9 - 12 EKİM 2019
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III. ULUSLARARASI TIP HUKUKU KONGRESİ

İSTANBUL MEDENİYET ÜNİVERSİTESİ

BİLDİRİLERİ KİTABI

III. INTERNATIONAL MEDICAL LAW CONGRESS

Presentations

CİLT 1

EDİTÖRLER

Prof. Dr. Dr. h.c. Hakan HAKERİ

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CONTEMPORARY DILEMMAS IN THE INTEGRATION OF ETHICS, MEDICINE AND LAW: A NEED FOR LEGAL SOLUTIONS

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Abstract

The disciplines of medicine, ethics and law have always shared a close and strong connection. This can be seen from the early ages, where the cohesion between these three disciplines were infused in the functions of the medical doctor who was portrayed not just as a healer but as a judge and the law maker. The fact that doctors were able to heal the wounded and prolong death made them infallible as they appeared to possess supernatural powers with the ability to communicate with demons and divinity. However, as society transformed to become more vociferous and egalitarian, the predominance of law as an instrument of social regulation has become considerably evident. Legislative enactments and judicial interventions are currently social norms in defining the boundaries of rights and wrongful conducts in the practice of medicine. Self-regulation within the medical profession is perceived as a thing of the past and respectable medical opinion is no longer treated with excessive deference. Furthermore, the discipline of ethics in which principles on respecting autonomy, justice and dignity permeate the field of medicine, is also facing ongoing ethical conflicts which require solutions in the form of legal interventions. Accordingly, it can be seen that the interface between medicine, ethics and law has expanded rapidly and presents a very intricate area. It is therefore imperative that various socio-legal measures are introduced to assist the medical profession in facing these contemporary challenges and consequently, provide a more harmonious interface between medicine, ethics and law.

Keywords: *Medical Ethics, Medical Law, Ethical Dilemmas, Legal Dilemmas, Legal Solutions*

Introduction

The rapid advancements in technology as well as the overwhelming influence of patient autonomy have clearly contributed to the growing importance of medical law and ethics. Although in ancient times, the medical profession has been accorded an unparalleled level of deference and perceived as a profession that will not commit any wrong; the contemporary healthcare setting has created an environment of rising expectations, accountability and demanding professional standards. Presently, even by having the ability to heal and save lives, the medical profession is no longer perceived as infallible as they are expected to deliver services in congruent with increasing societal needs, developing laws and high ethical standards. Substandard services and preventable medical errors are no longer tolerated and will be subjected to vociferous criticism amidst rising expectations of an egalitarian society.

Dilemmas in Medical Ethics and the Overwhelming Influence of Patient Autonomy

Ethics is classified as a sub-branch of applied philosophy that is intrinsically related to morality. The correlation between ethics and morality is that morality refers to social norms that distinguish from right and wrong, while ethics describes moral conduct based on the character and principles in each profession.[1] Medical ethics constitute a subdivision of ethics which is intrinsically linked to the application of clinical skills and knowledge. Medical ethics are essential in guiding medical judgements that need to be made for delivering what would be in the best interests of the patient.[2] They provide the fundamentals for good decision making and professional conduct for the medical profession as well as regulate the nature of relationship between the medical practitioner and the patient.

The development of medical ethics from the inception of the Hippocratic Oath has taken a thoroughly paternalistic position, emphasising on the patient's well-being above any of his dignitarian interest. The ethical principle of 'beneficence' which is the 'duty to do good and the promotion of a patient's well-being'[3] is considered to be the backbone of the concept of medical paternalism, which has been embedded in the Hippocratic Oath requiring the medical profession to undertake all necessary measures "for the benefit of the sick" according to their best abilities and judgement.[4] Medical

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1 Elsayed D and Ahmed R. (2009). Medical Ethics: What Is It? Why Is It Important?. No. 4. Sudan. J. Public Heal. 284-287, at p. 285.

2 Tallon C. (2012). Ethics and End of Life Care.. Vol. 1. Journal. Obs. Pain Med. 1-7, at p. 6.

3 Beauchamp T and Childress J. (2001). Principles of Medical Ethics. Oxford University Press: Oxford, at p. 173.

4 Lasagna, Louis. (1964). "Hippocratic Oath: Modern Version." Tufts University, http://www.pbs.org/wgbh/nova/body/hippocratic-oath-today.html.

paternalism therefore requires interference by the medical profession with the patient's freedom of action, justified on the grounds of the patient's best interest.[5] However, rising expectations in the advent of globalisation and commercialisation has caused such interference to be outmoded and is regarded as antithetical to the patient's fundamental right to determine his own health destiny. As respect for patient autonomy or the right to self-determination gains momentum in modern medicine, the medical profession "may not restrict nor negate the free wishes of an individual with respect to his own body…[o]ne must facilitate any desired action acceptable to a person's own judgment and in accordance with his own choice."[6] Accordingly, to infringe a patient's autonomy is "to deprive him of one essential component of his own good"[7] and this violates the aim of medicine to act for the good of the patient.[8] This view has been clearly reiterated in the English landmark case of *Montgomery v. Lanarkshire Health Board*, in which His Lordship emphasized that "patients are now widely regarded as persons holding rights, rather than as the passive recipients of the care of the medical profession. They are also widely treated as consumers exercising choices: a viewpoint which has underpinned some of the developments in the provision of healthcare services."[9]

Thus, it can be seen that the concept of patient autonomy and the right of self-determination have become a dominant influence in modern medical practice. The demands by patients to be given respect, independence and dignity in medical decision making have also been upheld and manifested in many ethical codes and judicial decisions. This can also be seen in the development of the law relating to informed consent, euthanasia, abortion, organ transplantation and confidentiality, where judicial and legislative intervention have clearly reflected the reinforcement of patient autonomy, in which patients' choices should be free from coercion and unwanted interference. Nevertheless, the overwhelming influence of patient autonomy has undeniably created dilemmas in the application of the principles of medical ethics. As a result, the medical profession faces a complex task of striking a balance between their own set of moral values and their ethical responsibilities towards patients, as well as the society at large, while at the same time being duty-bound to honour a patient's personal choices.

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5 *Ibid*.

6 See Elsayed, DEM, and REB Ahmed. (2009). Medical Ethics: What Is It? Why Is It Important?. *Sudanese Journal of Public Health*. Vol. 4, No. 1: 284–87.

7 Pellegrino and Thomasma. (1987). The Conflict between Autonomy and Beneficence in Medical Ethics: Proposal for a Resolution. Vol. 3, No. 23. *J. Contemp. Health L. & Pol'y*, 23-46, at pp. 36, 50.

8 *Ibid.*

9 [2015] UKSC 11.

The Inevitable Intervention of Law in Medical Practice

In an ambience of rapidly changing societal values, law, as an instrument of social regulation, seeks to regulate behaviour within the society, protect the rights of its members, as well as reflect public attitudes. In various aspects, legal intervention in medicine is deemed necessary and to some extent inevitable as it is one of the means of controlling medical practice in the interests of the community as a whole. Nevertheless, intervention of law in the area of medicine has raised difficult legal problems due to the existence of ethical, philosophical and religious dilemmas.

From one perspective, the medical profession should be given the exclusive prerogative to regulate themselves and determine the acceptable standards within the profession. Cases involving medicine and science are shrouded with intricacies and technicalities, which may be beyond the comprehension of any judge sitting at the court who has never undergone the rigours of medical training. Medicine, being an inexact science, may at times produce outcomes that are not predictable. In order to reach a just and accurate decision, the matter is best left in the hands of medical experts who are more adept in analysing such intricate issues. In this regard, Lord Browne Wilkinson in *Bolitho v City & Hackney Health Authority* aptly stated that "...it will seldom be right for a judge to reach the conclusion that views genuinely held by a competent medical expert are unreasonable. The assessment of medical risks and benefits is a matter of clinical judgment which a judge would not normally be able to make without expert evidence."[10] Thus, the standard of care for the medical profession is to be assessed by their peers.

From another perspective, legal and judicial interventions in the area of medicine are considered to be pivotal as "professions may adopt unreasonable practices. Hence, the court has an obligation to scrutinise professional practices to ensure that they accord with the standard of reasonableness imposed by the law[11]". The standard of care should conform to what is demanded by law and should not be determined by any profession or group in the community. Mr Justice Kirby and Mr Justice McHugh in the Australian case of *Naxakis v Western General Hospital* (1999) 73 ALJR 782[12] reiterated that expert opinion of fellow practitioner should not be determinative on the issue of whether or not the medical practitioner fell below the standard of care as such evidence may stem "from professional courtesy or collegial sympathy"[13]. Therefore, while expert medical opinion may be a useful guide for the courts in adjudicating on the appropriate standard of care, nevertheless, it is for the law to determine the appropriate standard of care for the medical profession.

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[10] [1997] 4 All ER 771, at p. 779.
[11] *F v R* (1982) 33 SASR 189. (S.C. of South Australia), at p. 194.
[12] (1999) 73 ALJR 782.
[13] Ibid., at p. 797.

Providing Legal Solutions to Contemporary Dilemmas in Medical Practice

Although legal intervention in medical practice is fraught with complexities due to the existence of ethical, philosophical and religious dilemmas, legal solutions play a pivotal and consequential role in addressing such issues. This predication finds its affirmation in the judgment made by Lord Hoffman in *Airedale NHS Trust v Bland*[14], where he asserted that "...medical ethics [is] to be formed by the law rather than the reverse."[15] Thus, law functions as a means of controlling the ethical conduct of the medical profession in safeguarding societal demands and interests which is evident in the following areas:

(i) Consent to Medical Treatment

Modern developments in medicine, science and technology have saved and improved the quality of lives of thousands of people each year. Such advancements, however, have led to circumstances where medical practitioners face quandaries in exercising their ethical and legal obligations to particular patients. One such situation is where the law of consent allows patients to opt for high-risk operations when the medical practitioners are ethically bound by the principle of beneficence to ensure that the patient's life is not jeopardised. As a general rule, medical treatment, even of a minor degree, should not proceed unless the medical practitioner has first obtained the patient's consent. Lord Goff in *Re F (Mental Patient: Sterilisation)*[16] stated that "[i]t is well established that, as a general rule, the performance of a medical operation upon a person without his or her consent is unlawful, as constituting both the crime of battery and the tort of trespass to person."[17] Lord Steyn in *Chester v Afshar*[18] emphasised that "in modern law, medical paternalism no longer rules and a patient has a prima facie right to be informed by a surgeon of a small, but well established, risk of serious injury as a result of surgery."[19] His Lordship went on to further state that "…a patient's right to an appropriate warning from a surgeon when faced with surgery ought normatively to be regarded as an important right which must be given effective protection whenever possible."[20] Thus, it can be seen that with the demands of patient autonomy and the right to self-determination, a patient's consent will only be legally valid if the consent is informed in nature. In other words, the validity of the consent must now be

[14] [1993] 1 All ER 821.
[15] Ibid., 858.
[16] [1989] 2 All ER 545.
[17] *Ibid.* at p. 548.
[18] [2004] 4 All ER 587.
[19] *Ibid.*, 594.
[20] *Id.*

based on the patient's knowledge of the nature, risks, consequences and alternatives associated with the proposed therapy.[21] Once the required information has been given to the patient, the patient "has an absolute right to choose whether to consent to medical treatment, to refuse it or to choose one rather than another of the treatments being offered."[22]

However, issues arise when there exists conflict between the right of a patient to opt or refuse a treatment once the consent is valid, and the ethical principle of beneficence of "doing the least harm to the patient", which must be strictly adhered to by medical practitioners. Cases concerning medical disclosure of risks, in particular, have caused conflict of values in the contemporary healthcare setting. On the one hand, a medical practitioner must act in what he perceives to be the best interest of his patient, and on the other hand, there exists the right of the patient to control his own life and to have the necessary information to do so. Such ethical dilemma requires legal intervention to provide appropriate solutions. To this end, it can be seen that courts in various jurisdictions have attached greater weight to the countervailing principle of a patient's self-determination, as it is the right of every human being to make decisions which affect his own life and welfare, as well as to decide on what risks he is willing to undertake. For instance, the 'reasonable prudent patient test' set forth by the United States case of *Canterbury v Spence*[23], which was adopted in the Australian landmark case of *Rogers v Whitaker*[24] reflects the highest respect for autonomy, individual autonomy and responsibility. The "reasonable prudent patient test' focuses on the needs and circumstances surrounding the patient in determining the scope of information to be given to the patient prior to medical treatment. The medical practitioner must consider all relevant factors concerning the patient, such as "the nature of the matter to be disclosed; the nature of the treatment; the desire of the patient for information; the temperament and health of the patient; and the general surrounding circumstances."[25] By doing so, the patient is conferred by law a sense of dignity, respect, independence, autonomy, information and self-determination in shaping his health destiny. Undeniably, the 'prudent patient test' has greatly influenced the development of medical jurisprudence in the standard of care for medical practitioners' disclosure of risks throughout common law jurisdictions. For instance, the Malaysian Federal Court in the recent case of *Zulhasnimar binte Hasan Basri and Another v. Dr. Kuppu Velumani P and Ors*[26] concurred that 'the reasonable prudent patient test'

[21] See *Chester v Afshar* [2002] 3 All ER 552; *Rogers v Whitaker* (1992) 175 CLR 479; *Chappel v Hart* [1998] 156 ALR 517.
[22] *Re T (Adult: Refusal of Medical Treatment)* [1992] 4 All ER 649, at pp. 652-653.
[23] 464 F. 2d 772 (D. C. Cir. 1972)
[24] (1992) 175 CLR 479; [1993] 4 Med LR 79; 16 BMLR 148
[25] *F v R* (1983) 33 SASR 189, at pp. 192 - 193.
[26] [2017] MLJU 1018.

is "the more appropriate test in the new millennium" and…in deciding whether a patient has been properly advised of the risks associated with a proposed treatment, the courts would no longer look to what a body of respectable members of the medical profession would do…but would follow the test propounded by the Australian case in *Rogers v Whitaker*."[27] Thus, it can be seen that in the contemporary healthcare setting, patients are no longer passive recipients of medical care. Instead, they want to be treated as co-producers or partners in any medical decision-making that will eventually affect their life and health.

(ii) End-of-Life Decisions

The emergence of sophisticated devices and treatment such as life-sustaining interventions has triggered a plethora of ethical issues pertaining to the dying process. The ethical principle of sanctity of life has always demanded that life is sacred and should be respected.[28] However, there are many occasions, in which the medical practitioner may face dilemmas particularly, in handling terminally ill patients. In such instances, patients may assert their autonomy by demanding that their death be hastened to reduce their suffering or to be allowed to die with dignity. In such occasions, patients' values and spiritual beliefs are significant as they provide a sense of security and belonging to the patient by offering him a way to find meaning in dying as in life.[29] It has been constantly promoted in modern medical practice that clinical assessments on quality of life at this stage are not solely contingent on medical findings, but "should be based primarily on the patient's values, goals and beliefs"[30], which makes respect for autonomy more pertinent in end-of-life decisions. Thus, it can be seen that contemporary dilemmas at the end of life clearly require legal solutions to assist the medical practitioners in deciding their course of action. Legal and judicial interventions are clearly pronounced in this area. The case of *Airedale NHS Trust v Bland*[31], emphasised that "it is established that the principle of self-determination requires that respect must be given to the wishes of the patient, so that, if an adult patient of sound mind refuses, however unreasonably, to consent to treatment or care by which his life would or might be prolonged, the doctors responsible for his care must give effect to his wishes, even though they do not consider it to be in his best interests to do so . . . To this extent, the principle of the sanctity of human life must yield to the principle of

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[27] *Ibid*, at paragraphs 96-97.

[28] The Declaration of Geneva mentioned the utmost respect for human life by stating that "all life is sacred on purely religious grounds, on the premise that all life comes from God."

[29] Mazanec, P. and Tyler M. K. (2003). Cultural Considerations in End-of-Life Care. Vol. 103, *AJN,* 50-58 at p. 56.

[30] Billings and Krakauer. (2011). Patient Autonomy and Physician Responsibility in End-of-Life Care. Vol. 171, No. 9, *Arch Intern Med.*, 849-853, at p. 851.

[31] [1993] 1 All ER 821.

self-determination: and, for present purposes perhaps more important, the [medical practitioner]'s duty to act in the best interests of his patient must likewise be qualified."[32] Further, "the patient's right of choice is not limited to decisions which others might regard as sensible. It exists notwithstanding that the reasons for making the choice are rational, irrational, unknown or even non-existent."[33] Hence, it can be seen that the right to determine what shall be done with one's own body is a basic human right firmly entrenched in and protected by the common law.[34] A patient's right to autonomy was again reiterated in *Ms B v An NHS Hospital Trust*[35], in which a patient who was mentally competent had repeatedly yet unsuccessfully requested for the withdrawal of medical therapy to which she was subjected. Ms B suffered a spinal cavernoma, which necessitated neurological surgery to remove it. During the course of her hospitalisation and treatment, she executed a living will stating that if at any point of time, she was incapable of giving instructions, she wanted treatment to be withdrawn if she was suffering from a life-threatening condition, permanent mental impairment or permanent unconsciousness. Unfortunately, as a result of the surgery, Mrs B became completely paralysed from the neck down and was treated with a ventilator to ease her respiratory problems. She eventually regained some movement in her head and was able to speak, pursuant to which she requested to her clinicians on several occasions to have the ventilator removed. The medical practitioners were not prepared to do so as they considered it to not be in her best interests, that is, it would inevitably lead to her death. In allowing Mrs B's claim for a declaration that the hospital had been treating her unlawfully, the court upheld the principle of self-determination, referring to the judgements delivered by the bench in *Bland* on the interface between the two conflicting principles of autonomy and preservation of life. It was accordingly ruled that the principle of "best interests" was not applicable in cases where the patient had the mental capacity to make relevant decisions about her medical treatment, and therefore a medical practitioner was under an obligation to respect the wishes of the patient, even if it was plain to all parties, including the patient, that death would ensue. However, the boundaries of lawfulness in relation to the patient's request in ending his or her life require legal intervention to ensure its permissibility. Many countries around the globe have stated explicitly in their respective legislations that a patient's request to end his own life would amount to suicide and therefore, unlawful and any medical practitioner who aids and abets the patient in such circumstances maybe committing a criminal offence. The Malaysian Penal Code, for example, makes it clear that a medical practitioner who deliberately takes active steps to

[32] *Ibid.* per Lord Goff at p. 866.
[33] Per Lord Donaldson in *Re T (An Adult: Medical Treatment)* [1992] 2 FCR 861 at p. 865.
[34] *Schloendorff v Society of New York Hospital* 105 N.E. 92 (N.Y. 1914), *per Justice Benjamin Cardozo.*
[35] [2002] All ER (D) 362 (Mar).

cause death or hastens the death of his terminally ill patient even at the request of his patient, would be committing culpable homicide. In jurisdictions where voluntary euthanasia and assisted suicide are practised, for example, the Netherlands, Canada, the state of Victoria in Australia and several states in the U.S, the law is used as a regulatory tool to ensure strict compliance with defined standards and procedures in such cases. In as much as legislative deterrence is needed, legislation also steps in as a means of safeguarding the interests of doctors in the course of exercising end-of-life decisions, such as the withholding or withdrawal of life-sustaining equipment, as well as palliative and terminal sedation. To this end, the law provides legal affirmation to the ethical justifications of such treatment options, and protects doctors from criminal liability. For instance, in Malaysia, the doctrine of double effect is to a certain extent, manifested in section 81, which exempts one from being incriminated if the act is done without any criminal intention to cause harm (although the person committing it knows that it is likely to cause harm), and it is done "in good faith for the purpose of avoiding other harm to person or property." The legal protection accorded to doctors is clearer and more pronounced in the Criminal Code Act 1899 of Queensland, under section 282A, which stipulates that a doctor will not be criminally responsible for providing palliative care to a patient if it is done in good faith and with reasonable care and skill, and this applies "even if the incidental effect of providing the palliative care is to hasten the other person's death." In the recent landmark case of *R (in the application of Nicklinson and another) v Ministry of Justice R (on the application of AM) v Director of Public Prosecutions*[36], the Supreme Court expressed the need for Parliament to intercede and decide on policy matters that involved moral and religious considerations, such as end-of-life decisions. Emphasis was made on the fact that legislature should be "allowed a wide margin of judgment" due to the nature of such cases, and is the more appropriate forum to assess and determine the issue. Thus, legislative intervention in this area is highly necessary and operates two-fold: (1) to provide assurance to medical practitioners that their actions are ethically and legally valid; and (2) to safeguard the preservation of a patient's autonomous rights and best interests in the modern healthcare environment.

(iii) Abortion

Abortion is one of the most controversial areas in medical law and ethics. The heated debate on abortion is wide-ranging and covers numerous conceptual issues, such as the beginning and inviolability of human life, and the autonomy of the woman to choose whether to reproduce and determine the fate of her unborn child. The central dilemma in abortion is whether a woman has a right to

[36] [2014] UKSC 38.

terminate the pregnancy if she wishes, or whether the foetus should be accorded legal personality, in which case its destruction may amount to murder. Society and law are therefore embroiled in this debate which requires legal solutions. The legal regimes in many countries are constantly searching for a consensus to address such issues, which is certainly a formidable task as the views on abortion differ from one jurisdiction to another, depending on the religion, customs and morality of the people. Nevertheless, many countries resort to legislative intervention in criminalizing abortion but provide exceptions with regard to its permissibility in certain circumstances. For instance, the English Abortion Act of 1967 ("1967 Act") permits abortion by a registered practitioner but subjected to certain conditions. The 1967 Act had created statutory defences to the crimes of procuring a miscarriage and destroying a viable fetus. Section 1(1) provides that an abortion may be lawful if the pregnancy is terminated by a registered medical practitioner if two registered medical practitioners are of the opinion, formed in good faith that: (a) the pregnancy has not exceeded its twenty fourth week and that the continuation of pregnancy creates risk, greater than if the pregnancy were terminated, of injury to the physical and mental health of the pregnant woman or any existing children of her family; or (b) termination is necessary to prevent grave permanent injury to the physical and mental health of the pregnant woman; or (c) the continuance of pregnancy would involve risk to the life of the pregnant woman, greater than if the pregnancy were terminated; or (d) that there is a substantial risk that if the child were born it would suffer such physical and mental abnormalities so as to be seriously handicapped. In Malaysia, sections 312 to 316 of the Penal Code deal with the issue of abortion, although it uses the phrase "causing miscarriage" in replacement of the term "abortion. Prior to the Penal Code (Amendment) Act 1989 (Act 727), abortion could only be conducted if there was a threat to the mother's life. The Penal Code (Amendment) Act 1989 however, made several amendments, for example, by inserting an exception in section 312 which allows the termination of pregnancy if "such practitioner is of the opinion, formed in good faith, that the continuance of the pregnancy would involve risk to the life of the pregnant woman or injury to the mental or physical health of the pregnant woman than if the pregnancy were terminated." The amendments also effected changes to the length of imprisonment for section 314. The current Penal Code (Revised 1997) (Act 574) incorporated the amendments made by the 1989 Act, which clarified and extended the circumstances in which abortion are legally permitted. Consequently, abortion has become a restrictive permissible act in Malaysia. As the abortion debate is immensely wide-ranging, embracing numerous concepts, such as the beginning of human life, the sanctity of life and legal right of a woman to choose what shall happen to her body, intervention of law in this area is highly necessary to provide a balance compromise in solving the ethical, religious and legal dilemmas.

(iv) Organ Transplantation

Organ transplantation is undoubtedly one of the triumphs of modern medicine. The procedure has become a routine medical practice which has been able to save and improve the quality of life of thousands of people each year. However, transplant activity raises difficult ethical and legal issues in its requirements for donated organs. Globally, the legal framework pertaining to the removal, storage, use and disposal of human tissue is under critical review. The role of the law in this field should be to protect both the donor and the recipient. Further, legal solutions and intervention are required in regulating cadaveric organ donation, living organ donation as well as commercialisation of human organs. Commercialisation of human organs, in particular, is a disturbing phenomenon and has become increasingly rampant. The World Health Organization (WHO) estimates that 10,000 black market operations involving human organs take place each year and kidneys make up 75% of the global illicit trade in organs.[37] For instance, in 2010, amongst the 106,879 solid organs known to have been transplanted in 95 member states, whether legally and illegally, about 73,179 (68.5%) were kidneys.[38] Commercialisation of human organs is considered to be a grave problem in Asia, as patients from India and Japan frequently flock to China, where such organs are often harvested from executed prisoners.[39] The lack or insufficiency of a legal framework or enforcing mechanism in these countries has clearly contributed to this problem.[40] However, it can be seen that legal solution was introduced by the Human Tissue Act 2004 (HTA 2004) which is a legislation to regulate organ transplantation activities in England, Northern Ireland and Wales. The HTA 2004 Act created the 'Human Tissue Authority' to "regulate the removal, storage, use and disposal of human bodies, organs and tissue" and in countering 'black market' organ sales, section 5(1) of the HTA 2004 criminalises any organ removal undertaken without the person's consent and persons may not correspondingly offer or provide a reward for the supply of any bodily materials defined in HTA 2004.[41]

Further, the high demands for organs have led to their shortage and this has resulted in many people alternatively seeking supplies from living persons who may be totally unrelated to the person in need of the organs. Thus, this very much warrants legislative intervention as more and more live transplants

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[37] Campbell, D & Davison, N. (2012). Illegal kidney trade booms as new organ is "sold every hour". Available at https://www.theguardian.com/world/2012/may/27/kidney-trade-illegal-operations-who.

[38] *Ibid.*

[39] See Minhua J, Yingguang Z. Beijing mulls new law on transplants of deathrow inmates organs. Caijing. 2005 Nov 28; China at world advanced level in organ transplant. People's Daily Online. 2006. Jun 12. Available at: http://english.people.com.cn/200606/12/eng20060612_273290.html.

[40] Shimazono, Y. (2012). "The state of the international organ trade: a provisional picture based on integration of available information". Available at https://www.who.int/bulletin/volumes/85/12/06-039370/en/.

[41] Section 32 Human Tissue Act 2004.

are taking place with the advancement of medical technology. Live donors, to all intents and purposes, do not benefit in any physical sense from donating their organs. Conversely, they run the risk of immediate harm, as well as possible long term side effects. Medical practitioners should accordingly uphold the ethical principles of beneficence and non-maleficence, and ensure that living donors face minimum risk in organ donation. Medical check-ups of potential donors should be as thorough and comprehensive as possible, and where there arises any doubt that the surgical risk factors are above the minimum and would jeopardise the potential donor, then it should not be carried out. The transplant procedure of body organs should be undertaken: (a) only by medical practitioners who possess special medical knowledge and technical competence, through special training, studies and practices; and (b) such procedures should only be carried out in accredited hospitals.[42] Further, confidentiality must be maintained at all times. This is to allow the patient (recipient) and the family of the donor to have their privacy respected. All these issues should be properly legislated. Further, individuals who are incapable of making informed decisions, for example, minors and mentally incompetent persons[43] should not qualify or be considered as potential living donors. It is arguable whether or not a competent adult may give valid consent for the removal of an organ for the purpose of transplantation. In many fields of medical law, most types of treatment are permitted so long as a valid consent is obtained from a competent person. Treatment is by its very definition, a form of therapeutic intervention, which is beneficial to the subject. Therefore, even if touching involves a certain amount of danger or hurt, such as surgery, it is possible to consent to such treatment. However, there are limits as to the types of physical interference an individual may consent to. An individual cannot consent to grievous bodily harm being inflicted upon him, nor can he consent to being murdered. Further, obtaining true consent may be difficult in two circumstances; (a) when the live donor is a relative, spouse or close friend, consent might not be freely given because of emotional attachments, family pressure or societal expectations: and (b) where the donor is influenced by financial inducements. Consequently, such issues require legal solutions. In Canada[44], there is a simple requirement that any consent to transplant during life must be followed by an independent assessment that will take into account the following considerations: (i) whether the transplant is the medical treatment of choice; (ii) whether all other members of the immediate family of the donor have been eliminated, for medical or other reasons, as potential donors; (iii) whether coercion has been exerted on the donor for the purpose of obtaining

[42] This is in line with Guiding Principle 2 of the World Health Organisation's Guiding Principles on Human Organ Transplantation.
[43] *Re Y (Mental Patient: Bone Marrow Donation)* [1997] Fam 10.
[44] The Uniform Human Tissue Donation Act 1990.

his or her consent to the transplant; and (iv) whether the removal of the tissue from the body of the donor will create a substantial health or other risk to the donor.

(v) Medical Confidentiality

The duty of medical confidentiality has been one of the core duties of medical practice as information created, disclosed, acquired directly or indirectly during the doctor-patient relationship is considered confidential and requires legitimate protection. Further, preserving confidentiality on the premise that the relationship between doctor and patient has been built on trust and confidence renders the duty to be considered sacrosanct. Confidentiality also serves various purposes in medicine. First of all, confidentiality gives recognition to patient autonomy. It acknowledges respect for the patient's sense of individuality and privacy. A patient's personal, physical and psychological secrets are kept confidential in order to decrease the sense of shame and vulnerability that would surface if the information would be revealed. Secondly, confidentiality protects doctors' integrity, which is important in improving the patient's health. Confidentiality permits individuals to trust that information given to their doctors will not be further dispersed. In doing so, communication will become honest and straightforward. *Gillon* aptly noted that "if patients did not believe that doctors would keep their secrets then they would not divulge embarrassing but potentially medically important information, thus, reducing their chances in getting the best medical care."[45] In many psychiatric cases, confidentiality is essential to psychiatric treatment. Without the assurance of complete secrecy, patients would be less inclined to receive treatment and those already in therapy would be unwilling to disclose important material. Therefore, violating confidentiality would seriously affect the care of the mentally ill, to the detriment of patients and society alike. The source for this duty can be found not only in the Hippocratic Oath, codes of ethics and religious tenets, but also in the common law, principles of equity and statutory provisions. Nevertheless, technological advancements and the growth of social networks have contributed to the difficulty in preserving confidentiality, as the information gathered tends to become vulnerable in unsecure environments. Further, the undertaking by the medical profession to preserve confidentiality is to safeguard a patient's dignity, privacy and autonomy, and this obligation extends even after the death of the patient.[46] Nevertheless, the patient's right to privacy must be balanced with other potentially conflicting interests. The duty of confidentiality therefore, is not an absolute concept. Pragmatism requires any countervailing moral or legal

[45] Gillon, R. (1996). *Philosophical Medical Ethics.* John Wiley, Chichester. at p.108.
[46] De Cruz, P. (2000). *Comparative Healthcare Law.* Cavendish Publishing: London., at p. 2000.

considerations to override the duty of confidentiality. In other words, the inviolability of the duty may be infracted when circumstances demand for the disclosure of such information. Thus, it is pertinent that the justifications for breaching confidentiality are developed through a proper legal framework.

There are several laws in Malaysia that require medical practitioners to disclose patient information to the relevant authorities, for example, the Prevention and Control of Infection Diseases Act 1988 (Act 342), the Poisons Act 1952 (Act 366) (sections 21(2), 23(2) and 24; Regulations 19 and 20 of the Poisons (Psychotropic Substances) Regulations 1989) and the Criminal Procedure Code (FMS Chapter 6). For instance, section 10(2) of the Prevention and Control of Infection Diseases Act 1988 requires medical practitioners to provide information of infectious diseases to the nearest Medical Officer of Health in the prescribed form. Similarly, section 27 of the Child Act 2001 states that "if a medical officer …believes on reasonable grounds that a child he is examining or treating is physically or emotionally injured as a result of being ill-treated, neglected, abandoned or exposed, or is sexually abused, he shall immediately inform the Protector"[47] and failing to comply with this, the medical officer "commits an offence and shall on conviction be liable to a fine not exceeding two years or to both".[48] Disclosure of a patient's HIV status is also a matter of concern, particularly in relation to those caring for the patient and his or her sexual partner(s). Under the common law, disclosure of a patient's HIV status is allowed, provided that two conditions are satisfied: first, that there is a real risk to the people to be informed; and secondly, that disclosure is the only practical way to protect them. The General Medical Council in England advises doctors to explain to patients the nature and implications of their disease, how they can protect others from infection and the importance of giving professional carers information about their condition. However, if patients still refuse to allow others to be informed of their status, disclosure is considered ethical provided that the doctor is of the opinion that there is a serious risk of death or serious harm, and that patients are told that the information will be disclosed.[49] Stigma and discrimination are usually inherent in a society's perception towards HIV patients. A study which was conducted in 2012 by the Positive Malaysian Treatment Access & Advocacy Group revealed that 15.6% of the people living with HIV respondents suffered discrimination in relation to their jobs or income, with 12.4% being refused employment and 6.4% having been refused promotion or having the nature of their job changed.[50] Thus, it is of paramount importance that the medical profession exercises caution and is discreet in

[47] Section 27(1) of the Malaysian Child Act 2001.
[48] Section 27(2) of the Malaysian Child Act 2001.
[49] General Medical Council (GMC). (1997). *Serious Communicable Diseases*. London, GMC, at paragraphs 18-23.
[50] Gurusamy, J. (2014). Employment and Education: Are We Stigmatising and Discriminating HIV Patients? *Berita MMA*. (Vol. 44 (March), at pp. 20-21.

releasing information about HIV patients, even to companies, insurance companies and managed care organisations without the patient's prior consent. The Malaysian HIV/AIDS Charter for Doctors states that "doctors should, without prejudice and discrimination, when carrying out blood or other tests, ensure that adequate pre and post-test counselling is conducted to ensure consent to testing." The Charter further explains that patients who are HIV positive shall be encouraged to inform the attending doctor(s) of their HIV status, and information about a patient's HIV status shall be restricted to medical professionals and other authorised personnel on a need-to-know basis. The law must strike a precarious equilibrium between protecting the rights and interests of the individual on the one hand, and maintaining the safety and interests of the public at large or any others who may be affected by the actions of such individual, on the other. The greater the potential harm to the public, the greater the pressure to curb the actions of the individual. It involves a fine balancing act, but at the end of the day, the law must ensure that any "protective privilege should end where public peril begins."[51]

Conclusion

Medical practitioners are constantly confronted with challenges amidst growing societal demands in modern healthcare. The ethical dilemmas faced by the medical profession require intervention from the law, which is imperative in order to determine the boundaries of legitimacy in guiding the actions and protecting the rights of both doctor and the public at large. Hence, there is a need to direct the conduct of the medical profession by way of a proper regulatory framework so that they are able to discharge their duties both ethically and lawfully. This will not only as a matter of course, improve the doctor-patient relationship, but also ultimately enhance the standard and quality of care provided as a whole.

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[51] *W v Egdell* [1990] 1 All ER 835, *per Lord Justice Bingham*.

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