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A comparative view of patients' rights in UK and Malaysia

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Abstract

Who shall be the ones to ultimately decide who deserves treatment? Thus, the most significant question that now begs to be answered is, by the medical profession more often than not, who exactly do we treat? In trying to reach the elusive goal of seemingly perfect health, a comparative study of the UK and Malaysian health care system has becomes inevitable. The results showed that patients' rights, as well as the relationship between medical accountability and ethics, and will further elaborate on the developments of the two concepts in Malaysia.

Keywords: patients' rights, ethics, medical, profession, accountability

Una visión comparativa de los derechos de los pacientes en el Reino Unido y Malasia

Resumen

¿Quiénes serán los que finalmente decidirán quién merece tratamiento? Por lo tanto, la pregunta más importante que ahora pide ser contestada es, por la profesión médica más a menudo que no, ¿a quién tratamos exactamente? Al tratar de alcanzar ese objetivo difícil de alcanzar con una salud aparentemente perfecta, resulta inevitable un estudio comparativo del sistema de atención de salud del Reino Unido y Malasia. Los resultados mostraron los derechos de los pacientes, así como la relación entre la responsabilidad médica y la ética, y profundizarán en los desarrollos de los dos conceptos en Malasia.

Palabras clave: derechos de los pacientes, ética, médico, profesión, responsabilidad.

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1. INTRODUCTION

Seeing as this article is about what a patient’s rights are, and how it is acknowledged in our health care system, a comparative study of the UK and Malaysian health care system is employed. This is done to better understand the continued relevance of certain provisions in the UK, and if they are no longer relevant, what steps are taken to do otherwise. In the meantime, with regards to the Malaysian health care system, several sources shall be looked into, and primary sources would include legislation and judicial decisions, in both the UK and Malaysia; as the UK has shown that they have a solid foundation, while secondary sources would then consist of legal writings by academicians.

In recent years, health care has steadily been increasing to become a precious commodity, and it can be said that the reason for this lies in the constantly rising health costs. And it is precisely this reason that the UK health care system is in continual transition (Klein, 1983), to find a proper and adequate method to suit the needs of an ever growing, and ever ageing society. Another thing to look at about patients’ rights would be the right to certain types of treatment. A 16-month-old boy who had been injured in a fall suffered cerebral palsy and the court asked his natural parents to determine whether, if a life-threatening event arose, the child should be given artificial ventilation or other life-saving measures that the clinicians in charge believed that was in his best interest. The parents had initially argued that no medical evidence favoured ventilation. Lord Donaldson held that The sad fact of life is that health authorities have may on occasion find that they have too few resources, either human or material or both, to treat all the patients whom they would like to treat in the way in which they would like to treat them. They must make choices. It would then be undesirable for the court to make an order for a particular treatment, without knowing if there were other patients more deserving of it.

Another relevant argument to look at, which relates to the right to certain kinds of treatments, would be the issue of gender dysphoria. Changes in attitudes have encouraged rising numbers of young people to identify themselves as gender-dysphoric. The terms 'gender dysphoria' and 'transsexualism' denote the experience of a gender identity opposite to that of one's anatomical sex, commonly characterized by a yearning to undergo medical gender reassignment. As a novel of strategies, to reduce the distress caused by the onset of puberty, young people with gender-dysphoria are increasingly seeking pubertal-suppression therapy. In accommodating their wishes, health care professionals must then confront a variety of clinical, ethical and legal issues (Downs & Whittle, 1998). It would seem with the arrival of the right to treatment, other issues, such as the gender dysphoria above, are beginning to make waves, all in the name of obtaining the right to a certain kind of treatment.

2. LITERATURE REVIEW

Illich says,

> "No one knows how much health care will be worth to him in terms of money and pain. Also, nobody knows if the most advantageous form of health care is obtained from medical procedures, from a travel agent, or by renouncing work on the

> night shift…The economics of health is a curious discipline, somewhat reminiscent of the theology of indulgences that before Luther…You can count what the friars collect, you can look at the temples they build, you can take part in the liturgies they indulge in, but you can only guess what the traffic in remission from purgatory does to the soul after death. Models developed to account for the willingness of taxpayers to foot the rising medical bills to constitute similar scholastic guesswork about the new world-spanning church of medicine” (Illich, 1976).

Meanwhile, Montgomery has even suggested that it may be thought that, like rights to life and liberty, the right to health care could be regarded as one of a group of basic rights which make active citizenship possible, as, with all basic rights, the State would be required to take specific steps to recognize health rights (Montgomery, 1992). Other arguments and thoughts about patients rights in health care can be found in the writings of Bole and Bondeson (1991). The deep meaning of the words health care itself cannot be denied, and in whatever language, and in whichever part of the world, its significance would be indisputable. As Freedman says, “the existence of scarce goods necessitates important issues on distribution, whereas the insistence on the right to a good ensures that some of it will be available to any rights bearer” (Freeden, 1991). Sometimes, however, there is confusion as to what part does the State play in the area of health care, and the argument of what exactly is the role of the State in providing sufficient health care is often as hotly debated as the idea of health care itself (Currer & Stacey, 1986).

Simon Williams, Director of Policy at The Patients Association, said, ”The findings of this survey are disturbing. The public believes that the NHS gives them many rights as patients when, in fact, patients in this country possess only a few entitlements”. The findings from this survey suggest that now would be a good time to begin a discussion about the patient rights in the UK. Some medical professionals worry that a rights-based healthcare system might bring the NHS more trouble. They are apprehensive of a wave of patients suddenly demanding entitlements. Worse still, doctors fear litigation from disgruntled patients who suspect that their new rights have not been respected. Fortunately, the good news from this survey is that, on the whole, the doctor-patient relationship is alive and well. Indeed, from the comments received, many patients are still content to defer to the wisdom of their doctors. Those principles of solidarity that formed the cornerstone of the NHS from its days of founding, over half a century ago, remain intact (The Patient Association, 2018).

Bernard Williams argues that

> "Leaving aside preventive medicine, the proper ground of distribution of medical care is ill health: this is a necessary truth. Now in very many societies, where ill health may work as a necessary condition for receiving treatment, it does not work as a sufficient condition, since such treatments cost money, and not all who are ill have money; hence the possession of sufficient money becomes, in fact, an additional necessary condition of actually receiving treatment" (Williams, 1962).

It would seem then that Williams was a firm advocate in the concept of allocation, and in the idea that if you had enough money, you would be ensured to receive treatment. Meanwhile, Robert Nozick counters that

> "Like others, Williams looks only to the question of allocation. He ignores the question of where things or actions to be allocated and distributed come from. Consequently, he does not consider whether

> they come already tied to people who have entitlements over them…people who therefore may decide for themselves to whom they will give the thing and on what grounds" (Nozick, 1974).

Of course, Nozick's argument has been criticized, as it emphasizes an individualistic approach, that a person would decide what to do with his resources, and that which is not feasible in today's society. Doyal and Gough (1991) have criticized Nozick, as to them, production is "a social process in which many mix their labour [and] any rights associated with ownership can no longer be focused exclusively on the individual". The idea that patients' do indeed have rights was initially an unfamiliar concept of the UK health care law. Such issues as informed consent are contained in the sphere of ordinary malpractice principles, and confidentiality is often justified concerning the public good. However, as Paul Craig has reminded us, particular interest may be incapable of being framed as a justifiable legal right, but it could still be believed that it generates a constitutional obligation (Craig, 1990; Baharvand, 2017).

3. METHODOLOGY

This study will employ several methodologies that are inter-related. These include a historical method, where the history of whistleblowing will be carefully studied, to determine how it came about and where it originated. An analysis will also be done to see how early whistleblowers were treated. Legislations and judicial decisions from various countries such as the United Kingdom and Malaysia will also be studied, while the doctrine of binding precedent in countries such as the United Kingdom and Malaysia will be examined. Secondary sources would consist of legal writings and journalistic articles by academicians and scholars. A comparative analysis would include company law and its origins in English common law, which was later received into our legal system. As such, a comparative study of English and Anglo-American common law, along with Malaysian law becomes inevitable. This is imperative to better understand the application and functions of patients' rights in other countries and to determine how they can be inserted into local law.

4. RESEARCH QUESTIONS

The ways to approach this is not simple, and there are several important issues that must be considered. Issues such as, health care prioritization and the people that deserve it? Or is it based on the seriousness of the sickness? And if either method is used, who are the bearers of such duties? Who shall be the ones to decide who deserves treatment ultimately? That would be none other than the medical profession, the doctors and nurses, and the like. Thus, the most significant question that now begs to be answered is, by the medical profession more often than not, who exactly do we treat?

5. RESULT AND DISCUSSION

An interesting story to look at, which fairly illustrates Nozick's point, would be the report of the Alzheimer case. This was where Nice, backed by an appeal panel, decided that three acetylcholinesterase inhibitors (AChEIs)-Aricept, Reminyl and Exelon, should no longer be made available on the NHS in the early stages of Alzheimer's. It recommended the use of the drugs for "moderate" Alzheimer's, but not for mild cases. It decided that the drugs, which cost about £2.50 per person a day, were not cost-effective about the benefits they offered to such sufferers and their carers. Although a judge ordered the Government's medicines watchdog to amend "discriminatory" guidance on drug treatment for Alzheimer's, the ruling did not pave the way for funding for all patients with "mild" symptoms (Express, 2007). It would seem then, that this does take into account the issue of allocation, as the High Court is quite concerned as to who is entitled to receive treatment (Taraz et al., 2018).

It is therefore inevitable that law and legal rights will exist at all levels of society. There are rights governing family relationships, education, as well as the government’s relationship with individuals. Many legal rights exist in the arena that the positive legal counterpart of human rights are moral rights, and would reflect those values as well as defending personal interests. And speaking of personal interests, an interesting area relating to this would, of course, be privacy. All individuals desire privacy, but none more so than medical patients. This is because patients would divulge intimate and sometimes embarrassing information to their doctors. Without the promise of privacy, they would then omit certain details and this is potentially dangerous, as it would affect the quality and nature of treatment given (Rajabi et al., 2018).

Confidentiality relates to the duty to maintain confidentiality, or in other simplistic words, to respect privacy. The people's right to privacy is contained in Article 12 of the United Nations (UN) Universal Declaration of Human Rights (1948). UN member countries are morally, and sometimes legally, bound by such declarations. Privacy relates to personal information that a person would not wish others to know. These issues of confidentiality, as well as its breaches, frequently arise in the area of medicine and health care. This is understandable, and also unavoidable, as medicine and its players take on a vital role in our lives. Meanwhile, in Razis' article, he gives the Hippocratic definition of confidentiality, where it is, "the absolute and without any exceptions observation of secrecy by the physicians". Confidentiality undoubtedly strengthens the trust in the patient-physician relationship and mutual trust is indispensable for both diagnostic work and therapeutic application (Razis, 1990).

As stated above, confidentiality plays a very important role in the medical profession. When people agree to seek medication, they are expected to provide personal information, and health workers, in every level, must commit to respecting and more significantly, maintaining the confidentiality of their subjects. When people disclose private information for any public health purpose, it is anticipated that the information will be held in utmost confidence. As such, under the ethical standard of respect, public health workers must respect privacy, and it is only with this trust in place can the many public health programs have a chance to succeed. Questions of confidentiality will come up about the recording of information concerning the patient's health status, in addition to access to that information by both the patient and others. Recent issues that have cropped up concern matters such as the arrival of HIV, about infected patients and infected healthcare workers, and access to the information by the patients themselves.

In their article, Braunack-Mayer and Mulligan (2003) emphasize the ethical importance of carefully attending to a patients' awareness and understanding about how their information is or would be used. Exceeding minimal legal duties by doing more than merely making patients aware of how their information will be used is important to building trust and providing effective healthcare. Additionally, in law, information provided to a medical practitioner by a patient becomes subject to a statutory duty to protect the patient's privacy and a common-law duty of confidence owed by the medical practitioner to the patient (Thompson, 2003). Medical law concerns both the rights and duties of the medical profession as well as the rights of the patient. The three major areas within medical law are the law on confidentiality, negligence and other torts about medical treatment, in addition to the criminal law about medical practice and treatment. There is also a wide range of issues concerning ethics and medical practice which are increasingly coming in droves before the courts.

Questions of confidentiality will most likely come up about the recording of information concerning the patient's health status, and access to that information by both the patient and others. Recent issues that have cropped up also concern matters such as the arrival of HIV, about infected patients and infected healthcare workers, and access to information by the patients themselves. Also, negligence suits for medical malpractice represent a thriving growth area in legal practice. Causes of action can range from breach of confidentiality, harm caused by failure to remove all medical equipment from the site of surgery, to actions for wrongful birth following a failed sterilization. For instance, a significant case to look at regarding the latter would be (Cattanach v Melchior, 2003), where it was held that the negligent doctor could be held responsible for the costs of raising and maintaining a healthy child, which was the result of a failed sterilization. Actions may also arise from the tort of trespass to the person when a doctor does not seek consent before treatment. All these issues correspond closely to the issue of medical negligence and immense caution must be used in dealing with this area.

With regards to the rights of health care, Section 1(1) of the National Health Service Act in the UK provides that, "It is the Secretary of State's duty to continue the promotion in England and Wales of a comprehensive health service designed to secure improvement: (a) in the physical and mental health of the people of those countries; and (b) in the prevention, diagnosis and treatment of illness". Meanwhile, Section 3 provides that "It is the Secretary of State's duty to provide throughout England and Wales, to such extent as he considers necessary to meet all the requirements: (a) hospital accommodation; (b) other accommodation for the purpose of any service provided under this Act; (c) medical, dental, nursing and ambulance services.

Regina v Secretary of State for Social Services ex parte Hincks in year 1980, provides a good example with regards to the above. Several patients, who had been waiting for up to three years for pain reliving operations, much longer than was medically advised, sued the Health Secretary. The delay rose as a result of a shortage of orthopaedic beds in the Birmingham area, a delay that was caused by a decision not to build a new block in the hospital on the grounds of cost. However, the Court of Appeal rejected the plaintiffs' claim. Lord Denning stated that the Health Secretary could only be considered to have failed in the discharge of the statutory duty only if his exercise of it was so unreasonable. Thus, the Act did not create an absolute duty to provide services, irrespective of economic decisions that were being done at the national level.

Also, Lord Denning stated that the provision had to be read subject to the qualification that the Secretary of State must meet all "reasonable requirements such as can be provided within the resources available". Further to this, Foster in his paper examines the law relating to healthcare resource allocation in England. The National Health Service (NHS) Act 1977 does not impose an absolute duty to provide specified healthcare services, and the courts will only interfere with a resource allocation decision made by an NHS body if that decision is frankly irrational (Foster, 2007). As such, it would seem that the Secretary of State would be guilty of not doing his duty only if the circumstances were undeniably unreasonable.

One other case, (R v Cambridgeshire HA ex p B (A Minor) 1995), a father was fighting for the right to obtain treatment for his dying daughter. This is one of the clearest examples of the practicality of rights as regarded by the English courts. B had been treated for lymphoma but was then diagnosed with leukaemia which was progressing steadily. She had a bone marrow transplant from her sister, but it was apparent that the cancer was moving to the final stages. Her doctor advised that further treatment was contra-indicated, a decision that the father challenged clinically then legally. A second opinion that was sought to put B's chances of survival higher than that of the fist, and with this opinion, he approached the health authority to fund a second bone marrow transplant. Taking into account the clinical judgment, nature of the treatment and the estimated chance of success, the health authority then declined to fund the treatment.

Initially, Laws J affirmed that

> "Off all human rights, most people would accord the most precious place to the right to life itself. Sometimes public authorities, who are subject to the jurisdiction of the court, have the power of life and death or at least to decide, as I find in the case here, whether a person otherwise facing certain death should, by means of all resources at the public body's disposal, be given the chance of life".

This is an echo of Lord Woolfe's judgment in (R v Lord Saville of Newdigate ex-pA, 1999), where he said that "where a fundamental right such as the right to life is engaged, the options open to a reasonable decision maker are curtailed". Nonetheless, it seems then that the court's influences are limited, even when involving a fundamental right such as the right to life itself, as the health authority does finally decide who exactly deserves to receive the right to treatment.

6. FINDINGS AND CONCLUSION

The NHS has repeatedly sought the promotion of a comprehensive health service to improve the physical and mental health of the nation, and this was done with providing effective service. Such services were given free, and it was made possible through State ownership and control of resources. It was provided free of charge, at the point of consumption, and would thus ensure a flow of freely available health care. The assumption was that society would grow healthier as a result of this, and the costs would soon cease to rise, and perhaps even fall. As Lee (1987) pointed out, the argument was flawed and should have been obvious then. Neoclassical writers such as Pigou (1928) in as early as the 1920s had shown themselves well aware of the price elasticity about public demand about public resources and such deficiencies should have been addressed much earlier.

Therefore, against this background, the endeavour to establish a workable notion of rights to health care, as a way of responding to the issue of just allocation of health care, as to who deserves it the most may be seen as a rhetorical nightmare. This is further compounded by the fact that, as it can be shown from the arguments above, the issue of health benefits, the allocation of it, and especially the question of whom exactly deserves them, shows that it, in the UK at least, now rests firmly in the hands of the medical profession and its many players. It seems that it can be said that, at least in this situation, that to receive is indeed much harder to give. Furthermore, people are beginning to appreciate that, try as one might, the health care budget cannot be infinite, nor can it meet every demand, but the current drive towards improving what we have got is, however, to be applauded (McLean, McLean & Mason, 2003).

Meanwhile, with regards to the position of patient’s rights in Malaysia, though much tamer than that of their Western counterparts, is also quite formidable. There exists a Patient’s Charter, which was drafted in the year 1995. This Memorandum of Understanding, which is dated 21st. August 1995 is between The Federation of Malaysian Consumers Associations, The Malaysian Medical Association, The Malaysian Dental

Association and The Malaysian Pharmaceutical Society. The Federation of Malaysian Consumers Associations (FOMCA) is committed to the protection of consumer rights and to consumer education, while The Malaysian Medical Association (MMA) is committed to sustaining the professional standard of medical ethics as to education, while directing public opinion on the problems of public health which affects the community at large. Meanwhile, The Malaysian Dental Association (MDA) is dedicated to supporting and promoting a high standard of ethics and professional conduct and directing public opinion on dentistry and the problems of dental health. Finally, The Malaysian Pharmaceutical Society (MPS) is committed to furthering the development of pharmacy, to enhancing the standards and ethics of the profession while assisting and improving the health services in the country.

Under the Patient's Charter which is contained under the MMA, it encompasses several rights that a patient is entitled, eight of them, to be exact. These include the right to health care and humane treatment, right to choice of care, right to acceptable safety, right to adequate information and consent, right to redress of grievances, right to participation and representation, right to a healthy environment and finally, the right to health education. Under the first one, which is the right to health care and humane treatment, every individual shall have access to competent health care and treatment regardless of age, sex, ethnic origin, religion, political affiliation, economic status or social class. Health care services shall be available by clinical need, regardless of the ability to pay, and it shall be the responsibility of the Government to ensure that every person has access to essential health services. Every patient shall be treated with care, consideration, respect and dignity without discrimination of any kind.

All drugs dispensed shall be of acceptable standards in terms of quality, efficacy and safety as determined by the Drug Control Authority of Malaysia. Every individual shall have the right to prompt emergency first aid treatment from the nearest government or private medical and health facility. Patients shall also be interviewed and examined in surroundings designed to ensure reasonable privacy and shall have the right to be chaperoned during any physical examination or treatment, except in cases of emergency where such conditions may not be possible. Finally, a child admitted to the hospital shall, whenever possible, have the right to the company of a parent or guardian.

In Malaysia itself, about RM150 million to RM200 million is being spent on medicine for diabetes, high blood pressure and high levels of cholesterol every year. The public's choice of an unhealthy lifestyle is setting the Government back by RM900million, as the cost for supplying the medicine to the public hospitals. Health Minister Datuk Seri Dr Chua Soi Lek said that 80% of premature coronary heart disease was caused by unhealthy eating, smoking and lack of exercise. He also emphasizes that "Heart disease is the number one killer in the country. In 2005, a total of 3,083 died from the disease while 39,770 were admitted to the hospital for it" (Zolkepli, 2007). He also added that there had been campaigns to promote a healthier lifestyle, but the choice to change their ways still, of course, remains with the public.

Another important feature under the Patient's Charter is the right to adequate information and consent. Here, a patient shall have the right to know the identity and professional status of the individuals providing service to the patient and to know which health professional is primarily responsible for the patient's care. A patient shall have the right to information regarding all aspects of medication, including, the right to adequate and understandable information on prescribed and purchased medicines, the right to the most effective and safe medicines and safety must be ensured by the manufacturers and by legislative control. This also includes the right to conveniently access medicines and the right to choose among competitive products.

All medicines shall be labelled and shall include the international non-proprietary name (INN) of the medicine, the dosage and how often the medicine has to be taken. In addition, the patient shall be informed about medication, including the following, the purpose of the medicine, the possible side effects, and the avoidance of any food, alcoholic beverages or other drugs, the duration necessary for any medication prescribed as well as the measures to be taken if a dose is forgotten or if an overdose is taken. A patient shall have the right to an itemized account after any treatment or consultation and to have this explained. If a patient is in a hospital or any health care facility, the patient shall, unless unconscious is consulted about any decision to discharge or transfer the patient to another facility (Karlina et al., 2019).

Where it is appropriate to a patient's condition or treatment, the patient shall be advised self-care, drugs administration, special precautions, which may be necessary or desirable, and the existence of special associations, facilities, aids or appliances which may be of assistance. A patient's consent shall be required before any procedure is carried out and in the case of a minor, the consent shall first be obtained from the parent or guardian. If a patient is unconscious and delay would be dangerous, a doctor is entitled to carry out any necessary treatment or operation.

A patient's consent shall be required for the inclusion of a patient in any research. The patient shall be adequately informed of the aims, methods, anticipated benefits and potential hazards of the study and the discomfort it may entail. The patient shall be informed that he or she is at liberty to abstain from participation in the study and that he or she is free to withdraw his or her consent to participation at any time. To ensure that the informed consent is not obtained under duress or from a patient in a dependent relationship to the health professional, the informed consent shall be obtained by a health professional who is not engaged in the investigation and who is completely independent of the official relationship between the patient and the health professional. In the case of a child, the informed consent shall be obtained from the parent or guardian. A patient shall have the right to have the details of the patient's condition, treatment, prognosis and all communication and other records relating to the patient's care to be treated as confidential, unless authorized in writing by the patient it is undesirable on medical grounds to seek a patient's consent but it is in the patient's own interest that confidentiality should be broken. The information is required by due legal process.

Further, under the right to redress of grievances, which is another important feature, a patient shall have access to appropriate grievance redress mechanisms. A patient shall have the right to seek legal advice as regards any alleged malpractice by the hospital, the hospital staff or by a doctor or other health professional. A patient shall also have the right to recover damages for injury or illness incurred or aggravated as a result of the failure of the health professional to exercise the duty and standard of care required of him or her while treating the patient. If in the event the medical professionals breach that standard of care, then the means of obtaining damages as a result of that said breach is contained in the law of negligence.

In Malaysia, one of the first cases that dealt with the issue of negligence was the case of (Chin Keow v Kerajaan Malaysia, 1967). In this case, an 'amah' found out that her legs and thighs were swollen with an ulcer. She went to see a Dr Devadeson at a public hospital for treatment. After examining her, the doctor injected procaine penicillin, which caused her death, an hour after it had been injected. As a result, the patient's family then sued the doctor for negligence. During the trial, it was held that the doctor was negligent in not checking the patient's medical care, which had clearly stated that she was allergic to penicillin. It was held to be good clinical practice for a doctor to ask a patient if the intended injection would cause any unwanted side-effects. And in reaching this decision, the courts proceeded to use the Bolam test, to determine if the doctor had indeed acted reasonably. The Bolam test was taken from the famous case in England, where it became the bar to regulate the medical profession.

In Bolam, it was stated that

> "The test is the standard of the ordinary skilled man exercising and professing to have that skill. A man need not possess the highest expert skill at the risk of being found negligent. It is well-established law that it is sufficient if he exercises the ordinary skill of an ordinary man exercising that particular art" (Bolam v. Friern HMC, 1957).

However, in light of the many evolvements of medicine, as well as the increase in clinical guidelines (Tingle, 2002), the Bolam test was evaluated numerous times, to ascertain if the reasonableness principle (Hickman, 2004) would still be suitable to use it in the present day. Issues such as whether negligence is a matter of social or ethical concept, which was raised several times before, must also be determined, and what happens after all these issues were considered (Montrose, 1958). Further on in this article, the exact importance of why this is so, especially about its impact on Malaysia, will be critically examined.

In Malaysia, there are many cases which involve doctors, nurses or the like. For instance, in (Elizabeth Choo v Govt of Malaysia & Anors, 1960), it involved an action for damages for personal injuries against the Government of Malaysia and the anaesthetist. The plaintiff was admitted to the General Hospital, Kuala Lumpur for piles operation but she left the hospital after 35 days without the operation being performed. Instead, another operation had to be performed for the repair of her colon which was perforated due to the alleged negligence of the anaesthetist during the sigmoidoscopic examination. Consequently, the plaintiff still suffers from haemorrhoids and is still unable to undergo the pile's operation because of the nervous shocks she suffered from the perforation of her colon. She then stated that she suffers and will continue to suffer pain and discomfort from her haemorrhoids. Again, by using the Bolam test, it was held that there was no negligence.

Similarly, in (Asiah Kamsah v Dr Rajinder Singh & Ors, 2002), the plaintiff delivered her second child at the Teluk Intan District Hospital and due to suspicion of fetus distress; she underwent a lower section caesarean operation done under general anaesthesia. Unfortunately, she did not recover from the operation and suffered permanent brain damage. She then claimed for damages and in deciding the negligence in this case, James Foong J used the test that was laid out in Bolam. Here, it was also held that there was no negligence.

There was initially some difficulty in helping patients achieve justice in the area of negligence, and this was caused by a variety of reasons. This issue was further emphasized by Judge Law Hop Bing, in the case of (Tan Ah Kow v the Govt of Malaysia, 1997), where he stated that "…civil litigation founded on medical negligence are few and apart in Malaysia…". This is further compounded by the fact that the Asian community as a whole is more family oriented and less individualistic. Further, they also believe that death is in God's hands, no matter come what may (Raja & Letchumanan, 1999). In contrast, Western society believes that fault comes with a price and thus, they are more inclined to take action for negligence. As a result, this has resulted in doctors engaging in defensive medicine. For doctors trying to evade medical litigation, they have resorted to the somewhat radical approaches, of what is now known as 'defensive medicine' or 'defensive behaviour' (Ngah, 1999).

It was in the highly celebrated case of (Foo Fio Na v Soo Fook Mun & Assunta Hospital, 2001), where Siti Normah Yaakob, of the Federal Court, stated that

> "On this basis we are of the view that the Rogers v Whittaker test would be a more appropriate and a viable test of this millennium then the Bolam test. To borrow a quote from Lord Woolfe's

> inaugural lecture in the new Provost series, delivered in London in 2001, the phrase ‘Doctor knows best’ should now be followed by the qualifying words ‘if he acts reasonably and logically and gets his facts right”.

Even as Malaysia makes a momentous decision in deciding to follow the approach laid out in (Rogers v Whittaker), there are still several areas that need improving. An example can be seen in the case of Lai Yok Shan, whose arm had to be removed when it became infected when she was incubated. This incident occurred due to some negligence on the part of the Tengku Ampuan Rahimah Hospital. Even though Health Minister Datuk Seri Dr Chua Soi Lek later apologized on behalf of the Health Ministry to the clients, the baby’s father, Lai Kian Khee expressed disappointment that no one from the hospital had offered or even approached him to discuss about the issue of receiving the ex-gratia payments, and he had to read about it in the newspaper. Dr Chua also emphasized that there must be clear and proper channels for persons to go through, in order for them to easily resolve any problems (Singh, 2007).

However, all is not lost. The right of patients over the years in Malaysia has been steadily improving. Under the Patient’s Charter 1995, there are several rights that a patient is entitled to, such as those that are already stated above. Such cases as (Tan Ah Kow v the Govt of Malaysia, 1997) have shown that doctors have a legal duty to inform patients of the risks resulting from a particular treatment, especially if the risk is serious and may well cause death or permanent disability. This marks a fundamental departure from the Bolam principle of the ‘doctor knows best rule’.

REFERENCES

KAMSAH, A.; SINGH, R., & ORS. 2002. 1 MLJ 484. Malaysia.

BOLAM, & Friern HMC. 1957. 1 WLR, pp. 582, 588.UK.

BOLE, T., & BONDESON, W. 1991. **Rights to health care.** Kluwer: Doordrecht. UK.

BRAUNACK-MAYER, A., & MULLIGAN, E. 2003. **Sharing patient information between professionals: Confidentiality and ethics.** Med J Aust, Vol. 178. pp. 277-279.Australia.

BAHARVAND, P. 2017. **Responsiveness of the health system towards patients admitted to west of Iran hospitals.** Electron J Gen Med.UK.

CATTANACH , & MELCHIOR. 2003. HCA 38. Australia.

CHIN, K , & KERAJAAN MALAYSIA. 1967. 2 MLJ 45. Malaysia.

CRAIG, P. 1990. **Public law and democracy in the United Kingdom and the United States.** Oxford: Clarendon, pp. 7.UK.

CURRER, C., & STACEY, M. 1986. **Concepts of health and disease: A comparative perspective.** Leamington Spa: Berg.UK.

DOWNS, C., & WHITTLE, J. 1998. **Seeking a gendered adolescence: Legal and ethical problems of puberty of puberty suppression among adolescents with gender dysphoria.** Manchester Metropolitan University. UK.

DOYAL, L., & GOUGH, I. 1991. **A theory of human need.** London: Macmillan, pp. 137-138.UK.

ELIZABETH .C , & Govt of Malaysia & Anors.1960. 1 LNS 24. Malaysia.

EXPRESS. 2007. **Legal blow for alzheimer's patients**. Retrieved from.UK.

FOO FIO NA ; SOO FOOK MUN & ASSUNTA HOSPITAL. 2001. 2 AMR 2205, pp. 154. Malaysia.

FOSTER, C. 2007. **Simple rationality? The law relating to healthcare resource allocation in England.** Journal of Medical Ethics, Vol. 33, N^{o} 7. pp. 404—407. UK.

FREEDEN, M. 1991. **Rights**. Buckingham: Open UP, pp. 92.UK.

HICKMAN, T. 2004. **The reasonableness principle: Reassessing its place in the public sphere.** The Cambridge Law Journal. UK.

ILLICH, I. 1976. **Limits to medicine**. Harmondsworth, Penguin, pp. 235.UK.

KARLINA, N., RUSLI, B., & CANDRADEWINI, S. 2019**. An analysis of social capital in empowerment community at uninhabitable house's renovation fund onwest bandung regency.** Humanities & Social Sciences Reviews. Vol. 7, N^o 3: 74-79. India.

KLEIN, R. 1983. **The politics of the National Health Service**. London: Longman.UK.

LEE, R. G. 1987**. Legal control of health-care allocation. In M. Ockelton (ed), Medicine, ethics and law**. Stuttgart: ARSP, pp. 94-96.Germany.

MCLEAN, S. A. M., MCLEAN, S., & MASON, J.K. 2003. **"Legal & Ethical Aspects of Healthcare".** Cambridge University Press.UK.

MONTGOMERY, J. 1992. **Rights to health and healthcare.** In A. Coote (ed), The welfare of citizens: Developing new social rights. London: IPPR, pp. 82.UK.

MONTROSE, J. 1958. **Is negligence an ethical or a sociological concept?** The Modern Law Review, Vol. 21, N^o 3, pp. 259-264.UK.

NGAH, A. 1999. **Medical negligence litigation: Is defensive medicine now the norm?** 12th Commonwealth Law Conference Kuala Lumpur.Malaysia.

NOZICK, R. 1974. **Anarchy, state and utopia.** Oxford: Basil Blackwell, pp. 233.UK.

PIGOU, A. 1928. **A study in public finance**. London: Macmillan.UK.

R v Cambridgeshire HA ex p B (A Minor). 1995. 23 BLMR 1 (CA).UK.

R v Lord Saville of Newdigate ex p A. 1999. 4 All ER 860, pp. 25.UK.

RAJA, S. S., & LETCHUMANAN, A. 1999. **Tamadun dunia**. Shah Alam: Fajar Bakti.Malaysia.

RAZIS, D. 1990. **Medical confidentiality**. International Journal for Quality in Health Care, Vol. 2, pp. 353-357.UK.

REGINA , & SECRETARY OF STATE for Social Services ex parte Hincks. 1980. 1 BMLR 93. UK.

SINGH, D. 2007. **Procedure on Yok Shan over in 10 minutes.** The Star. Malaysia.

TAN AH KOW , & THE GOVT OF MALAYSIA. 1997. 2 AMR 1382, pp. 17. Malaysia.

The Patient Association. 2018. **The public perception of patients rights within the UK NHS**. Retrieved from.UK.

THOMPSON, C. 2003. **Confidentiality and privacy: Beyond legal duties**. MJA, Vol. 178, N^{o} 6. pp. 252—253.Australia.

TINGLE, J. 2002. **Do Guidelines have Legal Implications?** Archives of Disease in Childhood.UK.

WILLIAMS, B. 1962. **The idea of equality.** In P. Laslett and W. G. Runciman (Eds.), Philosophy, Politics and Society, pp. 110-131.Netherlands.

ZOLKEPLI, F. 2007. **Poor health habits costing govt big money**. The Star. Malaysia.

RAJABI, J., BORHANI, F., EBADI, A., BAZMI, S. 2018. **Professional ethical competence for medical students: a qualitative study.** Electron J Gen Med, Vol. 15, N^{o} 3. UK.

TARAZ, Z., LOGHMANI, L., ABBASZADEH, A., AHMADI, F., SAFAVIBIAT, Z., BORHANI, F. 2018. **The relationship between ethical climate of hospital and moral courage of nursing staff.** Electron J Gen Med. UK.

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