Travelling For Cure: An Assessment To The Legal Aspect Of Medical Tourism In Malaysia

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Abstract

Malaysia is recognised as one of the top destinations for medical tourism in Asia. In effect, the industry's promising economical prospect encourages the government to devise policy to support and harness its development. As Malaysia is actively promoting herself as the hub for medical tourism, regulatory aspect is indeed imperative. In light of this, the paper aims to examine the existing legal framework governing medical tourism in Malaysia. Furthermore, this paper seeks to explore related issues which include liability issues in case of malpractice or negligence, and regulatory issues pertaining to advanced medical procedures such as stem cell therapy, gene therapy, or using 'experimental' pharmaceutical or medical devices.

Keywords: Medical tourism, Malaysia, legal aspect

Introduction

Malaysia, joining the league of Singapore, Thailand and India, has emerged as a major preferred destination for tourists seeking medical treatment and healthcare in Asia. This is evident from such international recognitions she received as the 'Health and Medical Tourism Destination of the Year' award for three consecutive years, 2015, 2016 and 2017 by the International Medical Travel Journal (IMTJ) (Bernama, 27 April 2017). The recognitions have cemented the country's position as the leading medical tourism destination.

Despite its economical benefit to the destination country, medical tourism is not without concerns. This growing industry has in fact raised ethical, social, public health policy, economic as well as legal issues. Bringing the legal issues into the limelight, this paper will focus on medical tourism in Malaysia. With the globalisation of medicine, particularly in this case through medical tourism, regulatory aspect is indeed imperative to ensure safety, integrity and efficiency. Hence, the paper first examines the existing legal framework governing medical tourism in Malaysia, before exploring the related issues which include liability issues in case of malpractice or negligence, and regulatory issues pertaining to experimental medical procedures, circumvention tourism, telemedicine and medical advertising.

A brief history of medical tourism

Medical tourism has a long history and has revolutionised through times. Comparatively, medical tourism in the earlier times was associated with 'health retreat' before it transitioned to a modern form as seen today which emphasizes on medical treatment and surgical procedures.

The practice of travelling for health has in fact trascended civilisations. Among the earliest were the ancient Greeks and Egyptians who travelled to hot springs and temple baths. Romans and Sumerians were believed to have built complexes around hot springs and temples with spas and flowing pools (Mestrovic, 2014). In India, *Ayurveda* and *Yoga* have long attracted travellers to learn the meditating and alternative-healing methods. Japan has also been popular for its natural mineral springs (*onsen*) for healing purpose.

Around the 16th and 17th centuries, spas and seaside resorts sprung in the European region and America, such as United Kingdom, Switzerland, Austria, Hungary and Germany. These places attracted the Europeans to cure skin infections, rheumatism, and other illnesses (Mestrovic, 2014). While in the 18th and 19th centuries, patients suffering tuberculosis travelled to stay at sanatoria established in the countryside and remote areas of Europe and America.

While the practice of health retreat for wellness and rejuvenation still prevalent, a new trend in health emerged in the 1980s. The rising cost of medical treatment had prompted patients to look for affordable options abroad. Cuba saw this as an opportunity and created programmes to attract medical tourists from America, Europe and India for eye and heart surgeries and cosmetic procedures. 'Tooth tourism' also grew in Central America with Americans travelled for dental treatments not covered by their insurance.

After the global economic crisis in 1997, Thailand promoted itself as a destination for cosmetic plastic surgery and routine medical check-ups. India has also positioned itself as the destination for medical tourism by offering cheaper cost. Singapore followed suit by offering high-tech medical facilities and medical expertise for complex medical procedures. In America, the trend of Americans going abroad for medical treatments has created medical tourism firms or companies which affiliate with medical facilities and hospitals abroad to promote medical services in the destination countries.

Medical tourism's historical background sheds light on how it is defined today. The scope of 'medical tourism' encompasses, principally, people who elect to travel across international borders for the purpose of receiving medical treatment. The treatment may span the full range of medical services, which commonly includes elective surgery, dental care and infertility treatment. Not all included within health trade, for instance, cosmetic surgery for aesthetic rather than reconstructive reason would be considered outside the health boundary (Lunt et.al, 2010). In relation to this, it has also been suggested that the term should be reconsidered to include the travelling of medical professionals across borders to give treatment (Behrmann and Smith, 2010).

'Health tourism' is broader in context to include all aspects of well-being, i.e. it is the travel for the purpose of maintaining, restoring or enhancing one's well-being in mind and body. Comparatively, 'medical tourism' focuses on travelling to restore or enhance an individual's health through medical intervention. Medical tourism is distuinguished from health tourism by virtue of differences in the types of intervention, setting and inputs (Lunt et.al, 2010). Medical tourism involves bio-medicine, hospitals or clinics, and medical devices. While health tourism, on the other hand, involves natural, traditional and complimentary medicine, and non-medical facility.

While there are views which oppose the use of the term 'medical tourism' as the words contradict each other, and carries connotation of pleasure which disregard the seriousness of patient mobility for treatment, the proponents value the concept of the term. As a concept, it conveys both the *willingness to travel* and *willingness to treat* as core processes within the global market of health travel (Lunt et.al, 2010). It also captures the commodification and commercialisation of health travel (Lunt et.al, 2010).

Medical tourism is dynamic and its growth pattern is influenced by range of factors which include economic climate, domestic policy changes, travel convenience, advertisement, geo-political shifts, the aspect of quality, and innovative and pioneering in medicine.

The scenario of medical tourism in malaysia

The emergence of the industry in Malaysia had been noticeable around the end of the 20th century. In the wake of the world economic crisis in 1997, healthcare and tourism are two areas which have been identified as part of the National Key Economic Areas (NKEA) for the country's growth. Medical tourism, being the combination of both, is thus recognised as the potential economic driver. The source of revenue is generated through foreign exchange.

The medical tourism industry in Malaysia is primarily private sector-driven. That said, the government plays an active role in facilitating its growth, evidently through regulatory mechanism, incentive in the form of investment tax allowance (ITA) as well as establishing Malaysian Healthcare Travel Council (MHTC), towards the ultimate goal of positioning Malaysia as the preferred destination for world-class healthcare services.

Quality, hospitality and cheaper costs are the pull factors which attract medical tourists to sought services at private facilities in Malaysia. According to the Health Minister, Datuk Seri Dr S. Subramaniam, 921,000 medical tourists sought treatment in Malaysia in 2016 and spent RM1.2 billion in hospitals, with private hospitals being the main provider (*The Star*, 2017). The major treatments sought by medical tourists were cardiology, oncology, orthopaedics, in vitro fertilisation (IVF), dental treatment and cosmetic surgery. Indonesia remained Malaysia's biggest medical tourism market with its people coming for all kinds of treatment. Medical tourists from China mostly seek pregnancy and infertility treatment, while Australians came for services not covered by their insurance policies (*The Star*, 2017).

The medical tourism in Malaysia is strictly supervised through regulation of the private hospitals and medical practitioners, nurses, and other medical officers nurses alike.

i) The Governing Bodies

Ministry of Health (MOH)

The Ministry of Health (MOH) is the government body responsible for health. It's establishment serves three main roles: i) to regulate healthcare sector, ii) to provide healthcare services and iii) to develop healthcare industry.

As the ministry which governs health-related matters, private hospitals, clinics, dental clinics and other healthcare facilities are required to register with MOH to acquire the approval to establish

and license to operate. It is important that private healthcare facilities and services are regulated; firstly, to warrant patient safety by regulating the doctors, medical officers and nurses, secondly, to ensure quality care by meeting the standard requirements set by MOH and thirdly, to safeguard against illegal activities associated with black market such as abortion and illegal organ transplant.

Malaysian Medical Council (MMC)

Malaysian Medical Council (MMC) is the body which regulates medical practitioners practising in Malaysia, both in public and private sectors. MMC is a supreme body, vested with the authority to make policy decisions. In pursuant to The Medical Act 1971 (Act 50), MMC is given the mandate to authorise the registration of medical practitioners and issue practising certificate or to refuse the application, regulate the conduct and ethics of registered medical practitioners (such as publishing the Code of Professional Conduct). The Council also handles complaints against the medical practitioners and hospitals practising and operating in Malaysia, whereby investigations will be carried out and disciplinary enquiries will be conducted to verify the case. The Council is given the mandate to impose punishments if the medical practitioners are found guilty, or the complainants may proceed with filing a suit in the Malaysian court.

Malaysia Healthcare Travel Council (MHTC)

MHTC is an agency under the MOH. Its function is to facilitate the overall development of the Malaysian healthcare travel industry and its sustainability, by promoting it globally and by coordinating industry collaborations and building public-private partnerships, so that issues affecting the industry can be effectively addressed (MHTC's website).

MHTC started as a small unit under MOH in 2005 to promote medical tourism industry which was still in infancy. With the growth of the industry, the government recognised the need for an agency to facilitate its development, hence, MHTC became a formal entity within MOH on 3rd July 2009. In 2011, it was incorporated as a standalone entity to allow greater flexibility to operate as a coordinating agency for the healthcare travel industry and promote Malaysia healthcare globally (MHTC's website).

The development of strategies and programmes are carried out by collaborating with various stakeholders, including the Association of Private Hospitals of Malaysia (APHM), Malaysian Dental Association (MDA), Malaysian External Trade Development Corporation (MATRADE), Malaysian Investment Development Authority (MIDA) and Tourism Malaysia. MHTC also coordinates promotional activities for Malaysian healthcare providers and related stakeholders. It also acts as a focal point or 'one-stop centre' for all matters related to healthcare travel such as assisting inquiries from travellers. For this purpose, concierges and lounges are also provided at the Kuala Lumpur International Airport and Penang International Airport.

As of 2017, 74 private hospitals are members of MHTC, with 19 hospitals categorised as 'elite' (*The Star*, 2017). The elite members are private healthcare institutions accredited by international healthcare accreditation agencies, such as the Joint Commission International (JCI), Malaysian Society for Quality in Health (MSQH), the Australian Council on Healthcare Standards (ACHS), Accreditations Canada, and the CHKS Accreditation Unit (UK). More than

branding, accreditation motivates the private hospitals to continuously improve their quality of medical care.

Based on corporate ownership, private hospitals can be categorised into two types. First, private hospitals which are government linked corporations (GLCs) which the state has majority vested equity interests in it e.g. National Heart Institute. Second, non-government linked corporations which are stand alone corporations e.g. Sunway (but some may have at least a 30% mandated *bumiputera* equity or GLC participation) (Nik Rosnah and Lee, 2011).

i) Statutory Provisions

Private Healthcare Facilities and Services Act 1998 (Act 586)

As with government hospitals, it is equally important that private hospitals and healthcare facilities are regulated. Even more so for the fact that medical tourists seek the service of private healthcare facilities. Thus, it is important that the regulations offer comprehensive protection to the relevant parties involved.

The Private Healthcare Facilities and Services Act 1998 (Act 586) and Regulations 2006, which came into effect on 1st May 2006, replaces the former Private Hospital Act 1971. The objective of Act 586 is primarily to further improve quality and access to health services provided by the private health sector (Eighth Malaysia Plan, 2001) as well as to rationalise medical charges to more affordable levels (Nik Rosnah and Lee, 2011).

The Act provides the regulations for the establishment, licensure, registration and operation of private healthcare facilities and services in Malaysia. The major core provisions of the Act are mandatory information disclosure of private healthcare providers, the enforcement capacity, and the temporary order for the closure of facilities and services on non compliance (Nik Rosnah and Lee, 2011).

In order to operate, private hospitals and other healthcare facilities and services need to go through two-tier application process. The first tier protocol requires the approval 'to establish and maintain' from MOH in compliance with Section 8 and 9 of Part III of the Act. While the second tier protocol requires them to obtain the license 'to provide and operate' as provided under Section 15 of Part IV. These provisions imply stringent requirement by the government so as to ensure patient's safety and quality care.

The first tier protocol entails the rigorous submission of the statutory details and declarations of the applicant, licensee, or holder of the certificate and person in charge, detailed submission of the architectural building facility plans, justification of the need for a new facility or service at the proposed location, the human resource capacity plan with supporting evidence of qualified healthcare professionals valid annual practising certificates, financial investment capacity and the description of any high technology medical equipments intended to be used (Nik Rosnah and Lee, 2011). This also include the requisite of ventilation system to follow the required specifications and standard as stipulated under Regulation 89. For the second tier protocol, a pre-licensing inspection shall be conducted by MOH and the State Medical and Health Office, as provided under Section 16, before a licence to 'provide and operate' can be granted to the applicant private healthcare provider.

Penalty will be imposed to unlicensed and unregistered private healthcare facilities and services if convicted, as sanctioned under Section 5 of Part II of the Act. The penalty which is in the form

of hefty amount of fine and imprisonment serves as a serious deterrence as patient safety may largely be compromised (Nik Rosnah and Lee, 2011).

With regard to administration, Sections 31 to 38 of Pat VI of the Act stipulate the accountability and responsibilities of a licensee, holder of certificate of registration and the person in charge of a licensed or registered private healthcare facility or service. This is to ensure that the private healthcare facility or service is operated and maintained by qualified medical practitioner as mandated under Section 32 of the Act, as such securing patient safety and quality care.

Medical Act 1971 (Act 50)

The Medical Act 1971 (Act 50), which came into force on 1 October 1971, amongst others, as mentioned in its preamble, provides for the registration of medical practitioners to practise medicine or surgery in Malaysia; which includes the requirements of academic qualifications, the procedure and conditions. Fraud and misrepresentation is considered an offence. Registration ensures that a medical practitioner is qualified and fit to practise, hence warranting patient safety and care.

Section 3(1) of the Act also essentially authorized the establishment of the Malaysian Medical Council (MMC), the body corporate which regulates medical practitioners practising in Malaysia. Pursuant to Section 4 of the Act, MMC is vested the legal powers to carry out its duties and functions prescribed in the Act and the regulation thereunder. Principally, the Council is given the mandate to authorise the registration of medical practitioners and issue practising certificate or to refuse the application (Part III of the Act), to prescribe and promulgate good medical practice by regulating the conduct and ethics of registered medical practitioners (such as publishing the Code of Professional Conduct), as well as to conduct disciplinary enquiries and impose punishments (Part IV of the Act).

ISSUES

Legal Suit for Medical Malpractice and Negligence

The society today is progressively educated of their rights, and as a result does not tend to see mistakes as misadventures. As such, patients are more willing to challenge medical practitioners and hospitals in the occurrence of any mishaps. Furthermore, with the commercialization of medicine, patients have certain expectations of the outcome of the treatment. In this sense, the aggrieved patients will likely resort to litigation as a channel to seek redress for their grievances.

In seeking legal redress, the main issue would be on deciding the jurisdiction's law to apply; whether to apply the law of the state where the tort was committed or the law of another jurisdiction which has an interest in the case.

The first case scenario is that a medical tourist may wish to initiate a legal action in his country. However, the plaintiff medical tourist may face difficulty in convincing the court that it has jurisdiction over the defendant Malaysian heathcare provider, particularly if the Malaysian medical practitioner neither reside nor practice in the state where the court sits. Nevertheless, the court may assert 'long arm' jurisdiction based on sufficient minimum contacts between the Malaysian medical practitioner and the state which the court sits (Noor Hazilah et.al, 2013). Minimum contacts would depend on the circumstances of each case, and factors such as correspondences between the plaintiff and the defendant through email exchanges and interactive websites may be instrumental (Noor Hazilah et.al, 2013). That said, even if the court finds that

there are sufficient minimum contacts, the plaintiff would also need to show that the exercise of jurisdiction is reasonable. If it is not reasonable, the court may dismiss the claim on the ground that the plaintiff's selected forum causes inconvenience, unfair or contrary to earlier agreements (Noor Hazilah et.al, 2013).

The second case scenario is that the plaintiff medical tourist initiates an action where the injury occurred, based on the principal of *lex loci delicti commissi* (law of the place where the tort was committed). This would be a better option, for the reason that the Malaysian court has jurisdiction over the defendant Malaysian healthcare providers. Courts are generally reluctant to assert jurisdiction over defendants who neither resides nor practice in the state which the court sits (Noor Hazilah et.al, 2013). While a medical practitioner can be prosecuted for criminal offence under the Penal Code in case of malpractice, the aggrieved parties often opt to filing a civil suit against the medical practitioner for negligence, to claim damages.

The law governing medical negligence in Malaysia is the law of tort. Tort system is adversarial and generally provides for compensation only when the claimant has successfully proven his case against the medical practitioner. To establish an action for negligence, the plaintiff has to prove the three elements: i) A duty of care was owed to him by the defendant, ii) That duty has been breached, and iii) The element of causation; that the breach resulted in the damage or injury. Nevertheless, in light of the current practice, it is a requirement, by the court's order, for the parties to go through 'management of case' stage before trial commences, where negotiation between parties is held to attempt settling the claims out-of-court. Mediation may also be considered as an alternative to litigation, which is cost-effective and less time-consuming.

The medical tourist could seek to hold medical tourism firm, if he sought its service, vicariously liable for the negligence of the Malaysian healthcare provider. It is a common practice for medical tourists to consult a medical tourism firms in their state in selecting the hospital and accommodation. The selection is usually based on the networking which already exists between the medical tourism firms and the selected hospitals abroad.

In the case the plaintiff wishes to file a suit in his country, the court would already have the jurisdiction over the firm. To succeed in his action, he would need to prove the existence of employer-employee relationship between the firm and the Malaysian hospital; whereby the firm acts as an employer who engages the service of the Malaysian hospital (employee). The operation of the doctrine of vicarious liability would shift the liability to the employers, provided that the employee is acting in the course of employment (referring to the act authourised by the employer). However, there is a possibility that the court may be unwilling to hold the firm vicariously liable particularly when the Malaysian healthcare provider acts more like independent contractor rather than employee of the firm, for factors that indicate their independency such as its autonomy to choose its own doctors and medical staffs, payment of salary managed by itself, and the fact that it also treat patients other than those referred to them by the firm (Noor Hazilah et.al, 2013)

Circumvention Tourism

There are medical tourists who travel abroad for services that are legal in the destination country but illegal in their home country such as abortion and assisted suicide (euthanasia). This practice

gives rise to a branch of medical tourism, coined as 'circumvention tourism'. As the word circumvent implies, circumvention tourists actively seek care for unapproved medicine in their country in another country where it is legalised, or where there is lack of enforcement. In a nutshell, the patient travel to circumvent domestic prohibitions on accessing certain medical services.

For instance, abortion is illegal in Malaysia, in which it is an offence under section 312 of the Penal Code (with the exception, with the woman's consent that it is done in good faith; to save the woman's life and to preserve her physical and mental health). However, it can be performed in Vietnam where it is legal.

This scenario raises the question of whether the medical tourist has a freedom to exercise his right over his own body, or a government in this case should criminalise its citizen for circumvention tourism. It was suggested that the government is permitted to indict its citizen for an offence committed abroad by applying prescriptive jurisdiction under customary international law, on the basis of 'Nationality Principle' which permits a state to assert jurisdiction over the acts of its citizens wherever they take place (Cohen, 2012).

Advanced and 'Experimental' Medical Procedures

Apart from travelling abroad or across border for the common medical treatment, there are medical tourists who seek advanced medical treatment, which mostly not yet approved in their country such as stem cell therapy and gene therapy. They look for specific opportunities to try unproven medical interventions that otherwise cannot be received in their country.

For instance, the application of stem cell therapy in Malaysia is restricted to specific treatments. As of late, the stem cell therapy approved is for the use of bone marrow transplant in the treatment of leukemia, lymphoma, myeloma, sickle cell anemia, thalassemia and tissue grafts, which has been proven clinically. Apart from these, other stem cell therapies are considered experimental. In this sense, an individual has the right to choose his treatment, and in making a decision, he should weigh both the potential risk and benefit. If by chance he chooses the risky path, and the experiment goes awry, he ought to bring the case to the attention of MMC, especially if there exists ethical concern. In pursuing science, patient safety should not be compromised.

In relation to this, there is probably a need for the Human Tissue Act 1974 (Act 130) to be revised to include the application of stem cell therapy. This is because the current Human Tissue Act only concern matters pertaining to organ transplant from cadaveric donors. In the same sense, while there exists Guidelines on the Use of Human Biological Samples for Research published by the MOH, the guidelines are focused to the clinical research setting.

In another context of advancement in medicine, it has been suggested that the growing trend of medical tourism and the global proliferation of clinical studies may also encourage recruitment of human subjects (or patients) to participate in a clinical trial in another country (Tointon, 2015). Patient recruitment typically involves recruiting subjects within a defined geographic range of a specific study site. In hindsight, clinical trial, however, attracts only specific group of

people who are motivated to contribute to the advancement of medicine, rather than receiving care.

The mechanism works as follow: first, patient subjects would be required to visit a clinic and be randomized to either a placebo or active study. They then would travel to one of several defined locations abroad and see a study doctor in their destination country. Upon arrival, participants will be required to keep a patient diary and have lab work done (Tointon, 2015). In most cases, the sponsor of the trial covers the costs associated with the study, such as the medicine and tests needed; and may include other costs such as standard of care or travel (Tointon, 2015).

With regard to Malaysia, clinical trials are monitored by the Clinical Research Malaysia (CRM), a non-profit company wholly owned by the Ministry of Health. Issue of liability in clinical trial of this kind, presumably, would be a complex one as it would involve several parties; the patient subject, the trial site at home country, the trial site at destination country, the sponsor, doctor, investigator and may be the Institutional Review Board (IRB).

Telemedicine

Telemedicine, as provided under section 2 of the Telemedicine Act 1997 (Act 564), is the practice of medicine using audio, visual and data communications. This means that telemedicine involves two-way communication between a patient and a healthcare provider via audio and video, or tranferring of data, across distances, to enable effective diagnosis, treatment, advice and other healthcare-related activities.

With the world racing towards the Fourth Industrial Revolution, coupled with the development of medical tourism, the deployment of telemedicine services in cross-border settings would become common in the near future. In the context of medical tourism, telemedicine could be the preferred method for patients who require follow up treatment in their home country, or for medical consultation. By offering easy access, it would be a useful cost-effective alternative to delivery of healthcare services. This include communication between doctor-patient and between doctors, patient and specialist if need be.

In case of Malaysia, telemedicine is recognised, as transpired from the legislation of Telemedicine Act 1997 (Act 564), even though it has yet to be enforced. The Act provides the provisions for practising telemedicine in Malaysia, in which it stipulates the requirement of a certificate issued by the Malaysian Medical Council (MMC). Section 3 of the Act mandated that besides fully registered medical practitioner holding a valid practising certificate, a medical practitioner who is registered outside Malaysia may practise telemedicine in Malaysia if granted a certificate, which would be valid for three years. The same applies for other medical officers, interns and nurses upon application by a registered medical practitioner. Pertaining to patient, the Act requires written consent to be obtained from the patient before practising telemedicine and stipulates patient confidentiality of their digital records.

In terms of liability, it has been argued that only the Malaysian fully registered medical practitioner will have the patient-doctor relationship and thus be liable for medical negligence and it is up to the Malaysian medical practitioner to arrange for an indemnity agreement with the medical practitioner residing outside Malaysia (Noor Hazilah et.al, 2013). Above that, there are

issues not addressed by the Act. For instance, the standard of care for telemedicine, the issue of liability for misdiagnosis due to technological error, how to maintain patients confidentiality and in this regard, the scope of medical practitioner's duty and liability, and the jurisdictional issue if a medical practitioner is sued (is he practising in the country where the patient resides or the country where he practises medicine?). For this, it seems that the Act needs to be reviewed and in addition, to also consider fresh approaches to new technologies of telecommunication which is fast-evolving. Furthermore, guidelines of the standard practice of telemedicine would also be necessary to complement the Act.

Medical Advertisement

In Malaysia, the government imposes strict control over advertisements related to medicine. The legislation governing advertisement of medicine and other medical-related services is the Medicines (Advertisement & Sale) Act 1956 (Act 290). The purpose of the Act is to prohibit certain advertisements relating to medical matters and to regulate the sell of substances recommended as a medicine. Relating to this, medical advertisements in the country is supervised by the Medicine Advertisement Board, established in pursuance to Medicine Advertisements Board Regulation 1976. The function of the board is to vet all advertisements relating to medicine and medical skill or service before given approval to be publicised. The board also has the authority to cancel any approval previously issued. Approval number will be given to an approved application and it is mandatory to display it on each advertisement published.

Medical professionals are discouraged from advertising to prevent abuse and protect consumers from deceptive practices and misleading information (and giving false hope), as well as to avoid unfair competition in the market by soliciting business. However, in light of the changing trends in medicine and society today, the government may need to loosen the reins. The Malaysian medical services and health facilities, while being promoted abroad, are not made aware to the local. As a result, while Malaysia is one of the preferred destinations among medical tourists, the locals are flocking elsewhere for medical treatments – not knowing that home is the best. Countries like Singapore and Thailand allow the medical industry to publish their services and patient testimonials which are easily accessible online (Chin, 2016). Hence, this issue has prompted MMC to review and revise the Code of Practice in the interest of the profession and the public (Chin, 2016). With some reservation, it is of the opinion that while dissemination of knowledge of medical services available in the country should be encouraged, self-advertisement of medical professionals however should be restricted.

Conclusion

The medical tourism industry in Malaysia is primarily private-sector driven. Motivated by the industry's great economic potential, the Malaysian Healthcare Travel Council (MHTC) is established to aid its growth by mainly promoting its members abroad and encourage collaborations between various stakeholders. Apart from affordable cost, quality has also been identified as one of the major pull factor for medical tourists to sought services from the private facilities in Malaysia. In relation to this, the regulatory system, amongst other aspects, is

instrumental in maintaining quality. It maintains quality by ensures professional integrity and patient safety. In this sense, the government, through the Ministry of Health (MOH) plays a significant role in regulating the private facilities and services. Regulations should offer guidance to medical professionals and ought not to tie their hands. Legislations and regulations in Malaysia have so far been put in place. Nevertheless, a number of existing legislations need to be reviewed and revised to keep pace with the advancement in medicine and the changing trend of the society today. It is imperative that regulation offer comprehensive protection to the relevant parties involved in medical tourism but above all, patient interest should be the utmost priority.

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