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AN EVALUATION OF CONSENT REQUIREMENT IN COMPETENT AND INCOMPETENT ADULTS IN MALAYSIA

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ABSTRACT

This is a conceptual paper to evaluate the consent requirement in competent and incompetent adults for medical treatment and healthcare in Malaysia. This study reviews literature on the history of consent requirement among competent and incompetent adults and its consequences in healthcare practice. It aims to evaluate the crucial elements of valid consent particularly the factors that affect the voluntariness and competency of the patient in giving consent. This paper reviews the existing literature surrounding the phenomenon of giving consent for medical treatment in the healthcare, particularly to how the element of competency affects such consent requirement. This study provides an overview of the perplexing nature of consent and the various concerns that have surrounded the topic leading to its recognition. Hence in Malaysia, there is no specific law which governs the provisions for competency in giving consent in the healthcare practice. This study aims to explore the Malaysian Medical Council Guideline on Consent for Treatment of Patients by Registered Medical Practitioner (MMC Guideline on Consent) and the current Malaysian laws to determine whether they are sufficient to address the competency element of consent requirement in adults. The study reviews the existing case laws and literature on the historical development of the elements of valid consent. Subsequently, the findings of the perusal of the MMC Guideline on Consent and the current statutory laws are presented and discussed. Finally, lack of empirical evidence is recognised in this paper and several suggestions are made for future research and recommendation for enactment of a new law pertaining to consent to medical treatment.

***KEYWORDS**: Competent, Incompetent, Consent*

INTRODUCTION

Consent is defined as a legally valid assent whereby an approval or permission to an action or a purpose is proffered voluntarily by a competent person.[1] The law protects an individual autonomy by giving that individual the right to bodily integrity via consent, and any contravention of consent causes a medical practitioner to be liable for battery in criminal law or trespass and/or negligence in tort law.[2] It is expressed that an operation performed on a capacious patient without his or her consent would be an infraction of the patient's right not to suffer torment or demeaning treatment.[3] The basic concept

[1]Bryan A. Garner and Henry Campbell Black, Black's Law Dictionary (8thEdn. Thomson/West 2004)
[2]Alasdair Maclean, *Autonomy, Informed Consent and Medical Law: A Relational Challenge* (Cambridge University Press 2009) 150; Jonathan Herring, *Medical Law and Ethics* (4th edn, OUP Oxford 2012) 149.
[3]Mason, J.K.., et al (2002.). Law and Medical Ethics, Butterworths LexisNexis, London.

of good medical practice also requires a doctor to attain consent from a patient prior to a medical procedure.[4] The common law has established that all adults who have the capacity are permitted to consent or refuse medical treatment[5] and it is presumed that all adults are competent until proven otherwise.[6] There is also a canonical doctrine in common law stating that no one is allowed to express consent on behalf of an adult patient.[7]

Purpose of Inquiry and Inquiry Questions

This Conceptual Paper Aims to Achieve the Following Objectives

To analyse whether the current common law principles adopted as part of the MMC Guideline on Consent are sufficient to address the consent requirement of the incompetent adults.

To evaluate the current Malaysian statutory laws for any evidence of statutory provisions highlighting the subject of consent to medical treatment and if there are any, to appraise the adequacy of the provisions in dealing with the competency element in adult patients.

This conceptual paper aims to answer the following questions:

Whether the current common law principles adopted as part of the MMC Guideline on Consent are sufficient to address the consent requirement of incompetent adults?

Are there any evidence of statutory provisions in Malaysia highlighting the subject of consent to medical treatment and if there are any, how adequate are the provisions in dealing with the competency element in adult patients?

Rationale and Significance

The MMC Guideline on Consent[8] proclaims that attaining a patient's consent is a fundamental element of good medical practice which carries certain legal requirements. It is further enunciated by the aforesaid guideline that failure to attain consent prior to any medical or surgical procedure may engender a disciplinary proceeding to be carried out against a medical practitioner. This disciplinary jurisdiction was conferred on the Malaysian Medical Council (MMC) by the statutory provisions in the Medical Act 1971. Nevertheless, nonconformity with the guideline has no substantial legal consequences as the disciplinary punishments merely affect a medical practitioner's ability to practice medicine and do not include the sanction in criminal law for battery or, the payment of damages in tort law for trespass or negligence.

Furthermore, the Malaysian Medical Association (MMA) has promulgated a written Code of Medical Ethics that is intended to be observed by its members. Section II (Ethical Obligations of Doctors to the Patient) of the aforesaid Code clearly expresses the duty to obtain consent from patients as the paramount ethical principle that needs to be complied with by medical practitioners. It is underscored that it is the duty of a medical practitioner to provide sufficient information to ensure that a patient is able to make an appropriate decision concerning his/her medical treatment. Apart from the Code, the MMA also has espoused a Patient's Charter which comprises the rights and responsibilities of patients and one of the imperative rights explicated in the Charter is the right to adequate information and consent. Similarly, although the MMA has its own Ethics Committee that is vested with the authority to consider complaints by the public and its members and

[4]Kennedy, I., Treat Me Right(1988), Essays in Medical Law and Ethics, Clarendon Press, Oxford.
[5]Ibid (note 2)
[6][1992]] 3 WLR 782
[7]Jonathan Herring, Medical Law and Ethics (4th edn, OUP Oxford 2012) 149
[8] Malaysian Medical Council Guideline on Consent

consequently, its Constitution authorises it to dismiss any of its members who are found guilty of any wrongdoing, nonetheless, the Code of Medical Ethics and Rules of Ethics Committee are legally toothless.

It is acknowledged that in Malaysia, there is no specific or comprehensive statutory law on consent to medical treatment. One exception being cases involving mental health patients whereby the governing law is the Malaysian Mental Health Act 2001[9] which has specific provisions on consent. Nonetheless, this Act only applies to those suffering from mental illness and is discussed thoroughly in the later part of the study. Accordingly, a detailed research on this topic will further equip the Malaysian law makers with the relevant policies that require further implementation on informed consent doctrine. Furthermore, this study helps to identify the methods or approaches that can be established to ensure effective implementation of policy guidelines in the medical practice.

DELIMITATIONS AND LIMITATIONS

This conceptual paper is delimited by several elements. Firstly, the paper only reviews one historical period of the development of the informed consent doctrine. This is a delimiting because it excludes periods before the requirement was in place and other periods where the doctrine was being implemented. Secondly, the study exclusively concentrates on particular case laws and literature where the doctrine was being implemented. Lastly, the need to make adult patients to understand the importance of consent in the medical treatment and this is delimiting because we lack a comprehensive legislation imposing this. This conceptual paper has its analytic restraints, for example, this paper relies on data that has been published because of the inability to collect primary data on the topic. Another limitation consist of incapability to explore all the relevant literature pertaining to the topic due to time constraints and the reliance of this paper on data that have already been published because of the practical inability to collect data on the topic.

LITERATURE REVIEW

Historical Perspectives of Informed Consent

For consent to be legally and effectively valid, it must be informed in nature, given voluntarily, and the person giving the consent must possess the required capacity.[10] These crucial elements of valid consent are discussed further as follows:

Informed Consent

The doctrine of informed consent prescribes two duties on the medical practitioners; first, the doctor has the duty to disclose information, and second, the doctor is required to attain an informed consent from the patient. To further apprehend the notion of informed consent, firstly we have to examine its history of legal development. In Schloendorff v New York Hospital[11], Judge Cardozo wrote a statement in his judgement that provided the foundation for the doctrine of informed consent:

> Every human being of adult years and sound mind has a right to determine what shall be done with his own body; and a surgeon who performs an operation without his patient's consent commits an assault, for which he is liable in damages.[12]

[9]Mental Health Act 2001
[10]Farrell AM, Brazier M. J Med Ethics 2016;42:85–88. doi:10.1136/medethics-2015-102861
[11]211 N.Y. 125 (1914), overruled in part by Bing v. Thunig, 2 N.Y.2d 656 (1957).
[12]Ibid (note 12)

This statement emphasises the patients' right to autonomy and self-determination in making decision about their medical treatment. The term informed consent was first used in 1957 in *Salgo v Leland Stanford Jr. University*[13] where the court formed a conclusion that a physician who withholds any information from his patient which is incumbent in forming an intelligent choice concerning the recommended treatment is said to infringe his duty to his patient and has subjected himself to liability. The court in *Salgo* appeared to acknowledge the concept of therapeutic exception that is to be implemented at a doctor's discretion. Under this exception, with the intention of protecting the patient from physical or psychological harm and in the event where disclosure would cloud decision-making, a doctor could use some discretion to reveal only facts that are required to acquire valid consent.[14] The doctrine of informed consent necessitates that patients are provided with all the information that are material in decision-making and that patients have the power to consent or refuse any proposed treatment.[15] The term 'material' was defined in *Canterbury v Spence*[16] in 1972 whereby the court entailed a physician to divulge information that a sensibly prudent person would find material in making a decision as regards a proposed medical procedure (the 'prudent patient' test). However, it is worth noting that prior to *Canterbury*, courts in the US adopted the reasonable doctor standard of disclosure before heading towards the 'prudent patient' test.[17]

The decision in Sidaway v The Royal Bethlem Hospital[18]has laid down the paternalistic principle in disclosure based on the decision in Bolam v Friern Health Management Committee[19] which opined that the information to be revealed to the patient regarding the proposed treatment was a matter to be decided by the reasonable doctor, albeit Lord Scarman in his dissenting judgement were in favour of the 'prudent patient' test[20]. Nevertheless, a recent UK Supreme Court judgement in Montgomery v Lanarkshire Health Board[21] has finally overridden Sidaway by which it is now mandatory for doctors to take 'reasonable care to ensure that the patient is aware of any material risks involved in any recommended treatment, and of any reasonable alternative or variant treatments.'

The Bolam principle has long been abandoned by the Australian law and this view was confirmed in Rogers v Whitaker.[22] It was held in the judgement that the law should recognise that a doctor has a duty to warn a patient of the material risk inherent in the proposed treatment; a risk is material if, in the circumstances of the particular case, a reasonable person in the patient's position, if warned of the risk, would likely to attach significance to it or if the medical practitioner is or should be reasonably aware that the particular patient, if warned the risk, would likely to attach significance to it.

In Malaysian courts, the Bolam principle has been traditionally applied with regards to the doctor's duty to disclose information until the Federal Court's decision in Foo Fio Na v Dr Soo Fook Mun & Ors[23] which opined that the Bolam principle is no longer applicable to the duty of care of a doctor in advising patient as regards the inherent and

[13][1957], 154 Cal App 2d 560, 317 P 2d 170.
[14]Ibid (note 14)
[15]Emma Cave, "The Ill-Informed: Consent to Medical Treatment and the Therapeutic Exception' [2017] 46 Common Law World Review 140.
[16] 464 F 2d 772, 789 (DC Ci 1972).
[17][1985] AC 871, at [904] per Lord Templeman
[18] [1985] A.C. 871 (HL), 876.
[19][1957] 1 W.L.R. 582 (QB).
[20][1985] AC 671
[21] UKSC 1, 2015.
[22][1992] 175 CLR 479 F.C. 92/045.
[23][2007] 1 MLJ 593

material risks of the suggested treatment and held that the principle laid out in Rogers v Whitaker is a more favourable test for this millennium. The Federal Court's latest judgement in Zulhasnimar binte Hasan Basri v Dr Kuppu Velumani P & Ors[24] affirmed the decision made in Foo Fio Na as regards to the duty of disclosure in consent to medical treatment. The Malaysian Medical Council (MMC) Guideline on Consent states that the elements of informed consent comprise 'informing the patient of the nature of the proposed procedure, surgery, treatment, or examination, possible alternative treatments, and the potential risks and benefits of the treatment.[25],

Voluntariness

Voluntariness is an intentional, volitional, and deliberate act which is free from coercion and undue influence.[26] Any consent that is given out of any pressure is considered as invalid, and to determine whether any pressure is overt, an individual must have been affected to the extent that he can no longer be held responsible for his action. Nonetheless, the ever-changing standards, expectations and beliefs of the society are often taken into consideration in the determination of the point at which the influence is sufficient enough to compromise any voluntary consent.[27]

Lord Donaldson wrote at length with regards to undue influence in his judgement for Re T (Adult: Refusal of Medical Treatment)[28] whereby he expressed that a doctor should appraise whether a decision is really made by the patient in situations where persuasion of some third party is suspected. He further wrote that as long as the patient's independence was not overborne, then it did not really matter how powerful the persuasion was. He proposed a question that needs to be contemplated in this condition:

Does the patient really mean what he says or is he merely saying it for a quiet life, to satisfy someone else or because the advice and persuasion to which he has been subjected is such that he can no longer think and decide for himself? In other words, is it a decision expressed in form only, not in reality?

In this case, a pregnant young woman was brought to a hospital following her involvement in vehicular crash. She had communicated on various instances that she refused any blood transfusion and signed a refusal form. However, it was believed that her refusal was influenced by her mother, a Jehovah's Witness who came to visit her at the hospital. She subsequently gave birth to a stillborn baby and her condition worsened. Her father and boyfriend brought her case to the court seeking approval for blood transfusions for her and claiming that her refusal was under pressure by her mother. The Court of Appeal found that her refusal of blood transfusion was not her own decision due to her weakened state that led to the undue influence of her mother.

However, it has also been submitted that in many instances, the issue of consent given under undue influence or coercion is frequently difficult to be demonstrated as depicted in Mrs U v Centre for Reproductive Medicine.[29] In Mrs U, an amendment had been made by a man to a form for infertility treatment that he and his wife were receiving so that his

[24][2017] 1 MLJ 593.
[25]MMC Guidelines on Consent
[26] Robert M Nelson and John F. Merz, 'Voluntariness of Consent for Research: An Empirical And Conceptual Review' (2002) 40 Medical Care
[27]Alexander McLean, Autonomy, Informed Consent and Medical Law: A Relational Challenge (Cambridge University Press 2009)
[28][1992] 3 WLR 782
[29]Lloyd's Rep Med 259

sperm could not be used after his death. The man subsequently and unexpectedly died, and his wife claimed that the amendment was invalid because it was done under the pressure of a nurse. The Court of Appeal approved the statement made by the High Court and found it hard to claim that a bright and literate man with a responsible career and in good shape could have his volition overborne so as to cause him to be unable to make his own decision and it was held that the amendment was not to be considered as being tarnished by the undue influence of the nurse. It was stated that more than pressure is required to prove undue influence in this case.

Real Consent

Consent to a proposed procedure is inadequate except if it is 'real' in the sense that there must be a relation between the consent obtained and the act performed. This applies even in the situation whereby the doctor believes that the procedure or operation is in the best interests of the patient.[30] It was concluded in Mohr v Williams[31] that consent attained for an operation of the right ear did not make ineffective the liability for battery if the surgeon performs an operation on the other ear. The concept of 'real consent' was further demonstrated in Chatterton v Gerson[32]by which the court held that the plaintiff's consent was 'real' when she was informed in general terms of the nature of her procedure which was recommended and she consented to it. In Potts v NWRHA[33] a woman consented to what was labelled as post-natal vaccination when in fact she was given a form of contraceptive. It is obvious that the woman never consented to a treatment of contraceptive and as a rsult, her consent was not 'real'.

Competence

All adults are assumed to have competency to consent or refuse treatment unless there is contrary evidence. Lord Donaldson in Re T[34] opined that even though the law assumes that all adults are competent, the right to self-determination requires the competency in decision-making to be examined and the assumption of competence can be refuted. The common law has established several criteria in assessing whether a patient has competency in making decision about his or her medical treatment. In Re C (Adult: Refusal of Treatment),[35] the court arranged the decision-making process into three stages; first, understanding and retaining the treatment information; second, believing it; and third, weighing the information, and balancing risks and needs to finally arrive at a decision. Applying the process in this case, the court held that the right of C's self-determination had not been overridden. Even though C's general capacity was undermined by schizophrenia, it had not been ascertained that he did not adequately understand the nature, purpose and consequences of the treatment that he refused. It was concluded that he absolutely comprehended his situation and had arrived at an unequivocal decision.

Following Re C, the Law Commission adopted the criteria established in Re C but recommended that the 'belief' requirement be dismissed as it was found to be unnecessary to the requirement that the person must be able to use the information.[36] The suggestion to disregard the 'belief' component in Re C was observed by the Court of Appeal in Re MB[37]

[30]Ibid (note 26, page 7)
[31][1905] 104 NW 2
[32][1981] 1 All ER 257
[33][1983] QB 348
[34][1992] 3 WLR 782
[35][1994] 1 WLR 290
[36]Law Commission, *Report on Mental Incapacity* (Law Comm. No. 231, 1995) para 3:;17; Alasdair Maclean, Autonomy, Informed Consent and Medical Law: A Relational Challenge (Cambridge University Press 2009) 154-155

where the court stated that elements that should be taken into consideration in determining capacity are: whether the patient can understand and retain the information material to the decision (especially information pertaining to possible repercussions of accepting or refusing a proposed treatment), and whether the patient is able to use the information and weigh it in the balance to arrive at a clear decision. The legal test proposed in Re MB was fundamentally implemented in Section 3(1) of Mental Capacity Act 2005.[38]

In Malaysia, a child is considered as incapable of giving consent for medical treatments. Anyone below the age of 18 is considered a minor under the Age of Majority Act 1971[39] and parents' consent in medical treatment will be deemed as indispensable. Similarly in the United Kingdom, the age of majority is 18 and consequently, those with parental responsibility can consent or refuse the medical treatment of the minor as accorded in the Child Act 2001.[40] Nonetheless, the position of consent involving a minor who is 16 years and above is explicated in the case of Gillick v West Norfolk and Wisbech Area Health Authority in the United Kingdom.[41] In this case, a mother of five daughters whom are all below sixteen wanted to obtain a declaration from the court so that doctors would not prescribe contraceptives to minors without the knowledge and consent of parents but the court declined to grant this declaration. Lord Fraser in this case stated that so long as the minors have the capacity and intelligence to understand the purpose of contraceptives and that it is in their best interests to receive them, then contraceptives can be given to minor girls even without parental consent. This is supported by the Article 12 (1) of United Nation Convention on the Rights of the Child (UNCCR)[42] which states that a child must be given rights to consent to medical treatment provided that the minor has the maturity and intelligence to understand the nature and implications of proposed medical or surgical procedures. To date, there is no decided case law that deals with the matter of Gillick competency in Malaysia. It is also worth noting that although a female minor in Malaysia is legally married, she is still considered to have no capacity to consent to medical treatment and her spouse who is akin to a legal guardian will consent on her behalf.

Applying the above principles, consent in infant medical treatment by doctors shall be granted by infant's legal guardian as provided under the Guardianship of Infants Act 1961.[43]Whilst the Law Reform (Marriage & Divorce) Act 1976[44] states that the parental responsibility for a child does not alter, albeit there are changes in the relationship status of a husband and a wife. Therefore, even when the parents are separated, those with parental responsibility are responsible for the child's medical treatment and consent from either parent is adjudged to be sufficient. In the case of Airedale NHS Trust v Bland,[45] Bland, who was a minor and a supporter of Liverpool Football Club, was caught up in the Hillsborough crash leading him to permanently remain in the persistent vegetative state. He was clinically unconscious and dependent on life support machines for three years. Subsequently, the hospital with the consent of his parents applied for a declaration to terminate his life support machines whereby it was granted because the court opined that continuing further treatment was not in the best interest of Bland even though, Lord Goff in his judgement reinstated that euthanasia is unlawful according to common law.

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[37] [1997] 2 FCR 541
[38]Mental Capacity Act 2005
[39] Age of Majority Act 1971
[40] Child Act 2001
[41][1986] AC 112
[42]UNCCR Declaration on the Rights of the Child
[43]Guardianship of Infants Act 1961
[44]Law Reform (Marriage & Divorce) Act 1976
[45] [1993] AC 789 HL

The MMC Guideline on Consent[46] states that patients are incapable of consenting if they are emotionally immature, highly stressful or suffering from Alzheimer's disease or Post Traumatic Stress Disorder (PTSD) since those conditions would impair a person's decision-making ability. Essentially, it means that if a patient is mentally ill by virtue of diminished responsibility, such as having battered woman syndrome and cannot consent to any medical treatment, then the next of kin, the spouse or a legal guardian appointed by a court as a deputy or a donee can consent for the patient's medical treatment. In the case of F v West Berkshire Health Authority,[47] the mother of a thirty-six-year-old woman whom had a mental age of a minor sought a court declaration to sterilise her daughter to prevent pregnancy and the court granted this declaration and held that the sterilisation is in the best interest of the patient and so is lawful.

METHODOLOGY

This conceptual paper is based solely on a review and analysis research of information from the medico-legal literature and the reported cases in the medical practice. Several methods were used to collect and analyse the literature. The search was conducted by Google Scholar engine and online journals. The approach of the proposed study is influenced by the nature and availability of information which was obtained from reported case laws, statutes and academic books available in the library. The methodology of the current study is oriented towards ensuring a thorough systematic search for information adopting a search criterion that is replicable and transparent. In the present study, attention is directed towards reliability and credibility of claims contained in the sources. Furthermore, the information found in the included sources is synthesised to find research evidence that could inform the decisions of policy makers.

DISCUSSIONS

The common law derived from Re F (Mental Patient: Sterilisation)[48] stated that a doctor can lawfully treat or perform an operation on an incompetent adult patient based on the principle of necessity as long as the treatment or operation is given in the 'best interests' of the said patient. In Re F, the patient was a mentally disabled woman who had a general and verbal mental capacity of a small child. She had been a voluntary in-patient at a mental hospital since she was 14 years of age and subsequently developed a sexual relationship with a male patient. Her doctors were of the opinion that she would not be able to cope with pregnancy and child birth due to her disability and due to the fact that other methods of contraception were not suitable for her and it would not be appropriate for the staff to prohibit her activity, it was deemed necessary in the patient's best interest for her to be sterilised. Her mother sought a declaration that the absence of her consent would not make sterilisation on her an unlawful act. The court granted her mother's declaration and it was lawful for the doctors to operate on her without her consent. The situation in this case was equated to an accident where it is necessary to provide medical treatment to unconscious victims. The court also asserted that the declaration granted does not imply that the act becomes lawful because the court has given its consent, but rather it is lawful by the merit of principle of necessity.[49] However, an important question that needs to be contemplated is 'how do we establish what is in the patient's best interests?' The common law seems to provide four different definitions of 'best interests'; best interests as determined by the patient's clinical needs, best interests by looking at a subjective assessment of the patient's social and welfare issues separately and following the doctor's determination of 'best medical interests', best interests as an objective evaluation of

[46] MMMC Guidelines on Consent
[47] [1989] 2 AC 1
[48] [1990] 2 AC 1
[49] [1990] 2 AC 1

what the 'reasonable' patient prefers if the patient views are unknown, and best interests as a combination of clinical and welfare preferences.[50]

In the United Kingdom, the common law modalities in the treatment of incompetent patients have been supplanted by the Mental Capacity Act (MCA) 2005[51]. The Act states who can make decisions on behalf of incompetent patients, in which situations, and how to approach the situation. Section 15 of MCA 2005 states that the court is given the power to make declarations as regards the lawfulness of any proposed act and they should take into consideration the criteria in establishing the best interests of the patient which is provided in Section 4. Section 4(4) clearly expresses that as far as practicable, the participation of the patient in question in decision-making should be encouraged. Furthermore, Section 4 (6) of the said Act states that in ascertaining what is in the best interests of a patient, there are three elements that should be taken into account; 'the person's past and present wishes and feelings, beliefs and values that would likely to influence his decision if he had capacity, and the other factors that he would be likely to consider if he were able to do so. It is submitted that a complicated situation may arise if there are conflicting views between the patient's past and present wishes since there are difficulties in determining an incompetent patient's present wishes.[52] It is also paramount to consult anyone named by the patient to be consulted on the issue at hand, anyone involved in the caring of the patient, anyone with particular interest in his welfare, any donee of a lasting power of attorney granted by the person, or any deputy appointed for the person by the court in establishing what would be the best interest of the patient. The Act also incorporates the Independent Mental Capacity Advocate (IMCA) where a person is appointed to support an incompetent patient who has no one to speak on their behalf, advance decisions to refuse treatment in the future if a patient should become incompetent (nonetheless, an advance decision is considered futile to any treatment which is considered necessary to save a patient's life, unless the advance directive is done in strict formalities with an express statement of 'even if life is at risk'), and a criminal offence of ill-treatment or neglect of incompetent patient.[53]

The MMC Guideline on Consent expresses that the procedure for emergency treatment or management is to be complied with for patients who are incapable of, or impaired with decision-making ability, and in an emergency to save life. Whilst consent for incompetent patients in a necessary elective or non-emergency operation is to be obtained from a relative, next-of-kin, or legal guardian after the relationship is established.[54] Meanwhile, according to Mental Health Act 2001, consent is not usually required for conventional treatment as stipulated in that Act except when the patient is planned for surgery, electroconvulsive therapy, or clinical trials. Consent in those situations may be given by the patient himself if he is competent after an assessment is performed by a psychiatrist, or by a relative if the patient is an incompetent adult or by two psychiatrists, one of whom shall be the attending psychiatrist, if there is no relative available and the patient himself lack the capacity to give consent.[55]Further, analysis on the laws reveal no evidence of specific and comprehensive statutory provisions on consent to medical treatment except for Mental

[50]Helen J. Taylor, 'What are "Best Interests"? A Critical Evaluation of "Best Interests" Decision-Making in Clinical Practice' [2016] 24 Medical Law Review 176
[51]Mental Capacity Act (MCA) 2005
[52]Mental Capacity Act 2005
[53]Ibid (note 42)
[54]MMC Guidelines
[55]Ibid (note 44, page 12)

Health Act 2001 which principally deals with those suffering from mental illness. Regardless, the English Common Law is applicable in our country in situation pertaining to consent to medical treatment where there are no written laws or statute.[56]

CONCLUSIONS AND RECOMMENDATIONS

This paper has explored the challenges faced by clinicians in attempting to make decisions in the best interests of their patients whilst obtaining consent without impartiality. The MCA 2005 has drawn attention to the need for decision makers to consider a range of issues wider than the patient's clinical interests, yet provides insufficient guidance on how the statutory principles should be applied in practice. The process is fraught with difficulties which prove to be challenging for the courts and more so for the clinician who lacks the same legal understanding. Consent to medical treatment lies at the root of the relationship between a doctor and his patient and must be given voluntarily by a patient who has the capacity to do so, after receiving adequate information in order for it to be a legally valid consent. Failure to obtain the consent of a patient before medical treatment will expose the doctor to criminal sanction for battery, or civil suit whether for trespass or medical negligence.

The law has accorded a patient with the right to make his own decision whether to give consent or to refuse to give consent regardless of whatever reason, be it rational or irrational. The most important thing is to ensure that the patients must be allowed to exercise their rights and this includes the right to make an advance decision regarding their medical treatment. Decision to give consent to medical treatment or to refuse to give consent in the event where the patient had become incapacitated must be communicated to the doctor/s and this can be achieved by way of an advance directive. It is our suggestion that there should be a specific Act addressing this issue. Malaysia can take the first step towards reforming this area of law by looking at the recent legal development of its neighbouring country, Singapore regarding consent to treatment involving incapacitated patients and advance directive. Singapore had passed two crucial statutory laws with the titles of Mental Capacity Act (Chapter 177A, 2010 Revised Edition) and Advance Medical Directive Act (Chapter 4A, 1997 Revised Edition) to deal with matters pertaining to incapacitated patient and advance directive respectively. As a conclusion, consent is a concept that forms the basis of the autonomous right of the patient to make his own decision. Kennedy summed it up perfectly when he opined that "consent, which lies at the root of self-determination, should be the conceptual mechanism whereby the right is guaranteed and safeguarded.[57]

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The author(s) declared no potential conflicts of interest with respect to the research, authorship, and/or publication of this article.

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[56]Mental Health Act 2001
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