in Malaysia and abroad, admission to local universities and entry into the civil service.

Non-Bumiputeras refer to ethnic groups which were brought into the country on a massive scale by the British to serve as labourers in the then British Malaya. They came mainly from China and India, and those who did not return were conferred citizenship after the country gained independence from British rule in 1957. They and their descendants are referred to in the population and housing census, and for administrative purposes, as ‘Chinese’ and ‘Indians’. This, however, belies the heterogeneity of those who come under these two broad labels. It also perpetuates the ‘divide and rule’ policy used during the colonial period where the population was then classified as ‘Malays’, ‘Chinese’ and ‘Indians’ with each focusing on a particular economic activity in separate parts of the country: the Malays worked in agriculture in the countryside, the Chinese in the tin mines in the urban areas and the Indians in rubber plantations which were previously jungles. They did not, and nor were they encouraged to, intermingle.

5. Inter-ethnic relationship in Malaysia has come a long way since then. People of all ethnic backgrounds are no longer segregated, and they now study, work and live alongside one another without awkwardness and distrust. There are even inter-racial marriages, and the different ethnic groups are no longer associated with any particular economic activity. But this state of harmonious co-existence had

---

8. Malaysian Chinese can at least be differentiated further into Hokkien, Cantonese, Hakka and Hailam, for instance, according to the regions they come from. Likewise, Malaysian Indians can be differentiated into Tamil, Malayala, Telegu and Sikh – see N. Jali, et al., Malaysian Studies, Nationhood and Citizenship 137 (Pearson Prentice-Hall 2003).
12. The Bumiputera/Non-Bumiputera divide is nevertheless a continuous source of racial and political tension, especially among younger generations of Malaysian Chinese and Indians who find it difficult to comprehend why they are still treated as ‘immigrants’ and second-class citizens in the country of their, and their father’s and grandfather’s, birth – see e.g., R. Mustapha, et al., Social Integration among Multi-ethnic Students at Selected Malaysian Universities in Peninsula Malaysia.
come only gradually and often at a very high cost. Indeed, inter-ethnic clashes and atrocities are not unknown in the history of this young nation.  

6. Statistics relating to the Malaysian population as at the end of 2010, are as follows:  

<table>
<thead>
<tr>
<th>Category</th>
<th>Number</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Malaysian Citizens</td>
<td>25,776,800</td>
<td>91.2%</td>
</tr>
<tr>
<td>Bumiputera</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Malays</td>
<td>14,015,500</td>
<td></td>
</tr>
<tr>
<td>Other Bumiputeras</td>
<td>3,026,600</td>
<td></td>
</tr>
<tr>
<td>Non-Bumiputera</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Chinese</td>
<td>6,451,300</td>
<td></td>
</tr>
<tr>
<td>Indian</td>
<td>1,924,600</td>
<td></td>
</tr>
<tr>
<td>Others</td>
<td>358,800</td>
<td></td>
</tr>
<tr>
<td>Non-Malaysian Citizens</td>
<td>2,473,700</td>
<td>8.8%</td>
</tr>
</tbody>
</table>

7. The Malays, as the figures show, make up nearly half of the population. Their language, Bahasa Melayu, is recognized as the official language for purposes of government administration and education. English is widely spoken in the country particularly in commerce and industry, and is taught as a second language in schools. Many other languages are also spoken in the country, and these include various Chinese dialects (e.g., Mandarin, Cantonese, Hakka, Hokkien, and Hainan), Tamil, Telegu, Malayalam, Kadazan, Murut and other regional dialects.

8. The country’s official religion is Islam, and it is practised by over 60% of the population. Malaysia is nevertheless a secular rather than an Islamic State. It is also a multi-religious State whereby Animism, Baha’ism, Buddhism, Christianity, Confucianism, Hinduism, Sikhism, Taoism and other belief systems are widely practised.

---

A Survey of Campus Social Climate, 1, ASEAN J. Teaching & Learning Higher Educ. 35 (2009). At the same time, it is said that the privileged status is detrimental to the Bumiputeras too as it impeded their ability to compete fairly with the non-Bumiputeras and the rest of the world – see T.W. Wing, Getting Malaysia Out of the Middle-Income Trap, http://ssrn.com/abstract=1534454 (2009).


17. The country follows the Sunni sect of Islam and the Shafi’i school of thought.

practised. Freedom of worship and the rights of the adherents of all faith groups to profess, practise and propagate their beliefs are guaranteed by the Constitution. However, the right to disbelieve and to adopt atheism, agnosticism and rationalism are not protected by the Constitution. Indeed, the country’s national ideology, the Rukunegara, declares a ‘belief in God’ (kepercayaan kepada Tuhan) as its first and most fundamental principle.

Further, citizens are free to change their religion but this right is generally restricted to non-Muslims. Malaysian Muslims are prohibited from leaving Islam and convert to another religion. Although this seems to run contrary to the Quranic injunction that (Islamic) faith should not be imposed nor forced upon others either by physical compulsion or other forms of coercion like social pressure, this austere stance stems from the Constitution’s definition of who qualifies as a ‘Malay’. According to Article 160 of the Constitution, a ‘Malay’ is one who professes the religion of Islam, habitually speaks the Malay language (Bahasa Melayu) and conforms to Malay custom. In this way, the word ‘Islam’ became synonymous with the word ‘Malay’, the ethnic group. ‘Malay’ is thereby a political term which essentially conflates ethnicity and religion. All Malays are therefore Muslims under the Constitution, and since religion confers group identity, it becomes an immutable...
trait rather than a result of individual choice or personal belief. From this standpoint, a renunciation of the Islamic faith is effectively a renunciation of one’s legally defined ethnic identity. Nowhere was this more stridently expressed than in this statement by the High Court in the high-profile case of a Malay woman who wanted to convert to Christianity in order to marry a Christian man: ‘the plaintiff is a Malay and therefore as long as she is a Malay by that definition she cannot renounce her Islamic religion at all. As a Malay, the plaintiff remains in the Islamic faith until her dying days’.

Non-Muslims who would like to marry Malays or other Malaysian Muslims are legally obliged to convert to Islam. Relationships among the different faith groups are generally tolerant. All major religious festivals like Christmas, Deepavali, Eid al-Fitr, the Hajj and Wesak have been declared as public holidays.

§3. POLITICAL AND JUDICIAL SYSTEMS

9. Malaysia’s political and judicial systems are modelled on, and influenced by, the British system of government. This is not so much a result of democratic choice as one of imposition and reception, both during the period of colonization and when the territory was on the brink of independence whereby the outgoing British administrators, through a commission led by Lord Reid, drafted a Constitution for an independent Malaya. Some pre-colonial traditions were nevertheless successfully retained, and these were weaved into the contemporary regime.

10. Before taking a closer look at these, it is important to note that although Malaya gained its independence from Britain on 31 August 1957, the Nation State which is today known as Malaysia was not formed until 6 September 1963. This new political entity brought together states in the independent Malaya (namely Johor, Kedah, Kelantan, Melaka, Negeri Sembilan, Pahang, Perak, Perlis, Pulau Pinang, Selangor and Terengganu), the island of Singapore (which had been granted self-government by Britain in 1958) and the territories of Sabah and

30. Although there have, regrettably, been a small number of incidents of religious conflicts in recent years where mosques, churches and temples were vandalized or destroyed in the name of religion – see Y.J. Amuda & A.S. Lazim, Application of the Hudaibiyah Treaty in the Contemporary Issues: Case Study of Multiracial Society in Malaysia 3 OIDA Intl. J. Sust. Dev. 51, 56 (2012); K. Lim & W. Har, Sanitising and Satanising Malaysia’s Cityscapes: Cultural Power from Malay Decolonialism to Islamic Occidentalism and Beyond, 4 Asian Soc. Science 44, 45–46 (2008).
32. Other members of the commission were Sir Ivor Jennings, Sir William McKell, Justice B. Malik and Justice Abdul Hamid – all of whom were from Commonwealth countries and who shared a common law, Westminster government background. There were no representatives from Malaya – see C. Evans, Constitutional Narratives: Constitutional Adjudication on the Religion Clauses in Australia and Malaysia, http://ssrn.com/abstract=1709127 (2009).
33. Prior to British colonization, the region was also colonized by the Portuguese (1511–1641) and the Dutch (1641–1824) – see Andaya & Andaya, supra n. 13, 40–41 & 58–59.
Sarawak (which had been British Crown Colonies from 1946). Singapore nevertheless seceded from Malaysia shortly after on 9 August 1965 and formed its own independent city state which is today known as the Republic of Singapore.

Since 1965, therefore, Malaysia has been a thirteen-state-strong nation. In addition, Kuala Lumpur and Putrajaya, which were originally part of the state of Selangor, were established as federal territories in 1974 and 2001 respectively. Labuan, which was originally part of the state of Sabah, was established as a federal territory in 1984.

11. The Federal Constitution of Malaysia (Perlembagaan Persekutuan) established the country as a constitutional monarchy and a federal parliamentary democracy. It is here necessary to point out that prior to British colonization, nine territories in what is now known as Peninsula or West Malaysia (i.e., Johor, Kedah, Kelantan, Negeri Sembilan, Pahang, Perak, Perlis, Selangor and Terengganu) are distinct political entities which were governed by their own respective hereditary Malay rulers called Sultans. This choice of a federal over a unified system of government was chosen mainly to preserve the sovereignty of the Sultans in their separate territories.34 Kerajaan persekutuan, or the federal model of government, combines effective central powers for dealing with common problems, whilst preserving some regional powers to deal with regional distinctiveness.35

12. Under the Constitution, the federation of Malaysia is to be headed by the Yang Di-Pertuan Agong (the Supreme Head or King).36 He is elected on a five-year rotation basis from one of the rulers of the states with a monarch,37 and by the nine Malay rulers themselves through a forum known as the Majlis Raja-Raja (Conference of Rulers).38 He is immune from any proceedings in any court in the land, and is the Supreme Commander of the Armed Forces. But he only reigns and does not govern. Indeed, Article 40(1) of the Constitution states that in the exercise of his functions under the Constitution or federal law, he is to act in accordance with the advice of the Cabinet or of a Minister acting under the general authority of the Cabinet; and upon receiving the advice, he shall accept and act in accordance with such advice.

The current Yang Di-Pertuan Agong is the ruler of the state of Kedah, Sultan Abdul Halim Mu'adzam Shah. His reign spans from 2011 to 2016, and he is the only ruler who has been appointed to the office twice. His first reign was from 1970 to 1975.

13. The Malaysian Constitution has been subjected to numerous amendments in the decades since independence. Its central structure has nevertheless remained
unchanged, and this provides both for the separation of powers between the legis-
lative, executive and judicial wings of government; and the division of powers
between federal and state authorities. The *Yang Di-Pertuan Agong*, as the head of
State, is the formal head of all the three branches of government.

14. Like the Westminster model upon which it was based, legislative authority
is vested by the Constitution in a Parliament, which consists of the *Yang Di-Pertuan
Agong* and two Houses of Parliament (*majlis*).\(^39\) The two Houses of Parliament are
known as the *Dewan Rakyat* (House of Representatives) and *Dewan Negara*
(Senate).

15. The *Dewan Rakyat*, the lower house, is the most important component of
Parliament. It is made up of representatives chosen directly by the public through
general elections. There are currently 222 such members (*wakil rakyat*): 153 from
constituencies in Peninsula Malaysia, 25 from Sabah, 31 from Sarawak, 11 from the
federal territory of Kuala Lumpur, and 1 each from the federal territories of Labuan
and Putrajaya. They serve five-year terms and must be at least 21 years of age at the
time they were elected.\(^40\) They must not be subject to a disqualification, and a per-
son is disqualified from being a member of either House of Parliament when he
or she:

– is and has been found or declared to be of unsound mind;
– is an undischarged bankrupt;
– holds an office for profit;
– has failed, as an electoral candidate or agent, to lodge any return of election
expenses required by law within the time and in the manner so required;
– has been convicted by a court of law in the federation and sentenced to impris-
onment for a term not less than one year or to a fine of not less than MYR 2,000
and has not received a free pardon; or
– has voluntarily acquired citizenship of, or exercised rights of citizenship in, any
country outside the federation or has made a declaration of allegiance to any
country outside the federation.\(^41\)

16. Members of the public who are eligible to vote in elections are citizens who
have attained the age of 18 and are of sound mind. General elections are held once
every five years.

As for who they choose to represent them in the *Dewan Rakyat*, the political
scene has, since 1957, been dominated by three main political parties: the United
Malay National Organization (UMNO), the Malaysian Chinese Association (MCA)
and the Malaysian Indian Congress (MIC). As their names suggest, they represent
the three main ethnic groups in the country. Together, they form the National Front
coalition (*Barisan Nasional*), a pragmatic partnership which allowed each party to

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safeguard the rights and interests of their respective ethnic group.\textsuperscript{42} It also helps reflect the ethnic-based character of Malaysian politics and the need to maintain inter-ethnic cooperation.\textsuperscript{43} The party has, in recent years been joined by eleven other component parties namely the Parti Gerakan Rakyat Malaysia (Gerakan), the People’s Progressive Party (PPP), the Parti Pesaka Bumiputra Bersatu Rakyat Sarawak (PBS), the Parti Rakyat Sarawak (PRS), the Sarawak People’s Democratic Party (SPDP), the Sarawak United People’s Party (SUPP), the United Pasokmomugon Kadazandusun Organization (UPKO), the Liberal Democratic Party (LDP) and the Indian Progressive Front (IPF). Barisan Nasional has been the ruling party since independence.

The country has a number of opposition parties and the most popular to date are the Democratic Action Party (DAP); the National Justice Party (Keadilan) and the Islamic Party of Malaysia (PAS).

17. The Dewan Negara, the upper house, consists of seventy members. Forty-four are appointed by the Yang Di-Pertuan Agong from among citizens who have rendered distinguished public service or have excelled in the professions, commerce, industry, agriculture, cultural activities or social service, or are representatives of racial minorities or are capable of representing the interests of aborigines.\textsuperscript{44} The remaining twenty-six are chosen by the thirteen State Legislative Assemblies who put forward two Senators each. Members of the Dewan Rakyat must be at least 30 years of age at the time of their appointment\textsuperscript{45} and must not be subject to a disqualification. They serve three-year terms that could be renewed only once.\textsuperscript{46} A person is not allowed to be a member of both Houses of Parliament at the same time.\textsuperscript{47}

18. With limited exceptions,\textsuperscript{48} bills may originate in either House/Dewan and would be sent to the other House/Dewan for approval. Once they are passed by the other House and agreement has been reached between the two Houses on any amendments made in them, they are presented to the Yang Di-Pertuan Agong for his assent. According to Article 66 of the Constitution, the Yang Di-Pertuan Agong shall give his assent within thirty days of the bills being presented to him by affixing the Public Seal on them, following which they would become law. If a bill is not assented to within the specified thirty days, it shall become law at the expiration of this period as if he had assented to it in the required manner. The role of the Yang

\textsuperscript{43} Neo, supra n. 26, 96.
\textsuperscript{44} Art. 45(2) of the Federal Constitution.
\textsuperscript{45} Art. 47 of the Federal Constitution.
\textsuperscript{46} Art. 45(3A) of the Federal Constitution.
\textsuperscript{47} Art. 49 of the Federal Constitution.
\textsuperscript{48} See Art. 67 of the Federal Constitution which expressly states that bills or amendments making provisions for certain issues (e.g., the imposition or increment of any tax, or the compounding or remission of any debt due to the federation) shall not be introduced in the House of Senate.
Di-Pertuan Agong as part of the legislature is therefore very limited and is purely ceremonial.\textsuperscript{49}

19. The Constitution also requires the Yang Di-Pertuan Agong to appoint a Cabinet of Ministers (Jemaah Menteri) to advise him in the exercise of his executive functions. For this, he shall first appoint a Prime Minister (Perdana Menteri), a matter which he has sole discretion of, to preside over the Cabinet. The Prime Minister must be a member of the Dewan Rakyat who in the Yang Di-Pertuan Agong’s judgment is likely to command the confidence of the majority of the members of that House\textsuperscript{50} and is not a person who is a citizen by naturalization.\textsuperscript{51} This has consistently been the President of UMNO who is traditionally also the Chairman of Barisan Nasional.


20. Upon the Prime Minister’s advice, the Yang Di-Pertuan Agong selects the individuals who would form the Cabinet of Ministers (Jemaah Menteri). The selection is made from among members of both Houses of Parliament. The Prime Minister of Malaysia, as the head of the government of a multi-ethnic country, needs to perform a difficult balancing act in the composition of his Cabinet. The choice is invariably dictated not just by administrative, but also by political, considerations. Apart from having to reflect the opinions within his party, it is necessary for him to include members of the component parties of Barisan Nasional, members of the different ethnic groups, representatives of the various states (particularly Sabah and Sarawak) and women, in order to reflect Malaysia’s pluralism.\textsuperscript{52}

The Cabinet, acting as the executive wing of the government, is responsible for formulating policies and development plans for the smooth running and growth of the country. The Constitution provides that it shall be collectively responsible to Parliament.\textsuperscript{53} This effectively requires every member to support all decisions of the Cabinet including those which they have voted against.\textsuperscript{54} A member who is unable to stand by a Cabinet decision in public would be expected to resign.

21. Governmental work is currently divided into, and shouldered by, the following twenty-four Ministries (Kementerian):

- Ministry of Agriculture and Agro-based Industry (Pertanian dan Industri Asas Tani)
- Ministry of Defence (Pertahanan)

\textsuperscript{50} Art. 43(2) of the Federal Constitution.
\textsuperscript{51} Art. 43(7) of the Federal Constitution.
\textsuperscript{52} Harding, \textit{supra} n. 49, 119.
\textsuperscript{53} Art. 43(3) of the Federal Constitution.
\textsuperscript{54} Harding, \textit{supra} n. 49, 119.
– Ministry of Domestic Trade, Cooperative and Consumerism (*Perdagangan Dalam Negeri, Koperasi dan Kepenggunaan*)
– Ministry of Education (*Pelajaran*)
– Ministry of Energy, Green Technology and Water (*Tenaga, Teknologi Hijau dan Air*)
– Ministry of Federal Territories and Urban Well-Being (*Wilayah Persekutuan dan Kesejahteraan Bandar*)
– Ministry of Finance (*Kewangan*)
– Ministry of Foreign Affairs (*Luar Negeri*)
– Ministry of Health (*Kesihatan*)
– Ministry of Higher Education (*Pengajian Tinggi*)
– Ministry of Home Affairs (*Dalam Negeri*)
– Ministry of Housing and Local Government (*Perumahan dan Kerajaan Tempatan*)
– Ministry of Human Resources (*Sumber Manusia*)
– Ministry of Information, Communication and Culture (*Penerangan, Komunikasi dan Kebudayaan*)
– Ministry of International Trade and Industry (*Perdagangan Antarabangsa dan Industri*)
– Ministry of Natural Resources and Environment (*Sumber Asli dan Alam Sekitar*)
– Ministry of Plantation, Industries and Commodities (*Perusahaan Perladangan dan Komoditi*)
– Ministry of Rural and Regional Development (*Kemajuan Luar Bandar dan Wilayah*)
– Ministry of Science, Technology and Innovation (*Sains, Teknologi dan Inovasi*)
– Ministry of Tourism (*Perbadanan Perikanan*)
– Ministry of Transport (*Pengangkutan*)
– Ministry of Youth and Sports (*Bela dan Sukan*)
– Ministry of Women, Family and Community Development (*Pembangunan Wanita, Keluarga dan Masyarakat*)
– Ministry of Works (*Kerja Raya*)

22. All Ministries, including *Perdana Putra* (the Prime Minister’s office), *Seri Perdana* (the Prime Minister’s official residence) and the Palace of Justice are located in the federal territory of Putrajaya. Named after Malaysia’s first Prime Minister Tunku Abdul Rahman Putra Al-Haj who is also known as *Bapa Malaysia* (father of the nation), Putrajaya is a planned city which took over from Kuala Lumpur as the federal government administrative centre. The move had been deemed necessary so as to reduce congestion and overcrowding in the capital city. The site was chosen in view of its strategic location of being just 25 kilometres south of Kuala Lumpur and 20 kilometres north of the Kuala Lumpur International Airport (KLIA) which is situated in the district of Sepang. Parliament, however, is still located in Kuala Lumpur.

23. As indicated above, legislative and executive powers are divided between federal and state authorities. The states of Johor, Kedah, Kelantan, Negeri Sembilan, Pahang, Perak, Perlis, Selangor and Terengganu are headed by their respective Sultans, each of whom is the religious leader (of the Islamic faith) of his respective state. Although Melaka, Pulau Pinang, Sabah and Sarawak are headed by their respective Yang Di-Pertua Negeri, for these states and the federal territories of Kuala Lumpur, Labuan and Putrajaya, it is the Yang Di-Pertuan Agong who is their Islamic religious leader.

24. Legislative authority at state level is vested in a State Legislative Assembly (Dewan Undangan Negeri) which passes laws that apply in the state. Unlike Parliament, the thirteen state legislative assemblies are unicameral. The members are elected through state elections which are held every five years alongside the election to the federal Parliament. The party with the largest majority forms the state government (kerajaan negeri). Its leader would be the head of the state government. In states with a monarch, he would be known as a Menteri Besar (Grand Minister) and in states without a monarchy, as a Ketua Menteri (Chief Minister). He would appoint members of the state executive council (majlis mesyuarat kerajaan negeri) from the state assembly and they, as led by the Menteri Besar or Ketua Menteri, exercise executive power through their various administrative portfolios.

25. The ninth Schedule of the Federal Constitution provides guidance on the issues that Parliament may legislate on and those that may be enacted by State Legislative Assemblies. It holds three Lists: the Federal List, the State List and the Concurrent List.

26. The Federal List contains matters that are of importance to the federation as a whole, in respect of which Parliament has power to pass laws on. These include: external affairs, defence of the federation or any part thereof and internal security; civil and criminal law and procedure and the administration of justice; citizenship and naturalization; the machinery of government; finance; trade, commerce and industry; shipping, navigation and fisheries; communications and transport; federal works and power; surveys, inquiries and research; education; medicine and health; labour and social security; and tourism.

On medicine and health, the federal government’s powers and responsibilities include matters relating to hospitals; clinics and dispensaries; the medical profession; maternity and child welfare; lepers and leper institutions; lunacy and mental deficiency (including places for reception and treatment); poisons, dangerous drugs, intoxicating drugs and liquors; and the manufacture and sale of drugs.

27. The State List includes matters like Islamic law and personal and family law of persons professing the religion of Islam; and other matters of regional concern such as agriculture and forestry; land; local government; state works and water;

56. Arts. 74 and 80 of the Federal Constitution.
57. Emphasis added.
machinery of the state government; state holidays; inquiries for state purposes; turtles and riverine fishing; libraries, museums, ancient and historical monuments and records and archaeological sites and remains; native law and custom; incorporation of authorities and bodies set up by state law; ports and harbours; regulation of traffic by water in ports and harbours or on rivers wholly within the state; and cadastral land surveys. Each state also possesses its own Constitution.

28. The Concurrent List delineates areas which both the federal and state governments can legislate on. These include social welfare; social services; protection of women, children and young persons; scholarships; protection of wild animals and wild birds; National Parks; animal husbandry; prevention of cruelty to animals, veterinary services and animal quarantine; town and country planning; vagrancy and itinerant hawkers; public health, sanitation and the protection against diseases; drainage and irrigation; rehabilitation of mining land and land which has suffered soil erosion, fire safety measures and fire precautions in the construction and maintenance of buildings; culture and sports; and housing and provisions for housing accommodation; and improvement trusts.

In the event where any state law is inconsistent with a federal law, the latter shall prevail. The state law shall, to the extent of the inconsistency, be void.

29. As for the three federal territories, they are governed directly by the federal government and are not subject to the laws of the states which they originated from.

30. Turning next to the Judiciary, this third branch of the government is endowed with the following powers: to decide on civil and criminal matters; to pronounce on the legality of legislative and executive acts; and to interpret the Federal and State Constitutions. These powers are exercised through a system of courts which consists of subordinate courts and superior courts.

31. The subordinate courts consist of the Penghulu’s (local headman’s) Courts; the Magistrates Courts; and the Sessions Courts. The Penghulu’s Courts attend to civil matters on claims which do not exceed MYR 50 and where the parties involved are of Asian race and speak and understand the Malay language. They also hear criminal cases, but their jurisdiction is limited to minor offences charged against a person of Asian race who can be punished with a fine which does not exceed MYR 25.

Parties who are dissatisfied with the decision of the Penghulu’s Courts can appeal to the Magistrates Courts. The Magistrates Courts also hear all civil matters where the claim does not exceed MYR 25,000; and criminal cases where the maximum term of imprisonment does not exceed ten years or which are punishable only with a fine.
Meanwhile, the Sessions Courts hear civil cases where the claims are over MYR 25,000 but do not exceed MYR 250,000. However, in matters relating to motor vehicle accidents, leasehold estates and distraint, they have unlimited jurisdiction. The Sessions Courts also hear all criminal cases with the exception of offences which are punishable by death. They may pass a wide range of sentences which the law empowers them to, except the death penalty.

32. The superior court system is a three-tiered system which consists of the High Courts; the Court of Appeal; and at the apex, the Federal Court.

There are two High Courts: one for Peninsula Malaysia and one for East Malaysia. They are known as the High Court of Malaya, and the High Court of Sabah and Sarawak respectively. They have general supervisory and revisionary jurisdiction over all the subordinate courts; and serve as appellate courts for appeals from the subordinate courts in both civil and criminal matters. They hear civil cases where the claim exceeds MYR 250,000 (except for cases relating to motor vehicle accidents, leasehold estates and distraint). They also have jurisdiction to hear all criminal matters including those where the sentence is capital punishment.

The Court of Appeal (Mahkamah Rayuan) hears civil and criminal appeals against rulings by the High Courts.

The Federal Court of Malaysia (Mahkamah Persekutuan Malaysia) is the highest judicial authority, and the final Court of Appeal, in Malaysia. It has original and exclusive jurisdiction to determine: any question in relation to whether a law passed by Parliament or a State Legislative Assembly is invalid; and disputes between states or between the federation and any state. Civil appeals from the Court of Appeal may be heard only after leave is granted by the Federal Court. It also hears criminal appeals from the Court of Appeal but only in relation to matters heard by the High Court in its original jurisdiction (rather than one appealed from the subordinate courts). Its decision binds all the courts underneath it. It is headed by the Chief Justice, a position currently held by Tan Sri Dato’ Sri Ahmad Fairuz Dato’ Sheikh Abdul Halim who took office in 2003.

33. The Court of Appeal and the Federal Court of Malaysia are based at the Palace of Justice (Istana Kehakiman) in Putrajaya. They are the only two courts where cases are heard by panels of judges. Cases in all other courts are heard by judges sitting individually.

34. The Yang Di-Pertuan Agong, acting on the advice of the Prime Minister and after consulting the Conference of Rulers, appoints the Chief Justice of the Federal Court, the President of the Court of Appeal, and the Chief Judges of the two High Courts.

62. Art. 121(2) of the Federal Constitution. Although the Privy Council used to be the highest Court of Appeal for Malaysia, this practice was abolished on Jan. 1, 1985 – see Foong, supra n. 60, 71.
64. Formerly known as the Lord President.
To be appointed a superior court judge, the individual must be a Malaysian citizen who in the ten years preceding his or her appointment has been an advocate in those courts or any of them or a member of the judicial and legal service of the federation or of a legal service of a state.\footnote{66} Judges of the superior courts retire at the age of 65 but may leave office at any time before then by tendering their resignation in writing to the Yang Di-Pertuan Agong. They shall not otherwise be removed from office unless they have breached any provision of the Code of Ethics prescribed under Article 125(3A) of the Constitution (currently the Judges’ Code of Ethics 1994), or on grounds of inability through infirmity of body or mind or any other cause which does not enable them to discharge the functions of their office.\footnote{67}

35. Although Malaysia’s courts have a centralized rather than a federal organization, running parallel to the national civil (or secular) court system is the Islamic (or religious) court system which operates at state level.\footnote{68} As observed previously, Islamic Law is a matter for which states are granted legislative authority. To this effect, all states have passed laws which apply to their Muslim inhabitants. They have also established Islamic courts, known as Syariah Courts (Mahkamah Syariah), to adjudicate on disputes which arise from the application of their version of Islamic Law. These courts only have jurisdiction over Muslims. Further, as state courts, their jurisdictions are confined to individual state boundaries.\footnote{69}

Cases that fall within their purview include family law matters (e.g., adoption, betrothal, marriage, nullity of marriage, judicial separation or divorce);\footnote{70} the maintenance of dependents, legitimacy or guardianship or custody of infants; wills or death-bed gifts of a deceased Muslim; the definition and regulation of charitable and religious endowments; and the division and inheritance of testate or intestate property. Syariah Courts also have jurisdiction over certain offences which are against the precepts of Islam like gambling, the consumption of alcohol, adultery, fornication, the ill-treatment of one’s wife and non-observance of fasting during the month of Ramadan (including, in some states, the act of selling food, drink or tobacco to Muslims for immediate consumption during fasting hours).\footnote{71} Their sentencing powers are limited to a maximum of three years imprisonment, any fine which does not exceed MYR 5,000 or whipping which does not exceed six strokes of the cane.\footnote{72}

To be appointed as a judge of the Syariah Court, an individual must be a Muslim and holds a degree in Syariah or Islamic Law. They must also obtain a Diploma in the Administration of Islamic Judiciary which is offered by Universiti Islam
Syariah judges are appointed by the Sultan of the respective states. For states without a monarch, it is the Yang Di-Pertuan Agong who appoints them.\textsuperscript{74}

\section*{Population and Vital Statistics}

36. The country has registered a three-fold rise in the population rate since the time of independence when it was populated only by 8.3 million inhabitants. Life expectancy at birth then was only 55.8 years for men and 58.2 for women.\textsuperscript{75} This has now increased to 72 years for men and 76.8 years for women.\textsuperscript{76}

37. As at the end of 2010, the crude birth rate was 17.5 per 1,000 population and the crude death rate was 4.8 per 1,000 population. The stillbirth rate was 4.6 per 1,000 births; the infant mortality rate was 6.5 per 1,000 live births; and the toddler mortality rate was 0.4 per 1,000 population aged 1–4 years. The maternal mortality ratio was 27.3 per 100,000 live births.\textsuperscript{77}

38. The number of live births recorded for the period 2009–2010 was 475,800, and the ratio between male and female babies was 52:48. The country’s crude rate of natural increase is 12.7 per 1000 population.\textsuperscript{78}

39. Malaysia has a relatively young population, with 45.6\% of its inhabitants under the age of 25. The overall sex ratio is 104 males to 100 females.\textsuperscript{79}

40. The country has experienced a steady increase in urbanization in recent decades. With only 27\% of its inhabitants living in urban areas from 1957 to 1970, this grew to 34\% in 1980, then 41\% in 1990 and 62\% in 2000.\textsuperscript{80} By 2010, up to 71\% of the population reside in urban areas.\textsuperscript{81} This was prompted by an economy which was becoming increasingly industrial-based – a trend which began under the leadership of Tun Dr Mahathir Mohamad.\textsuperscript{82} This brought changes to states, districts and towns, which over time led to a better standard of living through improved
housing and public amenities, as well as an expansion in educational and employment opportunities.\textsuperscript{83} However, as the discussion in the next part of the work shows, it also ushered in new challenges on the health front.

41. The five principal causes of death for adults in Malaysia are ischaemic heart disease, pneumonia, cerebrovascular disease, septicaemia and road traffic accidents.\textsuperscript{84}

§5. SOCIAL AND CULTURAL VALUES REGARDING HEALTH

42. As is the case in other countries, health in the wider sense incorporates a wide range of health-promoting and sustaining activities including chlorination and fluoridation of clean water supplies, proper sanitation and waste/sewage disposal, improved nutrition and food quality control, housing and environment/drainage programmes, occupational health and disease prevention.\textsuperscript{85}

In Malaysia, these are provided through the efforts of state governments and various ministries particularly the Ministry of Health; the Ministry of Energy, Green Technology and Water; the Ministry of Housing and Local Government; the Ministry of Natural Resources and Environment; the Ministry of Science, Technology and Innovation; and the Ministry of Human Resources. The Ministry of Education also runs school health programmes which include personal preventative care like dental care;\textsuperscript{86} assistance with nutrition for children from poorer families; screening for scoliosis;\textsuperscript{87} and immunizations and vaccinations against tuberculosis, diphtheria, tetanus, pertussis, poliomyelitis, measles and rubella.\textsuperscript{88} Because of the changes which these and better health care have brought, the country has witnessed a major shift in its disease pattern in the last century that is, from those characteristic of underdevelopment to that emblematic of industrialization and urbanization.\textsuperscript{89}

43. At the beginning of the twentieth century, the main diseases that were widespread fell into two broad categories.\textsuperscript{90}

The first are those which were generally long endemic in the country like cholera and smallpox. Alongside them were other conditions prevalent in the countryside

\textsuperscript{83} Department of Statistics, Compendium of Environment Statistics Malaysia 2011, 92.
\textsuperscript{89} World Health Organization (WHO)-Malaysia, Country Cooperation Strategy 2009-2013, 12.
\textsuperscript{90} M.D. Tate, The History of Medicine in Malaysia: The Foundation Years 36–37 (Academy of Medicine of Malaysia 2005).
like yaws, elephantiasis, hookworm and a range of skin infections which resulted from vitamin deficiencies and lack of proper hygiene.

The second category relates to afflictions associated with the colonial economy. The clearing of large tracts of jungle to produce commercially viable rubber plantations; the building of railways, roads and telegraph lines; and the extremely poor working conditions of those who toiled in the tin mines and rubber plantations; brought with them new diseases and led to the proliferation of existing ones. Added to these were overcrowded and squalid tenements of the towns, the very low standards of public sanitation and hygiene, and the shortage of clean water supply. These caused large numbers of the inhabitants to suffer from diseases like malaria, tuberculosis, typhoid, beri-beri, venereal disease and dysentery.

44. While those diseases are no longer major threats in the contemporary era, a growing number of the population are now afflicted with non-communicable, chronic and/or degenerative conditions like diabetes, hypertension, cardiovascular diseases, cancer, stroke, stress-induced mental illness, end stage renal disease, and obesity. An increasingly stressful and sedentary lifestyle (including

91. Since the migrant labourers from China and India were predominantly men, and they had come to Malaya without their wives, loneliness and the harsh conditions which they were working in made many turn to prostitutes for comfort. This was facilitated by the colonial government who brought in girls and young women, mainly from China, to work in the sex industry in Malaya. Sexually transmitted diseases were therefore rampant during this era – see C. Ng, et al., Feminism and the Women’s Movement in Malaysia: An Unsung (R)evolution (Routledge 2006); L. Manderson, Migrants, Minorities and Health: Historical and Contemporary Studies 49–69 (L. Marks & M. Worboys eds., Routledge 1997).


96. The three most prevalent forms are breast cancer, colorectal cancer and lung cancer – see National Health and Morbidity Survey 2006.


amongst adolescents and children); the popularity of fast food outlets; and air pollution are among the main contributory factors.

45. In addition, habits like cigarette smoking, and alcohol and drugs consumption play an important part. It is worthy of note that the prevalence of smoking among adults in Malaysia has consistently been above 20% (i.e., 21.5% in 1986, 24.8% in 1996 and 22.8% in 2006) and smoking rates among young people, including females, are on the rise. Pervasive tobacco advertising has managed to increase the perceived social value of smoking to Malaysians of all ages and both sexes. Many smokers believe that cigarette consumption is a means of relaxation which enhances their image and makes them more attractive to the opposite sex, and helps them control their body weight. It is reported that the amount a smoker’s household spends on tobacco varies from as low as 5% to as high as 65%, and the prevalence of smoking is highest among the socio-economically disadvantaged. In spite of society’s general disapproval of smoking and the presence of messages on cigarette packets warning about the health hazards of smoking, these do not motivate more than 70% of smokers to quit. It is estimated that up to 10,000 deaths a year are due to smoking-related diseases, and this figure is likely to increase to 30,000 by 2020 if the current trend continues.

46. High alcohol consumption has been identified as another widespread problem. According to the World Health Organization (WHO), Malaysia is the tenth largest consumer of alcohol in the world. This is indeed worrying both in view of the modest size of its population, as well as the fact that 60% of its population are Muslims for whom alcohol consumption is strictly forbidden. It was reported that over USD 500 million (MYR 1.5 billion) are spent on alcohol every year and the

References:
104. National Health and Morbidity Survey, Malaysia. This over-20% smoking prevalence was also registered amongst doctors, thereby serving as one of the barriers to implementing cessation interventions in the country – see G.H. Tee, et al., Changing Habits and Attitudes towards Smoking among Future Physicians, 62 Med. J. Malay. 383 (2007).
105. Notwithstanding the fact that it is generally considered improper and indecent in Malaysia for women to smoke in public – ibid., 387.
106. D. Efroymson & M.G. Velasco, Tobacco Use in Southeast Asia: Key Guidelines for Policy Development 17–18, 27 (Southeast Asia Tobacco Control Alliance 2007).
107. Ibid., 17–18.
108. Ibid., 27.
109. Ibid., 29.
per capita consumption is 7 litres.\textsuperscript{112} Although direct alcohol advertising over broadcast media is prohibited, alcohol companies are allowed to advertise in cinemas and in the print media. They also sponsor sporting, music and charitable events, and promote their brands with other products.\textsuperscript{113} Such is their success and influence that around 23\% of the Malaysian population consume alcohol on a regular basis, the majority of whom are men. Of these, 32.5\% reported a high intake.\textsuperscript{114} Alcohol abuse is known to have led to many serious health and social problems like mental illness, gastro-oesophageal reflux disease, reflex oesophagitis, liver failure, domestic abuse, child abuse and neglect, exacerbation of poverty and unemployment.\textsuperscript{115} Further, around 30\% of road traffic accidents nationwide are caused by drinking and driving, with 38\% of these resulting in fatalities.\textsuperscript{116}

47. Drug abuse too is rampant with the number of those suffering from drug addiction increasing at an exponential rate in the last few decades. With only 711 addicts detected in 1970, this number rose to 26,513 in 1982, then more than trebled to 92,310 in 1983,\textsuperscript{117} so much so that the then Prime Minister, Tun Dr Mathathir Mohamed, declared drugs (\textit{dadah}) as the nation’s number one enemy and a threat to national security.\textsuperscript{118} Legislation was amended to allow the death sentence to be made mandatory for those who smuggled more than 15 grams of heroin into the country,\textsuperscript{119} and for drug addicts to be detained and compelled to undergo compulsory rehabilitation for two years.\textsuperscript{120} But with 85\% of those detained relapsing after completing their rehabilitation, the correctional/criminal treatment approach is now gradually replaced with drug substitution therapy. Despite these measures, the problem persists and the number of drug addicts in the country has now grown to around 800,000.\textsuperscript{121} Ninety-eight per cent of these are males and a majority of them (up to 70\%) are between the ages of 20 to 39 years.\textsuperscript{122} The social and health problems which it produces are numerous. Apart from the wasted economic potential in terms of lost workforce, many drug addicts also engage in criminal activities (like theft, selling drugs, fraud and homicide) to support their addictive habits. The costs of their rehabilitation, therapy and drugs-related health problems also pose a burden on the country’s resources. Even more problematic is how their needle-sharing activity exposes society to the scourge of HIV and AIDS.

\textsuperscript{112} Ibid.
\textsuperscript{114} National Health and Morbidity Survey, Malaysia.
\textsuperscript{115} WHO (2004), \textit{supra n. 111}
\textsuperscript{116} The Road Safety Council, Malaysia.
\textsuperscript{118} Ibid.
\textsuperscript{119} Sale of Drugs Act 1952 (revised 1989).
\textsuperscript{120} Drug Dependents (Treatment and Rehabilitation) Act 1983.
\textsuperscript{121} J.S. Gill, et al., \textit{Anxiety Disorders among Incarcerated Drug Users}, 19, \textit{Malaysian J. Psych.} 3 (2010).
In just over twenty years since the first three HIV cases were detected in 1986, the cumulative number of reported HIV infections up to 2010 was a staggering 91,362. The same period witnessed 13,394 HIV/AIDS-related deaths. Statistically, the majority of the sufferers are males (90.8%), and studies show that the use and sharing of contaminated drug injecting equipment account for the majority of HIV transmissions in Malaysia (i.e., 70.6%). Other factors include heterosexual intercourse; and homosexual or bisexual contact. Alarming, up to 2.4% of sufferers are individuals aged 18 or under. Their exposure to HIV infection is acquired through sexual and physical violence; incest; sex work; human trafficking; and/or underage and unprotected sex. The stigma and discrimination they face have led to ostracization, exploitation, homelessness and loss of educational opportunity.

The population’s heavy reliance on motor vehicles for transportation has also contributed to rising numbers of death, physical injuries and disabilities caused by road traffic accidents. As at 2010, there were 20,006,953 registered vehicles on Malaysian roads—a staggering number in view of the fact that the total population is, as highlighted previously, only around 28 million. The majority of these were motorcycles and cars. According to statistics released by the Royal Malaysian Police (Polis DiRaja Malaysia), the same year saw 414,421 road accidents reported. From these, there were 6,872 fatalities and 21,397 injuries recorded. Thus apart from being the fifth highest cause of death in the country, road traffic accidents are also an encumbrance on the nation’s health resources not just through the need to provide immediate emergency procedures on site and life saving procedures in hospital, but also from the costs of the subsequent rehabilitation of those suffering injuries and/or disabilities. The relationship between transport and health goes further to include the issues of congestion, air and noise pollution, and visual intrusion—all of which can contribute to various health problems that put added pressure on the health sector.

125. Ibid.
126. Ibid.
127. Ibid., 31.
130. In recent years, this even includes ambulances—see K. Singh, Are We Safe in Ambulances?, 41 Berita MMA 94 (2011).
132. I.e., 9,773,671 and 9,468,397 respectively—ibid.
134. H. Moe, Road Traffic Injuries among Patients who Attended the Accidents and Emergency Unit of the University of Malaya Medical Centre, Malaysia, 11 J. Health & Translational Med. 22 (2008).
136. Ibid., 2–3.
50. On the issue of emergency medical services, the public had previously needed to dial different numbers to access the ambulance service, the police, and the fire and rescue department. Each of these agencies had used different communication systems, and there was no inter-agencies communication. In 2007, ‘999’ was introduced as a single nationwide emergency number for all kinds of emergencies, whether health-related or not. A trained telephone operator will direct the call to the nearest hospital, police station and/or the fire and rescue department, depending on the nature of assistance required. Whilst this is an improvement on the previous system, the country’s emergency access number is consistently plagued with prank calls (i.e., up to 68%) which led to wastage of resources. Traffic congestion on major roads in large cities also contributes to long ambulance response time. In Kuala Lumpur, for instance, it takes an average of 21.1 minutes from the time that a call is received to the time of the ambulance’s arrival.

51. Further, with 5.3% of the total population aged 65 and above (i.e., approximately 1.4 million), this too has serious implications for the country’s health resources. This age group is more likely to suffer from multiple chronic degenerative diseases – the most common among which are hypertension, arthritis/rheumatism, diabetes, vision problem, heart/circulatory disorder, cataracts, respiratory disorder, stroke, osteoporosis, mental impairment, dementia and depression. They therefore make increasing demands on general practice consultations and acute hospital admissions. Prescription drug use among them is predictably high and the enhancement in life-span due to innovations in drug therapy could also increase the likelihood of elderly patients seeking dental treatment. Of importance is this age group’s particular reliance on public, rather than private, health care on ground of costs. In this regard, it is interesting to note that the Ministry of Health has announced that beginning from 1 January 2012, the elderly would even be exempted from having to pay the nominal MYR 1 fee usually...
charged for those seeking outpatient care from public hospitals and clinics. They would also be entitled to a 50% discount for admission to third-class wards in public hospitals, with a maximum charge of MYR 250 for each admission. Thus, the cost of their care would be heavily shouldered by the government.

Chapter 2. General Description of the Health Care System

§1. General Review of the Health Care System

52. One interesting and significant feature of Malaysia's rich cultural mix is the presence and co-existence of many different models of health care. These include scientific medicine, Malay traditional medicine, traditional Chinese medicine, the folk medicine of the Orang Asli, homeopathy and ayurvedic medicine. In the formal sector, however, scientific medicine is the dominant system, and it is also the only model supported by the government.

53. The medical model was first introduced in the region in the nineteenth century in the early days of British occupation. Geared as they were to the cause of colonialism, health and medical services and infrastructure were catering only to the health care needs of colonial administrators and their families, and the labour force which was crucial to the colonial economy. They were therefore concentrated in territories which were the main hubs of commercial enterprise which also contained the highest number of British residents as these were the most prosperous and developed areas in the land. Those in the interior of the country, who numbered about half of the population but who were unconnected to colonial capitalism, were outside their remit. There was therefore a lack of any organized medical service for the public at large and of medical manpower and training facilities. The focus of the services had mainly been curative, with little, if any, attention paid to preventative medicine.

54. It was this urban-centred and curative-based orientation of pre-independence days that the country became heir to at the time of independence. Not only was this system immediately adopted as the country's formal health care system, the post-independence government also wasted no time in constructing a rural health system that was based on the medical model. All these therefore proceeded without any serious assessment of the viability of the system for post-


149. For an interesting discussion, see Tate, supra n. 90, 1–35.

150. H.L. Chee, *Health and Health Care in Malaysia: Present Trends and Implications for the Future* 7 (Universiti of Malaya Press 1990). The last five years have nevertheless witnessed an interesting change in outlook where traditional and complementary medicine have begun to be offered as adjuncts to allopathic medicine in a small number of public hospitals – see the discussion in Part I, Ch. 3 below.


153. Tate, supra n. 90, 38; R. Johnson, *British Imperialism* 112 (Palgrave Macmillan 2003).


155. Tate, supra n. 90, 88.

156. H.L. Chee, supra n. 150, 58.
Most notable was the absence of any meaningful effort to incorporate other models of health care, which were already widely utilized by the different ethnic groups, into the official framework.158

That said, the federal government was committed to the idea of ensuring that its health and medical services reach and benefit the country as a whole. In the design and implementation of the first in a series of five-yearly national development plans (Rancangan Malaysia Pertama 1966–1970) in which the health sector was a vital component, the focus and priority were on rectifying the disparity in the distribution of and access to health and medical services between urban and rural areas159 and among states. Attention also began to be paid to preventative medicine (particularly in relation to maternal and child health, and the control of communicable diseases). Likewise with the Second Malaysia Plan 1971–1975 (Rancangan Malaysia Kedua), the priority was to expand rural health services so as to bring about a more equitable distribution of health services throughout the country.160

These saw the establishment of rural health clinics (each of which was to serve between 2,000 and 4,000 people) and health centres (each of which would oversee four rural health clinics) which provided maternal and child care, communicable disease control, the rural environmental sanitation programme (e.g., the introduction of pour-flush latrines, sanitary wells and gravity-fed safe water supply and sanitary waste disposal) to control water-borne diseases, health education, outpatient care for common diseases and dental care.161 In addition to the rural health service, the federal government through the Ministry of Health also initiated a number of national public health programmes to tackle the country’s then most serious public health problems. These included programmes to: control tuberculosis using new anti-TB drugs and antibiotics; eradicate malaria using indoor house spraying of DDT to interrupt the transmission cycle; and control yaws and filariasis using antibiotics and anti-filarials. Also implemented were a national family planning programme using oral contraceptives, and an applied food and nutrition project which included nutrition education, de-worming and home gardening. All these managed to help improve the health of the population and considerably reduced the country’s disease burden so much so that by the 1970s, the life expectancy for men

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158. These other models of health care continue to be widely used until today, not just by their respective ethnic groups, but by others in the country too. Because of this, the government has eventually recognized the need to include them within the national health framework – see the discussion in Part I, Ch. 3 below.
159. There is an important racial and political dimension to this move in that rural health service was deemed as a significant means of advancing the economic development and welfare of the Bumiputeras, the majority of whom were living in rural areas in the early post-independence years – H.L. Chee, The Emergence of a Transnational Healthcare Service Industry in Malaysia, 8 (Asia Res. Inst., Working Paper Series No. 76, 2006).
160. Tan, supra n. 75, 94.
increased to 64 years (from 55.8 in 1957) and for women, to 69 years (from 58.2 in 1957).  

57. Following the realization of an extensive rural health service and a significant reduction in infectious diseases, the government shifted its focus in the 1980s towards identifying underserved population groups and their needs, and improving the utilization of existing services. A nutritional surveillance programme was also implemented to monitor the nutritional status of children under the age of 5. This has enabled public health staff to make an early intervention in cases of moderate and severe malnutrition. Other programmes included: encouraging mothers to breastfeed; school nutrition promotion; and prevention of iodine deficiency through iodized salt and the iodization of water supply in affected areas.  

58. Up until that point, the government has, in addition to its public health programmes, taken a direct role in the provision of health care services in the country. A referral system based on an ascending hierarchy of increasingly complex health facilities and services was used. At the base level, primary health care was delivered through rural clinics and urban health centres. Secondary and tertiary care were provided through hospitals and specialist medical institutions (e.g., for the treatment of mental illness, cancer, heart diseases and tuberculosis). Again, according to the complexity of the care needed, the patient could be referred to district hospitals (which provided general medical and nursing care); larger regional general hospitals located in state capitals (which are equipped with specialist services that range from basic to high technology care) and at the tertiary level, national referral centres (e.g., university hospitals and the national referral hospital that is, Kuala Lumpur Hospital).  

59. A change of direction was nevertheless signalled in the mid-1990s. In the Sixth (Rancangan Malaysia Ke-Enam 1991–1995) and Seventh (Rancangan Malaysia Ke-Tujuh 1996–2000) Malaysia Plans, the government announced that corporatization and privatization of hospitals and medical services would begin to be implemented. This was followed by a declaration that it intended to gradually reduce its role as the provider of health services, and to increase its regulatory and enforcement functions. Tied up as these plans were with the economic liberalization and

162. Ibid., 295–296.  
163. For instance, surveys carried out between 1977–1980 indicated that 12% of the population did not have adequate access to basic services, 70% of the rural population did not have safe water; and that only 52% of children had completed their primary immunization schedule. To address these problems, mobile health teams were sent out, using road and river transport, to the more remote villages. There, they provided medical and preventative care and set up the groundwork for sanitation measures until static infrastructure were available – ibid., 296.  
164. By mobilizing communities in partnership with health care professionals to create awareness of the medical and health services available – ibid.  
165. Ibid., 301.  
deregulation initiatives which have been vigorously pursued by the Mahathir administration since the mid-1980s;\(^\text{167}\) the increasingly market-oriented health policy they created has resulted in the growth of a thriving private health sector.\(^\text{168}\)

60. An initial step in this direction was the corporatization of the National Heart Institute (\textit{Institut Jantung Negara}) which was previously a Ministry of Health facility. Likewise with the public teaching hospitals affiliated to the medical faculties of \textit{Universiti Malaya} (UM), \textit{Universiti Kebangsaan Malaysia} (UKM) and \textit{Universiti Sains Malaysia} (USM) which were formerly under the control of the Ministry of Education. Another vital measure was to outsource the government drug procurement and distribution centre to the private sector which now acquires and supplies drugs to all public health facilities. Likewise, contracts were awarded to private companies for five support services for all public hospitals and clinical facilities, that is, the cleaning services, linen and laundry, clinical waste management, biomedical engineering maintenance and facility engineering maintenance.\(^\text{169}\)

61. But by far the most palpable effect of the push towards privatization is the unprecedented burgeoning of private hospitals and specialist clinics in major towns particularly Kuala Lumpur.\(^\text{170}\)

62. Still, it is necessary to point out that private health care is not a new phenomenon in Malaysia. Ever since the 1960s, there were a number of individually operated general practice clinics around the country. They are situated mainly in large cities and towns, and have provided the bulk of primary care in these areas.\(^\text{171}\) There were also several private hospitals around, but these are by and large voluntary or not-for-profit institutions. They were established by community and religious organizations to complement state-run hospitals.\(^\text{172}\) They were not investor-owned and are generally managed by boards of directors who offer their services on a voluntary basis. They have a charitable mission and usually have provisions for collecting donations which are exempted from tax as well as for providing treatment at no cost or at a discounted rate for those who cannot afford to pay.\(^\text{173}\) Specialist care was nevertheless still confined almost solely to government-funded general hospitals. Significantly, out-of-pocket payment in full for one’s medical treatment in a hospital was a concept which was alien to the general public then.\(^\text{174}\)

\[\text{167. Where he expounded the concept of ‘Malaysia Incorporated’ which envisioned the country as a corporative entity in which the government provides the enabling environment and the private sector operates as the main engine of growth – see H.L. Chee & S. Barraclough, supra n. 141, 20.}\]


\[\text{169. H.L. Chee, supra n. 159, 16.}\]


\[\text{171. K.K. Khoo, ‘Overview’ in S. Selvarajah and K.K. Khoo (eds.), supra n. 161, 5.}\]

\[\text{172. Wan Abdullah, supra n. 170, 93.}\]

\[\text{173. H.L. Chee & S. Barraclough, supra n. 166, 25.}\]

\[\text{174. Ong, supra n. 151, 163.}\]
Contrasted to these, the private hospitals built since the 1980s are mainly for-profit institutions. They receive huge injections of capital from local and international corporate investors and are jointly run by doctors and businessmen. One distinctive trait of these conglomerates (e.g., the Gleneagles group, Sime Darby, the Pantai conglomerate, the Kumpulan Perubatan (Johor) Healthcare (KPJ) which is a subsidiary of the Johor State Economic Development Corporation, Tan and Tan Development Berhad, and Parkway Holdings) is that they have broad investments, and health care is by no means their sole interest or specialty. In line with their other business interests, health care began to be perceived as a commodity to be sold to patients who are now deemed as consumers. Such was the zeal with which this goal was pursued that within a relatively short period of time, the private share of health care surged from 5.8% in 1981 to 55.6% in 2007.

The fees they charge are usually exorbitant and are out of the reach of many. Notwithstanding this, demand for their services is high among those who can avail themselves of private care. Among the reasons for this include: better interpersonal relations between patients and doctors; more attentive care; the comfort of no extended waiting; and the absence of a referral system which makes it possible for patients to be attended to by medical specialists on an unscreened, walk-in basis.

As can be seen from Table 2 below, their popularity and success have resulted in private hospitals now outnumbering public hospitals. As at the end of 2010, there were 254 private hospitals throughout the country compared to only 145 public hospitals. Most are concentrated in highly urbanized places (like Johor, Kuala Lumpur, Pulau Pinang and Selangor), thereby leading to duplication of services and inefficient use of resources.
Table 2 Private and Public Hospitals in Malaysia

<table>
<thead>
<tr>
<th>State</th>
<th>Public Hospital</th>
<th>Private Hospital</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Johor</td>
<td>13</td>
<td>37</td>
<td>50</td>
</tr>
<tr>
<td>Kedah</td>
<td>9</td>
<td>10</td>
<td>19</td>
</tr>
<tr>
<td>Kelantan</td>
<td>9</td>
<td>5</td>
<td>14</td>
</tr>
<tr>
<td>Kuala Lumpur</td>
<td>4</td>
<td>45</td>
<td>49</td>
</tr>
<tr>
<td>Labuan</td>
<td>1</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>Melaka</td>
<td>4</td>
<td>5</td>
<td>9</td>
</tr>
<tr>
<td>Negeri Sembilan</td>
<td>6</td>
<td>9</td>
<td>15</td>
</tr>
<tr>
<td>Pahang</td>
<td>10</td>
<td>9</td>
<td>19</td>
</tr>
<tr>
<td>Perak</td>
<td>16</td>
<td>15</td>
<td>31</td>
</tr>
<tr>
<td>Perlis</td>
<td>1</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Pulau Pinang</td>
<td>7</td>
<td>26</td>
<td>33</td>
</tr>
<tr>
<td>Putrajaya</td>
<td>1</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>Sabah</td>
<td>23</td>
<td>7</td>
<td>30</td>
</tr>
<tr>
<td>Sarawak</td>
<td>22</td>
<td>17</td>
<td>39</td>
</tr>
<tr>
<td>Selangor</td>
<td>13</td>
<td>65</td>
<td>78</td>
</tr>
<tr>
<td>Terengganu</td>
<td>6</td>
<td>3</td>
<td>9</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>145</strong></td>
<td><strong>254</strong></td>
<td><strong>399</strong></td>
</tr>
</tbody>
</table>

66. In more recent times, the consumers of private health care are drawn not only from people within the country. Malaysian health care has also been marketed to an overseas clientele. The impetus for this was the 1997 Asian economic crisis\textsuperscript{183} when the then nascent private health sector suffered a major setback after cash-strapped local patients of private hospitals shifted back to public health care.\textsuperscript{184} To save many of these facilities from downsizing or closing down, owners of private hospitals turned their attention to foreign countries to attract new consumers. Three categories of target markets were identified. The first are countries with inadequate medical facilities (like Indonesia, Myanmar, Vietnam and Laos). The second are those where medical treatment is very costly (like Singapore, Japan and Taiwan). The third are countries where long waiting lists exist in the public sector and where private health care is expensive (like the United Kingdom). Also targeted are the middle classes from the Middle East and China.\textsuperscript{185}


\textsuperscript{184} H.L. Chee, \textit{supra} n. 80, 4.

\textsuperscript{185} Ibid., 10.
67. Crucially, this marketing strategy was developed not only by and for the private hospitals themselves. Through the endorsement and support given by the Ministry of Health, the Ministry of Tourism and the Ministry of International Trade and Industry, the government too had been directly involved in actively promoting Malaysia as a destination for medical tourism from the very beginning. This is part of a strategy to increase revenue from tourism as well as to develop the industry in its own right.\(^ {186}\)

68. State involvement comes in three major ways.\(^ {187}\) The first is through tax incentives which are offered to support the growth of health care corporations. These include the provision of an industrial building allowance for hospital buildings, service tax exemption for expenses on medical advice and use of medical equipment, and tax deduction for expenses relating to pre-employment training. Hospitals that engage in medical tourism are also exempted from tax for all revenue received from foreign patients in excess of 5% of total hospital revenue. Second, it creates the institutional infrastructure for maintaining standards and quality (like an accreditation system,\(^ {188}\) standardization guidelines, and fee packaging guidelines). Third, the State takes a direct lead in the promotion of medical tourism overseas. To this end, the government has set up the Malaysia Healthcare Travel Council (MHTC)\(^ {189}\) to serve as the primary agency for formulating strategic plans to position Malaysia as a health care destination of choice and to spearhead marketing activities for the country’s medical travel industry.

69. The success of these initiatives has enabled Malaysia’s medical tourism industry to record more than 30% growth every year for the past few years.\(^ {190}\) To date, the majority of medical tourists have come from neighbouring countries like Indonesia (76.7%), Brunei, Thailand and Singapore.\(^ {191}\) Their numbers and the revenue which medical tourism has generated for the country are as follows:\(^ {192}\)

\(^{186}\) H.L. Chee & S. Barraclough, supra n. 166, 28.
\(^{188}\) E.g. through the establishment of the Malaysian Society for Quality in Health (MSQH) in collaboration with the Malaysian Medical Association and the Association of Private Hospitals of Malaysia. The Society is an independent not-for-profit organization which conducts a voluntary quality accreditation programme for Malaysian healthcare organizations, based on international codes. For further information regarding its accreditation programme, see the Society’s homepage at http://www.msqh.com.my.
\(^{189}\) See the homepage of the Malaysia Healthcare Travel Council (MHTC) at https://www.myhealthcare.gov.my.
\(^{190}\) W.W. Lim, Medical Tourism Hits Record 30% Growth per Year, The Star (May 11, 2012).
\(^{191}\) H.L. Chee & S. Barraclough, supra n. 166, 29.
\(^{192}\) Adapted from H.L. Chee, Medical Tourism and the State in Malaysia and Singapore, 10, Global Social Policy 336, 343 (2010).
### Table 3 Foreign Patient Numbers and Revenue from Medical Tourism

<table>
<thead>
<tr>
<th>Year</th>
<th>No. of Patients</th>
<th>Revenue (MYR million)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1998</td>
<td>39,114</td>
<td>14</td>
</tr>
<tr>
<td>1999</td>
<td>59,926</td>
<td>22</td>
</tr>
<tr>
<td>2000</td>
<td>56,133</td>
<td>33</td>
</tr>
<tr>
<td>2001</td>
<td>75,210</td>
<td>44</td>
</tr>
<tr>
<td>2002</td>
<td>84,585</td>
<td>36</td>
</tr>
<tr>
<td>2003</td>
<td>102,946</td>
<td>59</td>
</tr>
<tr>
<td>2004</td>
<td>174,189</td>
<td>105</td>
</tr>
<tr>
<td>2005</td>
<td>232,161</td>
<td>151</td>
</tr>
<tr>
<td>2006</td>
<td>296,687</td>
<td>204</td>
</tr>
<tr>
<td>2007</td>
<td>341,288</td>
<td>254</td>
</tr>
<tr>
<td>2008</td>
<td>374,063</td>
<td>299</td>
</tr>
<tr>
<td>Total</td>
<td>1,836,302</td>
<td>1221</td>
</tr>
</tbody>
</table>

70. In supporting the growth of the private sector and in marketing their services to the global medical tourism market, the State’s role in investor-led health care provision appears to be at odds with its role of ensuring the welfare and security of its citizens. For their part, the government claimed that the expansion of private health care would cater for those who can afford it, thereby freeing up public health care services for those who are not able to avail themselves of private health care.

71. To ensure the highest standard, a factor which is obviously vital to the industry’s longevity, only hospitals which can offer outstanding service and facilities are allowed to participate. Because of that, only the following 41 out of the 254 private hospitals in the country which have been recognized by the Ministry of Health as medical tourism hospitals.

### Table 4 List of Private Hospitals Approved for Medical Tourism

<table>
<thead>
<tr>
<th>Hospital</th>
<th>Location</th>
</tr>
</thead>
<tbody>
<tr>
<td>Assunta Hospital</td>
<td>Selangor</td>
</tr>
<tr>
<td>Columbia Asia Hospital</td>
<td>Selangor</td>
</tr>
<tr>
<td>Gleneagles Hospital Kuala Lumpur</td>
<td>Kuala Lumpur</td>
</tr>
</tbody>
</table>

---

193. H.L. Chee & S. Barraclough, supra n. 166, 32.
<table>
<thead>
<tr>
<th>Hospital</th>
<th>Location</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gleneagles Medical Centre</td>
<td>Pulau Pinang</td>
</tr>
<tr>
<td>Hospital Fatimah</td>
<td>Perak</td>
</tr>
<tr>
<td>HCS Medical Centre</td>
<td>Pulau Pinang</td>
</tr>
<tr>
<td>Island Hospital</td>
<td>Pulau Pinang</td>
</tr>
<tr>
<td>KPJ Amang Puteri Specialist Hospital</td>
<td>Selangor</td>
</tr>
<tr>
<td>KPJ Damansara Specialist Hospital</td>
<td>Selangor</td>
</tr>
<tr>
<td>KPJ Ipoh Specialist Hospital</td>
<td>Perak</td>
</tr>
<tr>
<td>KPJ Johor Specialist Hospital</td>
<td>Johor</td>
</tr>
<tr>
<td>KPJ Kajang Specialist Hospital</td>
<td>Selangor</td>
</tr>
<tr>
<td>KPJ Penang Specialist Hospital</td>
<td>Pulau Pinang</td>
</tr>
<tr>
<td>KPJ Selangor Specialist Hospital</td>
<td>Selangor</td>
</tr>
<tr>
<td>Lam Wah Ee Specialist Hospital</td>
<td>Pulau Pinang</td>
</tr>
<tr>
<td>LohGuanLye Specialists Centre</td>
<td>Pulau Pinang</td>
</tr>
<tr>
<td>Mahkota Medical Centre</td>
<td>Melaka</td>
</tr>
<tr>
<td>Mawar Renal Medical Centre</td>
<td>Negeri Sembilan</td>
</tr>
<tr>
<td>Mount Miriam Cancer Hospital</td>
<td>Pulau Pinang</td>
</tr>
<tr>
<td>National Heart Institute</td>
<td>Kuala Lumpur</td>
</tr>
<tr>
<td>NCI Cancer Hospital</td>
<td>Negeri Sembilan</td>
</tr>
<tr>
<td>Normah Medical Specialist Centre</td>
<td>Sarawak</td>
</tr>
<tr>
<td>Pantai Hospital Ayer Keroh</td>
<td>Melaka</td>
</tr>
<tr>
<td>Pantai Hospital Ipoh</td>
<td>Perak</td>
</tr>
<tr>
<td>Pantai Hospital Kuala Lumpur</td>
<td>Kuala Lumpur</td>
</tr>
<tr>
<td>Pantai Hospital Penang</td>
<td>Pulau Pinang</td>
</tr>
<tr>
<td>Penang Adventist Hospital</td>
<td>Pulau Pinang</td>
</tr>
<tr>
<td>Prince Court Medical Centre</td>
<td>Kuala Lumpur</td>
</tr>
<tr>
<td>Puteri Specialist Hospital</td>
<td>Johor</td>
</tr>
<tr>
<td>Putra Specialist Hospital</td>
<td>Melaka</td>
</tr>
<tr>
<td>Sabah Medical Centre</td>
<td>Sabah</td>
</tr>
<tr>
<td>Sentosa Medical Centre</td>
<td>Kuala Lumpur</td>
</tr>
<tr>
<td>Sime Darby Medical Centre Subang Jaya</td>
<td>Selangor</td>
</tr>
<tr>
<td>Sunway Medical Centre</td>
<td>Selangor</td>
</tr>
<tr>
<td>Taman Desa Medical Centre</td>
<td>Kuala Lumpur</td>
</tr>
<tr>
<td>Tawakal Hospital</td>
<td>Kuala Lumpur</td>
</tr>
<tr>
<td>Timberland Medical Centre</td>
<td>Sarawak</td>
</tr>
<tr>
<td>Tropicana Medical Centre</td>
<td>Selangor</td>
</tr>
<tr>
<td>Tun Hussein Onn National Eye Hospital</td>
<td>Selangor</td>
</tr>
<tr>
<td>Tung Shin Hospital</td>
<td>Kuala Lumpur</td>
</tr>
<tr>
<td>Universiti Malaya Specialist Centre</td>
<td>Kuala Lumpur</td>
</tr>
</tbody>
</table>
72. The stronger role played by the private sector means that there are now two parallel systems of health care delivery in the country: public and private. In terms of their utilization, different patterns are discernible for outpatient and inpatient services.

73. Outpatient care seems to be provided largely by the private sector whereby around 57% of the population use private clinics as the primary source of outpatient treatment. This takes place mainly in the urban areas. To ensure that the urban poor too are able to avail themselves of prompt yet inexpensive outpatient care, fifty 1Malaysia clinics (Klinik 1Malaysia) were launched across the country in 2010 by the then newly appointed Prime Minister, Dato' Sri Najib Razak. Named after the 1Malaysia manifesto and concept which he advanced as a rallying call for unity among the different ethnic groups when and since he came into power in 2009, a number of these clinics were set up in the urban areas of each state. They are open every day of the week including public holidays and only charge MYR 1 for their services. Manned by Medical Assistants, the clinics are able to offer:

- minor treatments for fever, cough or flu;
- follow-up treatments for patients with chronic conditions like diabetes, hypertension and asthma;
- minor surgical procedures like the cleaning of wounds and the removal of stitches; and
- tests for blood sugar level and blood pressure.

74. Inpatient care, on the other hand, is dominated by the public sector. Despite the fact that private hospitals outnumber public hospitals, figures in Table 5 below show that out of the 55,059 hospital beds available as at the end of 2010, 75% are provided by the public sector and only 25% by the private sector. And so it is that whilst health care in Malaysia may have experienced a shift from a system which was dominated by a public service ethos, the government is still the main provider of health care in Malaysia today. Although the comfort of inpatient care in public hospitals are distinguished by the beds’ location in first, second or third-class wards, all charges are invariably inexpensive as they are heavily subsidized by the government. Notably, over 86% of all beds in public hospitals are in ‘no frills’

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197. M. Ramesh, Malaysian Health Policy in Comparative Perspective in H.L. Chee & S. Barraclough (eds.), supra n. 166, 75.
198. For further information about the concept, see ‘1Malaysia’ available at http://1malaysia.com.my/about/about-1malaysia/.
199. I.e., 5 in Johor, 2 in Kedah, 3 in Kelantan, 3 in Melaka, 3 in Negeri Sembilan, 3 in Pahang, 4 in Perak, 1 in Perlis, 5 in Pulau Pinang, 4 in Sabah, 4 in Sarawak, 5 in Selangor, 3 in Terengganu and 5 in the federal territory of Kuala Lumpur – see ‘Klinik 1Malaysia’ available at http://www.moh.gov.my/v/k1m/.
200. They are also known as Assistant Medical Officers.
201. Adapted from Ministry of Health, Health Indicators 2010: Indicators for Monitoring and Evaluation of Strategy for All (2010), 122.
202. H.L. Chee, supra n. 80, 7.
203. See discussion in §3 below.
third-class wards\textsuperscript{204} which are provided at a nominal fee and are often free if the patient cannot afford the charge. These are, however, often crowded,\textsuperscript{205} and patients need to endure long waiting lists,\textsuperscript{206} and go through a protracted referral system as described above to consult a medical specialist.\textsuperscript{207}

\textit{Table 5}  Distribution of Hospital Beds in the Private and Public Sectors

<table>
<thead>
<tr>
<th>State</th>
<th>Public Sector</th>
<th>Private Sector</th>
<th>Total</th>
<th>Bed:Population Ratio</th>
</tr>
</thead>
<tbody>
<tr>
<td>Johor</td>
<td>4,941</td>
<td>1,110</td>
<td>6,051</td>
<td>1 : 553</td>
</tr>
<tr>
<td>Kedah</td>
<td>2,263</td>
<td>524</td>
<td>2,787</td>
<td>1 : 699</td>
</tr>
<tr>
<td>Kelantan</td>
<td>1,652</td>
<td>173</td>
<td>1,825</td>
<td>1 : 844</td>
</tr>
<tr>
<td>Kuala Lumpur</td>
<td>3,755</td>
<td>3,121</td>
<td>6,876</td>
<td>1 : 244</td>
</tr>
<tr>
<td>Labuan</td>
<td>109</td>
<td>0</td>
<td>109</td>
<td>1 : 797</td>
</tr>
<tr>
<td>Melaka</td>
<td>1,150</td>
<td>819</td>
<td>1,969</td>
<td>1 : 417</td>
</tr>
<tr>
<td>Negeri Sembilan</td>
<td>1,527</td>
<td>439</td>
<td>1,966</td>
<td>1 : 519</td>
</tr>
<tr>
<td>Pahang</td>
<td>1,907</td>
<td>213</td>
<td>2,120</td>
<td>1 : 708</td>
</tr>
<tr>
<td>Perak</td>
<td>5,817</td>
<td>906</td>
<td>6,723</td>
<td>1 : 350</td>
</tr>
<tr>
<td>Perlis</td>
<td>404</td>
<td>2</td>
<td>406</td>
<td>1 : 570</td>
</tr>
<tr>
<td>Pulau Pinang</td>
<td>2,677</td>
<td>2,053</td>
<td>4,730</td>
<td>1 : 330</td>
</tr>
<tr>
<td>Putrajaya</td>
<td>278</td>
<td>0</td>
<td>278</td>
<td>1 : 260</td>
</tr>
<tr>
<td>Sabah</td>
<td>4,155</td>
<td>277</td>
<td>4,432</td>
<td>1 : 724</td>
</tr>
<tr>
<td>Sarawak</td>
<td>3,568</td>
<td>587</td>
<td>4,155</td>
<td>1 : 595</td>
</tr>
<tr>
<td>Selangor</td>
<td>5,908</td>
<td>3,321</td>
<td>9,229</td>
<td>1 : 592</td>
</tr>
<tr>
<td>Terengganu</td>
<td>1,372</td>
<td>31</td>
<td>1,403</td>
<td>1 : 738</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>41,483</strong></td>
<td><strong>13,576</strong></td>
<td><strong>55,059</strong></td>
<td><strong>1 : 515</strong></td>
</tr>
</tbody>
</table>

75. The country’s current health care policy is embedded within the Tenth Malaysia Plan (\textit{Rancangan Malaysia Ke-Sepuluh 2011–2015}) where the government has reaffirmed its commitment to serve as a catalytic facilitator that creates an

\textsuperscript{204} Ramesh, \textit{supra} n. 197, 74.
\textsuperscript{205} It is not unusual for extension beds to be used when all the ordinary beds are occupied – see H.K. Kumar, \textit{A Comparison between the United Kingdom and Malaysian Systems: are We Heading in that Direction?}, 41 Berita MMA 16, 17 (2011).
\textsuperscript{206} The normal waiting time for an operation to be carried out is between two weeks and six months. This can be contrasted to the private sector where a required operation could be performed on the same or next day – \textit{ibid.}, 17; D.K.L. Quek, \textit{Health Reform: Understanding the Social Dynamics of Health Equity and Costs, Government’s Role, Public Response and Responsibility}, 41 Berita MMA 4 (2011).
\textsuperscript{207} C.K. Chan, \textit{The Welfarist State under Duress: Global Influences and Local Contingencies in Malaysia} in H.L. Chee & S. Barraclough (eds.), \textit{supra} n. 166, 91.
environment that is conducive for the ongoing expansion of the private sector through policy-making and regulation.\textsuperscript{208} Thus the private sector is expected to continue to be a key player in the health care sector. Regarding its plans to reform the health care delivery system during this period, the government has identified four vital areas.\textsuperscript{209}

The first is an effort to restructure the health care system to enhance coverage. For this, it would call for greater collaboration between the public and private sectors to ensure effective delivery and greater efficiency and affordability. Under this plan, the Ministry of Health will focus its efforts more on the governance than the delivery of health services. It would also review existing legislation and introduce new regulations which concentrate on issues like accreditation and credentializing. It also seeks to ensure that health care remains accessible and affordable to the general public.

Second, it plans to continue to upgrade and expand its health facilities across both urban and rural areas. In particular, primary care services would be further extended to underserved areas. One hundred ninety-seven new clinics (i.e., 156 rural clinics and 41 community health clinics) would be completed during the first half of the plan period. Another fifty \textit{Malaysia} clinics would be set up in poor urban areas and other underserved areas. Further, mobile clinics, flying doctor services and village health promoters would be expanded to remote areas. Secondary and tertiary care services would also be enhanced whereby four new and four replacement hospitals would be completed in the first two years of the plan. These include specialized medical institutions such as the National Cancer Institute and the Cheras Rehabilitation Centre.

Third, in response to the higher incidences of chronic conditions like diabetes, hypertension and cardiovascular diseases, the government aims to reduce demand for health care by promoting healthy lifestyles and disease prevention. Aggressive campaigns will be waged to emphasize healthy eating, physical activity, anti-smoking and mental health among school children, adolescents, women and the elderly. Sports and recreational activities will be promoted, and the private sector will be encouraged to set up new facilities in accessible areas. Beginning from 2011, it was mandatory for school children to be involved in at least one sports activity in school.

The fourth strategy is to invest in human resources for health. In order to meet the increased demand for the training of doctors and nurses, the government plans to increasingly utilize specialists from the private sector for training. It will also continue to outsource and collaborate with private training institutes to train allied health personnel. Other efforts in this vein include: expanding the specialist training allocation of doctors and other health care professionals; enhancing and expanding post-basic training for nurses and allied health care personnel; improving retention of staff in the public sector by providing better remuneration, career progression opportunities and better work conditions; and enhancing the quality of private health care through credentializing and structured training.

\textsuperscript{208} Chapter 7 of the Tenth Malaysia Plan.
\textsuperscript{209} Ibid., at Ch. 6.
76–79  General Introduction, Ch. 2, Description of the Health Care System

§2. REGULATION OF THE HEALTH CARE SYSTEM

76. This dual system of health care delivery that is, by public and private providers, which exist side by side and independent of one another,\(^{210}\) holds enormous ramifications for the regulation of health care in the country.

77. In the public sector, health and medical services come under the auspices of the Ministry of Health.\(^{211}\) Its range of activities and responsibilities spans curative, promotive, preventative and rehabilitative works. At the helm of this large government department is the Minister of Health, his Deputy and a Parliamentary Secretary, all of whom are politically appointed. Policies and major decisions on resource allocation are taken by the Minister. These policies, and the operational management of the medical, dental and pharmaceutical services as well as quality assurance are delegated to State Directors of Health who are accountable to the Minister of Health at the central level.

78. In relation to the private sector, the Private Healthcare Facilities and Services Act 1998 was introduced by the Government to replace the Private Hospitals Act 1971.\(^{212}\) This legislation, which only came into operation eight years later on the 1st of May 2006,\(^{213}\) aims to regulate and control private providers in an effort to see to it that standards on all medical and health-related services are adhered to. Wide powers are given to the Minister of Health and the Director-General of the Ministry of Health (Ketua Pengarah Kesihatan) in relation to the control, registration, regulation, monitoring, and licensing of private facilities and services. As can be seen below, the regulatory requirements are stringent and elaborate.

79. According to section 3 of the Act, a person can only establish or maintain any of the following private health care facilities or services after receiving the approval\(^{214}\) and a license\(^{215}\) from the Director-General of Health:

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210. H.L. Chee, supra n. 80, 84.
211. See the homepage of the Malaysian Ministry of Health at http://www.moh.gov.my.
212. The 1971 Act was passed to regulate the comparatively small pre-1980s private sector. It was to make them accountable to the Ministry of Health, as there had, until then, no legal authority to whom they had to report to. But it proved to be inadequate for the burgeoning private sector of the last three decades. Containing only 13 sections compared to a more wide-ranging 122 sections in the 1998 Act, it had specifically provided for the licensing and inspection of ‘private hospitals, nursing homes and maternity homes’. Only the following facilities came under the purview of this umbrella term: a maternity hospital; a medical hospital; a surgical hospital; a psychiatric hospital; a convalescent hospital; and a children’s hospital – see section 5 of the 1971 Act. Many services and facilities like medical and dental clinics, day surgeries, screening and diagnosis services, ambulance services, clinical laboratories, haemodialysis centres and hospices were therefore outside its scope – see R. Bakar, supra n. 182, 288.
213. Along with two Regulations and an Order. These are the: Private Healthcare Facilities and Services (Private Medical Clinics or Private Dental Clinics) Regulations 2006; Private Healthcare Facilities and Services (Private Hospitals and Other Private Healthcare Facilities) Regulations 2006; and Private Healthcare Facilities and Services (Official Identification Card) Order 2006.
214. Section 12.
215. Section 19(2).
– a private hospital;
– a private psychiatric hospital;
– a private ambulatory care centre;
– a private nursing home;
– a private psychiatric nursing home;
– a private maternity home;
– a private blood bank;
– a private haemodialysis centre;
– a private hospice;
– a private community mental health centre; and
– a private health care premises incorporating any two or more of the above facilities or services.

80. When applying for the approval which must be made in a prescribed form and manner and as accompanied by a prescribed fee, the application must be submitted along with a comprehensive plan for the establishment or maintenance of the proposed facility or service including the site plan, building layout plan, design, construction, specification, the type of facility or service to be provided and the proposed arrangements for manpower recruitment including arrangements for manpower training.216

In deciding whether to grant the approval, the Director-General will take into consideration the following matters: the nature of the health care facility or service to be provided; the extent to which such facilities are already available in an area; the present and future need for the facility or service in an area; or any other matter which is deemed relevant.217 The approval will only be granted if he is satisfied that the applicant is capable of providing adequate health care facilities or services and adequate and efficient management and administration for the proper conduct of the same. Where the applicant is a sole proprietor, he must be satisfied that the applicant has not been convicted of an offence involving fraud or dishonesty or is not an undischarged bankrupt. He must further be satisfied that no one who has been convicted of an offence involving fraud or dishonesty or who is an undischarged bankrupt is a member of the board of directors (or is a person responsible for the body corporate if the application is made by a body corporate; or is a partner if the application is made by a partnership; or is an office bearer of a society if the application is made by a society).218

81. Once approval is given (which may be with or without any terms or conditions), an application for a license to operate or provide a private health care facility or service needs to be made within three years from the date of the issuance of the approval.219

216. Section 8.
217. Section 9.
218. Section 11.
219. Failure to comply with this time limit will render the approval to be treated as having been revoked unless an extension is granted by the Director General — see sec. 14.
Upon receiving the application for a license, the Director-General shall appoint in writing two (or more) persons, one of whom shall be a registered medical practitioner, to inspect:

- the premises of the facility or service to ascertain that it complies with the building layout plan, design, construction and specification to which the approval to establish or maintain relates, and that it conforms to standards or requirements (including inspection of books, records, policies, standard operating procedures, clinical practice guidelines or the management or matters connected therewith);

and

- any equipment, apparatus, instrument, material, article, sample or substance or any other thing found in the premises, or any matter connected therewith.²²⁰

Report of the inspection must then be submitted to the Director-General as soon as practicable.²²¹ Upon receiving and having considered the report, the Director-General may then exercise his discretion to grant the applicant a license to operate, with or without terms or conditions, and upon payment of a prescribed fee.²²²

The license shall specify the type of private health care facility or service for which it is issued and the purpose for which the license may be maintained.²²³ It must be exhibited in a conspicuous part of the premises²²⁴ and remains in force for two years from the date on which it is issued, following which an application can be made for it to be renewed for a similar period by the grant of a new license.²²⁵

82. The approval to establish and maintain, and the license to operate or provide a private health care facility or service, may only be issued to a sole proprietor who is a registered medical practitioner; a partnership which consists of at least one partner who is a registered medical practitioner; or a body corporate whose board of directors consists of at least one person who is a registered medical practitioner.²²⁶ A license to operate or provide a private nursing home may nevertheless be issued to a registered nurse if contractual arrangements have been made for a registered medical practitioner to visit the patients in such homes at such frequency as may be prescribed.²²⁷ Likewise in the case of a private maternity home where a license may be issued to a registered midwife if similar contractual arrangements have been made.²²⁸ Further, a license to operate or provide a private hospice or a private haemodialysis centre on a voluntary or charitable basis may be issued to a society registered under the Societies Act 1966.

²²⁰ Section 16(1).
²²¹ Section 16(2).
²²² Section 19.
²²³ Section 20.
²²⁴ Section 23.
²²⁵ Section 22(1).
²²⁶ Section 6(1).
²²⁷ Section 6(2).
²²⁸ Section 6(3).
Similarly, section 4 of the 1998 Act states that no person shall establish, maintain, operate or provide a private medical clinic or private dental clinic unless the clinic has received a certificate of registration from the Director-General of Health. The certificate, which may only be issued to a registered medical practitioner or a registered dental practitioner respectively, must be exhibited in a conspicuous part of the clinic. However, a clinic which forms part of the premises of a licensed private health care facility and to which the clinic is organizationally, administratively and physically linked is not required to be registered separately.

The Director-General shall keep and maintain a register of all private health care facilities or services licensed under the Act and a register of all private medical and dental clinics registered under the same. A licensee of a private health care facility or service, and the holder of a certificate of registration of a private medical or dental clinic, are required, upon registration, to make available their policy statements in relation to their obligations to their patients. They are also required to establish a plan for grievance mechanism for the benefit of their patients. The Director-General also has the power to: suspend, revoke or refuse to renew licenses; and to suspend and revoke a certificate of registration, upon which the licensee or holder of the certificate shall surrender the license or certificate to him and cease operation for the relevant time period.

Anyone who contravenes the requirements outlined in sections 3 and 4 (i.e., practising without a license or a certificate of registration) commits an offence which in the case of an individual person is subject to a fine not exceeding MYR 300,000 and/or to imprisonment for a term not exceeding six months. In the case of a body corporate, partnership or society, the fine is an amount not exceeding MYR 500,000 and for a continuing offence, to a fine not exceeding MYR 5,000 for every day or part of a day during which the offence continues after conviction. Further, the person responsible for the body corporate, every partner in the partnership and the office bearers of the society shall be personally liable to a fine not exceeding MYR 300,000 and/or six months imprisonment; and for a continuing offence, to a fine not exceeding MYR 1,000 for every day or part of a day during which the offence continues after conviction.

In addition to the requirements outlined in the Act, the Association of Private Hospitals of Malaysia (APHM), which is a body which represents private hospitals and medical centres in the country, has also issued its own Code of Ethics for its members. This contains guidelines on the following matters: the objectives of a

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229. Section 7.
230. Section 28.
231. Section 4(2).
232. Section 35.
233. Section 36.
234. Sections 43–49.
235. Sections 50–51.
236. Section 5.
hospital; hospitals inter-relations; the responsibilities of individual hospitals; confidentiality; and public notices of private hospitals and advertisements.\textsuperscript{237}

87. As regards medical practitioners in both the public and private sectors, their main regulatory body is the Malaysian Medical Council (MMC) (\textit{Majlis Perubatan Malaysia}). Modelled on the General Medical Council of the United Kingdom (GMC), the body was created by the Medical Act 1971\textsuperscript{238} and was entrusted with the task of maintaining a Register of all medical practitioners who practise in Malaysia. It also regulates the conduct and ethics of registered practitioners; accredits local and foreign medical institutions; provides guidelines on the practice of medicine in Malaysia; empanels a Medical Review Panel to consider cases of doctors with mental illness or physical disability; advises and make recommendations to the Minister of Health on matters concerning the practice of medicine in Malaysia; and carries out such other acts as to give effect to the 1971 Act.

According to section 3 of the Act, the Council shall be presided over by the Director-General of Health. Its membership shall consist of registered Malaysian practitioners who are elected/nominated and appointed by the Minister of Health. The members shall hold office for a period not exceeding three years. They may nevertheless be re-nominated and re-appointed. The total membership of the Council currently stands at thirty-three. According to section 36 of the Act, the Council may make regulations to prescribe anything which under this Act is required to be prescribed.

88. Doctors working in the public sector are, in addition to being governed by the MMC, regulated under three tiers of regulatory structure: the state level, the ministerial level (Ministry of Health) and by the Public Services Department (Jabatan Perkhidmatan Awam). The Health Ministry, which has a Board of Inquiry that looks into ethical and disciplinary matters involving doctors in public service, does not assume a role in the regulation of doctors practising in the private sector.\textsuperscript{239}

§3. FINANCING OF THE HEALTH CARE SYSTEM

89. Malaysia’s total health care expenditure is 4.4\% of its GDP (Gross Domestic Product), and its total expenditure for health per capita is estimated at USD 307 per person.\textsuperscript{240}

\footnotesize{\textsuperscript{237} See http://www.hospitals-malaysia.org/.

\textsuperscript{238} At the time of writing, the Medical (Amendment) Act 2012, which sought to amend the 1971 Act, had just been passed by Parliament. As the new Act has yet to come into force, all references to the Medical Act in this monograph refers to the 1971 Act. Where relevant, changes proposed by the 2012 Act will be duly highlighted.

\textsuperscript{239} W.R. Wan Abdullah, \textit{Regulating Malaysia’s Private Health Care Sector} in H.L. Chee & S. Barraclough (eds.), supra n. 166, 47.

\textsuperscript{240} World Bank, Health Expenditure (\% of GDP), available at http://data.worldbank.org/indicator/SH.XPD.TOTL.ZS.}
90. Public health services are funded predominantly through central treasury funds. These services, despite operating within a more restricted welfare framework, are heavily subsidized by the government.241 Visits to rural health facilities are free, a nominal fee of MYR 1 is charged for visits to urban clinics, and only MYR 3 per day is charged for hospital beds in third-class wards. Even hospitalization in first and second-class wards, which are already free for civil servants, are relatively inexpensive. Daily charges range from MYR 40 to MYR 80 for a bed in a first-class ward and are set at MYR 30 for a bed in a second-class ward.242 The public health care system is therefore inexpensive for its end-users and is generally equitable.243 Those prices, as pointed out by Dr David Quek, President of the Malaysian Medical Association (MMA) from 2009–2011, have essentially remained the same since the 1970s. Indeed, up to 98% (MYR 12.9 billion) of the cost of public health services are met by the government while patients pay a mere 2%.244

91. As for private health care, this operates on a fee-for-service basis. The expenditure involved is financed using one or more of the following methods:

– patients may make out-of-pocket payments themselves. This currently forms the largest component of payment for this sector that is, 57% (MYR 10.8 billion);
– their employers may have subscribed to medical reimbursement schemes for them and their families;245 and
– some patients purchase private health insurance to meet the costs of their health care and those of their family members.246 The government currently allows a tax relief up to MYR 3,000 on medical insurance and tax concessions of up to MYR 5,000 for the costs of medical treatment of the taxpayer’s parents.247

92. As part of the incentives given to the private sector, the government also provides reimbursement for the treatment of civil servants and those from lower socioeconomic backgrounds at specialist private hospitals like the Institut Jantung Negara (National Heart Institute).248

93. In addition, it also allows employees to make withdrawals from the Employees’ Provident Fund (EPF) (Kumpulan Wang Simpanan Pekerja)249 for the

241. H.L. Chee, supra n. 192, 339.
243. Ramesh, supra n. 197, 81.
245. Ibid.
246. Around 0.1% of the population uses this as a means for financing their health care – see The National Health and Morbidity Survey II, vol. 3, 1999.
248. Wan Abdullah, supra n. 170, 100.
249. This is a compulsory retirement savings scheme for all employees in Malaysia. A contribution of 12% (or 13% for those with a monthly income lower than MYR 5,000) from employers and 11% from employees’ wages are required every month.
treatment of major ailments for themselves and their spouses, children, stepchildren, adopted children, parents, parents-in-law, step-parents, foster parents, and siblings. Under the scheme, 30% of the monthly contributions into the fund are placed into Account II, from which patients can withdraw all their savings or the actual medical cost, whichever is lower.

Fifty-five critical illnesses have been recognized for this purpose namely: aplastic anaemia, appallic syndrome, Alzheimer’s disease, benign tumour of the brain, blindness, cancer, cardiomyopathy, chronic liver disease, chronic lung disease, coma, coronary artery disease, deafness, encephalitis, fulminant viral hepatitis, cardiac arrest, heart valve replacement, kidney failure, loss of the ability to live independently, speech loss, major burns, major head trauma, major organ transplant, medullary systic disease, meningitis, motor neurone disease, multiple sclerosis, muscular dystrophy, paralysis, Parkinson’s disease, poliomyelitis, primary pulmonary, stroke, surgery to aorta, systemic lupus erythematosus with lupus nephritis, terminal illness, total permanent disability, severe chronic obstructive pulmonary disease/emphysema, secondary pulmonary hypertension, bronchiectasis, lung fibrosis, obstructive sleep apnoea, chronic inflammatory bowel disease, bilateral renal calculi requiring surgical intervention, congenital urinary abnormalities requiring urgent and major surgical intervention, systemic sclerosis with pulmonary hypertension, lymphoma, thalassaemia major requiring chelating agent, hematopoetic stem cell transplantation, AIDS, schizophrenia, bipolar mood, major depression and three conditions for family members below the age of 16 that is, severe asthma, leukaemia and intellectual impairment due to accident or sickness.

According to Tan Sri Azlan Zainol, the EPF Chief Executive Officer, this is to ‘help ease the financial burden of members in seeking immediate and the necessary medical treatment’. Although the treatment can be sought in either the public or private sector, the fact that the cost of care in the public sector is very low seems to imply that the withdrawal is allowed more for the purpose of private health care.

This, as well as the tax relief given for the purchase of private insurance clearly shows that just as the government promotes the growth of private hospitals, it also encourages patients to turn to this sector for their medical care.

The current mixed public-private system is likely to change with the government’s announcement that an alternative source of funding other than central treasury funds would be established. A National Health Insurance Scheme (NHIS) now seems poised to replace the prevailing system. The scheme, when it comes into operation, would be based on a ‘community-rated’ model in which health care costs would be spread across the population, with participation being compulsory for those who are healthy and financially able, whilst the government would provide coverage for disadvantaged groups like the poor, the elderly and pensioners, and the

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250. The remaining 70% is placed into Account I which cannot be withdrawn until the employee reaches the age of 55. This is meant to be used for the employee’s retirement.


Specialized packages would also be available for those wishing to have better health care service, and the scheme would be managed by the National Healthcare Financing Authority. However, even if such a scheme is put in place, the utilization of private health care would still entail an out-of-pocket or third-party payment.

Chapter 3. Sources of Medical Law

95. The law governing the delivery of the country’s health care is derived primarily from the following sources: Acts of Parliament, the Federal Constitution, court decisions, the Penal Code (which is the primary source of substantive criminal law in Malaysia); and guidelines and circulars issued by the MMC, the Ministry of Health and the Director-General of Health.

96. For matters that are not explicitly provided for by these sources, Malaysian courts are, by virtue of section 3 of the Civil Law Act 1956, allowed to apply the common law of England and the rules of equity as administered in England. However, this shall be applied only as far as the circumstances of the Malaysian society and culture permit, and are subject to such qualifications as domestic circumstances render necessary. Malaysian judges have also, in more recent times, made references to judgments passed in other Commonwealth jurisdictions.
Chapter 1. Access to the Medical Profession

97. Prior to the twentieth century, practitioners of scientific medicine in this region were made up entirely of doctors who came from Britain.256 Their presence on these shores, as observed earlier, was to cater to the health care needs of colonial administrators and to serve the colonial economy. But as the colonial economy burgeoned and the local population increased rapidly (mainly through immigration than natural increase), the problem of a severe shortage of subordinate (i.e., Asian) staff to assist the British doctors in the hospitals began to arise and persisted. This was initially addressed by recruiting hospital assistants from India.257 But as recruits were not easy to find and recruiting costs were high, a local apprenticeship scheme was introduced in 1879 in which promising local youths were sent for a three-year course at the Madras Medical College in India. Upon their return to Malaya, they were absorbed into the medical service as ‘assistant surgeons’ to which they were tied by a bond of fifteen years. But this system too did not thrive not least because the pay was mediocre, the work conditions demanding and career progression extremely limited as there were no prospects of them being promoted to full medical officers.258

98. In the early years of the twentieth century, the idea of setting up a local school for medical training began to be seriously considered both by the British administrators and leaders of the local community. In its Report, the Commission of Enquiry into the System of English Education in the Colony which was set up in 1901 said that it could ‘feel the great advantage which would accrue to the colony … by the introduction of a system of training which would produce, out of local material, men better qualified to supply the demand for assistant surgeons and general practitioners among the native population and the poorer inhabitants’. 259 Leaders of non-European communities also petitioned for the establishment of a local

257. M.D. Tate, supra n. 90, 82.
258. Ibid., 76–77.
medical school that would provide ‘a proper supply of trained medical men who are in racial sympathy with those whom they attend’.  

99. From money raised by both sides, the Straits and Federated Malay States Government Medical School was officially opened on 28 September 1905 in Singapore. The school offered, for the first time, an opportunity for local students to train locally as doctors by undergoing a full-time five-year course in medicine, surgery and midwifery. Its first intake was a very modest number of twenty-three students: sixteen took the five-year medical course and seven took a two-year hospital assistant’s course. Of the sixteen, the first batch which graduated in 1910 with the LMS (Licentiate in Medicine and Surgery) Diploma consisted of only seven students.

100. In just over a decade after the school’s opening, the Diploma in Medicine which it awarded received official recognition from the General Council of Medical Education of Great Britain in 1916. This placed graduates of the school on the General Council’s Colonial List on the British Medical Register which entitled them to practise anywhere within the British Empire. Even so, graduates of the school were treated differently from British doctors by the colonial government. They were initially styled Assistant Surgeons, then Assistant Medical Officers, and were made to play a subordinate role to, and paid half the salary of, their British counterparts who were designated Medical Officers and were entitled to full sabbatical leave after every three years of service. Even those who had acquired postgraduate qualifications on their own initiative from the royal colleges in the United Kingdom after qualifying locally, remained as Assistant Surgeons upon their return and were therefore denied specialist status.

101. The Japanese conquest and occupation of Malaya during the Second World War served as a catalyst which prompted local doctors to ventilate their discontent and seek redress for this lopsided relationship. Between 1942 and 1945, when British doctors were all interned in Changi Prison in Singapore, the medical services were left entirely in the charge of locally-trained Asian doctors who not only ran the hospitals, but also trained their younger colleagues on major surgery and in
managing severe illness.\textsuperscript{267} They looked after the medical and health needs of the civilian population under stressful war conditions and with severe constraints in medical supplies and facilities.\textsuperscript{268} When the British returned after the war to re-establish colonial administration,\textsuperscript{269} the by then self-confident and experienced Asian doctors refused to accept having to revert to a lowly ‘assistant’ status. Led by members of the school’s alumni association, the local doctors campaigned for a unified medical service which would accord local doctors the same status, salary and opportunities for postgraduate leave as the expatriate Medical Officers. Although this was eventually acceded to, and all doctors were duly recognized as Medical Officers, British doctors received a special expatriate allowance.\textsuperscript{270} Further, when independence from British rule came in 1957, practically all the expatriates left the medical service with a very handsome payout in the form of the Malayanization Bounty.\textsuperscript{271} Their posts were systematically replaced by the medical alumni from the school.

102. In the period between 1905 to just after the Second World War, the school itself had undergone a number of transformations. It was renamed the King Edward VII School of Medicine in 1913 after receiving a bequest from the King Edward VII Foundation which enabled it to create and fund more teaching posts. A second name change occurred in 1920 when ‘School’ was replaced by ‘College’ to reflect its enhanced academic status as an institution of university standard.\textsuperscript{272} In 1949, it was amalgamated with the Raffles College for Higher Education in the Arts and Science, to create a new university with full degree granting powers: Universiti Malaya, which was based in Singapore.

A decision was then made in 1962 that the university should have two autonomous branches of equal status: one based in Singapore and the other in Kuala Lumpur. The one in Singapore became known as the University of Singapore and the King Edward VII College of Medicine became its Faculty of Medicine.\textsuperscript{273} The one based in Kuala Lumpur retained its name as Universiti Malaya (UM), but it did not yet have a medical school. To ensure an adequate supply of doctors to bring into fruition the post-independence government’s aspiration to make health and medical services available throughout the country, a new Faculty of Medicine was set up in 1962 at the university. Its first Dean, Tan Sri Professor Thamboo John Danaraj, was a graduate of King Edward VII’s College of Medicine, as were a number of its early teaching staff. As all medical faculties subsequently set up in Malaysian public universities had followed UM’s lead, this historical factor helps elucidate why the

\textsuperscript{267} M.J. Rajakumar, \textit{ibid}.


\textsuperscript{270} Tan, \textit{supra} n. 256, 170.

\textsuperscript{271} \textit{Ibid}., 171.

\textsuperscript{272} Lim, \textit{supra} n. 262, 21–22.

\textsuperscript{273} The university has since merged with Nanyang University in 1980 to form the National University of Singapore (NUS) and this faculty became the NUS’ Faculty of Medicine. Since 2005, the faculty is known as the Yong Loo Lin School of Medicine – see NUS, \textit{Yong Loo Lin School of Medicine – Our History} available at http://medicine.nus.edu.sg/corporate/about-history.html

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medical profession in Malaysia retains its orientation to British education to the present day.\(^{274}\)

Its first intake of sixty-three students graduated in 1969 and the Faculty of Medicine at Universiti Malaya has since produced thousands of the country’s medical practitioners. But with a doctor to population ratio of 1:4,543 in 1970, another medical faculty was established in 1973 at Universiti Kebangsaan Malaysia,\(^{275}\) and this was followed soon after by the launch of a medical faculty in Universiti Sains Malaysia in 1981.\(^{276,277}\) They were joined, over a decade later, by medical faculties set up at Universiti Islam Antarabangsa Malaysia (UIAM) and Universiti Malaysia Sarawak (UNIMAS) in 1995; and Universiti Putra Malaysia (UPM) in 1996.

\(^{103}\) Competition for places to study Medicine at these publicly funded universities is very stiff. It is a subject which the country’s best students usually opt to pursue.\(^{278}\) It is nevertheless worth adding that Malaysian parents play a huge role in their children’s career choice and many high achieving students have been pressurized into studying Medicine whether or not they have the right aptitude for this.\(^{279}\) With demand for places often outstripping supply, the shortfall in places was met by sending students to study Medicine abroad. This was funded both by the government through public scholarships, and by parents themselves. Although this practice still continues to the present day,\(^{280}\) many more medical schools have since been established in the country.

\(^{104}\) There are currently eleven public universities and eighteen private institutions that offer medical courses in Malaysia.\(^{281}\) Several other institutions are awaiting accreditation from the Malaysian Qualifications Agency (MQA). This is a body created under the Malaysian Qualifications Agency Act 2007, and it is authorized to accredit both public and private medical schools. In the accreditation of medical

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274. M.J. Rajakumar, supra n. 266, xvi.
275. For further details, see M. Mohd. Nor, Universiti Kebangsaan Malaysia Faculty of Medicine in S. Selvarajah & K.K. Khoo (eds.), supra n. 161, 379–405.
277. Interestingly, the founding Deans of these two medical faculties were both graduates of the Faculty of Medicine at Universiti Malaya – see H.O. Wong, The University of Malaya Medical Centre in S. Selvarajah & K.K. Khoo (eds.), supra n. 161, 409.
278. Which, according to the country’s 4th Lord President Tun Mohamed Suffian Mohamed Hashim, helps account for why it is mainly doctors who usually take the lead in speaking, writing and forming public opinion in Malaysia. Prominent among them include Tun Dr Mahathir Mohamed, Tun Dr Ismail Abdul Rahman, Tan Sri Dr Tan Chee Khoon, Tan Sri Dr Mohamed Said, and Dr Lim Chong Eu – see M.S. Mohd. Hashim, Without Fear or Favour x (C.K. Tan ed., Eastern Universities Press 1984).
279. K.J. Singh, Innovation in and out of universities, 24 The Star (Sept. 12, 2011). This is not without its problems. Many young graduates have had to defer or extend their housemanship training owing to mental health problems which were the consequence of having been ‘incongruously bullied into a profession that he or she had underestimated the scope of or the task at hand’ – see D.K.L. Quek, MMA Reflections: Transform or Reform, Change We Must!, 41 Berita MMA 4, 5 (2011).
280. Main destinations are medical schools in Australia, Egypt, India, Indonesia, Ireland and the United Kingdom.
281. See Tables 8 and 9 below.
programmes, it is advised by a Joint Technical Committee which comprises of the MMC, the Ministry of Higher Education and the Public Services Department (Jabatan Perkhidmatan Awam).\footnote{M. Mohamed, \textit{Ensuring the Standard of Medical Graduates in Malaysia}, 15 Malaysian J. Med. Sci. 1 (2008).} Accreditation is carried out in conformity with the basic and quality development standards outlined within the World Federation for Medical Education (WFME)’s ‘International Standards in Medical Education’\footnote{Ibid. For further details, see MMC, \textit{Guidelines for the accreditation of basic medical education programmes in Malaysia} (2007).} It is pertinent to note that with the exception of the country’s first six public medical schools and the International Medical University (a private medical school which was established in 1992), all other medical schools in the country, public and private, received their accreditation in the twenty-first century.

105. This sudden expansion in the number of places to study Medicine is steered by the same privatization agenda which underpins contemporary Malaysian health care. Just as in the case of medical tourism, the government is promoting Malaysia as a preferred destination for higher and tertiary education for overseas students.\footnote{‘Education Malaysia’, the marketing strategy used by the Ministry of Higher Education to promote Malaysian higher education at the international level, managed to attract just under 2,000 students to Malaysia in 1995. By 2009, this number had grown to 80,750 with the majority of overseas students coming from China, Indonesia and Middle Eastern and North African countries – see the Ministry of Higher Education, \textit{International Students 2009} available at https://jpt.mohe.gov.my/menupemasaran.php.} Alongside the rapid increase in the number of public universities set up since the 1990s, corporate investors were strongly encouraged to set up private institutions of higher education and forge links with overseas universities to deliver various foreign degree programmes\footnote{Mainly in popular subjects like Accounting and Finance, Business Studies, Computer Science, Economics, Engineering, Hotel Catering and Management, and Pharmacy.} at costs that are lower than they would be if students were to study for the same qualifications at the parent institutions. The last few decades have therefore seen the mushrooming of initiatives like twinning programmes, credit-transfer programmes, advance-standing programmes, external degree programmes and distance learning programmes.\footnote{H.P. See, ‘
Donaldization’ of education: The Malaysian experience available at http://ssrn.com/abstract=1496627.} Some foreign universities have also set up off-shore campuses in Malaysia.\footnote{E.g. Nottingham University, Monash University, Reading University, Curtin University of Technology, Swinburne University of Technology and Newcastle University.}

106. Because of the impact which this wider development has made on medical education, the MMC has imposed a number of minimum criteria and qualifications for entry into a medical programme at both public and private institutions.\footnote{MMC, \textit{Minimum Qualifications for Entry into a Medical Programme} (adopted on Jan. 16, 2012).} In particular, this is to ensure that admission into such programmes at for-profit private institutions are not made only on the basis of the students’ ability to pay, and that there should be some parity in the quality of students admitted into public and private institutions.

\footnotetext[283]{Ibid. For further details, see MMC, \textit{Guidelines for the accreditation of basic medical education programmes in Malaysia} (2007).}
\footnotetext[284]{‘Education Malaysia’, the marketing strategy used by the Ministry of Higher Education to promote Malaysian higher education at the international level, managed to attract just under 2,000 students to Malaysia in 1995. By 2009, this number had grown to 80,750 with the majority of overseas students coming from China, Indonesia and Middle Eastern and North African countries – see the Ministry of Higher Education, \textit{International Students 2009} available at https://jpt.mohe.gov.my/menupemasaran.php.}
\footnotetext[285]{Mainly in popular subjects like Accounting and Finance, Business Studies, Computer Science, Economics, Engineering, Hotel Catering and Management, and Pharmacy.}
\footnotetext[286]{H.P. See, ‘
\footnotetext[287]{E.g. Nottingham University, Monash University, Reading University, Curtin University of Technology, Swinburne University of Technology and Newcastle University.}
\footnotetext[288]{MMC, \textit{Minimum Qualifications for Entry into a Medical Programme} (adopted on Jan. 16, 2012).}
First, in recognition of the fact that selection for admission for medical studies implies selection into the medical profession, the MMC made it clear that an applicant’s fitness to practise Medicine upon graduation is an important factor to be considered in the selection for entry into any medical programme. In line with this, all applicants would need to declare if they have:

- been found guilty of any criminal offence(s);
- serious physical or mental illness; and/or
- serious communicable disease(s) which may impact upon their future practice.

Failure to declare information which would affect their fitness to practise may lead to the termination of their medical studies. An applicant who has been found guilty of: offences(s) affecting the human body; recent or serious dishonesty (e.g., cheating at examinations, falsification of documents and plagiarism); serious physical or mental illness; and/or serious communicable disease(s); shall be disqualified from entry into a medical programme.

Second, all applicants must have attained a level of competence in English that would enable them to complete the course successfully.

Third, in terms of academic attainment, all applicants, except those who already hold degrees in the arts or humanities, shall have attained at least B grades in Biology, Chemistry, Physics, Mathematics (or Additional Mathematics) and another subject at School Certificate (i.e., Sijil Pelajaran Malaysia) level. This is usually attained at the age of 17. In addition, they would need to have achieved a minimum of the following at Higher School Certificate level or its equivalent (see Table 6289). This is usually attained at 20 that is, the age at which most Malaysian students commence tertiary education.

Table 6 Pre-University Qualifications for Entry into Medical Schools in Malaysia

<table>
<thead>
<tr>
<th>Examination</th>
<th>Requirements</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sijil Tinggi Pelajaran Malaysia (STPM)</td>
<td>Grades BBB, ABC or AAC in three subjects that is, Biology, Chemistry, Physics or Mathematics</td>
</tr>
<tr>
<td>(Malaysian Higher Education Certificate)</td>
<td></td>
</tr>
<tr>
<td>General Certificate of Education Advanced (‘A’) Levels</td>
<td>Grades BBB in three subjects that is, Biology, Chemistry, Physics or Mathematics</td>
</tr>
</tbody>
</table>

289. Source: ibid.
<table>
<thead>
<tr>
<th>Examination</th>
<th>Requirements</th>
</tr>
</thead>
<tbody>
<tr>
<td>– Matriculation</td>
<td>Cumulative Grade Point</td>
</tr>
<tr>
<td>– Foundation in Science; or</td>
<td>Average (CGPA) of at least 3.0 (out of 4) in three subjects (i.e., Biology, Chemistry, Physics or Mathematics); and the course must not be less than one year in the same institution</td>
</tr>
<tr>
<td>– Pre-Medical Course</td>
<td></td>
</tr>
<tr>
<td>– United Education Certificate (UEC)</td>
<td>B4 each in five subjects that is, Biology, Chemistry, Physics, Mathematics and Additional Mathematics</td>
</tr>
<tr>
<td>– Monash University Foundation Pre-University Programme</td>
<td>Aggregate or average of 80% in any three subjects that is, Biology, Chemistry, Physics or Mathematics</td>
</tr>
<tr>
<td>– New South Wales Foundation</td>
<td></td>
</tr>
<tr>
<td>– Western Australia Curriculum Council</td>
<td></td>
</tr>
<tr>
<td>– HSC Sydney Australia</td>
<td></td>
</tr>
<tr>
<td>– Trinity College Foundation Studies</td>
<td></td>
</tr>
<tr>
<td>– Australian Universities Foundation Programmes</td>
<td></td>
</tr>
<tr>
<td>– South Australian Matriculation (SAM); or</td>
<td></td>
</tr>
<tr>
<td>– Victoria Certificate of Education, Australia Year 12</td>
<td></td>
</tr>
<tr>
<td>– National Certificate of Educational Achievement (NCEA) Level 3; or</td>
<td>Average of 80% in any three subjects that is, Biology, Chemistry, Physics or Mathematics</td>
</tr>
<tr>
<td>– New Zealand Bursary</td>
<td></td>
</tr>
<tr>
<td>– Canadian Pre-University; or</td>
<td>Average of 80% in any three subjects that is, Biology, Chemistry, Physics or Mathematics</td>
</tr>
<tr>
<td>– Canadian International Matriculation Programme /Canadian Grade 12/13</td>
<td></td>
</tr>
<tr>
<td>– Indian Pre-University</td>
<td>Average of 70% in any three subjects that is, Biology, Chemistry, Physics or Mathematics</td>
</tr>
<tr>
<td>– International Baccalaureate</td>
<td>30 points with a minimum of two Science subjects or Mathematics at higher level and one Science subject at standard level; and attained a minimum score of 4 each in Biology, Chemistry, Physics or Mathematics</td>
</tr>
</tbody>
</table>
For applicants who already hold a diploma or a degree, the minimum requirements demanded by the MMC are as follows:

<table>
<thead>
<tr>
<th>Qualification</th>
<th>Requirements</th>
</tr>
</thead>
<tbody>
<tr>
<td>Diploma in Health Sciences</td>
<td>CGPA of at least 3.5 (out of 4); and the course must not be less than five semesters or 2.5 years in the same institution</td>
</tr>
<tr>
<td>Degree in Medical Sciences</td>
<td>CGPA of at least 3.3 (out of 4)</td>
</tr>
<tr>
<td></td>
<td>(for admission into a five-year undergraduate medical programme)</td>
</tr>
<tr>
<td>Degree in Medical Sciences</td>
<td>CGPA of at least 3.5 (out of 4)</td>
</tr>
<tr>
<td></td>
<td>(for admission into a four-year graduate medical programme)</td>
</tr>
<tr>
<td>Degree in the Arts and Humanities</td>
<td>CGPA of at least 3.5 (out of 4)</td>
</tr>
<tr>
<td></td>
<td>(for admission into a five-year undergraduate medical programme);</td>
</tr>
<tr>
<td></td>
<td>and</td>
</tr>
<tr>
<td></td>
<td>3 Cs each in Biology, Chemistry, Physics, General Science, Mathematics or Additional Mathematics at SPM level or its equivalent;</td>
</tr>
<tr>
<td></td>
<td>or</td>
</tr>
<tr>
<td></td>
<td>an accredited bridging course</td>
</tr>
<tr>
<td>Degree in the Arts and Humanities</td>
<td>CGPA 4.0 (out of 4)</td>
</tr>
<tr>
<td></td>
<td>(for admission into a four-year graduate medical programme)</td>
</tr>
<tr>
<td></td>
<td>and</td>
</tr>
<tr>
<td></td>
<td>3 Cs each in Biology, Chemistry, Physics, General Science, Mathematics or Additional Mathematics at SPM level or its equivalent;</td>
</tr>
<tr>
<td></td>
<td>or</td>
</tr>
<tr>
<td></td>
<td>an accredited bridging course</td>
</tr>
</tbody>
</table>

Further, all applicants shall be required to pass an aptitude test and/or an interview and/or a university entrance examination. They shall have attained credits in Bahasa Melayu and English if they are to later seek employment in the public sector.

107. Students may also choose to undertake their entire medical studies abroad. However, they too are subject to the fitness to practise guidelines issued by the

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290. Ibid.

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MMC. Failure to comply would disqualify them from gaining provisional registration upon graduation. This would mean that they would not be able to undertake the internship training which, as discussed below, is a crucial stage in a medical graduate’s journey in being a registered medical practitioner in Malaysia. Further, applicants may only choose to study in an institution listed in the Second Schedule of the 1971 Act. The schedule lists the names of nearly 400 institutions from thirty-four countries around the world, including the ones in Malaysia.

§1. TRAINING OF PHYSICIANS

108. The normal duration for undergraduate medical studies in Malaysia is five years. Below is a list of the public universities that offer such programmes. They each provide their own structure of training and curriculum, and confer degrees on graduates who have met the standard of knowledge and proficiency laid down in their respective regulations. The qualifications they award are either the Bachelor of Medicine and Bachelor of Surgery (MBBS) (Sarjana Muda Perubatan dan Sarjana Muda Pembedahan) or that of Doctor of Medicine (MD) (Doktor Perubatan).

<table>
<thead>
<tr>
<th>Institution</th>
<th>Qualification Awarded</th>
<th>Duration of Study</th>
</tr>
</thead>
<tbody>
<tr>
<td>Universiti Islam Antarabangsa Malaysia (UIAM) (International Islamic University, Malaysia)</td>
<td>MBBS</td>
<td>5 years</td>
</tr>
<tr>
<td>Universiti Kebangsaan Malaysia (UKM) (National University of Malaysia)</td>
<td>MD</td>
<td>5 years</td>
</tr>
<tr>
<td>Universiti Malaya (UM) (University of Malaya)</td>
<td>MBBS</td>
<td>5 years</td>
</tr>
<tr>
<td>Universiti Malaysia Sabah (UMS) (University of Malaysia, Sabah)</td>
<td>MBBS</td>
<td>5 years</td>
</tr>
<tr>
<td>Universiti Malaysia Sarawak (UNIMAS) (University of Malaysia, Sarawak)</td>
<td>MD</td>
<td>5 years</td>
</tr>
</tbody>
</table>

291. Unlike the USA, Medicine is normally studied at undergraduate level in Malaysia. But see the new graduate Medical programme introduced by the Perdana University Graduate School of Medicine (PUGSOM) below. For discussion, see M.L. Seow, Malaysia’s First Private Graduate Medical School and Teaching Hospital, 41, no. 1 Berita MMA 19 (2011).

292. The information is collated from the data available on their respective websites.
<table>
<thead>
<tr>
<th>Institution</th>
<th>Qualification Awarded</th>
<th>Duration of Study</th>
</tr>
</thead>
<tbody>
<tr>
<td><em>Universiti Pertahanan Nasional Malaysia</em> (UPNM) (National Defence University of Malaysia)</td>
<td>MD</td>
<td>5 years</td>
</tr>
<tr>
<td><em>Universiti Putra Malaysia (UPM)</em> (Putra University, Malaysia)</td>
<td>MD</td>
<td>5 years</td>
</tr>
<tr>
<td><em>Universiti Sains Islam Malaysia (USIM)</em> (The Islamic Science University of Malaysia)</td>
<td>MBBS</td>
<td>6 years</td>
</tr>
<tr>
<td><em>Universiti Sains Malaysia (USM)</em> (Science University of Malaysia)</td>
<td>MD</td>
<td>5 years</td>
</tr>
<tr>
<td><em>Universiti Sultan Zainal Abidin (UniSZA)</em> (Sultan Zainal Abidin University, Malaysia)</td>
<td>MBBS</td>
<td>5 years</td>
</tr>
<tr>
<td><em>Universiti Teknologi MARA (UiTM)</em> MARA University of Technology</td>
<td>MBBS</td>
<td>5 years</td>
</tr>
<tr>
<td></td>
<td>MBBS with Advanced Medical Science (whereby students spend an additional year engaging in research activities and writing a dissertation)</td>
<td>6 years</td>
</tr>
</tbody>
</table>

109. Private higher education institutions that offer medical courses are as below. Students attending these institutions either complete the whole duration of their training locally, or undergo part of it (either the pre-clinical or clinical phase) at affiliated institutions abroad. Unless stated otherwise, the qualifications are awarded by the local institutions themselves.

293. The information is collated from the data available on their respective websites.
<table>
<thead>
<tr>
<th>Institution</th>
<th>Qualification Awarded</th>
<th>Duration of Study</th>
</tr>
</thead>
<tbody>
<tr>
<td>Allianze University College of Medical Sciences (AUCMS)</td>
<td>MD</td>
<td>5 years in Malaysia</td>
</tr>
<tr>
<td>(The programme is run in collaboration with Universiti Sumatera Utara, Indonesia)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>ASEAN Metropolitan University College</td>
<td>MBBS</td>
<td>2.5 years in Malaysia, 2.5 years in India</td>
</tr>
<tr>
<td>Asian Institute of Medicine, Science and Technology (AIMST) University</td>
<td>MBBS</td>
<td>5 years in Malaysia</td>
</tr>
<tr>
<td>Cyberjaya University College of Medical Sciences (CUCMS)</td>
<td>MBBS</td>
<td>5 years in Malaysia</td>
</tr>
<tr>
<td>Insaniah University College</td>
<td>MBBS</td>
<td>5 years in Malaysia</td>
</tr>
<tr>
<td>International Medical University (IMU)</td>
<td>MBBS</td>
<td>5 years in Malaysia</td>
</tr>
<tr>
<td>MAHSA University College</td>
<td>MBBS</td>
<td>5 years in Malaysia</td>
</tr>
<tr>
<td>Management and Science University (MSU)</td>
<td>MBBS</td>
<td>5 years in Malaysia</td>
</tr>
<tr>
<td>(but students can opt to pursue the programme at MSU’s off-shore campus in Bangalore, India)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Melaka-Manipal Medical College</td>
<td>MBBS</td>
<td>2.5 years in India, 2.5 years in Malaysia</td>
</tr>
<tr>
<td>(awarded by Manipal University, India)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Monash University Sunway Campus</td>
<td>MBBS</td>
<td>5 years in Malaysia</td>
</tr>
<tr>
<td>(awarded by Monash University, Australia)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>(but all students are required to spend three months training in clinical settings in Australia during the final year of the programme)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Institution</td>
<td>Qualification Awarded</td>
<td>Duration of Study</td>
</tr>
<tr>
<td>-----------------------------------------------------------------</td>
<td>--------------------------------------------------------------------------------------</td>
<td>----------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Newcastle University Medicine Malaysia (NUMed Malaysia)</td>
<td>MBBS (awarded by Newcastle University, UK)</td>
<td>5 years (all in Malaysia, except for the 4th year where students undertake clinical placement in Newcastle, UK)</td>
</tr>
<tr>
<td>Penang Medical College</td>
<td>MB BCh BAO (awarded by the National University of Ireland) and Licentiates of the Royal College of Surgeon in Ireland (RCSI) and the Royal College of Physicians of Ireland</td>
<td>2 years at either RCSI or University College Dublin (UCD), Ireland 3 years in Malaysia</td>
</tr>
<tr>
<td>Perdana University Graduate School of Medicine (PUGSOM)</td>
<td>MD</td>
<td>4 years in Malaysia</td>
</tr>
<tr>
<td>(The programme is run in collaboration with the Johns Hopkins University School of Medicine and is based on the American model of graduate medical education. The School accepts students who have completed a bachelor’s degree or its equivalent in another subject)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>SEGI University College</td>
<td>MBBS</td>
<td>5 years in Malaysia</td>
</tr>
<tr>
<td>Taylor’s University School of Medicine</td>
<td>MBBS</td>
<td>5 years in Malaysia</td>
</tr>
<tr>
<td>University College Sedaya International (UCSI)</td>
<td>MD</td>
<td>5 years in Malaysia</td>
</tr>
</tbody>
</table>
Institution| Qualification Awarded| Duration of Study
---|---|---
Universiti Kuala Lumpur Royal College of Medicine Perak (UniKL RCMP)| MBBS| 5 years in Malaysia
(Its curriculum is based on the University of Sheffield’s MBChB programme but both MBBS qualifications are awarded by Universiti Kuala Lumpur)| MBBS (in collaboration with the Vinayaka Missions University, India)| 2 years in Malaysia| 3 years in India
Universiti Tunku Abdul Rahman (UTAR) (Tunku Abdul Rahman University)| MBBS| 5 years in Malaysia

110. Upon completion of their medical studies either locally or abroad, all medical graduates intending to practise in Malaysia are required to undergo a period of supervised and structured training in an approved hospital or institution. The aim is to enable them to consolidate and expand their theoretical clinical knowledge and technical skills, and to adopt the various changes in medical technology. It is also a period during which appropriate professional attitudes are inculcated. In particular, interns are expected to develop their: communication skills (with patients and colleagues); presentation skills; and awareness of ethico-legal issues surrounding their work.

111. Section 13(2) of the Medical Act 1971 specified that four months of this period shall be spent in a resident surgical post, another four months in a resident medical post, and the other four months in a resident obstetrical and gynaecological post. Since 1 January 2008, the minimum period has been extended to two years to ensure the attainment of sufficient clinical training in major disciplines. Interns now undertake four-monthly postings in the following six disciplines: internal medicine; paediatrics; surgery; orthopaedics; obstetrics and gynaecology; and emergency medicine. This period can be extended if the intern was on maternity or sick leave. It could also be extended, or the intern could be denied full registration, due to attitude problem, lack of knowledge, incompetence, insubordination or other disciplinary problems, mental illness or physical disability and poor work performance.

112. To initiate the process, new graduates would first need to apply to join the civil service. They would then attend a compulsory induction and citizenship course, during which they would be given their posting letters. Upon completion of the course, they would need to immediately report to the respective State Health Department (Jabatan Kesihatan Negeri). They are known as House Officers (Pegawai Perubatan Latihan Siswaazah) during the internship period. The total duration of the internship or housemanship training should not exceed six years. Their appointment in government service is made by the Public Services Department.

113. The body which is responsible for matters relating to houseman training is the Medical Qualifying Board. Established by the 1971 Act, the Board’s main duties are: to evaluate and approve hospitals as houseman training centres; to decide on standards and criteria of houseman training module; and to approve for full registration based on training experience. It is chaired by a Director-General and consists of an equal number of representatives from each of the Faculties of Medicine of the universities established under the country’s Universities and University Colleges Act 1971. Sixty-three hospitals across the country have been approved as housemanship training centres by the Board.

§2. MANPOWER PLANNING

114. Malaysia’s doctor-population ratio has changed significantly since independence. While this stood at 1:7,352 in 1957, the ratio was 1:859 in 2010. The government aims to bring the number further down to 1:600 by the year 2020.

<table>
<thead>
<tr>
<th>State</th>
<th>Public Sector</th>
<th>Private Sector</th>
<th>Total</th>
<th>Doctor : Population</th>
</tr>
</thead>
<tbody>
<tr>
<td>Johor</td>
<td>1,646</td>
<td>1,085</td>
<td>2,731</td>
<td>1 : 1,226</td>
</tr>
<tr>
<td>Kedah</td>
<td>1,276</td>
<td>482</td>
<td>1,758</td>
<td>1 : 1,108</td>
</tr>
<tr>
<td>Kelantan</td>
<td>858</td>
<td>222</td>
<td>1,080</td>
<td>1 : 1,426</td>
</tr>
<tr>
<td>Kuala Lumpur</td>
<td>2,738</td>
<td>1,958</td>
<td>4,696</td>
<td>1 : 357</td>
</tr>
<tr>
<td>Labuan</td>
<td>27</td>
<td>16</td>
<td>43</td>
<td>1 : 2,021</td>
</tr>
<tr>
<td>Melaka</td>
<td>729</td>
<td>408</td>
<td>1,137</td>
<td>1 : 722</td>
</tr>
<tr>
<td>Negeri Sembilan</td>
<td>1,007</td>
<td>398</td>
<td>1,405</td>
<td>1 : 727</td>
</tr>
<tr>
<td>Pahang</td>
<td>1,023</td>
<td>350</td>
<td>1,373</td>
<td>1 : 1093</td>
</tr>
</tbody>
</table>

300. M.I. Merican, *Challenges to Medical Students*, speech delivered at AIMST University on Dec. 18, 2010.
### Table 10: Doctor-population ratios in Malaysia

<table>
<thead>
<tr>
<th>State</th>
<th>Public Sector</th>
<th>Private Sector</th>
<th>Total</th>
<th>Doctor : Population</th>
</tr>
</thead>
<tbody>
<tr>
<td>Perak</td>
<td>1,898</td>
<td>871</td>
<td>2,769</td>
<td>1 : 850</td>
</tr>
<tr>
<td>Perlis</td>
<td>251</td>
<td>37</td>
<td>288</td>
<td>1 : 804</td>
</tr>
<tr>
<td>Pulau Pinang</td>
<td>1,281</td>
<td>975</td>
<td>2,256</td>
<td>1 : 692</td>
</tr>
<tr>
<td>Putrajaya</td>
<td>240</td>
<td>13</td>
<td>253</td>
<td>1 : 286</td>
</tr>
<tr>
<td>Sabah</td>
<td>1,339</td>
<td>390</td>
<td>1,729</td>
<td>1 : 1,855</td>
</tr>
<tr>
<td>Sarawak</td>
<td>1,254</td>
<td>403</td>
<td>1,657</td>
<td>1 : 1,491</td>
</tr>
<tr>
<td>Selangor</td>
<td>3,190</td>
<td>2,738</td>
<td>5,928</td>
<td>1 : 921</td>
</tr>
<tr>
<td>Terengganu</td>
<td>672</td>
<td>204</td>
<td>876</td>
<td>1 : 1,183</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>22,429</strong></td>
<td><strong>10,550</strong></td>
<td><strong>32,979</strong></td>
<td><strong>1 : 859</strong></td>
</tr>
</tbody>
</table>

115. In terms of distribution, Table 10 indicates that most of the country’s doctors work in the same more urbanized areas highlighted previously. The majority of doctors are also based in Peninsula Malaysia. Sabah, Sarawak and Labuan therefore have the poorest doctor-population ratios in the country.

116. In addition, the figures show that more than 30% of doctors work in private practice. More doctors are joining them every year because of the higher remuneration and better working conditions in the private sector. Compared to them, doctors in the public sector work between 45 and 120 hours a week. The government has eventually recognized that such long working hours are not conducive for the delivery of quality health care. In the 2012 Budget delivered by the Prime Minister (who is also the country’s Finance Minister) in the Dewan Rakyat on 7 October 2011, the government has pledged that no Medical Officers would now have to work longer than an average of sixty hours per week. They (and Medical Specialists) would be entitled to allowances that range from MYR 30 to MYR 80 for each night that they are on-call. A new time-based promotion scheme has also recently been introduced to retain more doctors in the public sector.

117. The issue of doctors gravitating towards the private sector is particularly marked in the case of medical specialists. Up until around 1980, almost all specialists were in government service. However, because of the widespread development of private hospitals, approximately 60% of all specialists now work in this sector. As 75% of all admissions are to government hospitals, this group therefore caters only for the needs of 25% of the inpatient population. The majority is

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302. Adapted from Ministry of Health, Health Indicators 2010: Indicators for Monitoring and Evaluation of Strategy for All (2010), 130.
tended to by the remaining 40% of specialists who remain in the public sector. Even here, the referral system (from district hospitals to general hospitals to national referral centres), has resulted in specialists concentrated in particular localities rather than being evenly distributed around the country.

§3. LICENSING OF PHYSICIANS

I. General Practitioners

118. According to the Medical Act 1971, persons intending to practise as medical practitioners in the country would need to be registered on the Malaysian Medical Register. In the four decades since the Act was passed, there has been a manifold increase in the number of registered practitioners in the country. With less than 1,000 names on the Register in 1971, this grew to 32,979 in 2010.

119. Four types of registration are recognized:

(1) Provisional Registration
(2) Full Registration (without conditions)
(3) Full Registration (with conditions and restrictions) and
(4) Temporary Registration.

A. Registration of Medical Practitioners

120. Pursuant to section 12 of the 1971 Act, Provisional Registration is open to medical graduates who obtained their degrees from an institution listed in the Second Schedule of the Act. This type of registration is solely for the purpose of enabling them to undergo their internship which is a prerequisite for full registration to practise medicine. Immediately upon being provisionally registered, section 13(2) requires them to engage in employment in a resident medical capacity. As noted above, this is for a period of not less than two years and not more than six years, in a hospital or institution approved by the Medical Qualifying Board.

121. Graduates from institutions which are not listed in the Second Schedule but who would like to practise in Malaysia would first have to sit and pass the Medical Qualifying Examination before they are eligible for provisional registration and be allowed to undergo the housemanship training. Rules concerning the examination are outlined in the Medical (Setting of Examination for Provisional Registration) Regulations 1993.

Candidates would need to submit their application to sit the examination to the MMC at least three months before the first day of the proposed examination of the examining body which sets the examination, along with a prescribed fee. The examination is conducted twice a year by Universiti Kebangsaan Malaysia, Universiti Malaya and Universiti Sains Malaysia. Each of the examining bodies may set their own dates for the examination, and candidates shall be subject to their rules and regulations as regards the examination. Candidates are assigned the university
where they are to sit for the examination by means of a ballot. The MMC will then provide the universities with details about the candidates who will sit their examinations and they, in turn, will inform the candidates regarding their preparatory courses. Candidates who fail the examination will be assigned to the same examining body for a further attempt. But once they have exhausted the number of resits allowed by their examining body, they are not allowed to make an application to sit for an examination set by another examining body. Candidates are generally allowed only three attempts.

The main aim of the Medical Qualifying Examination is to ensure that candidates possess the prerequisite basic knowledge and clinical skills to practise safe medicine. The examination will assess them at par with final year medical students. Only Malaysian citizens, permanent residents and those related to Malaysians by blood or marriage are eligible to sit for the examination.

122. A medical practitioner who has been provisionally registered under section 12 and who can provide evidence (i.e., a certificate) that he has satisfied the conditions required by section 13(2), would then need to be fully registered to carry out unsupervised medical practice. Practitioners may be conferred either Full Registration without any condition or constraint,\(^\text{308}\) or Full Registration subject to restrictions and conditions as stipulated by the Health Minister, after seeking advice from the Evaluation Committee appointed by the MMC.\(^\text{309}\)

123. Any fully registered practitioner wishing to practise as a medical practitioner would need to make an application in a prescribed form and pay a prescribed fee for a certificate to practise during any particular year.\(^\text{310}\) The Registrar would then issue him with an Annual Practising Certificate (APC) which authorizes him to practise as a medical practitioner during the year for which the certificate is issued. The application and the certificate need to specify the address of the principal place and all other places of practice of the applicant. The document needs to be renewed annually, without which, the doctor would not be allowed to practise Medicine.\(^\text{311}\)

124. As soon as the above are in order or at any time thereafter, the registered medical practitioner is required under section 41 of the Act to assume appointment in a medical capacity in a public institution of medicine as determined by the Director-General of the MMC. This is for a continuous period of not less than three years, during which he is known as a Medical Officer.

In accordance with section 40, the failure to comply with this requirement may result in the practitioner’s registration being revoked and his name struck off the Register. For any person whose name is struck off on this ground, it shall not be restored on the Register except upon a direction given by the Minister of Health, who may then give such direction upon an application in writing being made to him.

\(^{308}\) Pursuant to sec. 14(1) of the Act.
\(^{309}\) Section 14(3).
\(^{310}\) Section 20.
\(^{311}\) The Ministry of Health is currently planning to make it mandatory for doctors to earn adequate CPD (Continuing Professional Development) points before being eligible for the APC – see N.K.S. Tharmaseelan, *Continued Professional Development*, 41 Berita MMA 10 (2011).
by the doctor disciplined. While he is fulfilling the terms and conditions imposed, he shall be deemed to be fully registered so far as necessary to satisfy those terms and conditions but no further. Once these are fulfilled, he shall then be entitled to a certificate issued by the Director-General as evidence thereof, and the decision by the Minister to restore the name is deemed final, and it is not to be questioned or reviewed in any court of law.

125. On the compulsory public service itself, section 42 states that the Minister may in respect of any person, any class of persons, or all persons during such period as he may specify, grant a reduction as he considers appropriate or a complete exemption from the period of service required under section 41. He may also, if any person applies to him in writing, grant a postponement to such person from commencing the service for such a period as he may consider appropriate if he is satisfied that it would be considered just and reasonable to do so. This decision too shall be final and shall not be questioned or reviewed in any court. Medical practitioners who have complied with the compulsory requirement may decide to leave public service to join the private sector.

126. Pursuant to section 16 of the Act, Temporary Registration may be conferred to foreign practitioners who intend to practise Medicine in Malaysia for the purposes of undergoing postgraduate studies at local institutions; the training of local practitioners during workshops or conferences; or facilitating research or attachment in clinically related fields. The practitioners must be registered with their respective countries’ Medical Councils. Application for a Temporary Registration Certificate (TPC) needs to be made in writing through a practitioner registered with the MMC who holds a valid and current APC six weeks prior to practice. This practitioner shall be the guarantor who will supervise the practice of the doctor issued with temporary registration. This type of registration enables the doctor to practise Medicine in Malaysia for a period of not more than three months, during which time he is deemed to be a fully registered doctor.

B. Restriction on Registration

127. By virtue of section 19 of the Act, the Council is also empowered to decline to enter onto the register the names of anyone applying for provisional or full registration who has been found guilty of an offence involving fraud, dishonesty or moral turpitude or an offence punishable with imprisonment for a term of two years or more.

The same for anyone who, after due inquiry by the Council, is found to have been guilty of infamous conduct in any professional respect or to be otherwise not of good fame and character.

Likewise for those who have been found to be unfit to perform their professional duties because of their mental or physical condition after due inquiry has been carried out into these by a medical review panel which is made up of not less than three medical practitioners appointed by the Council.
C. Restoration of Name to Register After Being Struck Off or Suspended From the Register

128. The Council may order the name of a registered practitioner to be struck off or be suspended from the Register in the exercise of its disciplinary jurisdiction. In the first situation, the practitioner is not thereafter entitled to be registered as a medical practitioner under the provisions of the Act. However, the Council may, if it thinks fit, on the application of the person struck off, order that his name be restored to the Register.

In the case of a practitioner whose registration has been suspended, he shall be entitled to apply for his certificate of registration and APC (if this has not expired) to be returned to him at the expiration of the period of suspension, but not earlier.\(^{312}\)

D. Cessation of Registration

129. A registered medical practitioner is regarded as impaired if he is not able to fulfil his professional or personal responsibilities. He is thus unable to practise Medicine safely and with reasonable skill. This could be attributable to one or more of the following conditions: mental illness; neurological illness; substance abuse and dependence; physical disabilities or handicap; medical conditions (including those related to ageing and chronic infections); and any other condition which the MMC may decide as to give rise to impairment in a practitioner. All registered medical practitioners are under an ethical obligation to report impaired practitioners who fulfil the conditions above and whose continued performance and practice place patients and the community at risk. The report should be made to the most senior registered medical practitioner in the health care facility where the impaired colleague was practising in, and/or directly to the Council.\(^{315}\)

130. Registered practitioners would cease to be on the Register upon being admitted to or confined in a mental hospital under the provisions of any law; or where they are certified by a medical review panel which shall consist of not less than three medical practitioners appointed by the Council, to be unfit to perform their professional duty by reason of their mental or physical condition. Cessation on these grounds would not enable the practitioner to be re-registered unless he can satisfy the Council that his condition warrants such registration.\(^{314}\)

131. Where the Council is satisfied that a registered person is deceased or is no longer practising Medicine in Malaysia, an endorsement will accordingly be made against his name in the Register.\(^{315}\)

\(^{312}\) Section 31A.
\(^{313}\) MMC, Managing Impaired Registered Medical Practitioners, Guideline 001/2010.
\(^{314}\) Section 24.
\(^{315}\) Section 23.
132. Although the compulsory retirement age for those in government service is 58 years old,\textsuperscript{317} the MMC acknowledges that retirement from medical practice should not be dependent on age. This is on account of the fact that experienced medical practitioners can still contribute significantly to the delivery of health care in the country. For this reason, it is supportive of medical practitioners who wish to work in private practice beyond the age of 70 years. However, the Council may impose restrictions on any practising privileges which it deems fit. These include limiting the area of practice to the practitioner’s core competence or requiring that he practises within a team. When imposing any restrictions, the Council shall ensure that those who are able to demonstrate the required competencies to practise beyond this age threshold are not unfairly restricted. In exercising its judgment, it would need to be first satisfied that the practitioner is ‘fit to work’. For this, the practitioner would have to prove that he has the requisite qualifications, skills and competence; and is physically and mentally fit for that work. Second, the Council would need to be satisfied that the practitioner has participated and will continue to participate in appropriate continuing professional development.

When the practitioner applies for his APC, he would also need to declare his health status which includes vision, hearing, speech and motor skills. He may also be required by the Council to either undergo an independent health assessment or to provide a medical report which attests to his physical and mental fitness to practise.

In order to demonstrate his continued competence in the area of work which he desires to continue to practise, he would need to provide at least the following information: current practice profile; any limitations on practice whether voluntary or imposed (with those imposed by age-related illness to be clearly stated); proposed practice profile in the subsequent year and how any limitations on practice have been addressed in the practice profile; any investigated complaints of a professional nature and the outcome of such investigations; and evidence of ongoing participation in continuous professional development. Where he practises in a health care institution or group practice, he would need to have the testimony from at least one other registered medical practitioner in the same institution or group practice; and confirmation of appropriate arrangements for cover in the event of, but not limited to, illness.

Further, since some medical indemnity organizations may stipulate additional requirements for practitioners in this age group, the practitioner needs to provide evidence to the Council and/or the health care institution or group practice that he is currently either a member of a medical indemnity organization or is receiving coverage from an insurance company.

\textsuperscript{316} MMC, \textit{Guidelines for Medical Practice for Doctors beyond the Age of 70 Years} (April 2009).
\textsuperscript{317} MMA, SCHOMOS Guidebook 2010.
II. Medical Specialists

133. The training and regulation of medical specialists develop at a somewhat slower pace than that for general practice. For one, local training opportunities for medical specialization did not become available until 1973.318 Doctors in the early post-independence years had to be sent abroad for specialist training. These were mainly to the United Kingdom, Australia and New Zealand, where training were undertaken under the auspices of the respective Royal Colleges. As this was a very costly route, only a few doctors could be sent. The government, keen for training to take place locally, directed the universities to assume responsibility for developing postgraduate medical education in collaboration with the Ministry of Health.319

134. For this, the lead was taken by the three oldest medical faculties in the country that is, those at Universiti Malaya, Universiti Kebangsaan Malaysia and Universiti Sains Malaysia. They each developed, and offered Masters programmes in various fields of medical specialization to medical doctors in the country.320 This set on course an important trajectory since unlike the Royal Colleges of the United Kingdom and Australia, for instance, training to be a medical specialist in Malaysia has been, and continues to be, university-based rather than profession-based.321

135. But as more and more Masters programmes started to be developed, the Ministries of Health and Education began to be concerned at the lack of standardization and coordination among the different providers.322 Each of the three universities was conducting its own postgraduate medical specialist training programmes. Their educational philosophies, criteria for student intake, syllabuses and core modules, assessment methods, and durations of study, differ from one another.

136. After discussions initiated by the two Ministries, it was agreed that all local Masters programmes leading to medical specialization would now:

– be of four-year duration; and
– only admit candidates who have had at least two years post-qualification experience.

137. The country’s highest authority in relation to postgraduate studies in Medicine is the Conjoint Board for Postgraduate Medical Education, based at the Ministry of Education. Membership consists of: the Dean and two representatives from each of the medical faculties; the Director of the Higher Education Division at the Ministry of Education; the Director of Manpower and Training Division at the Ministry of Health; and the Master of the Academy of Medicine of Malaysia. The Board will decide whether a proposed postgraduate medical course can run; and will work

318. When the Faculty of Medicine at Universiti Malaya offered postgraduate courses in Pathology, Public Health and Psychological Medicine – see Wong, supra n. 277, 409.
319. Nor, supra n. 275, 393–394.
320. In recent years, they have also begun to admit postgraduate students from abroad.
321. Tan, supra n. 256, 173.
towards ensuring that the standards among the courses offered by the three universities are equivalent.

The Masters programmes which are currently offered are as below. Because of the ever-increasing numbers applying for a place, UIAM too has in recent years joined the three universities in providing its own postgraduate medical courses.

<table>
<thead>
<tr>
<th>Institution</th>
<th>Specialist Training Programmes Offered</th>
</tr>
</thead>
</table>
| Universiti Malaya (UM) | Masters of Anaesthesiology (MAnaes)  
Masters of Clinical Oncology (MCO)  
Masters of Emergency Medicine (MEmMed)  
Masters of Family Medicine (MFamMed)  
Masters of Internal Medicine (MinMed)  
Masters of Medical Science in Clinical Pathology (MMedSciClinPath)  
Masters of Obstetrics and Gynaecology (MObGyn)  
Masters of Ophthalmology (MOpthmal)  
Masters of Orthopaedic Surgery (MOrthSurg)  
Masters of Otorhinolaryngology (Head and Neck Surgery) (MOrl)  
Masters of Paediatrics (MPaeds)  
Masters of Paediatrics Surgery (MPaedSurg)  
Masters of Pathology (MPath)  
Masters of Psychological Medicine (MPM)  
Masters of Radiology (MRad)  
Masters of Rehabilitation Medicine (MRehabMed)  
Masters of Sports Medicine (MSpMed)  
Masters of Surgery (MSurg)  
Masters of Medical Physics (MMedPhysics)  
Masters of Medical Science in Public Health (MMedSci(PH))  
Masters of Public Health (MPH) |

323. Doctors are still allowed to go abroad to pursue their specialist training – for a list of institutions and qualifications recognized by the MMC for this purpose, see Director General of Health, ‘Surat pekeliling Ketua Pengarah Kesihatan Malaysia bilangan 15/2012 senarai ijazah lanjutan kepakaran yang diktiraf oleh kerajaan dalam pelbagai disiplin perubatan dan pergigian (semakan pada Mac 2012), Apr. 5, 2012.


325. The information is collated from the data available on their respective websites.
<table>
<thead>
<tr>
<th>Institution</th>
<th>Specialist Training Programmes Offered</th>
</tr>
</thead>
<tbody>
<tr>
<td><em>Universiti Kebangsaan</em></td>
<td>Masters of Surgery (General Surgery) (MSurg)</td>
</tr>
<tr>
<td><em>Malaysia (UKM)</em></td>
<td>Masters of Surgery (Orthopaedics) (MSurg)</td>
</tr>
<tr>
<td></td>
<td>Masters of Surgery (Otorhinolaryngology) (MSurg)</td>
</tr>
<tr>
<td></td>
<td>Masters of Surgery (Ophthalmology) (MSurg)</td>
</tr>
<tr>
<td></td>
<td>Masters of Surgery (Radiology) (MSurg)</td>
</tr>
<tr>
<td></td>
<td>Masters of Surgery (Paediatrics) (MSurg)</td>
</tr>
<tr>
<td></td>
<td>Masters of Surgery (Psychiatry) (MSurg)</td>
</tr>
<tr>
<td></td>
<td>Masters of Surgery (Anaesthesiology) (MSurg)</td>
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<tr>
<td></td>
<td>Masters of Obstetrics and Gynaecology (MObGyn)</td>
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<td></td>
<td>Masters of Medicine (Internal Medicine) (MMed)</td>
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<tr>
<td></td>
<td>Masters of Medicine (Family Medicine) (MMed)</td>
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<td></td>
<td>Masters of Pathology (MPat)</td>
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<td></td>
<td>Masters of Public Health (MPH)</td>
</tr>
<tr>
<td><em>Universiti Sains</em></td>
<td>Masters of Medicine (Internal Medicine) (MMed)</td>
</tr>
<tr>
<td><em>Malaysia (USM)</em></td>
<td>Masters of Medicine (Paediatrics) (MMed)</td>
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<td></td>
<td>Masters of Medicine (Surgery) (MMed)</td>
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<td></td>
<td>Masters of Medicine (Obstetrics and Gynaecology) (MMed)</td>
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<tr>
<td></td>
<td>Masters of Medicine (Orthopaedics) (MMed)</td>
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<td>Masters of Medicine (Anaesthesiology) (MMed)</td>
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<td>Masters of Medicine (Family Medicine) (MMed)</td>
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<td></td>
<td>Masters of Surgery (Neurosurgery) (MSurg)</td>
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<td></td>
<td>Masters of Pathology (Anatomic Pathology) (MPat)</td>
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<td></td>
<td>Masters of Pathology (Medical Microbiology) (MPat)</td>
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<tr>
<td></td>
<td>Masters of Pathology (Clinical Immunology) (MPat)</td>
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<td></td>
<td>Masters of Pathology (Chemical Pathology) (MPat)</td>
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<tr>
<td></td>
<td>Masters of Pathology (Medical Genetic) (MPat)</td>
</tr>
</tbody>
</table>
Institution Specialist Training Programmes Offered

Universiti Islam Antarabangsa Malaysia (UIAM)

Masters of Medicine (Anatomy) (MMed)
Masters of Medicine (Biochemistry) (MMed)
Masters of Medicine (Microbiology) (MMed)
Masters of Medicine (Obstetrics and Gynaecology) (MMed)
Masters of Medicine (Orthopaedics) (MMed)
Masters of Medicine (Parasitology) (MMed)
Masters of Medicine (Pharmacology) (MMed)
Masters of Medicine (Physiology) (MMed)
Masters of Medicine (Surgery) (MMed)

Part I, Ch. 1, Access to the Medical Profession

139. Although specialization is encouraged by the Ministry of Health, it is highly competitive and those who pursue specialist studies on government scholarships would have to serve seven years obligatory public service after they qualified.326 Promotions and scholarships for further studies are made mainly on the basis of seniority.327 Upon completion of their specialist training, the medical practitioner will be known as a Consultant (perunding perubatan).

140. Whilst the Medical Act 1971 requires all medical practitioners, both specialists and non-specialists, to be registered with the MMC, the Act does not make any provision for a specialist Register. However, in response to the increasing numbers of specialists in the country, a National Specialist Register (NSR) was launched in 2006. This is managed by the Academy of Medicine of Malaysia (AMM) and has the support of the Ministry of Health and the MMC.

The main aims of the Register are: to ensure that doctors designated as specialists are adequately trained and competent to exercise a higher level of care in their chosen field of expertise; to enable medical practitioners to identify the appropriate specialists whom they can contact for a second opinion or further management; and to protect the public and help them to identify the relevant medical specialists who they may wish to consult or be referred to.326

141. Specialties registrable on the Register are:

– Anaesthesiology
– Emergency Medicine
– Family Medicine
– Internal Medicine
– Nuclear Medicine
– Obstetrics and Gynaecology

142. Registration with the NSR is on a voluntary basis.\textsuperscript{329} It needs to be renewed once every five years upon proof of continuing professional development and continuing medical education activities undertaken by the medical practitioner practising as a specialist. This is upon the payment of a fee which is currently set at MYR 1,000 for fellows and members of AMM, and MYR 1,500 for non-fellows and non-members. As the NSR is self-sustaining, the fee goes towards the cost of maintaining the Register.\textsuperscript{330}

\textsuperscript{329} This will change when the Medical (Amendment) Act 2012 comes into force where it would be mandatory for the names of all registered medical practitioners practising as specialists to be entered into the Specialist Register.

\textsuperscript{330} Further information is available from the homepage of the National Specialist Register at http://www.nsr.org.my/.
Chapter 2. Practice of Medicine

§1. Legal Conditions for the Practice of Medicine

143. The practice of Medicine is regulated by the Medical Act 1971, and any of the regulations made to set down anything which this Act requires to be stipulated.

144. As discussed previously, a person is eligible to register to practise Medicine in Malaysia only if he holds any of the qualifications conferred by the institutions mentioned earlier or other institutions specified in the Second Schedule of the Act.331 This Schedule outlines the country in which a qualification is granted; the name of the institution granting the qualification; and a description of the qualification itself.

A person who holds a qualification in Medicine and Surgery other than those listed in the Schedule may nevertheless be deemed suitable for registration if he passes the Medical Qualifying Examination set by UM, UKM or USM; and produces to the Registrar evidence that subject to his being provisionally registered, he has been selected for employment as a House Officer, or that he is otherwise eligible to be fully or partially exempted from this on satisfying the Council that he has had experience which is not less both in character and scope and in length of time than the experience demanded by section 12 of the Act.332

145. Being fully registered under the Act entitles the doctor to practise Medicine, Surgery and Midwifery, and to recover in due course of law reasonable charges for professional aid, advice and visits, and the value of any medicine or appliances made available to his patients.333 The practitioner registered must, however, be in possession of an APC at the time the service was rendered.

Although the 1971 Act does not specify the scope of and the limits to the terms ‘Medicine, Surgery and Midwifery’, it indicated in section 34(2) that only registered medical practitioners can hold themselves out as being qualified, competent or willing to undertake the treatment of diseases of the human eye or the prescription of remedies or the giving of advice in connection with the treatment thereof.

146. Further, the Poisons Act 1952 specified that only registered medical practitioners (and registered pharmacists) are allowed to dispense, compound or mix any poison with any other substance (whether a poison or not) for the purpose of being used for medical treatment.334 Likewise, only they (and registered dentists and veterinary officers) are allowed to sell, supply or administer such poisons to their patients. Every medicine containing such poisons shall be prepared by or under their immediate supervision. Any doctor who sells or supplies any poison or medicine

331. Section 12(1)(a)(i).
332. Section 13(6).
333. Section 26.
334. Section 12.
Part I, Ch. 2, Practice of Medicine 147–150

containing a poison not prepared by him or under his immediate personal supervision shall be guilty of an offence under the Act.\(^\text{335}\)

147. The Dangerous Drugs Act 1952 too stipulated that dangerous drugs can only be administered by or under the direction of a registered medical practitioner (and a registered dentist).\(^\text{336}\)

148. Meanwhile, the Human Tissues Act 1974 stated that only registered medical practitioners can remove and use any part of a human body for purposes of organ donation and transplantation.\(^\text{337}\)

§2. **Illegal Practice of Medicine**

149. Section 33(1) of the Medical Act 1971 makes it an offence for anyone not registered or exempted from registration on the Malaysian Medical Register to:

- wilfully and falsely pretend to be registered under the Act or to be qualified to practise medicine or surgery;
- wilfully and falsely takes or uses the name or title of physician, doctor of medicine, licentiate in medicine and surgery, bachelor of medicine, surgeon, general practitioner or apothecary;
- wilfully and falsely takes or uses any name, title, addition or description implying that he is registered under this Act, or that he is recognized by law as a physician or surgeon or licentiate in medicine and surgery or a practitioner in medicine or an apothecary;
- wilfully and falsely takes or uses any name, title, addition or description, or uses any instrument, calculated to induce any person to believe that he is qualified to practise medicine or surgery according to modern scientific methods;
- practises medicine or surgery;
- uses the term ‘clinic’, ‘dispensary’, ‘hospital’ or the equivalent of any of these terms in any other language in the signboard over his place of practice in purported practice of medicine or surgery as a person registered under the Act; or
- uses a symbol designed by the Council for the use of registered medical practitioners only.

150. For the purposes of the subsection above, section 33(2) makes clear that the taking or using of the term ‘doctor’, ‘clinic’, ‘dispensary’ or ‘hospital’ or the equivalent of these in another language in relation to the practice of medicine or surgery, shall be deemed to be the taking or using of a name, title, addition or description calculated to induce any person to believe that he is qualified to practise Medicine or Surgery according to modern scientific methods. This provision further explains

335. Section 19.
336. Section 14(2).
337. Section 3.
that the using by any person in the practice of Medicine or Surgery of a sphygmo-
manometer, stethoscope, hypodermic syringe or other instruments used exclusively
by those qualified to practise Medicine or Surgery according to modern scientific
methods, shall be deemed to be using the instruments calculated to induce a person
to believe that he is qualified to practise Medicine or Surgery according to those
methods.

151. It would likewise be wrong for a registered medical practitioner to assist
an unqualified or unregistered person to attend, treat or perform an operation upon
anyone in respect of matters requiring professional discretion or skill (e.g., by
administering anaesthetic). 338 Anyone doing so would be liable to disciplinary
action by the MMC.

338. MMC, Code of Professional Conduct, Part II, para. 1.4.3.
Chapter 3. Traditional and Complementary Medicine

152. Although scientific medicine can only be practised by registered medical practitioners, section 34(1) of the 1971 Act states that:

nothing in this Act shall be deemed to affect the right of any person, not being a person taking or using any name, title, addition or description calculated to induce any person to believe that he is qualified to practise medicine or surgery according to modern scientific methods, to practise systems of therapeutics or surgery according to purely Malay, Chinese, Indian or other native methods, and to demand and recover reasonable charges in respect of such practice.

153. Indeed it is estimated that there are around 15,000 practitioners of traditional and complementary medicine (T & CM) in the country. And with up to 69.4% of Malaysians having used some form of T & CM in their lifetime, the government is now keen to integrate this into the modern medical system.

154. In 2004, a Traditional and Complementary Medicine Division was set up within the Ministry of Health to:

– regulate T & CM practitioners using a phased approach, from self-regulation to statutory regulation;
– facilitate the development of T & CM practices and its integration into the country’s health care system;
– set up and maintain a register for all T & CM practitioners;
– ensure that practitioners undergo a formalized system of education and training;
– oversee and lead the development of: standards and criteria in the field; regulation and monitoring of accredited training centres and the quality, standards and effectiveness of their programmes; and
– to promote research and evidence-based practice.

155. T & CM is defined by the Ministry of Health as:

a form of health-related practice designed to prevent, treat and/or manage illnesses and/or preserve the mental and physical well-being of individuals and includes practices such as traditional Malay medicine, Islamic medical

340. Z.M. Siti, et al., Use of Traditional and Complementary Medicine in Malaysia: A Baseline Study, 17 Complementary Therapies Med. 292 (2009). In another study, it was shown that the majority of those who had used complementary medicine are those with higher educational attainment. Their reasons for seeking complementary medicine include: a sense of being empowered by the process; a feeling of being more in control of their illness; and disappointment with and concerned over the side-effects of conventional medicine – see N. Mokhtar, Use of Complementary Medicine amongst Asthmatic Patients in Primary Care 61 Med. J. Malay. 125 (2006).
practice, traditional Chinese medicine, traditional Indian medicine, homoeopathy and complementary therapies, and excludes medical or dental practices utilised by registered medical or dental practitioners.\(^{343}\)

156. The first integrated hospital was established in Kepala Batas, Pulau Pinang, in 2007.\(^{344}\) Since then, nine more hospitals have incorporated one or more of the five different T & CM practices approved for use in public hospitals as adjunct treatments for several medical conditions. These are as follows.\(^{345}\)

### Table 12 List of Integrated Hospitals

<table>
<thead>
<tr>
<th>T &amp; CM Practices</th>
<th>Integrated Hospital</th>
</tr>
</thead>
<tbody>
<tr>
<td>Acupuncture (for chronic pain and post-stroke management)</td>
<td>Duchess of Kent Hospital, Kepala Batas Hospital, Port Dickson Hospital, Putrajaya Hospital, Sarawak Public Hospital, Sultan Hajah Kalsom Hospital, Sultan Ismail Hospital, Sultanah Bahiyah Hospital, Sultanah Nur Zahirah Hospital</td>
</tr>
<tr>
<td>Herbal Therapy (as an adjunct treatment for cancer patients)</td>
<td>Kepala Batas Hospital, Putrajaya Hospital, Sultan Ismail Hospital</td>
</tr>
<tr>
<td>Malay Massage (urut) (for chronic pain and post-stroke management)</td>
<td>Duchess of Kent Hospital, Kepala Batas Hospital, Port Dickson Hospital, Putrajaya Hospital, Raja Perempuan Zainab II Hospital, Sarawak Public Hospital, Sultan Hajah Kalsom Hospital, Sultan Ismail Hospital, Sultanah Bahiyah Hospital, Sultanah Nur Zahirah Hospital</td>
</tr>
<tr>
<td>Malay Postnatal Treatment</td>
<td>Duchess of Kent Hospital, Putrajaya Hospital, Raja Perempuan Zainab II Hospital, Sultan Ismail Hospital, Sultanah Bahiyah Hospital</td>
</tr>
<tr>
<td>Shirodhara</td>
<td>Port Dickson Hospital</td>
</tr>
</tbody>
</table>

\(^{343}\) Ibid., 3.
\(^{344}\) Ibid., 2.
\(^{345}\) Adapted from information available on the Traditional and Complementary Medicine Division’s website at http://tcm.moh.gov.my/v4/bmelayu/modules/mastop_publish/?tac=15.
157. In addition, three private hospitals are also providing integrated services: the Lam Wah Ee Hospital, the Tung Shin Hospital and Hospital Putra.

158. There is thus far no standard or consistent route which needs to be followed to acquire the skills and knowledge needed to be a T & CM practitioner. Some even acquired their skills by having these handed down from one generation to another.346 In future, the Ministry of Health expects practitioners to undergo formal training before they can practise T & CM. To date, seven degree programmes347 and six diploma programmes348 have been approved. Some of these have begun to be offered by the following local institutions:349

Table 13  List of Courses in Traditional and Complementary Medicine

<table>
<thead>
<tr>
<th>Institution</th>
<th>Courses Offered</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cyberjaya University College of Medical Sciences (CUCMS)</td>
<td>• Bachelor of Homeopathy</td>
</tr>
<tr>
<td>International Medical University (IMU)</td>
<td>• Bachelor of Science in Chinese Medicine</td>
</tr>
<tr>
<td></td>
<td>• Bachelor of Science in Chiropractic</td>
</tr>
<tr>
<td>INTI International University College (MSU)</td>
<td>• Bachelor of Traditional Chinese Medicine</td>
</tr>
<tr>
<td>Management and Science University (MSU)</td>
<td>• Bachelor of Traditional Chinese Medicine</td>
</tr>
<tr>
<td></td>
<td>• Diploma in Traditional Chinese Medicine</td>
</tr>
<tr>
<td>Melaka College of Complementary Medicine</td>
<td>• Diploma in Natural Medicine</td>
</tr>
<tr>
<td>Southern College</td>
<td>• University Foundation for Degree Programme (Traditional Chinese Medicine)</td>
</tr>
<tr>
<td></td>
<td>• Bachelor Degree in Traditional Chinese Medicine (in collaboration with Xiamen University, China)</td>
</tr>
<tr>
<td>Universiti Tunku Abdul Rahman</td>
<td>• Bachelor of Traditional Chinese Medicine</td>
</tr>
</tbody>
</table>
The Public Services Department has also given its approval for Malaysian students to study Chinese Medicine at three universities in China: the Beijing University of Chinese Medicine (BUCM), the Nanjing University of Chinese Medicine (NUCM) and the Shanghai University of Traditional Chinese Medicine (SHUTCM).

The Ministry of Health’s Traditional and Complementary Medicine Division has signed a Memorandum of Understanding (MOU) with China in order to foster cooperation on policy-making, regulation and the promotion of traditional medicine; and with India in relation to the traditional system of Indian medicine. A Traditional and Complementary Medicine Bill is in the process of being tabled before Parliament. Once enacted, only qualified T & CM practitioners would be eligible to register with the Ministry of Health and be allowed to practise in the country. Under the proposed law, they would also be under a legal obligation to refer a patient to a registered medical practitioner if the condition which the patient suffers from is not in the T & CM practitioner’s field of expertise. Until this happens, the Division is promoting voluntary registration of T & CM practitioners and over 3,000 have now registered. The Division has also published Good Practice Guidelines (on Acupuncture, Chiropractic, Herbal Therapy, Malay Massage, and Malay Postnatal Care), and a Code of Ethics, which it encourages T & CM practitioners in the country to adopt through the current process of self-regulation.
Chapter 4. Control Over the Practice of Medicine

§1. PROFESSIONAL LIABILITY

161. When acting in a professional capacity, registered medical practitioners have obligations under civil law. These could arise under tort or contract.

162. Tortious liability could potentially arise under two headings. The first is trespass to the person. Under civil law, medical treatment for adult patients must be preceded by their consent. For the consent to be valid, the patient must be of sound mind and that the decision to undergo the treatment must have been made voluntarily based on an understanding of the nature of the proposed procedure. Any transgression of the limits of consent could expose the doctor to a charge of trespass to the person (or battery), for which he or she may be ordered to pay damages. The only exception would be in situations where any delay in obtaining consent would put the patient’s life under threat.

163. Another important tortious liability is that for negligence. This would attend any departure from a proper exercise of the doctor’s duty of care in the course of medical treatment which results in injury to the patient. This encompasses the realms of diagnosis, treatment and even the provision of proper advice to the patient upon discharge from hospital. To meet their obligations under tort law, the standard of care expected of a registered medical practitioner is not that of the highest or a very high standard. They are only expected to demonstrate a fair and reasonable standard of care and skill. This is determined by reference to what would be accepted as proper by a responsible body of medical practitioners. That this is so, is irrespective of the fact that there may be other doctors who would adopt a different approach, or even the existence of other bodies of opinion that would consider a particular approach adopted by the doctor as unacceptable. This is in

354. Dr K.S. Sivananthan v. Government of Malaysia [2000] 7 CLJ per PS Gill J. at 414. For a discussion of the doctor’s duty to inform patients of the risks of a proposed treatment, see Part II, Ch. 1, §2 below.
conformity with the principle known as the ‘Bolam test’ which was expatiated by the English courts in Bolam v. Friern Hospital Management Committee.\footnote{359}

Thus the law allows scope for differences of opinion. Likewise for medical specialists, the contents of their duty of care are determined by what would be accepted as proper by a responsible body of practitioners from the same branch of speciality as them.\footnote{360} However, in acknowledgement of the reluctance on the part of doctors to condemn their colleagues,\footnote{361} the courts assert that the opinion or approach adopted must be able to withstand logical analysis. In other words, the practice or approach must be shown to be reasonable, respectable and responsible.\footnote{362}

164. The burden of proving that there is a breach of a duty of care on the part of the doctor is shouldered by the plaintiff. This is an onerous task not least because, as mentioned above, a doctor is not negligent merely because he took a different view or approach from some other doctors. To prove a breach of the duty of care, the plaintiff would have to prove that the defendant doctor has acted in such a way which no practitioner in his area of practice or specialty would be guilty of, if acting with ordinary care.\footnote{363} Thus it is only in very exceptional circumstances that doctors have been found by the courts to have failed in the exercise of their duty of care.

Case law, to date, shows that these include situations where:

- the doctor’s lack of proper monitoring of a road accident victim’s response after the application of a plaster cast to his leg resulted in the leg having to be amputated twice;\footnote{364}
- when a dilation and curettage procedure resulted in the perforation of the uterus, multiple perforations in the rectum and multiple lacerations in the small intestines;\footnote{365}

\footnote{359. [1957] 1 WLR 582. This test has long been endorsed and applied in Malaysia – see e.g. Swamy v. Matthews [1967] 1 MLJ 142; Elizabeth Choo v. Government of Malaysia and Another [1970] 2 MLJ 171. For further discussion, see PN. John Kassim, Does the Bolam Principle Still Reigns in Medical Negligence Cases in Malaysia?, available at http://www.eimjm.com/Vol2-No1/Vol2-No1-H3.htm.}

\footnote{360. Liew Sin Kiong v. Dr Sharon D.M. Paulraj [1996] 2 CLJ 995 per Ian H.C. Chin J.}

\footnote{361. Payremalu Veerappan v. Dr Amarjeet Kaur and Others [2001] 4 CLJ 380 per VT Singham JC at 399.}

\footnote{362. This is in line with, and an endorsement of, the position outlined by the House of Lords in Bolitho v. City & Hackney Health Authority [1998] AC 232 – see Lechemanavasagar S. Karuppih v. Dr Thomas Yau Pak Chenk and Another [2008] 3 CLJ 7 per Rohana Yusuf J.}

\footnote{363. Lechemanavasagar S. Karuppih v. Dr Thomas Yau Pak Chenk and Another [2008] 3 CLJ 7 per Rohana Yusuf J.}

\footnote{364. Kow Nan Seng v. Nagamah and Others [1981] 1 LNS 147 (where the judge condemned the doctor’s lack of proper skill and observation as ‘a case of bad treatment in which a patient went in with a fairly good leg and came out without it’ – per Salleh Abas F.J.).}

\footnote{365. Lian Mui Mui v. Dr R. Venkat Krishman [1991] 1 CLJ 207 (where the judge remarked that he was convinced that the defendant doctor ‘did not realize he had perforated the uterine wall and con- tinued scraping with the sharp end of the curette by using a little more force with repeated strokes causing multiple injuries to the plaintiff and when he realized it was too late. The injuries suffered by the plaintiff following a dilation and curettege procedure are rare’ per Mohd Noor Ahmad J at 212).}
Part 1, Ch. 4, Control Over the Practice of Medicine 165–166

– when a penicillin injection was administered without ascertaining whether the patient was allergic to the drug and which resulted in her death shortly after receiving the injection; 366

– where a child died from acute haemorrhagic pancreatitis after the doctors had wrongly diagnosed her condition as acute perforated appendicitis and proceeded to perform an appendectomy without undertaking all necessary diagnostic procedures which would have ruled out their diagnosis; 367

– where a catalogue of wrongdoings led to the death of a pregnant woman shortly after she gave birth. 368

165. To compound the difficulty, the patient must further prove that there is a causal link between the doctor’s dereliction from the standard of care and the injury suffered by him. 369 This requires him to prove on the balance of probabilities (i.e., a chance of 51% or more) that he would not have suffered the injury had it not been for the breach. 370

166. Doctors who are found liable for negligence could be ordered by the courts to pay compensation to the aggrieved patients. The award of compensatory damages aims to restore the patient, in financial terms, as close as possible to the position he would have been in had the wrongful act or omission not taken place. This covers items like loss of income, medical treatment expenses, costs of future medical care, nursing care, any necessary renovations to the patient’s home to accommodate his disabilities; his pain and suffering; loss of amenities; transportation costs to and fro hospital; and other out-of-pocket expenses. 371

Further, in their analysis of the appropriate amount to be awarded for the different types of injuries suffered by patients, courts are guided by the Compendium of Personal Injury Awards issued by the Malaysian Bar Council. 372 This document is divided into three sections. The first, which focuses on orthopaedic injuries, discusses awards of damages for injuries to the skull, facial bones, teeth, clavicle and shoulder, arm, rib cage, pelvis, leg and spine; as well as amputations of arms and legs. The second section focuses on internal injuries, and it discusses injuries to the brain, eyes, ears/hearing, sense of smell/taste, voice box (larynx), lungs, abdomen


368. Dr Wong Wai Ping and Another v. Woon Lin Sing and Others [1999] 6 CLJ 23.

369. Dominic Pathacheary and Others v. Dr Goon Siew Fong and Another [2007] 5 CLJ 38; Udhaya Kumar Karuppusamy and Another v. Penguasa Hospital Daerah Pontian and Others [2005] 1 CLJ 143.


and sexual organs. The third looks at external injuries namely those associated with the skin and include soft tissue injuries, lacerations, haematomas, degloving injuries, skin grafts, abrasions and scarring. For each type of injury highlighted, a minimum suggested amount and a higher threshold were tabulated, based on the contemporary trend of awards in Malaysian courts. Alongside these are the factors that are to be taken into account when considering what would be the appropriate amount, from the suggested minimum and maximum figures, to award a particular patient. Judges are nevertheless at liberty to award below or above the stipulated quantum if the circumstances so dictate.  

167. Aggravated damages could also be awarded as a form of a higher compensation to reflect the court’s disapproval of a doctor’s actions which were conducted in such a way as to result in the patient suffering more than he would ordinarily be expected to in such a situation. For the patient to be entitled to this form of compensation, the acts must be calculated to injure the patient’s feelings.  

168. Exemplary damages could likewise be awarded. This serves as a serious punishment to the doctor and a deterrence to others. To qualify for this, the patient has to prove the culpability of the doctor’s conduct which ought to be so outrageous as to warrant punishment or deterrence.  

169. A patient who is treated privately is also owed a duty under contract. In the absence of unequivocal terms in the contract guaranteeing a cure or success of the treatment, the scope of the duty is generally no larger than the duty in tort that is, to exercise reasonable skill and care.

170. According to section 2 of the Public Authorities Act 1948, any action against parties acting in the execution of a statutory or public duty has to be commenced within three years of the act, neglect or default complained of. Thus any actions against doctors working in the public sector and their employer (i.e., the Government of Malaysia) would therefore need to be instituted within this time framework.

171. By contrast, patients treated privately have six years from the time the cause of action accrued to bring actions against their doctors. This is by virtue of section 6(1) of the Limitation Act 1953.

172. Any doctor who is found liable and had to pay compensation possesses a right to recover contribution or be indemnified against any other doctors or parties who are, or would if sued have been, liable in respect of the same damage, whether

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374. See e.g. Lee Ewe Poh v. Dr Lim Teik Man and Another [2011] 4 CLJ 397 at 414–415.
375. Ibid., 414.
376. See e.g. Al-Hamidi Chek Mat v. Dr Ganga Devi and Others [2010] 9 CLJ 193.
as joint tortfeasors or otherwise. The proceedings for contribution are regarded as independent of and separate from proceedings by a patient against his doctor. Time only begins to run from the date the doctor was held liable to the patient.

173. Further, in accordance with section 304A of the Penal Code 2006, a doctor whose negligence resulted in the death of the patient could be punished with imprisonment for up to two years and/or a fine.

II. Criminal Liability

174. Treatments given without consent or which go outside the limits of consent could likewise give rise to liability in criminal law. The penalty could be a fine and/or imprisonment.

III. Vicarious Liability

175. For doctors (and other paramedical staff) working in public health institutions, the Malaysian Government would be vicariously liable for the wrongs committed in the course of their employment. Section 34B of the Medical Act 1971 also states that the government would be vicariously liable for torts committed by a fully registered practitioner who is not a public officer, and who at the request of or by arrangement with the government, was carrying out any investigation, examination, treatment or management of any patient in any government hospital, clinic or health centre.

176. The owners and operators of private hospitals could be vicariously liable for the negligence of doctors practising in their facilities. This would be determined by ascertaining whether they have control over the doctors so as to create a special employer-employee relationship. This could be manifested by, among other things, having power over how much salary the doctors are paid and whether the hospital could control the work which the doctors do. If this element of control is proven, the hospital would be vicariously liable for their doctors’ negligence. The doctors nevertheless remain primarily liable for their actions. The party in charge of private health care facilities or services is also vicariously liable for the continued practice of any impaired practitioner in their facilities.

However, where the arrangement is such that the doctor was an independent contractor who had his own set up in the treatment, management and care of the patient (i.e., where he is free to operate his own clinic within the hospital, accepts any patients he wishes, is at liberty to charge a different fee despite the existence of a schedule of fees, and has full control over his own work and the methods he wishes

377. Section 10 of the Civil Law Act 1956. See Dr Sivananthan v. Government of Malaysia [2000] 7 CLJ 408; Thian Kiong Ming v. Dr Francis Ting Swee Sieng and Sarawak Medical Centre Sdn Bhd [Suit number: 22-178-2008-I].


380. MMC, Managing Impaired Registered Medical Practitioners, MMC Guideline 001/2010.
to employ in performing his responsibilities), and who had only paid to use the private hospital’s facilities (e.g., its premises and operating theatres) instead of being given a remuneration by the hospital, no vicarious liability arises under such circumstances.\footnote{381}

\section*{§2. QUALITY ASSURANCE}

\textbf{177.} As part of its efforts to maintain safety and quality improvement in hospitals, the Ministry of Health has, since 1985, implemented a Quality Assurance Programme (QAP). This takes a close look at the technical accountability and transparency of different health programmes on offer including promotive, preventative and curative care; pharmaceutical and laboratory services; health planning and development; training; and food quality and safety. There are, to date, 145 indicators covering 9 programmes. The Malaysian QAP adopts a combination of two main and complementary strategies: the National Indicator Approach (NIA) and the Hospital Specific/District Specific Approach (HSA/DSA).\footnote{382}

\section*{§3. REVIEW BOARD}

\textbf{178.} A National Patient Safety Council (\textit{Majlis Keselamatan Pesakit Malaysia})\footnote{383} was launched in 2003 by the Ministry of Health to:

\begin{itemize}
  \item advise the Minister of Health on national patient safety policies, strategies and action plans;
  \item promote and facilitate patient safety at national, regional and international levels;
  \item enhance the implementation of evidence-based patient safety strategies; and
  \item monitor and evaluate the progress and achievement of the national patient safety goals.\footnote{384}
\end{itemize}

\textbf{179.} This independent body, which is chaired by the Director-General of Health, is currently leading national efforts in improving patient safety by raising awareness of its significance in the country’s health care system; and by encouraging and facilitating stakeholders to take positive actions in advancing patient safety in the delivery of health care. The Council has twenty-two members who are experts drawn from across the health care industry. They include representatives from the university hospitals, the private sector and the Ministry of Health.

\footnote{381. \textit{Tan Eng Siew and Another v. Dr Jagjit Singh Sidhu and Another} [2006] 5 CLJ 175 per Foong J.; \textit{Wu Siew Yong v. Pulau Pinang Clinic Sdn Bhd and Another} [2011] 1 CLJ 255 per Chew JC.}
\footnote{382. For further information, see the Malaysian QAP’s website at http://www.ihsr.gov.my/index.php?option=com_content&view=article&id=87&Itemid=72&lang=en.}
\footnote{383. See the official portal of the National Patient Safety Council of Malaysia at http://patientsafety.moh.gov.my/}
\footnote{384. Terms of Reference endorsed on Mar. 8, 2011 by the National Patient Safety Council of Malaysia Meeting 1/2010.}
§4. DISCIPLINARY ORGANIZATIONS

I. The Malaysian Medical Register

A. Disciplinary Jurisdiction of the Malaysian Medical Council

180. Another important role played by the MMC is that which pertains to disciplinary matters. For this, section 29 of the Medical Act 1971 states that it shall have disciplinary jurisdiction over all persons registered under the Act, and this authority may be exercised over those who:

– have been convicted in Malaysia or elsewhere of any offence punishable with imprisonment (whether in itself only or in addition to or in lieu of a fine);
– have been guilty of an infamous conduct in any professional respect;
– have obtained registration by fraud or misrepresentation;
– was not at the time of their registration entitled to be registered; or
– have since been removed from the Register of medical practitioners maintained in any place outside Malaysia.

B. Disciplinary Inquiries

181. The structure and procedures for disciplinary inquiries are laid down in the Medical Regulations 1974. The President of the Council may, as indicated by Regulation number 26, from time to time appoint a committee from among practitioners who are willing to make a preliminary investigation into complaints or information touching on any of the disciplinary matters mentioned in the preceding paragraph. Such a committee is known as a Preliminary Investigation Committee and shall consist of no less than three nor more than six individuals as the President may from time to time think fit and shall be appointed in connection with one, or more than one complaint or information touching any of those matters. The decision of the Committee shall be unanimous or by a majority.

182. Regulation numbers 27 and 28 state that a complaint or information made against a practitioner that accuses him of any of the above-mentioned matters over which the Council has disciplinary jurisdiction shall be forwarded by the President of the Council to the Chairman of such a Committee. It is open to the Committee to summarily dismiss any complaint or information if it is satisfied that:

– the name or address of the complainant is unknown or untraceable;
– that even if the facts were true, the facts do not constitute a disciplinary matter; or
– for reasons which must be recorded, that there is reason to doubt the truth of the complaint or information.

However, the Committee may, before the summary dismissal, require the complainant to make a statutory declaration of the facts alleged by him.
183. But where the Committee is satisfied that there are grounds for the complaint to be supported, it shall, following Regulation number 29, require the attendance of the complainant and the practitioner before the Committee by order in writing. A preliminary inquiry into the allegation would then be carried out. Should the Committee be satisfied that there are insufficient grounds for it, a recommendation shall be made to the Council that no action be taken. However, if it finds that the statements taken from the parties support the charge, the Committee shall recommend to the Council that there shall be an inquiry by the Council.

184. Where a recommendation has been made that there shall be a disciplinary inquiry against the practitioner, one would be carried out. Both the complainant and the practitioner may be represented by lawyers. The Committee will hear oral evidence and receive written statements and submissions. The proceedings are recorded verbatim and are conducted in Bahasa Melayu and/or English. An interpreter is made available where the complainant is not conversant in these languages. Should the Committee come to the conclusion that there are insufficient grounds to support the allegation against the practitioner, it shall direct that the charge be dismissed, and the practitioner would be informed accordingly. Should the reverse be found, a charge will be made, and the Committee will explain to the practitioner that he is at liberty to state his defence on the charge made against him. The practitioner may elect to enter his defence before the Committee, or defend himself at the Council level.

185. If he elects to make his defence before the Committee, the Committee shall take his statement and record it word for word as far as possible. If it finds that there are insufficient grounds to support the charge, a recommendation would be made to the Council that no action be taken. If the reverse is found, it would recommend to the Council that there shall be an inquiry by the Council. The records of any such inquiry need to be sent to the Council within sixty days of the completion of the inquiry. If the practitioner elects to defend himself at the Council level, the Committee shall recommend to the Council that there shall be an inquiry by the Council.

186. Following the Committee’s recommendations that there shall be an inquiry, the Council shall, in compliance with Regulation number 31, hold a disciplinary inquiry against the practitioner. The Council is also empowered by the Regulation to hold an inquiry, for reasons to be recorded, in cases where the Committee has recommended that no action be taken. It will serve on the practitioner a notice specifying the date, time and place where the inquiry will take place and provide him with a copy of the charge or charges made against him. The practitioner may be required to make any further statement as the Council deems necessary and to call such other persons as he may require to support his defence.

187. If the Council then finds that no case has been made against the practitioner, it shall direct that the charge be dismissed, and the practitioner will be informed accordingly. If the Council finds the practitioner guilty of any disciplinary matter

385. Regulation number 30.
specified in section 29 of the 1971 Act, it shall inform the practitioner of its finding and the grounds for its decision. The practitioner will then be requested to make any plea in mitigation as he deems fit.

C. Disciplinary Sanctions

188. After the plea in mitigation is heard, the Council is empowered by section 30 of the 1971 Act to impose any of the following measures:

– to order the name of the practitioner to be struck off from the Register;
– to order his name to be suspended from the Register for such a period as it may think fit;
– to order such persons to be reprimanded; or
– to make any of these orders but suspend the application thereof, subject to such conditions as the Council may think fit, for a period, or periods in the aggregate, not exceeding two years.

The Council may, in any case, make such order as it thinks appropriate in relation to the payment of the costs of the Registrar, of any complainant or of the practitioner. Any costs awarded can be recovered as a civil debt.

189. From the above, it can be seen that complaints against medical practitioners are dealt with using a two-tier system where the Preliminary Investigation Committee undertakes the initial investigation and the Council conducts an inquiry. The process provides practitioners with ample opportunity to state their case and defend their actions. Throughout, the disciplinary investigation is conducted only by fellow practitioners and invites no input from members of the laity or persons from other professions. It is therefore not a process noted for its transparency. Nonetheless, the outcomes of the hearings from 2008–2011 show that the Council has not been slow to censure and discipline practitioners who fall foul of the MMC’s Code of Professional Conduct.386

190. They demonstrate that practitioners have been struck off the MMC Register for offences like:

– falsely claiming to be the graduate of a particular university when they were the graduate of another university, repeatedly absconding from their place of employment and making false accusation of wrongful dismissal against their employer and subsequently demanding monetary compensation;
– allowing unqualified and unregistered persons to attend, treat and prescribe scheduled drugs to patients, without immediate personal supervision;

– purchasing and storing psychotropic drugs of dependence and/or dangerous drugs and poisons, not for the purpose of *bona fide* treatment, but for the purposes of prescribing and supplying the same to sustain the addiction of certain individuals;

– allowing and/or leaving their unqualified assistants to sell scheduled poisons or preparations containing scheduled poisons to the public; and

– maintaining and operating a private medical clinic without the requisite registrations as required by the Private Healthcare Facilities and Services Act 1998, employing and/or permitting an unqualified person to run the clinic in their absence, and being only provisionally registered under the 1971 Act had treated patients, administered/prescribed medication and issued medical certificates without obtaining full registration nor possessing an APC.

191. Meanwhile, suspension from the MMC Register for periods which range from six months to two years has been meted out for offences like:

– failing to obtain their patient’s consent for surgery and the administration of anaesthesia before conducting an operation and relied instead on a consent form signed by the patient many months prior to the operation, failing to inform the patient or to obtain the patient’s consent for another practitioner to perform or to be involved in the performance of the operation, and improperly delegating duties to or permitting another practitioner to perform or to be involved in the performance of the operation without the patient’s prior consent (six months suspension);

– abusing their professional privileges and skills in failing to examine their patients before issuing medical certificates, and by signing such certificates which were untrue, misleading and improper (one year suspension);

– issuing medical certificates containing false and/or inaccurate statements regarding their patient’s condition (one year suspension);

– allowing their patients to be examined and attended to by a clinic assistant who is not medically trained or qualified (one year suspension);

– signed false medical reports pertaining to injuries said to have been sustained by a person whom they have never attended to, issued false receipts and medical certificates for persons they have never attended to, and falsely representing that such persons had sought treatment at their clinic when this was not the case (two years suspension);

– attesting their signature as a witness to a will when they have not seen their patient executing the will and knowing the patient to be comatose and on life support system (two years suspension);

– claiming, via advertisements and in articles, that they are a specialist in a particular area of medical practice when they did not have such qualifications (two years suspension).

192. As for incidents for which practitioners have received a reprimand from the Council, these include offences like:

– failing to inform their patient that they were going to begin a vaginal digital examination after a pap smear examination, and failing to obtain and procure the patient’s valid consent to the procedure;
Part 1, Ch. 4, Control Over the Practice of Medicine 193–195

– failing to provide competent and considerate professional management by neglecting to explain the details of the procedure they performed, other possible alternatives and the complications that might arise;
– failing to provide a conscientious assessment of the history, symptoms and signs of an infant patient’s condition when they attended him at hospital in that no examination was conducted thoroughly or at all;
– failing to provide thorough professional attention to a histopathology report which then caused a delay in the treatment of a patient with serious breast cancer;
– practising Medicine at a place not permitted under their full registration certificate and APC;
– failing to conduct a proper examination and to prepare an honest report as a government pathologist or forensic pathologist entrusted with the responsibility of performing an autopsy on the body of someone who died while in custody;
– failing to conduct a professional assessment of their patient that is, of the history, symptoms and signs of their patient’s condition before beginning therapy sessions for laser treatment; and
– issuing a letter to an external party and improperly disclosing information as to the reasons for their patient’s visit to their clinic without the patient’s consent.

193. The vast majority of those who were struck off, suspended and remanded were in private practice. This gives rise to concern that some doctors, in pursuit of financial gain, have been willing to compromise their professionalism and ethics.\textsuperscript{387}

D. Appeal Against Orders of the Council

194. Any practitioner against whom any of the above order is made, may appeal to the High Court. The High Court may then affirm, reverse or vary the order appealed against, or it may give such direction as it thinks proper. This decision by the High Court upon such appeal shall be final.\textsuperscript{388}

II. Professional Codes

195. In carrying out their disciplinary functions, the Preliminary Investigation Committee and the Council are guided by the Code of Professional Conduct which the MMC is responsible for enforcing.\textsuperscript{389} The contents, which delineate the minimum standards of conduct expected of a registered medical practitioner (rather than ideal behaviour), are divided into three parts.

\textsuperscript{387} N.K.S. Tharmaseelan, \textit{Medical Certificates (MCs)}, 41 Berita MMA 20 (2011).
\textsuperscript{388} Section 31 of the Medical Act 1971.
\textsuperscript{389} H.L. Chee, \textit{supra} n. 150, 63.
196. Part I outlines the powers of the Council. This includes a clarification of its disciplinary jurisdiction as conferred by section 29 of the 1971 Act and the meaning of infamous conduct in a professional respect.\textsuperscript{390}

It also indicates that in considering convictions, the Council is bound to accept the verdict of any court of law as conclusive evidence that the practitioner was guilty of the offence for which he was convicted. Medical practitioners who face any criminal charges were therefore warned to remember this should they be advised to enter a guilty plea or to not appeal against a conviction in order to avoid publicity or a severe sentence.

197. Part II is dedicated to personal conduct and personal behaviour which the practitioner needs to take into account in order to avoid committing any act which qualifies as an infamous conduct. These, which the Code discusses in detail, are grouped into the following four headings:

\begin{itemize}
\item neglect or disregard of professional responsibilities;
\item abuse of professional privileges and skills;
\item conduct derogatory to the reputation of the medical profession; and
\item advertising, canvassing and related professional offences.
\end{itemize}

198. Part III focuses on Disciplinary Procedure. It outlines the membership of the Preliminary Investigation Committee and its duties, powers and protocol; the procedure for appealing against an order of the Council; restoration of the practitioner’s name to the Register; and the Council’s and the Committee’s right to appoint a legal adviser to assist them in any inquiry relating to disciplinary issues. It also identifies the categories of persons who would be disqualified from attending or participating in any of the Council’s or Committee’s meetings which dealt with any disciplinary matter.

\section{III. Biomedical Ethics Committee}

199. Very few hospitals have their own clinical ethics committee, and neither does the country have a national hospital ethics committee. Doctors therefore solve the ethical problems they confront in consultation with the patients concerned and their family members,\textsuperscript{391} and with fellow workers like nurse managers.\textsuperscript{392} For this, they may seek guidance from the MMC’s Code of Professional Conduct and the MMC’s guidelines on a wide range of matters; as well as the Malaysian Medical Association (MMA)’s Code of Ethics if they are members of this organization.

\begin{itemize}
\item For this, the MMC endorses the definition proffered by Lord Justice Lopes in \textit{Allinson v. General Council of Medical Education and Registration} [1894] 1 QB 750, i.e., as something ‘which will be reasonably regarded as disgraceful or dishonourable by his professional brethren of good repute and competency’.\textsuperscript{390}
\end{itemize}
Part II. The Physician-Patient Relationship

Chapter 1. General Description

§1. Rights and Duties of Physicians and Patients

200. The rights of patients and the duties of doctors have yet to be explicitly enshrined in any legislation.

201. A Patient’s Charter has nevertheless been voluntarily adopted by the Federation of Malaysian Consumers Associations (FOMCA), the Malaysian Medical Association (MMA), the Medical Dental Association (MDS) and the Malaysian Pharmaceutical Society (MPS), which emphasizes that every patient has the right to:

- health care and humane treatment
- choice of care
- acceptable safety
- adequate information and consent
- redress of grievances
- participation and representation
- health education; and
- a healthy environment.

202. The MMC’s Code of Professional Conduct has meanwhile made clear that the public is entitled to expect doctors to provide and maintain a good standard of medical care. This includes:

- careful assessment of the history, symptoms and signs of a patient’s condition;
- sufficiently thorough professional attention and where necessary, diagnostic investigation;
- competent and considerate professional management;

394. MMC’s Code of Professional Conduct, Part II.
appropriate and prompt action upon evidence suggesting the existence of a condi-
tion requiring urgent medical intervention; and
readiness, where the circumstances so warrant, to consult appropriate profes-
sional colleagues.

203. Some of the rights and duties mentioned above are endorsed by case law as
well as by specific guidelines issued by the MMC. These will be looked at below.

§2. INFORMED CONSENT

204. The idea that patients should be acquainted with relevant information
before their consent to a proposed procedure is obtained, has received increasing
recognition in the courts. In the case of Liew Sin Keong v. Dr Sharon D.M. Paul-
raj, it was noted that ‘it is common ground that there is a duty on a doctor to warn
the patient of any material risk in undergoing or foregoing surgery or treatment’. Advice-giving and information on risks and side-effects are therefore demanded by
Malaysian law. The only exception would be in emergencies, or where disclosure
would cause distress or be harmful to the patient, and when the patient has waived
his right to be informed. Otherwise, the failure to perform the duty could lead to
liability in negligence if the risk which should have been disclosed materialized,
thereby causing the patient injury.

205. However, when it comes to the scope of disclosure, the courts have not
always been consistent in their approach. Several High Court cases in the 1990s like
Kamalan a/p Raman and Others v. Eastern Plantation Agency (Johore) Sdn Bhd
Ulu Tiram Estate, Ulu Tiram, Johore and Anor; Hong Chuan Lay v. Dr Eddie Soo
Fook Mun, Tan Ah Kau v. Government of Malaysia, and Liew Sin Kiong itself,
showed a strong preference for a patient-oriented standard of disclosure as pro-
pounded by the High Court of Australia in Rogers v. Whittaker. Under this
approach, the decision of whether a risk should be disclosed is a matter to be deter-
mmed on the basis of its materiality to the particular patient before the doctor.

206. In the later case of Dr Soo Fook Mun v. Foo Fio Na and Another
Appeal, the Court of Appeal was nevertheless more inclined to follow the doctor-
oriented approach adopted by the House of Lords in Sidaway v. Board of Governors
of the Bethlem Royal Hospital and the Maudsley Hospital. This approach
perceived the issue of how much information to disclose as one for clinical judgment,
and a doctor is not negligent as long as his action is accepted as proper by a

396. Per Ian Chin J at 203.
402. [1985] 2 WLR 480.
responsible body of medical practitioners. In other words, the scope of the doctor’s duty to inform is determined through the application of the Bolam test. As this case was decided in a higher court, the doctor-oriented approach was followed by the High Courts in a number of cases until the patient was granted leave to appeal by the Federal Court.

207. In delivering its judgment, the Federal Court ruled that ‘the Bolam test has no relevance to the duty and standard of care of a medical practitioner in providing advice to a patient on the inherent and material risks of the proposed treatment’. Instead, it emphasized that ‘the Rogers test would be a more appropriate and viable test of this millennium than the Bolam test’. This ruling by the highest court in the land has therefore put some finality on how Malaysian courts will now deal with the scope of information disclosure.

208. In practice, however, this can be very challenging, at least for now. The implementation of the Rogers’ standard of disclosure requires doctors to have some background knowledge of the patient’s personal or family circumstances, and the priorities which they attach to certain issues like the quality as opposed to the quantity of life. These can usually only be attained through sustained communication with the patient. This puts a potentially onerous duty on doctors who are, as the discussion on medical negligence shows, more accustomed to a paternalistic mode of operating than the doctor-patient partnership now required by the law. This is compounded by the multicultural and multiracial background of the country, with patients having varying levels of understanding (as influenced by issues like social and family norms, education, age, gender and language) which could make information disclosure difficult especially where the procedures are complicated and involve advanced technology.

403. Provided this viewpoint is ‘responsible, reasonable and respectable’ i.e. it must be able to withstand logical analysis – see Bolitho v. City of Hackney Health Authority [1998] AC 232 and Pearce v. United Bristol Healthcare NHS Trust [1999] PIQR 53.

404. With the exception of procedures which involve a substantial risk of grave adverse consequences. In such cases, it is the court that will be the ultimate arbiter on the adequacy of information disclosure – Sidaway v. Board of Governors of the Bethlem Royal Hospital and the Maudsley Hospital per Lord Bridge at 500–505.


407. Per Tan Sri Siti Norma Yaakob at 611.

408. Ibid., at 610. As this renunciation of the Bolam test makes reference only to pre-treatment information disclosure, the test is therefore still applicable in the realms of diagnosis and treatment in Malaysia.


410. Ibid., 200–201.


It nevertheless signals the law’s recognition of the need for doctors to start treating their patients as partners in decision-making – a development that will help take their relationship closer to the ideals expounded in the Patient’s Charter and one which medical schools in the country are placing more emphasis on in their training programmes.

§3. CONFIDENTIALITY

The position as regards the confidentiality of the doctor-patient communication is clarified by the MMC’s guideline on medical records and medical reports. This upholds the view that patients have the right to expect that their doctors would not disclose to others any personal information obtained in the course of their treatment, unless their permission is first obtained. This professional duty of confidentiality applies both to any information which the patient revealed to the doctor, as well as any independent opinion and clinical judgment which the doctor arrived at regarding the patient’s management as recorded in the patient’s medical records.

A patient’s medical records also encompass referral notes to other doctors for consultation or co-management; laboratory and histopathological reports; drug prescriptions; nurses’ reports; consent forms; at-own-risk discharge forms; operation and anaesthetic notes; printouts from monitoring equipment (e.g., electrocardiogram and electro-encephalogram); letters to and from other health professionals; computerized or electronic records; and recordings of telephone consultations or instructions relevant to the care of the patient.

This therefore places a responsibility on doctors to, among other things, ensure that:

– the information is effectively protected against improper disclosure when it is disposed of, stored, transmitted or received;
– patients are informed whenever any information is likely to be disclosed to others involved in their health care, and that they have the opportunity to withhold permission;
– any information given to health workers or any other third party is done on the understanding that it is given in confidence; and
– the doctor must respect requests by third parties.

Failure to adhere to these requirements may render the doctor liable both to disciplinary proceedings and civil proceedings for breach of confidentiality. On the claim for breach of confidentiality, the courts have highlighted that three requirements must be satisfied. First, the information must have the necessary quality of

415. MMC, Medical Records and Medical Reports, Guideline 002/2006.
confidence about it. Second, the information must have been imparted in circumstances importing an obligation of confidence. Third, there must be an unauthorized use or disclosure of that information.416

211. A doctor may, in compliance with section 18 of the Domestic Violence Act 1994, provide information to an appropriate person or statutory agency if he believes that the patient is a victim of neglect or physical or sexual abuse and is unable to give or withhold consent to disclosure. The doctor must be satisfied that the disclosure is in the patient’s best medical interest. A doctor may also do so when it is judged that seeking consent for the disclosure may be damaging to the patient yet disclosure would be in his interest (e.g., disclosing to a close relative about the patient’s terminal condition).417

212. Disclosure without consent to an appropriate person or authority may also be necessary in the public interest where a failure to disclose may expose the patient or others to the risk of death or serious harm.418 These circumstances include cases where the patient continues to drive a motor vehicle against medical advice; and where disclosure is necessary for the prevention or detection of a serious crime like murder, culpable homicide not amounting to murder, attempt to murder, kidnapping and abducting.419 The disclosure may also relate to specific statutory requirements (e.g., notification of a communicable disease)420 or if the doctor is ordered to do so by a judge or if summoned to assist with an inquest or comparable judicial investigation.421 Whilst the doctor may object on the ground of the need to protect patient confidentiality, this contention may be overruled by the presiding judge and non-compliance may lead to contempt of court.422

213. It is necessary to add that audio and visual recordings also form a part of the patient’s medical record.423 They are therefore subject to the same expectations regarding confidentiality and consent. According to the MMC, the word ‘recording’ denotes ‘the originals or copies of audio recordings, photographs and other visual images of patients made by any recording device, which includes mobile telephones and webcams’.424 Practitioners are reminded that patient autonomy needs to be respected whenever recordings are made or used. This is manifested first and foremost by seeking patients’ consent prior to the recording, copying, storing and transmission of any

418. Ibid., para. 7.
419. Section 13(1)(a) of the Criminal Procedure Code.
420. See sec. 10 of the Prevention and Control of Infectious Diseases Act 1988 which requires the reporting of incidences of syphilis, gonorrhea, chancroid and HIV/AIDS. In addition, neonatal tetanus is also a notifiable disease in Malaysia even though tetanus is not spread from one person to another – see H.S.S. Amar-Singh, Neonatal Tetanus in Malaysia, 64 Med. J. Malay. 1 (2009).
424. Ibid., para. 9.
For this, patients must be furnished with information which they want or need to know regarding the purpose of the recording (e.g., for investigation and/or treatment; teaching, training or research; and/or publication or medico-legal purposes). Whilst it is good practice to obtain written consent, consent could also be documented in the patient’s medical records. The consent must be obtained without exerting any pressure on the patient. If the patient objects to the recording, this should not be made against his or her wishes. As with the case of other information contained in the patient’s medical records, non-compliance with these requirements may render the doctor liable both to disciplinary proceedings and civil proceedings for breach of confidentiality.

214. The seriousness with which the courts treat the matter was recently illustrated in the case of *Lee Ewe Poh v. Dr Lim Teik Man and Another*. In this case, a surgeon who performed a procedure known as Stapler Haemorrhoidectomy on a female patient took photographs of her anus and vagina when she was under anaesthetic. He took one photograph before the procedure and one after, both of which were done without her knowledge and consent. She only found out about this from the nurse when she called the hospital after the operation to inquire about what took place during the procedure. The surgeon, when sued for violating her privacy and/or dignity and for breaching confidentiality, claimed that the photographs were taken in order to facilitate easy explanation to the patient after the procedure, and that such an action was in accordance with accepted medical practice. The court nevertheless found him liable both for invasion of privacy rights and breach of confidentiality. On the first claim, it was highlighted that:

> the privacy right of a female in relation to her modesty, decency and dignity in the context of the high moral value existing in *our society* is her fundamental right in sustaining that high morality that is demanded of her and it ought to be entrenched. Hence, it is just right that our law should be sensitive to such rights.

On the claim for breach of confidentiality, the court held that the fact that the hospital nurse was able to know of the confidential information makes it tantamount to a disclosure or publication of the information, even where there is no direct evidence that the photographs have been disseminated by the surgeon. Importantly, it was stressed that for surgeons to take photographs of the intimate part of a female patient’s anatomy, her consent must first be obtained. Since this had not been obtained beforehand, the surgeon was ordered to destroy the memory card which held the two photographs. Although the facts of this case are exceptional, it also underlines the significance of consent before any images are taken. In situations where photographs are absolutely necessary and there is no opportunity to seek the

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425. Exceptions are nevertheless recognized for the following recordings: x-rays; ultrasound and endoscopy images; images of pathology slides; and recordings of organ or foetal function (e.g., electrocardiogram and cardiotocograph). Separate consent is not required for these, as such recordings are deemed to have been made as part of the patient’s care or treatment – *ibid.*, para. 16.


427. Per Chew Soo Ho JC at 405 (emphasis added).
patient’s consent (e.g., the patient was unconscious), the courts pointed out that the patient must still be informed at the first available opportunity for their consent. If consent was refused, any images taken must be surrendered or destroyed.\textsuperscript{428}

215. Where consent to recording is given, the MMC states that the patient should be given the opportunity to view the recording, withdraw consent for its future use or to stipulate conditions for its usage. The recording shall not be used for purposes other than what the patient originally agreed to unless he or she has given further consent to the additional use of the recording. Discussion to this effect shall be documented in the patient’s medical records. Also, the recording shall not harm the patient or compromise his or her dignity. It must be ended immediately upon the patient’s request or when it is apparent that it was having an adverse effect on the patient’s management. The recording must be kept in a secure environment. Should the patient request for a copy of the recording, this shall be given to him or her. Further, since recordings made for clinical purposes form part of the patient’s medical records, their disclosure to a third party need to be in compliance with the MMC’s guideline.\textsuperscript{429}

216. As regards patients who are incompetent, recordings can be made as part of the care or treatment of a patient if the doctor seeks the consent of someone who has legal authority to decide on the patient’s behalf. If no one can be found who can act in this capacity, the recordings may be made if they constitute an essential part of the care or treatment of the patient.\textsuperscript{430}

217. In relation to deceased patients, any recordings made when he or she is alive can only be used in conformity with his or her wishes as regards the use of the recordings (e.g., for teaching and research). In situations where the recordings may get into the public domain and the patient is identifiable, the patient’s family must be consulted. Where the recordings include information about a genetic condition or contains details about the patient’s family, the family is within its power to prevent the recordings from being used.\textsuperscript{431}

§4. COMPLAINTS

218. Although the patient’s right to complaint does not enjoy statutory protection, the MMC’s disciplinary procedures and the interests protected under civil law do offer some, albeit limited, recognition of the right.

\textsuperscript{428} Ibid., 412.  
\textsuperscript{429} MMC Guideline 001/2010, paras. 10–15.  
\textsuperscript{430} Ibid., paras. 33 and 34.  
\textsuperscript{431} Ibid., paras. 42 and 43.
§5. ACCESS TO MEDICAL RECORD

219. No legislation has yet been enacted that would enable patients to access their medical records. The MMC nevertheless acknowledges that patients should: have access to their medical records for legitimate purpose and in good faith; know what personal information is recorded and who has access to them; and expect the records are accurate.432 They are allowed to inform the doctor of any factual errors in their medical records, but should not seek to change any entries which the doctor made in the course of consultation, diagnosis and management as these were recorded on the basis of the doctor’s clinical judgment.

220. Further, neither is the legal position clear on the issue of ownership of information on the records.433 On this matter, the MMC opined that patients’ medical records are the property of the medical practitioner and the hospital where they are retained. The records are also the intellectual property of the doctor who has written them, and belong morally and ethically to the doctor and his patient.434

221. Interestingly, doctors themselves are not under an obligation to keep medical records in any specified form or manner.435 The only exception are cases involving the prescription of dangerous drugs where it is a requirement under the Poisons Act 1952 and the Dangerous Drugs Act 1952 that records are kept of the prescription and supply of such drugs to patients. The current practice, as appears to be endorsed by the Minister of Health, is to allow patients to have access to medical reports (i.e., documents that are prepared to contain relevant information that are summarized based on the medical records) but not to medical records themselves even if these are available.436

435. They are nevertheless encouraged to record all relevant details of their management of their patients – MMA, Code of Ethics, sec. II.

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Chapter 2. The Physician-Patient Relationship in Specific Terms

§1. THE MINOR PATIENT

222. According to section 2 of the Age of Majority Act 1971, a person is legally an adult when he or she reaches the age of 18. Before someone reaches this age of majority, consent for their medical treatment needs to be given by their parent or guardian except in the case of emergencies.

§2. THE MENTAL PATIENT

223. There are approximately 5,500 psychiatric beds in the public sector. Out of these 85.5% are in mental institutions and the remainder in district and general hospitals with resident psychiatrists. With funding for mental health services forming only 3% of the government’s total health budget, the private sector is now playing an increasing role in this field, but most insurance schemes still do not offer coverage for the treatment of mental illness.

224. The Mental Health Act 2001 and the Mental Health Regulations 2010 have been introduced to regulate the admission, detention, lodging, care, treatment, rehabilitation, control and protection of mentally disordered persons. The 2001 Act empowers the Minister of Health to appoint, in respect of every public and private psychiatric hospital a Medical Director who shall be the person in charge and a Deputy Director. Both posts shall be held by qualified psychiatrists.

225. According to section 9 of the Act, a person may be admitted to a psychiatric hospital as a voluntary patient upon his or her own request. For minors, an application could be made on his or her behalf by his or her guardian to the Medical Director of the psychiatric hospital. It is open to the Medical Director to refuse to admit a person as a voluntary patient if he or she is not satisfied that the person is likely to benefit from the care or treatment in the hospital as a voluntary patient. Patients who are admitted may give notice to the Medical Director requesting their discharge from the hospital. They should not thenceforth be kept in the hospital for longer than seventy-two hours from the date the notice was given.

However, an order could be made for their detention for a further period not exceeding one month if, after being examined by a medical officer or registered medical practitioner not involved in the management of the patients, he or she is...
satisfied that the patients are mentally disordered, and it is necessary for the health and safety of the patients and for the protection of other persons that they continue to receive further care and treatment in the hospital.

It is within the jurisdiction of the Medical Director to grant leave of absence to any voluntary patient. He or she may also at any time discharge a voluntary patient if satisfied that it is in the interest of the patient to be discharged, and that the patient is not in need of any further care and treatment in the hospital.

226. Individuals may also be admitted into a psychiatric hospital against their will. This is governed by section 10 of the 2001 Act which states that a person who is suspected to be mentally disordered may be admitted and detained in a psychiatric hospital upon:

- an application made to the Medical Director by a relative of the person; and
- the recommendation of a medical officer or registered medical practitioner based on a personal examination of the person made not more than five days before the admission of the person that the person is suffering from mental disorder of a nature or degree which warrants his or her admission into a psychiatric hospital for the purposes of assessment or treatment, or that he or she ought to be detained in the interest of his or her own health or safety or with a view to the protection of other persons.

That application and recommendation constitute as sufficient authority for the person making the application, or a police officer or any other person authorized by the applicant, to take the person in question to a psychiatric hospital.

The Medical Director of the relevant psychiatric hospital shall, for anyone admitted into his or her hospital under this section, examine or make sure that a medical officer or a registered medical practitioner (other than the medical officer or registered medical practitioner who makes the initial recommendation) examines the person within twenty-four hours of his or her admission, to determine whether the continued detention of the person is justified. Following the examination, if the Medical Director is not satisfied that the continued detention of the person is justified, he or she shall discharge the person. If he or she is satisfied that detention is justified, he or she shall make an order for the person to be detained for a period not more than one month. If the person is not discharged earlier than this period, the Medical Director shall, before the expiration of the order, ensure that the person is examined as to ascertain whether or not the continued detention of the person is justified. This examination must be conducted by two medical officers or registered medical practitioners, one of whom must be a psychiatrist. If they are not satisfied that the continued detention of the person is justified, they shall discharge the person. If, on the other hand, they are satisfied that the continued detention of the person is justified, they shall make an order for the further detention of the person for a period not more than three months. The Medical Director is placed under an obligation to examine or cause to be examined, at least once a week involuntary patients.
detained in his or her hospital to ascertain whether or not the continued detention of
the person is necessary.\textsuperscript{442}

227. The 2010 Regulations state that a psychiatric facility needs to ensure that
each patient has a care plan that would help with the management of the patient dur-
ing their treatment at the hospital and upon their discharge.

228. In situations where a mentally disordered patient needs to undergo surgery,
electroconvulsive therapy (ECT) or clinical trials, consent to the procedure may be
given by:\textsuperscript{443}

\begin{itemize}
\item the patient himself or herself if he or she has the capacity to give consent as
 assessed by a psychiatrist;\textsuperscript{444}
\item his or her guardian in the case of a minor or a relative in situations where the
 patient is not capable of giving consent; or
\item two psychiatrists, one of whom shall be the attending psychiatrist, if there are no
 guardians or relatives who are available or traceable.
\end{itemize}

229. In cases of emergencies, consent for surgery or ECT may be given by:\textsuperscript{445}

\begin{itemize}
\item the patient’s guardian or relative; or
\item two medical officers or two registered practitioners (one of whom shall prefer-
 ably be a psychiatrist) where there are no guardians or relatives who are imme-
 diately available or traceable.
\end{itemize}

230. Consent is not required for other forms of conventional treatment.\textsuperscript{446}

§3. THE DYING PATIENT

231. As to be discussed below, active euthanasia, whereupon a doctor commits
an act to bring about the death of their patient, is currently illegal in Malaysia.\textsuperscript{447}
But can they withhold or withdraw life-prolonging yet futile interventions from
patients whose deaths are deemed imminent? In other words, is passive euthanasia
allowed? The legal position is currently unclear and the MMC too is silent on the
matter.

\textsuperscript{442} Section 20.
\textsuperscript{443} Section 77(1).
\textsuperscript{444} The law makes it obligatory upon a doctor to consider this option first before turning to the sub-
 sequent two options. In determining the patient’s capacity for consent, the examining psychiatrist
shall consider whether or not the person can understand the condition for which the treatment is
proposed; the nature and purpose of the treatment; the risks involved in undergoing and not under-
going the treatment; and whether his ability to consent is affected by his condition -- see sec. 77(5)
of the Mental Health Act 2001.
\textsuperscript{445} Section 77(3).
\textsuperscript{446} Section 77(4).
\textsuperscript{447} See the discussion in Part II, Ch. 3, §5 below.
Guidelines from the Malaysian Medical Association (MMA)’s Code of Ethics suggest that such futile interventions could be withheld or withdrawn, or that a doctor may allow irreversible pathology to continue without active resuscitation. The patient’s wishes as expressed in an advance directive, if any, and the wishes of family members in such matters should be consulted and respected. But where the therapy is considered to be life saving, the MMA is of the view that it should never be withheld.  

Chapter 3. Specific Activities

§1. Abortion

233. Abortion, which is the termination of pregnancy before birth that results in the death of the foetus,\(^{449}\) is a criminal offence in Malaysia. Although the country does not have any specific legislation which focuses on abortion, the legal position on this issue can be gleaned from the Penal Code.

234. According to section 312 of the Code, where the pregnant woman consents, for pregnancies in the early stages of gestation, any person who voluntarily causes her to miscarry (including the pregnant woman herself) shall be punished with imprisonment for up to three years and/or be fined. If the pregnancy is at a more advanced stage (i.e., after quickening\(^{450}\), the period for which the perpetrator could be imprisoned is up to seven years, and he or she may also face a fine.\(^{451}\)

An exception is nevertheless recognized on therapeutic grounds. For this, it is specified in the code that the section does not extend to a registered medical practitioner who terminates a woman’s pregnancy if the practitioner is of the opinion that to proceed with the pregnancy would be life-threatening or otherwise be harmful to the pregnant woman’s physical or mental health, greater than if the pregnancy were terminated. Importantly, it is only registered medical practitioners who are allowed to make the decision as to whether a termination is to be carried out. In reaching this decision and in so acting, the doctor is to proceed with the utmost good faith.\(^{452}\) For purposes of the law, the opinion of only one doctor would be sufficient. As no time limit is delineated here, abortion under section 312 can be performed at any time during the gestation period.

However, since no exceptions were made for pregnancies caused by rape or incest, these on their own are not legitimate grounds for abortion. It has nevertheless been argued that should the pregnant woman be able to demonstrate that such a pregnancy was causing her enormous mental distress, abortion could potentially be permissible then.\(^{453}\) Nor could an abortion be carried out where the foetus is discovered to be disabled unless it were shown that the defect or malformation had an

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\(^{450}\) Which is around the 4th month of pregnancy – see United Nations Department of Economic and Social Affairs, ‘Malaysia: abortion policy’, 120.

\(^{451}\) The court is prepared to hold this section infringed even in cases where the woman is not actually pregnant – see Munah bin Ali v. Pendakwaraya [1958] MLJ 159.

\(^{452}\) See Pendakwaraya v. Dr Nadason Kanalingum (1985) 2 MLJ 123 (the doctor was here found guilty for performing an abortion that was not unconditionally for the purpose of saving the woman’s life). Non-therapeutic abortion is also regarded as a serious infamous conduct by the MMC which exposes the practitioner to disciplinary punishment. A criminal conviction for this, be it in Malaysia or elsewhere, may serve as grounds for disciplinary action – see MMC, Code of Professional Conduct, sec. II, para. 2.1.5.

effect on the health or life of the mother.\textsuperscript{454} Equally, abortion cannot be sought on economic or social grounds.

235. Pursuant to section 314, if an abortion which is carried out with the pregnant woman’s consent resulted in her death, the perpetrator shall be punished with imprisonment for up to ten years and also be liable to a fine. It is not clear whether this covers registered medical practitioners acting under section 312. It has been opined by Ravindran that a practitioner may not be at fault for causing the miscarriage, but he would be guilty of a criminal offence under section 314 should the woman die.\textsuperscript{455} This may, however, be too harsh an outcome for doctors who are acting in good faith and could not therefore have been the intention of the legislators who drafted the exception to section 312. What would be more appropriate perhaps, is to exempt registered medical practitioners from this part of section 314 and subject them merely to malpractice law in the event of any injury or death which results from the practitioner’s negligence.

236. Where the pregnant woman has not given her consent to the offence defined in section 312, anyone who does an act which causes a miscarriage, whether the woman is quick with child or not, shall be punished with imprisonment for up to twenty years and shall also be liable to a fine.\textsuperscript{456} It is arguable that this applies equally to registered medical practitioners. Likewise if the abortion resulted in the death of the woman which would subject any perpetrator also to twenty years imprisonment.\textsuperscript{457}

237. The fear of inadvertently infringing the law has resulted in there being strict accessibility to abortion services in public hospitals. Even in hospitals which provide the service, this is often not in accordance with the full permissibility of the Penal Code.\textsuperscript{458} Those who need to avail themselves of such services therefore turn to the private sector where the cost of an abortion can range from MYR 300 to MYR 2,000, making it out of the reach of young women, and those from low income groups.\textsuperscript{459}

238. Yet it has been estimated that there is one abortion for every five pregnancies in the country.\textsuperscript{460} Many of those who find that they need to avail themselves of

\begin{itemize}
\item \textsuperscript{456} Section 313.
\item \textsuperscript{457} Section 314.
\item \textsuperscript{458} \textit{Increasing Access to the Reproductive Right to Contraceptive Information and Services, SRHR Education for Youth and Legal Abortion} 12 (R. Abdullah ed., Asian-Pacific Resource and Research Centre for Women 2009).
\item \textsuperscript{459} R. Abdullah, \textit{Abortion in Malaysia: Legal Yet Still Inaccessible}, 15 Asian-P. Resource & Res. Centre Women (ARROWS) 8 (2009).
\item \textsuperscript{460} C.Y. Ng, \textit{One Abortion for Every Five Pregnancies}, The Star (May 26, 2009).
\end{itemize}
this service are under the age of 30. A growing number are unmarried teenage girls who are sexually active. With abortion on request not currently allowed, it has been reported that some women have resorted to either self-help measures like the taking of herbs, pills and other attempts to bring on menstruation; or seeking the services of individuals not legally recognized to carry out an abortion like bomohs (traditional Malay medicine men), sinsehs (traditional Chinese medicine men) and other untrained persons. This has sometimes resulted in the death of the woman. Although there have been calls for the law to be more liberalized, this is still not responded to as abortion is generally not allowed in Islam, the religion of the majority of the population.

§2. ASSISTED REPRODUCTION

239. In vitro fertilization (IVF) techniques were first conducted in Malaysia in 1984. Following a live birth which took place shortly afterwards in 1987, demand for this and other assisted reproductive technology (ART) like gamete intrafallopian transfer (GIFT) and embryo transfer (ET), has increased sharply.

240. According to the Health Minister, infertility affects between 10% and 15% of couples in Malaysia and that infertility cases make up approximately 15% to 20% of the gynaecological problems in public hospitals. There are four publicly funded ART centres in the country (one each in Kuala Lumpur, Terengganu, Kedah and Sabah) and they are supported by three other satellite hospitals. The private sector too has made its presence felt in this regard. Indeed they have been encouraged by the government not only to cater for local demand, but to open their doors to foreigners as part of the medical tourism movement.

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464. Ravindran, supra n. 455.
465. Ibid.
467. Ravindran, supra. n. 455
469. Ibid.
470. Speech by Dato’ Sri Liow Tiong Lai, the Minister of Health of Malaysia, at the official launch of Sunfert IVF Centre in Sunway Medical Centre, Oct. 5, 2011.
241. But there is likewise no specific legislation that regulates this area of medical practice. A doctor involved in the use of ART would therefore need to be guided by and comply with the guidelines issued by the MMC on this matter.\(^{471}\)

242. The guideline was very clear in its instruction that doctors can only offer services involving ART to married couples. This is to reflect the widely held belief of the Malaysian society that marriage should precede procreation.

243. Everyone who is accepted to undergo assisted reproduction must be tested for transmittable disease before any procedure is performed on them. Detailed records of this must be kept and be easily retrievable. Accurate record keeping and labelling must also be made with regard to gametes and embryos, and the medical practitioner must ensure that proper standards are maintained in relation to their storage and handling. Records that are made and kept must be such as to enable authorized personnel to trace what happens to the embryos and gametes from the start of their journey in the practitioner’s care.\(^{472}\)

244. The practitioner must make sure that any therapies involving ART are only given after receiving the couple’s written consent to any particular procedure. The consent must be preceded by sufficient information regarding the procedure including its success rates and complications. The guideline further adds that the couple’s consent to the use of genetic material for treatment needs also be sought as must their decision as to whether, upon successful treatment, they would like the genetic material to be disposed of or be stored further. Couples have a right to determine how long they would like their genetic material stored, but this cannot exceed the maximum period of five years. This period could be extended to ten years if approved by the Ministry of Health. One of the conditions that the couple must agree to is that in the event that they get separated, divorced or if one of them dies whilst treatment is going on, any stored gametes must be destroyed.\(^{473}\)

245. The practitioner and the couple must also agree on the number of embryos to be transferred. Informed consent documents must be completed for this, and agreement recorded in the clinical record.\(^{474}\)

246. Sex selection for social or personal reasons\(^ {475}\) is not allowed. The only exceptions are in cases where a particular gender is predisposed to a serious genetic condition that would be inherited from one of the would-be parents (e.g., haemophilia, Duchenne muscular dystrophy and fragile X syndrome).\(^ {476}\)

247. It is important to point out that according to the guideline, the ‘mixing of gametes and embryos of different parental origin so as to confuse the biological


\(^{472}\) Paragraph 3.

\(^{473}\) Paragraph 4.

\(^{474}\) Paragraph 5.

\(^{475}\) E.g. the general tendency in Asian society of preferring to have sons rather than daughters.

\(^{476}\) MMC Guideline 003/2008, para. 9.
parentage of the conceptus’ is prohibited.\textsuperscript{477} This seems to suggest that egg and sperm donations are not allowed in Malaysia, and that only the couple’s own gametes must be used. But elsewhere in the guideline, it was stated that ‘the use of donor semen should be guided primarily by medical needs and the religious sensitivities of the couple and the medical practitioner involved.’\textsuperscript{478} This seems to make room for the possibility of sperm donation, an option which is more applicable to non-Muslims than for Muslims as procreation for the latter cannot involve the genetic material of a third party.\textsuperscript{479}

248. Surrogacy, an arrangement where one woman agrees to become pregnant and bears a child for another couple and to surrender the child to them when the child is born, is prohibited in Malaysia as it is not an acceptable practice for the majority of religions in the country.\textsuperscript{480}

249. Reproductive cloning (the creation of a foetus whose genome is derived entirely from another individual) is also prohibited in Malaysia.\textsuperscript{481}

§3. Prenatal Diagnosis

250. Birth defects rate as one of the top three common causes of perinatal deaths in Malaysia.\textsuperscript{482} But the country does not as yet have any national system of routine antenatal screening and documentation for birth defects during antenatal stage. Nor is such programme planned to be introduced in the near future, not least because the law does not allow the abortion of disabled foetuses (unless, as discussed above, this has an effect on the mother’s health or life).\textsuperscript{483}

Prenatal screening would nevertheless be made available to those who requests for it. The majority of Malaysian women who had a screening test are those who gave birth in private hospitals.\textsuperscript{484}

251. The absence of any systematic antenatal screening in the country is nevertheless counterbalanced by serious efforts to screen children for medical and

\textsuperscript{477. Ibid., para. 15.}
\textsuperscript{478. Ibid., para. 13.}
\textsuperscript{479. In the case of IVF technology, for instance, it has been opined that this technology can be used by Muslims only where the egg and sperm to be fertilized are those of the wife’s and the husband’s, and where this recourse is necessitated by medical reasons and that the procedure is carried out by a qualified physician. Fertilization with the sperm of a donor is strictly prohibited – see M.C. Inhorn, ‘Making Muslim babies: Sunni versus Shi’a approaches to IVF and gamete donation’, paper presented at the IUSSP Annual Conference, France, July 2005.}
\textsuperscript{480. MMC ‘Medical genetics and genetic services’, Guideline 010/2006, para. 12.}
\textsuperscript{481. Ibid.}
\textsuperscript{482. N.Y. Boo, Birth Defects, the Challenges Ahead for Malaysia, 60 Med. J. Malay. (2005).}
\textsuperscript{483. Ministry of Health, Maternal Screening for Foetal Abnormality (Report). Against this background, the MMC is of the view that newborn genetic screening and testing should be mandatory and be free of charge if early diagnosis and treatment will benefit the child – see para. 6, MMC Guideline 010/2006.}
\textsuperscript{484. Ho, supra n. 454, 57.}
developmental problems soon after they are born. To this end, the Family Health Development Division of the Ministry of Health conducts specific developmental screenings at five months, twelve months, eighteen months and four years; and offer appropriate assistance to those who needs them.\textsuperscript{485}

\section*{4. ORGAN TRANSPLANTATION}

252. Organ and tissue transplantations have been carried out in Malaysia since the early 1970s.\textsuperscript{486} The two major sources of tissues and organs are cadaveric donors and live donors, at a ratio of 1:3.\textsuperscript{487}

253. Procurement from deceased donors is regulated by the Human Tissue Act 1974. The Act allows organs and tissues to be removed from cadavers for therapeutic, educational and research purposes under two circumstances.

The first is when an adult donor, whilst alive, makes known in writing (or orally in the presence of two witnesses) his wish to donate his organs after his death.\textsuperscript{488} Doctors may then, upon his death, proceed to remove his organs, although this is usually done only after consultation with his relatives.\textsuperscript{489} Hence the system in place is an opt-in system and for this, the maximum cut off age for adult donors is set at 70.\textsuperscript{490} Anyone below the age of 18 too can make known his desire to be an organ donor by signing an organ donor pledge form. Prior to doing this, however, he would need to seek the permission of those with parental responsibility who would also then have to witness the pledge.

The second situation where organs can be removed from cadavers is when no objection has ever been raised by the deceased during his lifetime and consent is obtained from his next-of-kin.\textsuperscript{491}

254. As for live donors, these can either be those who are genetically and/or emotionally\textsuperscript{492} related to the recipients (live related donors) or those who are not in any way related to the recipients (live unrelated donors). As the 1974 Act only addresses the transplantation of cadaveric tissues and organs, it is now under review to cater for development in the field of live (as well as cadaveric) organ transfer. In the absence of any clear legal authority on the position of live donors, reliance is

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\textsuperscript{487} MMC, Organ Transplantation Guideline 006/2006, 19.

\textsuperscript{488} Section 2(1).


\textsuperscript{491} Section 2(2) of the Human Tissues Act 1974.

\textsuperscript{492} E.g. spouses or close friends.
currently placed on the MMC’s general guideline for organ donation by living donors, the Ministry of Health’s National Organ, Tissue and Cell Transplantation Policy, and the Director-General of Health’s circular on the matter. Taken together, their advice to medical practitioners and other stakeholders in the public and private sectors can be summarized as follows.493

An individual willing to donate organ and/or tissue must be: a competent adult; aware of all attending risks, benefits and possible consequences; physically and mentally fit; fully aware of the decision he or she is taking; able to fully evaluate and understand all information given to him or her; free from coercion; and followed up for life. The individual must also be informed that he or she can withdraw his or her consent at any time without the need to offer a reason. Importantly, the organ and/or tissue must be given altruistically. No money should therefore exchange hands in the procurement of his or her organs and/or tissues. The only payment permitted is for expenses incurred by the donor. The donor should ideally be related to the recipient.

For unrelated live organ donation, prior authorization would also need to be obtained from the Unrelated Transplant Approval Committee (UTAC). The committee was established to evaluate application for organ donation by live donors who are not related to the recipient either through blood ties or emotion. With the exception of regenerative tissues, such donation must fulfil the following criteria: that there is no cadaveric donor available nor a compatible donor from genetically or emotionally related family members; and that there is no alternative treatment. The donor and the recipient (or his family) should be introduced to each other to avoid any financial transaction.

255. As regards minors, no organ and/or tissue shall be removed from their body for purposes of transplantation. The only exception would be for regenerative tissues. Similarly, no organ and/or tissue shall be removed from prisoners awaiting execution and mentally disabled persons. Live donation of organs from prisoners may be considered for immediate relatives in life-threatening circumstances. However, this is subject to approval from relevant authorities.

256. Organ and tissue procurement and transplantation can only be carried out in accredited centres by qualified persons. Most of the transplant centres in Malaysia are public hospitals while a small number of private institutions also have the relevant facilities.494 These centres would need to have written guidelines and standard operating procedures. They include: criteria for eligibility to be a donor; detailed donor evaluation including psychosocial and medical assessments; and plans for life-long donor follow-up.

257. In order to ascertain when cadaveric organ donation can take place, there is a need to determine when exactly is the point of death. This is to ensure that no organs are removed from a patient who is still alive, thus exposing the doctor to the charge of murder. However, there is currently no statutory definition of death in Malaysia. For medico-legal purposes, guidance is currently provided by the guideline issued by the MMC\(^\text{495}\) and the Consensus Statement on Brain Death 2003 which was published jointly by the Ministry of Health, the Malaysian Academy of Medicine and the Malaysian Society of Neurosciences. According to these documents, a patient is recognized as dead when the function of his or her brain as a whole, including that of the brain stem, is irreversibly lost. The diagnosis of death is therefore based on an examination of the nervous system.

258. Brain death can only be certified by two medical specialists (preferably anaesthesiologists, physicians, neurologists and neurosurgeons) with at least three years of postgraduate clinical experience and who are trained in brain death assessment. They must not be members of an organ transplant team. The diagnosis must take place in areas of the hospital with full facilities for intensive cardiopulmonary care of comatose patients. Two assessments must be conducted before death is certified. After the first assessment, a repeat assessment and certification must be carried out at least six hours later either by the same pair or a second pair of specialists. The time of death is taken as the time of the second testing and is to be declared by the doctors performing the repeat test.

§5. Euthanasia

259. According to section 309 of the Penal Code, anyone who attempts to take their own life but is unsuccessful after taking some action towards this purpose, is guilty of a criminal offence. He or she could be punished with up to one year in prison and/or a fine. As for anyone who abets another person to commit suicide, this too is a criminal offence in Malaysia which is punishable with up to ten years in prison and a fine. Thus, can doctors legally assist their patients to die if they are driven purely by compassion? There does not appear to be clear and specific laws relating to the issue of euthanasia, and case law too has been silent on the matter. There are nevertheless several provisions of the Penal Code that bear direct relevance to the question of how far, if at all, may doctors assist their patients to die.\(^\text{496}\)

260. According to section 299 of the Code, anyone who ‘causes death by doing an act with the intention of causing death, or with the intention of causing such bodily injury as is likely to cause death, or with the knowledge that he is likely by such act to cause death, commits the offence of culpable homicide’. A doctor who intentionally does an act to a patient who was labouring under a disorder, disease or


bodily infirmity and thereby hastens the patient’s death, shall be caught by this pro-
vision. That this is so, is irrespective of whether his or her action was prompted
by compassion for the patient. A doctor found guilty of this could face imprison-
ment of up to twenty-four years as well as a fine.

261. A doctor’s action may also court the more serious charge of murder which
carries with it a mandatory death sentence. This offence is dealt with under section
300 which states that culpable homicide is murder if:

– the act by which the death is caused is done with the intention of causing death;
– it is done with the intention of causing such bodily injury as the offender knows
to be likely to cause the death of the person to whom the harm is caused;
– it is done with the intention of causing bodily injury to any person, and the bodily
injury intended to be inflicted is sufficient in the ordinary course of nature to
cause death; or
– the person committing the act knows that it is so imminently dangerous that it
must in all probability cause death, or such bodily injury as is likely to cause
death, and commits such act without any excuse for incurring the risk of causing
death, or such injury as aforesaid.

262. A doctor who assists a patient to die by injecting a lethal drug or air into
his patient’s body with the intention of and for the purpose of causing the patient’s
death, would therefore be committing murder under the first limb of the section.
A doctor who administers a lethal drug into the body of his terminally ill patient
with the intention of causing death would also be liable under the third and fourth
limbs. This is in view of the fact that the introduction of the chemical into his
patient’s body may amount to bodily injury which subsequently causes death, and
in the absence of a valid excuse, it is ‘an act that is so imminently dangerous that
it must in all probability cause death’.

263. Section 300 nevertheless contains several exceptions. Of these, the follow-
ing is of particular significance: ‘Culpable homicide is not murder when the person
whose death is caused, being above the age of 18 years, suffers death, or takes the
risk of death with his own consent.’ This exception suggests that adults who are
capable of giving consent, are entitled to request for and consent to the active and
direct termination of their lives. Plus, as physician-assisted death by necessity
implies that the request for death is made voluntarily and thereby with consent,
active euthanasia falls squarely within this exception and would therefore not
amount to murder under section 300. This being the case, a doctor who
administers a lethal drug to a consenting terminally ill patient may therefore use the

497. See Explanation 1 to the section.
498. Section 304 of the Code.
499. Talib, supra n. 496, 109.
500. Ibid., 108.
501. Exception 5.
502. Talib, supra n. 496, 110.
503. Ibid.
exception to help reduce his offence from one of murder to that of culpable homicide, hence avoiding the death penalty.\textsuperscript{504} That said, there is some uncertainty as to whether the exception can apply given the public policy that consent to being killed is ineffective.\textsuperscript{505}

264. If a doctor who intends and attempts unsuccessfully to cause death in a manner that would amount to murder had he succeeded, following section 307 he could be punished with up to ten years imprisonment and a fine. If hurt is caused to anyone by such act, the sentence could extend to twenty years in prison. However, as highlighted by Talib, it is only if active euthanasia is deemed as the more serious offence of murder would a doctor be guilty under this section. Otherwise, he would be liable for the offence of attempting to commit culpable homicide not amounting to murder. According to section 308, this brings with it a sentence of up to three years imprisonment and/or a fine. The punishment may even extend to seven years imprisonment and/or a fine if the act caused hurt to any person.

265. A doctor assisting a terminally ill patient to end his life may alternatively be charged under one of two provisions which relate to the abetment to suicide: sections 306 and 305.

By virtue of section 306, a doctor who supplies a terminally ill patient with a lethal drug that the patient could and does take himself, and which then led to the patient’s death, may be caught by the provision.\textsuperscript{506} Meanwhile, section 305 states that if any child (i.e., persons under 18 years of age) or any insane person, any delirious person, any mentally disabled person, or any person in a state of intoxication commits suicide, one who abets the commission of such suicide, including a doctor, is punishable with death or imprisonment for up to twenty years and a fine. Here, if the person was in a state of intoxication as a result of receiving pain-relieving medication which he himself had requested in order to hasten his own death, the terminally ill patient may be said to be committing suicide and the doctor who abetted in this manner could be caught by the wordings of section 305 (or section 306).\textsuperscript{507}

266. In the light of the above, any unequivocal act of active euthanasia is therefore strictly prohibited in Malaysia. However, the situation is different as regards passive euthanasia. If treatment is withdrawn or withheld in compliance with the terminally ill patient’s request or if continuation of treatment would be futile, the act does not fall within the ambit of section 299 nor section 300 since the withdrawal or withholding of treatment is an omission rather than an act.\textsuperscript{508} Passive euthanasia would not therefore amount to the offence of culpable homicide not amounting to murder, nor to the offence of murder itself.\textsuperscript{509}

\textsuperscript{504} Ibid., 111.
\textsuperscript{505} Ibid., 118.
\textsuperscript{506} Ibid., 117.
\textsuperscript{507} Ibid.
\textsuperscript{508} Ibid., 133.
\textsuperscript{509} See the discussion in Part II, Ch. 2, §3 above.
§6. Research and Experimentation Involving Human Subjects

267. With the increasing prevalence of non-communicable diseases among the population, the government acknowledges the need for clinical trials and biomedical research in Malaysia. Apart from recognizing the valuable resources available from the extensive network of public and private hospitals, the following patient registries have also been set up:

- Malaysian Liver Disease Registry
- Malaysian National Neonatal Registry
- Malaysian Registry of Intensive Care
- National Cancer Patient Registry: Breast Cancer
- National Cancer Patient Registry: Colorectal Cancer
- National Cancer Patient Registry: Hematology Malignancy
- National Cancer Patient Registry: Nasopharyngeal Cancer
- National Cancer Patient Registry: Solid Tumour Cancer
- National Cardiovascular Disease Database
- National Dermatology Registry: Malaysian Psoriasis Registry
- National Dermatology Registry: Skin Biopsy Registry
- National Eye Database
- National Hearing and Ontology-Related Disease/Cochlear Implant
- National Inflammatory Arthritis Registry
- National Mental Health Registry
- National Neurology/Stroke Registry
- National Nuclear Medicine Database
- National Obstetrics and Gynaecology and Maternal Mortality Register
- National Orthopaedic Registry: Diabetic Hand and Foot Disorder
- National Orthopaedic Registry: Hip Fracture
- National Renal Registry: Malaysian Dialysis and Transplant Registry
- National Renal Registry: Malaysian Registry of Renal Biopsy
- National Suicide Registry
- National Transplant Registry
- National Trauma Database
- Percutaneous Coronary Intervention Registry

268. Guidelines for conducting clinical trials and biomedical research involving human subjects derive mainly from the MMC (as outlined in its ‘Guideline on clinical trials and biomedical research’ and Code of Professional Conduct) and the

510. It is also, at the same time, keen to promote Malaysia as the choice location for the global clinical research outsourcing industry – see Clinical Research Malaysia, Discover Malaysia as Your Preferred Clinical Trial Destination with Clinical Research Malaysia (Clinical Research Malaysia 2011).


Ministry of Health’s Guideline for Good Clinical Practice (GCP). These are based on the ethical principles outlined in the World Medical Association (WMA)’s Declaration of Helsinki.

269. According to the MMC, any trials or research involving human beings can only be done if preceded by the individual’s voluntary and informed consent. Hence before medical research is conducted on human beings, doctors must first inform them of the purpose of the study, methods, benefits and risks anticipated, and any discomfort the procedure or process may entail. They are also to be informed that they have the right to abstain from participation in the study or are free to leave at any time without reprisal. None of the information provided to the subjects must contain any language that has the effect of waiving any legal rights or that divests the practitioner or their institution from liability for negligence. The prospective subject must not be coerced nor be under the undue influence of the practitioner or other parties to participate or to continue participating in the study.

270. The subject’s informed consent must be given in writing, and it must be signed and personally dated by the subject and by the person who conducted the informed consent discussion. If the subject is not able to read, an impartial witness needs to be present during the entire informed consent discussion. Once the subject has orally consented to participate in the study and has signed (if capable of doing so) and/or placed his thumbprint on the informed consent form, the witness should sign and personally date the consent form.

271. In the case of minors or the mentally disabled, the written consent must be given by the subject’s legally acceptable representative.

272. The study, before it can commence, must first receive the written and dated approval from an IRB/IEC (institutional review board/independent ethics committee) to the trial protocol, the written informed consent form and any other written information to be given to the subjects. The IRB/IEC should consist of members who collectively have the qualifications and experience to review and evaluate the science, medical aspects and ethics of the proposed study. It has been recommended that there should be at least five members with at least one whose primary area of interest is in a non-scientific area and at least another who is independent of the institutional/trial site.

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513. Which is based on the ICH Harmonized Tripartite Guideline E6: Guideline for Good Clinical Practice, with some adaptations built in to suit domestic requirements.
514. MMC, Code of Professional Conduct, Part II, para. 1.5.1.
516. Ibid., para. 4.8.3.
517. Ibid., para. 4.8.9.
518. Ibid., para. 4.8.8.
519. Ibid., para. 4.4.1.
520. Ibid., para. 3.2.1.
There are currently thirteen IRB/IECs in Malaysia.\textsuperscript{521} The one for the Ministry of Health is a centralized body known as the Medical Research and Ethics Committee (MREC). It caters for research at public health facilities. Universities and private hospitals have their own IRB/IECs.\textsuperscript{522}

273. All information relating to the study must be recorded, handled and stored in a manner that would allow for its accurate reporting, interpretation and verification.\textsuperscript{523} Written summaries of the trial status must be submitted to the IRB/IEC on an annual basis or more frequently should this be requested by the IRB/IEC.\textsuperscript{524}

274. The rights, safety and well-being of the human subjects should be at the forefront of the medical practitioner’s consideration, and that these should prevail over the interests of science and society.\textsuperscript{525} Any research which involves vulnerable groups like prisoners, pregnant women, persons who are mentally disabled, and those who are economically and educationally disadvantaged, needs to be conducted in such a manner where the medical practitioner is cognisant of the individual’s rights throughout the study.\textsuperscript{526} If during or after their participation in the study they experienced any adverse events, medical care must be provided to the subjects.\textsuperscript{527}

275. At the end of the study, the practitioner must provide the IRB/IEC with a summary of the study’s outcome. Research findings must be reported accurately and promptly, and the results of any research should not be suppressed whether they are adverse or favourable.\textsuperscript{528} The practitioner is prohibited from publishing his research results in the lay media. Likewise with duplicate publications, in different medical journals.\textsuperscript{529}

§7. TRANSSEXUAL INTERVENTIONS

276. It is estimated that there are around 50,000 transsexuals (i.e., individuals who ‘establish a permanent psychological identity of the sex opposite to their biological sex, as determined at birth’)\textsuperscript{530} in Malaysia.\textsuperscript{531} They are generally marginalized and shunned by society.\textsuperscript{532} Unable to find ordinary employment even if qualified, many

\begin{itemize}
\item \textsuperscript{521} Clinical Research Malaysia, supra n. 510, 10.
\item \textsuperscript{522} Ibid.
\item \textsuperscript{523} Ministry of Health, Malaysian Guideline for Good Clinical Practice, supra n. 515, para. 2.10.
\item \textsuperscript{524} Ibid., para. 2.1.4.
\item \textsuperscript{525} Ibid., para. 2.3.
\item \textsuperscript{526} MMC Guideline 009/2006, para. 2.3.
\item \textsuperscript{527} Ministry of Health, Malaysian Guideline for Good Clinical Practice, supra n. 515, para. 2.1.4.
\item \textsuperscript{528} Ibid., para. 2.3.
\item \textsuperscript{529} Ministry of Health, Malaysian Guideline for Good Clinical Practice, supra n. 515, para. 4.3.2.
\item \textsuperscript{530} E.L. Wong, Neither Here Nor There: The Legal Dilemma of the Transsexual Community in Malaysia, https://www.malaysianbar.org.my (2005).
\item \textsuperscript{532} Y.K. Teh, Mak Nyahs (Male Transsexuals) in Malaysia: The Influence of Culture and Religion on Their Identity, 5 Intl. J.Transgenderism (2001).
\end{itemize}
have had to work in the entertainment field or the sex industry to support themselves economically. They even face discrimination from the police who commonly arrest and charge them under the Minor Offences Act 1955 for cross-dressing (an offence which is interpreted as indecent behaviour under the Act). They have also experienced physical and sexual abuse whilst in prison both from prison wardens and other inmates. One out of ten transsexuals in Malaysia has attempted suicide. Some have therefore desired undergoing gender reassignment surgery to attain some level of psychological reconciliation and social acceptability.

277. However, the Conference of Rulers has, on the 24 February 1983, endorsed a fatwa (religious edict) issued by Malaysia’s National Council of Islamic Religious Affairs which prohibited Malaysian Muslims from undergoing sex change operations. According to the fatwa, a person is supposed to live as a male or female based on how they were born, and that Islam prohibits any act which attempts to interfere with this. It would therefore be an offence for Malaysian doctors to perform this procedure on Muslim patients. In any event, many transsexuals within this religious group have already internalized the unacceptability and sinful nature of such a radical surgery that they would not contemplate having one. A small minority, it has been reported, have gone abroad, mainly to Thailand, to have the surgery performed.

278. As the fatwa does not affect non-Muslim transsexuals in the country, it is not an offence for doctors to carry out the surgery on them, and to assist them medically and psychologically both pre- and post-surgery. Presumably, these would and could only be performed by non-Muslim doctors.

279. However, even if the surgery was conducted either in Malaysia or abroad, the National Registration Department does not allow the transsexual’s gender to be changed on his or her identity card and other legal documents. Legally, the person would still be identified as male or female depending on what was registered in their birth certificate when they were born. This therefore deprives them, among other things, of the opportunity to marry lawfully as Malaysia does not recognize same-sex marriages.

534. Ibid.
537. Teh (2001), supra n. 532.
538. Ibid.
539. Wong, supra n. 530.
540. Ibid.
Part III. The Physician in Relation to the Health Care System

Chapter 1. Collegial Relationships

§1. ASSOCIATIONS

I. The Malaysian Medical Association

280. Doctors in the country are represented by the Malaysian Medical Association (MMA) (Persatuan Perubatan Malaysia), a body registered under the Societies Act 1966. Established in 1959, it has fourteen branches nationwide: one in each of the thirteen states and one for the federal territories.

281. The Association’s objectives are to:

– promote and maintain the honour and interest of the medical profession in Malaysia;
– serve as the vehicle of the integrated voice of the profession;
– help promote the highest possible professional and ethical standards of medical care in the country;
– participate in the conduct of medical education, as may be appropriate;\footnote{541}
– influence health policies in the community; and
– encourage social, cultural and charitable activities in building a united Malaysian nation.

282. The Association publishes a quarterly journal called the Medical Journal of Malaysia\footnote{542} and a newsletter known as Berita MMA. It has issued position papers

\footnote{541. The Association was actively involved in the campaign to set up the country’s first three medical faculties – see N. Arumugam, The Malaysian Medical Association in S. Selvarajah & K.K. Khoo (eds.), supra n. 161, 142.}

\footnote{542. Which was originally known as the Journal of the Straits Medical Association, For an interesting discussion of its history, see K.G. Lim, The Medical Journal of Malaysia: Its History and Its Mission, 66 Med. J. Malay. 173 (2011).}
on a wide range of issues like house calls, telemedicine, medical records, the inti-
mate examination of female patients, organ donation and transplantation, environ-
mental health, women’s health, traditional medicine, prescription and dispensing, 
care of the elderly, genetic testing and ethical issues in clinical audit. It also pub-
lishes its own Schedule of Fees which is to act as a guideline on what, in the view 
of the MMA, are fee levels which are fair to private patients, doctors (general prac-
titioners, specialists and occupational health physicians) and third-party payers. This 
contains extensive lists which cover simple investigations and procedures, and pro-
cedures and treatments connected with the brain, the cranium and other intracranial 
organs; the spine, the spinal cord and peripheral nerves; the eyes and orbital con-
tents; the ears, the nose and throat; the face, the mouth, head and neck; the breasts; 
cardiology; cardiothoracic surgery; the vascular system; laparoscopic gastro-
intestinal tract procedures; the abdomen; the urinary system and male reproductive 
glands; female reproductive organs; the skin and subcutaneous tissue; the bones and 
joints; paediatric surgery; and interventional radiology.  

283. The Association has its own Ethics Committee and Code of Medical Eth-
ics. It is a member of several international organizations namely the Medical 
Association of South East Asian Nations (MASEAN), the Commonwealth Medical 
Association (CMA), the Confederation of Medical Associations in Asia and Oce-
ania (CMAAO), and the World Medical Association (WMA). Its leaders have held 
various posts in these organizations, including Dato’ Dr N. Arumugam who was the 
President of the WMA in 2006; Dr P. Krishnan who was the President of the CMA 
between 2001 to 2004; and Dr Teoh Sian Chin who was elected as the Chairman of 

284. The Association has seven categories of membership: honorary; life; ordi-
mary; overseas; associate; student and exempt. The subscription rate for ordinary 
members is MYR 250 per annum. Membership statistics according to state and 
category of membership are as follows: 

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546. Arumugam, supra n. 541, 146–147.  
547. See the Constitution of the Malaysian Medical Association 2011.  
548. Although this self-regulated professional representative body is currently the largest doctors’ asso-
ciation in Malaysia, the figures show that only around 30% of all doctors are currently members. 
Its membership has suffered a steady decline over the decades where around 70% of doctors were 
members in the 1970s, 60% in the 1980s and 50% in the 1990s – see Y.S. Lee, The Malaysian 
Medical Association and Penang in H.T. Ong, supra n. 151, 152; M. Cardosa, The President’s 
Part III, Ch. 1, Collegial Relationships

Table 14 Membership of the Malaysian Medical Association

<table>
<thead>
<tr>
<th>State</th>
<th>Ordinary Members</th>
<th>Life Members</th>
<th>Student Members</th>
</tr>
</thead>
<tbody>
<tr>
<td>Johor</td>
<td>230</td>
<td>397</td>
<td>43</td>
</tr>
<tr>
<td>Kedah</td>
<td>162</td>
<td>198</td>
<td>124</td>
</tr>
<tr>
<td>Kelantan</td>
<td>78</td>
<td>105</td>
<td>111</td>
</tr>
<tr>
<td>Melaka</td>
<td>140</td>
<td>184</td>
<td>615</td>
</tr>
<tr>
<td>Negeri Sembilan</td>
<td>142</td>
<td>222</td>
<td>27</td>
</tr>
<tr>
<td>Pahang</td>
<td>113</td>
<td>155</td>
<td>9</td>
</tr>
<tr>
<td>Perak</td>
<td>649</td>
<td>550</td>
<td>107</td>
</tr>
<tr>
<td>Perlis</td>
<td>53</td>
<td>21</td>
<td>1</td>
</tr>
<tr>
<td>Pulau Pinang</td>
<td>236</td>
<td>410</td>
<td>163</td>
</tr>
<tr>
<td>Sabah</td>
<td>187</td>
<td>236</td>
<td>95</td>
</tr>
<tr>
<td>Sarawak</td>
<td>326</td>
<td>306</td>
<td>13</td>
</tr>
<tr>
<td>Selangor</td>
<td>581</td>
<td>845</td>
<td>161</td>
</tr>
<tr>
<td>Terengganu</td>
<td>35</td>
<td>45</td>
<td>12</td>
</tr>
<tr>
<td>The Federal Territories</td>
<td>622</td>
<td>920</td>
<td>95</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>3554</strong></td>
<td><strong>4594</strong></td>
<td><strong>1576</strong></td>
</tr>
</tbody>
</table>

Overseas Members = 130
Exempt Members = 327
Honorary Members = 7
Associate Members = 2

II. The Academy of Medicine of Malaysia

285. The medical specialists in the country are represented by the Academy of Medicine of Malaysia (AAM). The Academy was established in 1966 and embraces all specialties in medicine. It is divided into the following ten colleges to enable the individuality of each specialty to be maintained:

– The College of Anaesthesiologists
– The College of Dental Specialists
– The College of Emergency Physicians
– The College of Obstetricians and Gynaecologists
– The College of Paediatrics
– The College of Pathologists
– The College of Physicians
– The College of Public Health Medicine
– The College of Radiology
– The College of Surgeons

286. To be admitted into the Academy as ordinary members, candidates must have a recognized higher professional qualification; and must have worked in their
respective specialties for a period of five years. They must also have contributed to a recognized medical journal and presented papers at clinical meetings.

287. Fellowship of the Academy is open to those who have been ordinary members for at least ten years, are in good standing, and have made a significant contribution to the advancement of the practice of medicine. Fellowships may nevertheless be conferred on those who have been ordinary members for less than ten years if they have contributed significantly to the improvement of specialist practice in Malaysia for ten years and have at least ten credited publications. Distinguished members of the medical profession, scientists or eminent individuals from other professions may also be admitted as Honorary Fellows of the Academy.550

288. The AAM is the organization which, as discussed previously, currently manages the National Specialist Register (NSR) although specialists do not need to be a member of the Academy to be registered on the NSR. In addition to this important role, it also issues clinical practice guidelines for its members; organizes and sponsors symposia on medical and paramedical topics; and coordinates quarterly scientific meetings where doctors could present their work. It also holds an annual Malaysia-Singapore Congress of Medicine, a forum for members and colleagues in the two countries to share their research and work experiences.

§2. COLLEGIALITY AMONG PHYSICIANS

289. The presence of the two-tier system of public and private health care has had interesting implications on the relationship among doctors in the country. Whilst those in private service are cordial towards those in government service and vice versa, the two sectors remain parallel. Integration, if at all only takes place when their patients needed specialist service, whereupon they may be referred into the government service. Public patients are also at times referred to private hospitals for certain specialist procedures.551

Chapter 2. Relationship with Other Health Care Providers

§1. **Dentists**

290. Medicine and dentistry are treated as separate and distinct professions in Malaysia.

291. According to the Dental Act 1971, a person is deemed to practise dentistry if he or she:

- treats or attempts to treat or professes to treat, cure, relieve or prevent any disease, deficiency or lesion or pain of the human teeth or jaws;
- performs or attempts to perform any operation on human teeth or jaws;
- inserts or attempts to insert any artificial teeth or appliances for the restoration, regulation or improvement of the teeth or accessory structures;
- performs any radiographic work in connection with human teeth or jaws or the oral cavity;
- gives any treatment, advice or attendance on or to any person in connection with the fitting or insertion for the purpose of fitting or fixing of artificial teeth or of a crown or bridge or an appliance for the restoration or regulation of the human teeth or jaws;
- gives any anaesthetic in connection with any such operation or treatment as mentioned above; or
- holds himself or herself out whether directly or indirectly as practising dentistry.\(^{552}\)

292. The field is regulated along very similar lines to Medicine. Like the latter, it is self-regulatory and therefore enjoys professional autonomy. The Dental Act 1971, the statute which currently regulates dentistry in Malaysia, created the Malaysian Dental Council (MDC) which like the MMC, is responsible for, among other things: the registration, deregistration and regulation of practitioners; approving dental degrees; and fostering and maintaining high standards of personal conduct and professional ethics in the practice of dentistry. This statutory body, whilst independent, is housed within the Oral Health Division of the Ministry of Heath.

293. Only registered dental practitioners are allowed to practise dentistry on terms understood above.\(^{553}\) This does not, however, preclude the extraction of teeth for the relief of pain or the application of remedies for such purposes, by registered medical practitioners.\(^{554}\) Nor does any provision in the Act operate to prevent the practice of Medicine or Surgery by a medical practitioner.\(^{555}\) Dentists are also

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552. Section 2(2).
553. Sections 36(1) and 37(1).
554. Section 37(2).
555. Section 41(1).
expected to refer a case to a patient’s medical practitioner where he requires a medical opinion in the course of or prior to managing a patient. 556 Where the patient does not have a regular medical practitioner, the dentist may refer him to any medical practitioner in whom the patient has confidence. 557

294. Anyone wishing to practise dentistry in Malaysia would need to be registered with the Council. The Register contains two divisions.

295. Division I records the names of those eligible to be registered as dental surgeons. These are practitioners who hold any of the following qualifications from approved higher education institutions (local or abroad) as specified in the Second Schedule of the Act:

- Bachelor of Dental Surgery
- Bachelor of Dental Science
- Licenciate in Dental Science
- Licenciate in Dental Surgery
- Doctorate in Dental Surgery
- Bachelor of Dental Medicine and Surgery.

296. Upon registration with the Council, dental graduates will need to complete a three-year mandatory national service before they can choose to practise either in the public or private sector. 558 During this period of service, a dental graduate will assume appointment as a Dental Officer in the public services, where they will be exposed to a wide range of programmes within the Ministry of Health as well as gain clinical experience. 559

297. Division II records the names of those who immediately before the Act came into force, were registered as a dentist under the Register maintained under the pre-independence Registration of Dentists Ordinance 1948 of Peninsula Malaysia. These are dentists who were trained through an apprentice system before and after the Second World War. Most of them had never received any formal training. They needed to have made their application for registration within six months of the coming into force of the 1971 Act. Entry to this division was effectively closed in 1972. From then until the present day, only formally trained and qualified dental surgeons are allowed to register under the Act. 560 As of 31 December 2009, there were only thirty-nine of such practitioners left in the country, and all of them work

556. MDC, Code of Professional Conduct (2008), para. 1.9(g).
557. Ibid., para. 1.9 (h).
558. This requirement only applies to dental graduates who registered on or after June 29, 2001 when this requirement was first introduced by the amendment to Part VII on ‘Supplementary Provisions for National Purposes’ of the 1971 Act. Prior to this date, a dental surgeon could start practising in either the public or private sector upon registering with the Council and being in possession of a valid annual practising certificate.
559. Section 47(1).
in the private sector.\textsuperscript{561} Of these, twenty-nine were practising in Sabah and Sarawak.\textsuperscript{562} Their numbers are steadily decreasing and would eventually peter out.

According to Table 15,\textsuperscript{563} the dentist-to-population ratio is currently 1:7437. A pattern similar to doctors can be observed, in that most dentists can be found in Johor, Kuala Lumpur, Perak, Pulau Pinang and Selangor. The majority of dentists work in Peninsula Malaysia, thereby leaving Sabah, Sarawak and Labuan with very poor dentist-to-population ratios. But unlike doctors, the number of dentists working in the public and private sectors seem rather even overall. At state level, discrepancies can nevertheless be seen in Kedah, Kelantan, Negeri Sembilan, Pahang, Perlis, and Terengganu.

\textbf{Table 15 Distribution of Dentists According to Sectors and States}

<table>
<thead>
<tr>
<th>State</th>
<th>Public Sector</th>
<th>Private Sector</th>
<th>Total</th>
<th>Dentist : Population</th>
</tr>
</thead>
<tbody>
<tr>
<td>Johor</td>
<td>170</td>
<td>171</td>
<td>341</td>
<td>1 : 9,819</td>
</tr>
<tr>
<td>Kedah</td>
<td>129</td>
<td>51</td>
<td>180</td>
<td>1 : 10,820</td>
</tr>
<tr>
<td>Kelantan</td>
<td>158</td>
<td>47</td>
<td>205</td>
<td>1 : 7,510</td>
</tr>
<tr>
<td>Kuala Lumpur</td>
<td>351</td>
<td>388</td>
<td>739</td>
<td>1 : 2,266</td>
</tr>
<tr>
<td>Labuan</td>
<td>4</td>
<td>3</td>
<td>7</td>
<td>1 : 12,415</td>
</tr>
<tr>
<td>Melaka</td>
<td>80</td>
<td>49</td>
<td>129</td>
<td>1 : 6,365</td>
</tr>
<tr>
<td>Negeri Sembilan</td>
<td>120</td>
<td>52</td>
<td>172</td>
<td>1 : 5,936</td>
</tr>
<tr>
<td>Pahang</td>
<td>136</td>
<td>48</td>
<td>184</td>
<td>1 : 8,157</td>
</tr>
<tr>
<td>Perak</td>
<td>170</td>
<td>120</td>
<td>290</td>
<td>1 : 8,113</td>
</tr>
<tr>
<td>Perlis</td>
<td>37</td>
<td>5</td>
<td>42</td>
<td>1 : 5,513</td>
</tr>
<tr>
<td>Pulau Pinang</td>
<td>137</td>
<td>142</td>
<td>279</td>
<td>1 : 5,596</td>
</tr>
<tr>
<td>Putrajaya</td>
<td>43</td>
<td>1</td>
<td>44</td>
<td>1 : 1,646</td>
</tr>
<tr>
<td>Sabah</td>
<td>100</td>
<td>79</td>
<td>179</td>
<td>1 : 17,915</td>
</tr>
<tr>
<td>Sarawak</td>
<td>111</td>
<td>76</td>
<td>187</td>
<td>1 : 13,215</td>
</tr>
<tr>
<td>Selangor</td>
<td>213</td>
<td>484</td>
<td>697</td>
<td>1 : 7,837</td>
</tr>
<tr>
<td>Terengganu</td>
<td>96</td>
<td>39</td>
<td>135</td>
<td>1 : 7,674</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>2,055</strong></td>
<td><strong>1,755</strong></td>
<td><strong>3,810</strong></td>
<td>1 : 7,437</td>
</tr>
</tbody>
</table>

\textsuperscript{561} Malaysian Dental Council, *Annual Report 2009* 17 (Malaysian Dental Council 2010).
\textsuperscript{562} Ibid., 18.
\textsuperscript{563} Adapted from Ministry of Health, *Health Indicators 2010: Indicators for Monitoring and Evaluation of Strategy for All* (2010), 131.
299. The majority of dental surgeons are trained locally. Between 1972 and 2001, Universiti Malaya was the only university which trained dentists in the country.\textsuperscript{564} It was not until 2002 and 2004 that Universiti Kebangsaan Malaysia and Universiti Sains Malaysia produced their first batches of dental graduates respectively. They are now joined by three other public universities (Universiti Teknologi MARA, Universiti Sains Islam Malaysia and Universiti Islam Antarabangsa Malaysia) and six private higher education institutions.

300. Any registered dental practitioner who wishes to continue in practice would need to apply for an APC not later than the first day of December in any particular year.\textsuperscript{565} The certificate will specify the principal place of practice and all other places of practice of the practitioner.\textsuperscript{566} Those in private practice must display it, alongside the certificate of registration, in a conspicuous place in any premises in which he practises dentistry.\textsuperscript{567} Where a registered dental practitioner practises at two or more addresses, both the original copy of the APC and the original copy of his certificate of registration must be displayed at his principal place of practice. As for his every other place of practice, certified copies of each of these certificates must be displayed in those premises.\textsuperscript{568} From 2006, all private dental clinics were also required to be registered following the implementation of the Private Healthcare Facilities and Services Act 1998 and its regulations.\textsuperscript{569} They are then subject to inspections carried out by teams from the State Health Departments to ascertain their level of compliance with the requirements of the Act.

301. Only registered persons with APCs in force are entitled to recover in due course of law reasonable charges for professional aid, advice, visit, dental operation or dental attendance and the value of any dental appliances rendered, made or supplied by him to his patients.\textsuperscript{570} Equally, only dental certificates issued and signed by registered dental surgeons shall be valid in the eyes of the law.\textsuperscript{571} It is an offence against the Act for any unregistered person to wilfully and falsely pretend to be registered under the Act, or wilfully and falsely take or use the name or title of dentist, dental surgeon, qualified dentist, doctor of dental surgery, professor of dentistry and surgeon dentist.\textsuperscript{572} Likewise, with the usage of the terms ‘dental clinic’, ‘dental dispensary’ or ‘dental hospital’ or their equivalent in any

\textsuperscript{564} Note, however, that the first dental school in the region was set up at the King Edward VII College of Medicine in Singapore. Between 1935 until the setting up of the Faculty of Dentistry at Universiti Malaya in Kuala Lumpur, this dental school was the main source of trained dental professionals for Malaya and later Malaysia – see Canaganayagam, supra n. 560, 77.

\textsuperscript{565} Section 19(2) of the Dental Act 1971.

\textsuperscript{566} Section 19(6).

\textsuperscript{567} Section 29(1).

\textsuperscript{568} Section 29(2).

\textsuperscript{569} See the discussion in the General Introduction, Ch. 2, §2 above.

\textsuperscript{570} Section 25(1).

\textsuperscript{571} Section 26.

\textsuperscript{572} Section 36(1)(b).
other language in a signboard over his place of practice in purported practice of dentistry as a person registered under the Act\textsuperscript{573} or the usage of a symbol designed by the MDC for the use of registered dental practitioners only.\textsuperscript{574}

303. Registered practitioners would have to abide by the Code of Professional Conduct issued by the Council.\textsuperscript{575} This document provides guidelines on the duties and responsibilities of practitioners to their patients, colleagues, the profession and the public; ethical behaviour; good practice management and the definition of infamous conduct in a professional respect. The Council also has disciplinary jurisdiction over all registered dental practitioners and is responsible for investigating complaints made against them on ethical and/or disciplinary matters.

304. Since 1997, the six main categories of cases which have been brought before the Council are those pertaining to:

\begin{itemize}
  \item negligence (e.g., tooth extracted after treatment, lack of pre- and post-operative advice and care, perforation of root during root canal treatment) and/or fraud (e.g., prolonged treatment and where patients were not informed of the extent and cost of treatment);
  \item cost-related complaints;
  \item advertisement;
  \item sexual molestation;
  \item drug abuse; and
  \item unethical behaviour (e.g., failure to pay dental laboratory bills, non-settlement of telephone bills, selling medical certificates, rudeness to patients, spitting/shouting at patients).\textsuperscript{576}
\end{itemize}

305. The range of disciplinary actions available to the Council are as follows:

\begin{itemize}
  \item order that the name of the registered practitioner be struck off or suspended from the Register;
  \item order that the person be reprimanded; or
  \item make any of these orders but suspend its application subject to such conditions as the Council may think fit for a period or periods in the aggregate not exceeding two years.\textsuperscript{577}
\end{itemize}

306. Unlike Medicine, there is still no Specialist Register held for dentists. The Ministry of Health recognizes nine specialties: oral-maxillofacial surgery, orthodontics, periodontics, paediatric dentistry, restorative dentistry, oral pathology, oral medicine, dental public health and special needs dentistry. There appears to be an acute shortage of dental specialists in Malaysia so much so that in the public sector,

\textsuperscript{573} Section 36(1)(f).
\textsuperscript{574} Section 36(1)(g).
\textsuperscript{575} MDC, Code of Professional Conduct (2008).
\textsuperscript{577} Section 33(1) of the Dental Act 1971.
patients can be on the waiting list for orthodontic treatment for up to five years.\(^{578}\)

Also, some states do not offer any full-time periodontic, paediatric and restorative specialist care.\(^{579}\) The MDC is therefore encouraging the three most established dental schools in the country (namely UM, UKM and USM) to expand the number of specialties taught at postgraduate level as well as the training places available.\(^{580}\)

307. In addition, plans are under way to develop nine centres of excellence for five specific areas of oral health care across the country. These are as follows: the launching of Kuala Lumpur Hospital, Tunku Ampuan Rahimah Hospital Klang and Sungai Buloh Hospital as centres of excellence for Maxillofacial Trauma; Hospital Ummi Kuching Sarawak and Hospital Queen Elizabeth Kota Kinabalu as centres of excellence for Oral Cancer and Jaw Tumours; Tuanku Jaafar Hospital Seremban and Selayang Hospital as centres of excellence for Orthognathic Surgery/Maxillofacial Deformities; Tunku Zainab II Hospital Kota Kinabalu as a centre of excellence for Cleft Lip and Palate; and the Kuala Lumpur Paediatric Institute as a centre of excellence for Paediatric Special Needs Oral Healthcare.\(^{581}\) Further, the Oral Surgery Clinic in Kuala Lumpur Hospital, which is already acknowledged as a tertiary centre for all oral surgery conditions, will receive monetary and other forms of assistance to help ensure that it retains this tertiary status.\(^{582}\)

308. The profession is represented by the Malaysian Dental Association (Persatuan Doktor Pergigian Malaysia). Established in 1938 and known then as the Malayen Dental Association, the organization seeks to unite and maintain the honour and interest of dentists in Malaysia.\(^{583}\) It also aims to promote study and research in the field of dentistry. As part of this effort, it publishes a biannual journal known as the Malaysian Dental Journal (MDJ) which is also freely accessible to the public from the organization’s homepage.\(^{584}\)

§2. PHARMACISTS

309. The practice of pharmacy in Malaysia has undergone extensive growth in the years after independence. With there being only twenty-three pharmacists in 1957,\(^ {585}\) the number has significantly increased to 7,759 in 2010. Like Medicine, this development is attributable in no small part to the proliferation of local higher

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579. Ibid.
580. I. Abdul Razak, From the Editor’s Desk, 5 Malaysian Dental Bull. 2 (2009).
582. Ibid.
education institutions in the twenty-first century which offer undergraduate pharmacy programmes, and the steady increase in application from school leavers to study Pharmacy.

310. Pharmaceutical practice in Malaysia is governed by the Registration of Pharmacists Act 1951 (revised-1989 and amended-2003). This statute establishes the Malaysian Pharmacy Board (Lembaga Farmasi Malaysia), a body which regulates the profession and pharmaceutical practice in the country. Its responsibilities include:

– the registration and deregistration of pharmacists and bodies corporate;
– the registration of provisionally registered pharmacists;
– to recognize Pharmacy degrees;
– to approve premises for training;
– the setting up of guidelines and standards relating to the recognition of Pharmacy degrees; and
– to conduct inquiries on complaints of unethical practices.

311. To practise as a pharmacist in Malaysia, a person must hold an undergraduate degree in Pharmacy from an institution (local or abroad) which is recognized by the Board. Upon graduation, he or she would be entitled to be provisionally registered on the Board’s Register of pharmacists with the aim of enabling him or her to undergo a mandatory one-year pre-registration training programme in one of the hospitals around the country approved for this purpose. It is only upon the successful completion of this placement, as well as having passed a Pharmacist Jurisprudence examination (which focuses on domestic laws and regulations relating to the sale and supply of medicines) conducted by the Board, that he or she would be eligible for full registration as a pharmacist. He or she would then need to undergo a year of compulsory national service in the public sector. This is a requirement imposed by the Ministry of Health in order to enhance clinical pharmacy services in public hospitals and health clinics in Malaysia. Failure to

586. Up to 1996, Universiti Sains Malaysia was the sole provider of this programme of study. It has since been joined by four other public universities and over ten private institutions.


588. The list of registrable qualifications and institutions can be found in Sch. 1 of the Act.

589. Section 6.

590. The list of approved hospitals can be found in Sch. 2 of the Act. These consist of government hospitals and university hospitals.

591. Section 6B.

592. This was reduced from a period of three years in October 2011 – see Ministry of Health, ‘Tempoh khidmat wajib pegawai farmasi di Kementerian Kesihatan Malaysia dipendekkan dari 3 tahun kepada 1 tahun’, Press Release Oct. 12, 2011.

comply with this requirement will subject the person to a fine of up to MYR 50,000 and his or her name struck off the Register.312

312. Only pharmacists registered under the Act are allowed to use the name or title of pharmaceutical chemist, pharmacist, chemist and druggist, druggist, or pharmacist.313 Likewise, only they are allowed to take or use in connection with the sale of good by retail, the name or title of chemist or any other name, title, addition or description implying that he or any person employed by him is registered or entitled to be registered under the Act.314 For the importation, manufacturing, sale and use of poisons (including psychotropic substances and dangerous drugs) and products (medicines, health supplements and cosmetics); and advertisements relating to products, medical skills and services, they are regulated and controlled by the Poisons Act 1952, the Dangerous Drugs Act 1952, the Sale of Drugs Act 1952 and the Medicines (Advertisement and Sale) Act 1956, and their respective regulations.

313. Fully registered pharmacists work in various settings. These include public and private hospitals; community pharmacies; pharmaceutical trading companies; factories manufacturing pharmaceuticals, health products and cosmetics; research laboratories; and universities.315 In order to have their names retained on the Register, they are required to apply before the end of every year that they are in practice, an annual retention certificate (sijil pengekalan tahunan ahli farmasi) for the ensuing year.316

Table 16 Distribution of Pharmacists According to Sectors and States

<table>
<thead>
<tr>
<th>State</th>
<th>Public Sector</th>
<th>Private Sector</th>
<th>Total</th>
<th>Pharmacist : Population</th>
</tr>
</thead>
<tbody>
<tr>
<td>Johor</td>
<td>401</td>
<td>225</td>
<td>626</td>
<td>1 : 5,349</td>
</tr>
<tr>
<td>Kedah</td>
<td>249</td>
<td>153</td>
<td>402</td>
<td>1 : 4,845</td>
</tr>
<tr>
<td>Kelantan</td>
<td>199</td>
<td>85</td>
<td>284</td>
<td>1 : 5,421</td>
</tr>
<tr>
<td>Kuala Lumpur</td>
<td>479</td>
<td>493</td>
<td>972</td>
<td>1 : 1,797</td>
</tr>
<tr>
<td>Labuan</td>
<td>20</td>
<td>8</td>
<td>28</td>
<td>1 : 3,104</td>
</tr>
<tr>
<td>Melaka</td>
<td>153</td>
<td>89</td>
<td>242</td>
<td>1 : 3,393</td>
</tr>
<tr>
<td>Negeri Sembilan</td>
<td>209</td>
<td>88</td>
<td>297</td>
<td>1 : 3,438</td>
</tr>
<tr>
<td>Pahang</td>
<td>283</td>
<td>64</td>
<td>347</td>
<td>1 : 4,325</td>
</tr>
<tr>
<td>Perak</td>
<td>415</td>
<td>205</td>
<td>620</td>
<td>1 : 3,795</td>
</tr>
</tbody>
</table>

312. Sections 11(B) and 11(C) of the 1951 Act.
313. Section 7.
314. Ibid.
316. Section 16 of the 1951 Act.
### Table

<table>
<thead>
<tr>
<th>State</th>
<th>Public Sector</th>
<th>Private Sector</th>
<th>Total</th>
<th>Pharmacist : Population</th>
</tr>
</thead>
<tbody>
<tr>
<td>Perlis</td>
<td>72</td>
<td>18</td>
<td>90</td>
<td>1 : 2,573</td>
</tr>
<tr>
<td>Pulau Pinang</td>
<td>324</td>
<td>334</td>
<td>658</td>
<td>1 : 2,373</td>
</tr>
<tr>
<td>Putrajaya</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>-</td>
</tr>
<tr>
<td>Sabah</td>
<td>341</td>
<td>206</td>
<td>547</td>
<td>1 : 5,862</td>
</tr>
<tr>
<td>Sarawak</td>
<td>335</td>
<td>216</td>
<td>551</td>
<td>1 : 4,485</td>
</tr>
<tr>
<td>Selangor</td>
<td>962</td>
<td>939</td>
<td>1901</td>
<td>1 : 2,873</td>
</tr>
<tr>
<td>Terengganu</td>
<td>168</td>
<td>26</td>
<td>194</td>
<td>1 : 5,340</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>4,610</strong></td>
<td><strong>3,149</strong></td>
<td><strong>7,759</strong></td>
<td><strong>1 : 3,652</strong></td>
</tr>
</tbody>
</table>

314. In terms of distribution, the figures above show a predictable correlation with the distribution of hospitals and doctors. Once again, East Malaysia registers a rather poor pharmacist-to-population ratio, but this does not seem to differ markedly from states in Peninsula Malaysia. There is a 60:40 split between those who work in the public and private sectors.

315. A noteworthy feature of pharmaceutical practice in Malaysia is that there are two frameworks in operation. Pharmacists serving in the public sector have full control over the supply of medicines since doctors in public hospitals do not provide pharmaceutical services to patients. Compared to this, pharmacists working in the private sector enjoy neither autonomy nor monopoly over the supply of medicines. This is due to historical reasons whereby because of the shortage of pharmacists in the few decades after independence, doctors in private practice were allowed to stock and dispense medicines in their clinics. Although the number of registered pharmacists has since grown, doctors in private clinics and private hospitals still continue to dispense medicines to their patients. There are ongoing debates over whether doctors in the private sector should, like their counterparts in public service whose roles are mainly confined to diagnosis and prescription, now relinquish the right to dispense medicine so as to harmonize the practice in the public and private sectors.

316. The profession is represented by the Malaysian Pharmaceutical Society (MPS) (Persatuan Farmasi Malaysia), a national body which was established in 1967.

599. Adapted from Ministry of Health, Health Indicators 2010: Indicators for Monitoring and Evaluation of Strategy for All (2010), 132.
601. This practice could also have been influenced by Traditional Chinese Medicine, where a visit to the practitioner meant almost the same thing as purchasing medicine – see K.G. Lim, Private Medical Practice, 41 Berita MMA 28, 29 (2011).
317. As regards the relationship between the medical and pharmaceutical professions, the MMA specifies that a doctor should not arrange with a pharmacist for the payment of a commission on business transacted. Neither should he hold a financial interest in the pharmacist’s shop, and professional cards should not be handed to pharmacists for further distribution.  

§3. Nurses

318. Nursing in Malaysia is regulated by the Nurses Act 1950. The Act established the Malaysian Nursing Board (Lembaga Jururawat Malaysia), a body set up to control the training, registration and professional practice of nurses in the country. Its duties therefore include:

- the registration and deregistration of all categories of nurses practising in Malaysia;
- the issuance of annual practicing certificates;
- the supervision and monitoring of nursing practices in all private and public health facilities;
- the investigation of all complaints relating to nursing practice;
- the implementation of continuous professional development programmes for all categories of practising nurses;
- approving all nursing training curriculums at public and private higher education institutions; and
- conducting a pre-registration licensing examination for those wishing to be registered as a nurse.

319. To practise as a nurse in Malaysia, a person must either be a holder of a Degree or a Diploma in Nursing (obtained locally or from abroad). They must then sit for the Board’s licensing examination, the successful completion of which entitles them to apply to the Board for recognition as a registered nurse. All registered nurses would have to observe the Board’s Code of Professional Conduct for Nurses which outlines important matters concerning professional nursing practice (e.g., respect for patient, standards of care, accountability, patient advocacy and teamwork); duty of care; conducts which would amount to abuse of professional privileges and skills, and those derogatory to the reputation of the profession; advertising, canvassing and related professional offences; and disciplinary proceedings.

603. MMA’s Code of Ethics, sec. II. See also MMC, Relationship Between Doctors and the Pharmaceutical Industry, Guideline 007/2006.
604. Section 3.
605. Apart from registered nurses, the register also contains supplementary parts which record the names of assistant nurses; nurses trained in the nursing and care of persons suffering from mental disease; nurses trained in public health; rural nurses in Peninsula Malaysia; community nurses in Sarawak; and rural health nurses in Sabah — sec. 4(2).
320. There were 61,760 registered nurses in the country in 2010, and this gives a nurse-to-population ratio of 1:645. Of these, only 417 are male nurses since nursing has widely been perceived as a ‘female profession’ in Malaysia. A new job description called Medical Assistants has therefore had to be created, and this career pathway has managed to attract more male applicants. There is nevertheless evidence to suggest that the local perception of nursing as a gender-segregated vocation is beginning to change. However, this is not happening swiftly enough to meet the reported shortage of nurses in the country. Up to around 1,300 nurses are recruited annually from neighbouring countries like India, the Philippines, Indonesia, Myanmar and Vietnam. Further, it is estimated that 0.9% of local nurses leave the country to work abroad every year.

321. The government is supporting an expansion in the number of public and private institutions which provide nursing courses. School leavers, particularly male students, are encouraged to consider nursing as a career choice. It has been suggested that were male students to pursue nursing at the same rate as females, the nursing shortage in Malaysia would be resolved.

322. Apart from assisting doctors on a wide range of activities, nurses are allowed to carry out several procedures on their own, for example, the administration of vaccination and immunization; testing for diabetes, cholesterol level and blood pressure; and conducting pregnancy and smear tests.

323. Around two-thirds of nurses work in the public sector, and they are represented by the Malayan Nurses’ Union. The mandatory retirement age for them is 58.

§4. MIDWIVES

324. In the field of midwifery, village midwives (bidan kampung) used to play a crucial role in child delivery in the pre-independence and early independence years. Although they did not receive any formal training, they enjoyed the confidence of the general public, particularly in rural areas. The field has since...
undergone tremendous changes when the Ministry of Health took wider control over
the training, qualification and practice of midwives in the country.

325. The field is now regulated by the Midwives Act 1966 which defines the
term ‘midwife’ as:

a person who for a fee, salary or other reward or compensation, performs ser-
vices requiring an understanding of the principles and applications of proce-
dure and techniques for the care of normal child-bearing women from the
beginning of pregnancy until the end of puerperium (i.e. a period of 6 weeks
following delivery where the attendance of a midwife is required) and the care
of their normal infants during the neonatal period. 617

Hence to be eligible to practise, all midwives would now need to have undergone
a highly specialized formal training.

326. The Act also created the Malaysian Midwives Board (Lembaga Bidan
Malaysia). This body is responsible for:

– approving institutions as schools to provide training for the purpose of any quali-
fying examination for registration with the Board;
– determining the qualifications of lecturers and teachers;
– conducting the board’s final examination;
– the registration and deregistration of nurses and midwives who have passed this
examination;
– regulating the practice of midwifery and the conduct of midwives;
– the implementation of continuous professional development programmes for
midwives;
– prescribing the procedures to be followed when investigating complaints relating
to the conduct of midwives; and
– prescribing any fees payable.

327. Registered midwives would have to conform to the Code of Professional
Conduct and Practice of a Midwife issued by the Board. The code outlines the scope
of a midwife’s general duties and responsibilities; her specific duties in relation to
attending a mother during home confinement; the procedure to follow when arrang-
ing for someone else to act as her substitute; and her responsibilities in relation to
the notifications of maternal death, stillbirth, neonatal death, notifiable disease and
birth.

328. Importantly, although midwives enjoy a high degree of autonomy and inde-
pendence in their work, the code makes clear that she has a duty to refer to a reg-
istered medical practitioner in any of the following circumstances:

617. Section 2.
– when the patient has a history of stillbirth or abortion, previous pregnancy induced hypertension, or postpartum haemorrhage;
– in all cases in which a woman during pregnancy, labour or the puerperium appears to be dying or appears to be dead;
– in any case where the patient is unusually short (less than 145cm) or deformed, or where there is vaginal bleeding, any abnormality or complication (e.g., anaemia, excessive vomiting, oedema, fits or convulsions, severe varicose veins, purulent vaginal discharges or sores of the genitals), any albumin or sugar in the urine, an increase in blood pressure, a gross discrepancy in uterine size, reduced foetal movement, or abnormal lie or malpresentation;
– when a woman in labour displays any abnormality or complication such as fits or convulsions, abnormal vaginal discharge, sores on the genitals, a malpresentation or where no presentation can be made out, vaginal bleeding, where the placenta and membranes have not been completely expelled within fifteen minutes after the birth of the child, any degree of laceration of the perineum or of other injuries to the soft parts, where labour is prolonged, and any other medical conditions that required medical aid;
– when a woman during puerperium displays any abnormality or complication such as fits or convulsions, sub involution of uterus with abdominal swelling and tenderness, offensive lochia, rigor with raised temperature, rise of temperature above 38 degree centigrade or a temperature of 37.4 degree centigrade or above on three successive readings, unusual swelling of the breasts with local tenderness or pain, excessive bleeding or unequal leg oedema, tenderness of lower limbs, shortness of breath and chest pain, and episiotomy of perineal wound breakdown; and
– when there is abnormality or complication relating to the child such as injuries received during birth, any malformation or deformity, any reason the child appears likely to die, the child shows any respiratory distress, jaundice, inflammation of or discharge from the eyes, cord sepsis, any infections (like oral thrush, skin eruptions or diarrhoea), G6PD deficiency, or where the baby weighs less than 2500 grams at birth.

§5. MEDICAL ASSISTANTS

329. Medical Assistants (or Assistant Medical Officers) are regulated by the Medical Assistants (Registration) Act 1977 which created a Medical Assistants (Registration) Board (Lembaga Pembantu Perubatan Malaysia). The Board is responsible for:

– the registration and deregistration of medical assistants;
– approving the institutions which provide training;
– approving the academic qualifications of their teaching staff and the training facilities;
– conducting the Medical Assistants Board examination; and
– determining any fee payable.

618. Malaysian Midwives Board, Code of Professional Conduct and Practice of a Midwife, para. 3.2.1.
330. To practise as a Medical Assistant, a person must obtain a Diploma in Medical Assistant. Prior to 2006, training was conducted solely by the Ministry of Health but private colleges whose training programmes are approved by the Board may also now offer the course. To gain a place on these programmes, students must first be certified by registered medical practitioners as medically fit and are free from mental illness, physical and sensory disability, infectious diseases (like HIV/AIDS, and Hepatitis B and C), epilepsy, genetic diseases and drug abuse.\(^6\) Upon completion of the Diploma, they must sit for the Board’s examination before being eligible to be registered as Medical Assistants.

331. They can then be employed in various settings like hospitals and health care facilities, community and health services, higher education institutions, industrial and plantation health sectors, research institutions and other health-related agencies.\(^7\)

332. To continue practising as a Medical Assistant, their certificate of registration would need to be renewed on an annual basis. They usually work independently or with minimal supervision from registered medical practitioners. Their role became particularly prominent with the setting up of the 1Malaysia clinics whereby, as discussed previously, they are the ones tasked with the responsibility of running these clinics.

333. As of 2011, there is a total of 10,350 Medical Assistants in the country, giving a profession-to-population ratio of 1:2,738.\(^8\) Of these, a large proportion (i.e., 9,556) work in the public sector and only 794 work in the private sector.\(^9\)

§6. \textsc{Paramedical Professionals}

334. According to the statistics available for 2010, the country has 2039 radiographers, 807 physiotherapists, 4980 medical laboratory technologists, 649 occupational therapists, 749 dental technologist and 2950 dental surgery assistants.\(^10\)

335. The work of paramedical professionals or allied health professionals are still largely unregulated. An Allied Health Professions Bill, which aims to ensure the quality and safety of the care provided by health care practitioners allied to medical practice is nevertheless on the horizon. Once enacted, it would seek to register and control the practices of twenty-three such professions\(^11\) which serve three fields: clinical, laboratory and public health.

\(^7\) Ibid., 6.
\(^8\) Ibid. 6.
\(^9\) Ibid. 6.
\(^10\) Ibid.
\(^11\) E.g. radiographers, microbiologists, forensic scientists, speech therapists, psychologists, physiotherapists, dietitians, medical social workers, health education officers, and occupational therapists.
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