

INDIVIDUALISM IN THE CONTEXT OF MEDICAL TREATMENT

Mohd Zamre Mohd Zahir^{1*}, Tengku Noor Azira Tengku Zainudin¹, Ramalinggam Rajamanickam¹, Abd Halim Sapani², Muhamad Sayuti Hassan @ Yahya¹, Ahnaf Ahmad³, Rozlinda Mohamed Fadzil¹, Rachel Decruz¹ & Nor Afandi Mohd Sohime⁴

¹Faculty of Law, Universiti Kebangsaan Malaysia (UKM), 43600 UKM Bangi, Selangor, Malaysia

²Prince Mohammed bin Abdul Aziz Hospital, 40740 Madinah, Saudi Arabia

³Jabatan Kehakiman Syariah Negeri Terengganu, Aras 5, Bangunan Mahkamah Syariah, Jln. Sultan Mohamad, 21100 Kuala Terengganu Terengganu Darul Iman

⁴Messrs. Syazwan Norasikin Hilmi & Associates, Suite 25A.03A, Level 25, Johor Bahru City Square Office Tower, 106-108, Jalan Wong Ah Fook, 80000, Johor Bahru, Johor

*Corresponding author email: zamre@ukm.edu.my

Abstract: *The common and individualistic understanding of autonomy is that an individual has the right to exercise his autonomy for medical treatment. In contemporary decades, this pattern has been faced in numerous disciplinary and intellectual ways. In particular, the problem here is that advocates of autonomy have argued that the personalities, desires, preferences and indeed autonomy of individuals are almost often influenced by their relationships with others including doctors. There is a problem for individuals who have suffered from COVID-19 to implement their autonomy in making decisions about medical treatment. Therefore, in the sense of medical practice, this article seeks to examine and address problems relating to the concept of patient autonomy. The methodology engaged in this article is qualitatively based. Autonomy is essential because the patient needs to make sure that he or she is actively involved in the medical treatment, and not just bow to his doctor. As a result, we can see here that patients may be quite experienced about their illnesses, but they commonly do not know the entire picture of it. Good Health and Well-being (Sustainable Development Goal 3) enables individuals to continue to do what they value, retain the ability to make decisions, preserve their independence and uphold their own autonomy. However, the most important thing is whether there is enough autonomy in medical practice and whether the autonomy of the patients must be respected. This article suggested that it is important to have clear guidelines and laws with regard to patients in Malaysia including those who suffered from COVID-19 since the guideline and laws with regard to this principle of autonomy i.e. to make decisions for medical treatment is still unclear. It is suggested that it is incumbent for the government to prepare a policy response to address the needs of hospital resources and the economic aspect too.*

Keywords: Autonomy, COVID-19, economy, medical law, Sustainable Development Goal 3.

Introduction

Is there a limit to a patient's autonomy when it comes to medical treatment decisions? A problem like this needs the doctor to deal with it on a regular basis. The goal is to shift care in the proper direction by working with patients and their representatives who are making medical

treatment decisions. How much control should patients have over their medical treatment decisions? Is not the reaction obvious? ‘As much control as possible,’ would be the most spontaneous response. Why would not a patient want to be in charge of his or her medical treatment? When could a patient’s ability to make medical treatment decisions be limited? Autonomy is one of the main principles in many parts of the world that drive clinical practice and study (Beauchamp TL & Childress, 2013). Beauchamp and Childress established the other three standards of clinical ethics which are the well-known principles of non-maleficence, beneficence and justice. At the same time, autonomy comes closely linked to an especially western post-enlightenment concept of an adult person as a restricted individual, who can live his life freely and preferably independently of the control of influences in accordance with his self-elect strategy (Macfarlane, A, 1978).

In the field of medicine, at the start of the mid-20th century, the concept of personal freedom had been raised as a cornerstone of medical ethics. The epitome of personal freedom is a patient in the field of Western biomedicine expressing a decision he or she made independently (Edward S Dove, et. al., 2017). Summarised in words from a respected American judge Benjamin Cardozo, the value of this understanding of autonomy was referring to: any person with a good mind and an adult has a right to decide what to do with his or her body; a surgeon who carries out an operation without the permission of the patient commits an assault as per mentioned in the case of **Schloendorff v New York General Hospital** (1914) 105 NE 92. Not only that, for example, according to Charles, procedures in the mortuary and for the postmortem of a person also emphasize legal and medical ethics aspects (Charles A., 2021).

A very individualistic approach to autonomy is regarded by many inside and outside the field of medicine as an optimistic growth, which “serves as a corrective to the highly paternalist relationship between doctors and patients.” (Katz, J., 2002, 1984). Apart from the fundamental role of individualism in West conceptualization, individualistic autonomy, especially in law, has practical advantages. For example, King and Moulton have argued that individualist autonomy offers an appealingly simple formula for patient autonomy by creating an apparently straightforward rule for how and by whom to make decisions (e.g., by the affected patient or participant) (Edward S Dove, et al., 2017).

According to Tengku Noor Azira Tengku Zainudin et al., the patient has a right under the principle of patient autonomy that is recognized by law to determine for himself whether or not to give consent, rationally or not, irrespective of the cause (Zainudin, T. N. A. T., et al., 2015). The most crucial part is to ensure that patients are able to implement their rights, including the right to make an early decision on their medical treatment. Under the principle of patient autonomy recognized by law, a patient has the right to make his own decision whether to give consent or to refuse to give consent notwithstanding of whatever reason, rational or not. The most essential thing is to ensure that the patients must be permitted to exercise their rights and this includes to right to make an advance decision regarding their medical treatment (Zainudin, T. N. A. T., et al., 2015).

The fact is even an expert who becomes a patient may lose objectivity about specific details of treatment. It is the responsibility of the doctor or healthcare professional who is proposing treatment to provide the patient with all appropriate details so that he or she can make an informed decision. Aside from that, the patient is often in a state of illness that makes

completely deliberative decision-making daunting at best. The patient may be in pain, emotionally traumatised, or otherwise incapable of making a fully unemotional, and rational decision. So, when it comes to a patient's autonomy in making medical treatment decisions, autonomy is limited when practising it causes or may cause harm to others. When harm to others is sufficiently grave, it overrides the principle of autonomy.

Materials And Methods

This article adopted a pure legal research methodology by using qualitative analysis on the autonomy in medical practice and research. By using content analysis, this article analysed the data on autonomy's context with regard to medical treatment. Referring to Krippendorff (2004), analysis of content can range from simple word counting to thematic analysis or conceptual analysis. Content analysis is a research method for determining the existence of specific words, topics, or concepts in qualitative data (i.e. text). Authors can quantify and analyse the presence, meanings, and relationships of specific words, themes, or concepts using content analysis (Columbia University Irving Medical Center, 2019). Authors, for example, can assess the language used in a news, article and documents to look for prejudice or partiality. Authors can then deduce information about the texts' meanings, the writer(s), the audience, and even the culture and time period in which the text was written (Columbia University Irving Medical Center, 2019).

Individualism In The Context Of Autonomy

Robert Audi characterizes autonomy as an autonomous means of control to provide justification for controlling and manipulating one's attitudes (Audi, Robert, 2001). This inspiration can be contained in a corresponding practical judgment, an internal role known as motivational internism, or can come to a practical judgment externally as a wish, regardless of the judgment (Audi, Robert, 1991). Besides that, when we are focusing on autonomy, there is an aspect of medical paternalism that we need to highlight. Medical paternalism is a collection of medical beliefs and procedures in which a doctor decides that the wishes or choices of a patient should not be honoured. Throughout the early to mid-20th century, these practises were present and were marked by a paternalistic approach and a lack of respect for patient autonomy (Brennan, Troyen, 1991). Paternalism has been restricted in recent years, and blind trust in doctors' decisions has become frowned upon (Medical Protection Society Limited, 2017). Therefore, the autonomy principle is used to determine patient's decision over the doctor who wanted to make decision for his or her patient.

Jennings (Jennings, 2007) and Griffin (Griffin, 2008) draw a distinction between autonomy as it relates to concerns of free will and autonomy as it relates to political freedom within a community to act without interference from third parties or the State (Berlin, 1969). We separate the notions terminologically by adopting their methodologies. For our purposes, autonomy refers to the ability to choose one's own actions, therefore an "autonomous agent" is someone who has that ability, and liberty refers to the ability to act without the intervention of a third party. As a result, a prisoner may have a high amount of autonomy while having severely limited liberty, while a person with a low "mental age" may have a low level of autonomy while potentially having a lot of liberty. Importantly, interference with liberty can occur through both omissions and actions. The controllers of a public building with no wheelchair access, for example, have not deliberately interfered with wheelchair users' liberty to enter, hitherto there is nevertheless an interference with liberty (Coggon & Miola, 2011). Interfering with liberty necessitates some sort of agency, and appropriate safeguards to promote liberty are

not restricted to “negative obligations” to merely leave individuals alone, as is the case in law (Griffin, 2008).

Previously, Malaysia’s Temporary Measures for Reducing the Impact of Coronavirus Disease 2019 (COVID-19) Act 2020 (COVID Act) was gazetted and came into force on 23 October 2020. The COVID Act will take effect on 23 October 2020, for a period of two years, or in compliance with the date or term of the applicable sections of the Act (Saritha Devi Kirupalani, 2021). One of the measures taken by the Malaysian government to assist individuals and businesses affected by the COVID-19 pandemic is the COVID Act. Its goal is to reduce the pandemic’s impact. Parties’ failure to perform contractual responsibilities as a result of steps taken under the Prevention and Control of Infectious Disease Act 1988 and in such a situation are described in Part II of the COVID Act, the innocent party will not be entitled to exercise their rights, post 23 October 2020 as per the COVID Act.

The COVID Act has worked to fix as many facets of the pandemic as possible. However, the measures have been criticised as being too little and too late to relieve the pressure created by the pandemic (Saritha Devi Kirupalani, 2021). Despite the fact that various changes to Malaysian legislation are commonly apply retrospectively, the savings provisions mentioned above have the effect of watering down their intended purpose. Nonetheless, in these unprecedented times, the introduction of the COVID Act is a step in the right direction. Following the implementation of the Act, additional amendments may be required to improve or add to the prescribed steps for resolving the various issues that arise as a result of the pandemic.

Act 342, the Prevention and Control of Infectious Diseases Act of 1988, may be of assistance. This is a law that regulates the prevention and control of infectious diseases. Any disease listed in Part II of the Act’s First Schedule is considered an infectious disease. COVID-19, obviously, is not on the list. Nevertheless, under the said schedule, this new disease could be classified as “any other life-threatening microbial infection.” If the Minister of Health is satisfied that there is an outbreak/threat of an epidemic of any infectious disease in any area in Malaysia, Section 11(1) of the Prevention and Control of Infectious Diseases Act 1988 applies, the Minister may by gazette declare that area to be an infectious local area. However, Malaysia’s Temporary Measures for Reducing the Impact of Coronavirus Disease 2019 (COVID-19) Act 2020 and the Prevention and Control of Infectious Diseases Act 1988 seem lack of a notion with regard to patient’s autonomy towards medical treatment.

John Stuart Mill first developed the individualistic concept of autonomy as enlightened self-determination in his 1869 essay *On Liberty* (Mill, JS, 2015). Mill emphasizes the value of autonomy and originality when he claims that it is really important, not only what men do, but also the manner to do it (Scarre, G., 2007). His focus seemed to be on the value of being a certain way, rather than the value of experiences (Scarre, G., 2007). Individual autonomy is an idea commonly understood to refer to one’s own ability, to live one’s own lives in a manner that is understood to be own and not to be created by external manipulation or distortion or damage. This individualistic notion strongly affects a popular conception of the autonomy of bioethics, not least because in the heartland of individualistic self-reliance some of the most early and strongest bioethics institutions were born (Jonsen, A, 2003). It is heavy emphasis on personal independence, the conceptualisation of personal autonomy is negative freedom in biological ethics, namely free intervention (Berlin, 2002, 1958), plays a central role, rather than the ‘positive’ conditions and circumstances that people need to be in place to lead safe,

dignified and meaningful lives. The most important form of the autonomy is do no harm to others. An individual cannot harm the other as to fulfil his desire (Mill, JS, 2015). The principle of do no harm is a popular theory in Mill's text book.

This is relevant to our legal analysis insofar as the issues become political rather than solely moral in nature (Coggon & Miola, 2011). It may seem strange that Kant's concerns are relevant in the metaphysics of free will, but it is clear that there is what Geuss describes as a "strong 'Kantian' strand" (Geuss, 2008) in contemporary political philosophy in general, and medical law in particular (Veitch, 2007), or in Gray's terms, a pursuit of "the ideal of rational consensus" (Gray, 2000). This can be seen though their projects are markedly unlike, Geuss and Gray assume a Hobbesian perspective to express their dissatisfaction with the dominance in political philosophy of (as they see it) misplaced faith in the relevance, applicability, and potency of such unitary, "rationalised," abstract theorising, typified most forcefully for them in Rawls' influential theory of justice (Rawls, 1999).

The consequence of conceptualising (something approximating) the Kantian abstraction of a person, deducing what kind of rights, obligations, etc., it would have, and then formulating notions of the legitimate State or laws and institutions around these is disputed to be challenging. This is true both practically and conceptually since it contradicts the type of moral pluralism that is present in the world that the theory would be 'applied' in (Coggon & Miola, 2011). We leave ourselves with a concept that is unassailably established in an exclusive rationality by wedding autonomy with rationality, as Kantian theory does, and then wedding this to prescriptive social norms (Coggon & Miola, 2011). There are two related ramifications of this, which are at the heart of the legal issues surrounding mental ability. First, a practical truth about what options are considered free is established, implying paternalistic worries that people should only be free to do what is right, with political structures and legal processes in place to ensure this. Gray's fears (unsurprisingly) echo those of Berlin in this regard (Berlin, 1969). Tensions emerge over the extent to which people should be permitted to act "irrationally," as well as how rationality is produced in the first place. Second, because theories based on "rational consensus" can be traced back to a single, exclusive moral theory, they serve as practical denials of moral pluralism, according to Gray. They believe that a single ethic is the morally and socially desirable objective that governments and 'rational citizens' should strive toward (Coggon & Miola, 2011).

Many people are effectively denied the power of choice as a result of an overabundance of concern about rationality, which narrows the available possibilities even further. Too much concern for liberty, on the other hand, makes everyone a slave to ignorance (unwisdom) (Coggon & Miola, 2011). In terms of medical law, autonomy demands a focus on ensuring that an agent has the rational acumen (mental capacity) to make a decision, whereas liberty demands a focus on demonstrating that she is in the rightful position to make a decision (legal capacity) (Bielby, 2005).

Analysts who interpret autonomy to entail self-government in a broad sense prefer to focus on the purity of agency involved in decision-making (Gillon, 2003). There is a concern not only about one's ability to reason, but also about one's ability to utilise reason effectively. We measure the quality of a person's exercise of autonomy by the soundness of her reasoning, given her own values, (Ronald Dworkin, 1993) if we are value-agnostic, as medical law requires of healthcare practitioners when it mandates that the substance of, or "rationality" underneath, a patient's choice not be questioned (Re T (Adult: Refusal of Treatment) [1993])

Fam. 95; sections 1(4) of Mental Capacity Act 2005 (United Kingdom)).

The exercise of reason is therefore essential to autonomy, and a sound foundation of information and comprehension is essential to reasonable thinking. It is commonly agreed that increasing people's ability to make independent judgments is a desirable thing (Coggon & Miola, 2011). Belief in autonomy permits us to engage with ourselves as moral notions, applying praise, blame, just desert, and just reward to ourselves. It provides for responsibility, with all the benefits and drawbacks that entails. Although abnegation or denial of autonomy is occasionally beneficial, free will is generally a good thing to take for granted (Alper, 1998). It enables people to accept or have responsibility forced on them, as well as society to build and sustain institutions based on notions like justice. And it appears to be something that the majority of people take for granted (Coggon & Miola, 2011).

Respect for self-government is closely associated with the value of privacy and consent, notion or practice in the form of clinical practice and study (Maclean, A., 2009). Onora O'Neill summarized that the duties of the patient to be divulged, to be given permission, confidentiality, and to preserve the privacy of patient autonomy are defined primarily (and maybe exclusively) by the principle of respect for autonomy (O'Neill, O., 2002). The informed consent functions as a procedure by a person who lawfully uses his autonomous power to authorize or deny another person to act on or in connection with him (Zainudin, T. N. A. T., et al., 2015).

Therefore, the principle of autonomy should be respected. However, when harm to others is sufficiently grave, it overrides the principle of autonomy. It is because by harming others it will cause more danger occurs. For instance, if a patient wants to get treatment by harming others such as by taking his or her internal organ without his or her consent might cause great danger to the said person. Not only that, the doctor who assisting the patient to perform such action can be sued according to law by harming others. So, this situation cannot be cooperated since it will cause harm to others.

Sustainable Development Goals 3 (SDG) and ASEAN

The Sustainable Development Goals (UN SDGs, sometimes known as the Global Goals) are a collection of 17 goals with 169 targets that all UN Member States have committed to achieving by 2030 (World Health Organization, 2021). They outlined a vision of a world without poverty, hunger, or sickness. In SDG 3, "Ensure healthy lives and promote well-being for all at all ages," health takes centre stage, underpinned by 13 targets that cover a wide spectrum of WHO's work (World Health Organization, 2021). Sustainable development necessitates the adoption of healthy lifestyles and the promotion of well-being by people of all ages. COVID-19 is wreaking havoc on the world's economy and disrupting the lives of billions of people. The right to health and principle of autonomy corresponds with SDG3 as it brings healthcare as close as possible to where people live and work, and constitutes a crucial element of an ongoing healthcare process. With the rapid spread of COVID-19, the Malaysian Government is closely monitoring the chain of positive cases whilst upholding the principle of patients' autonomy. Meanwhile, a number of ASEAN Member States (AMS) have seen a substantial drop in extreme poverty over the years, as well as an increase in middle-class populations and healthcare spending (ASEAN, 2017). Ageing populations, sedentary lifestyles leading to obesity, and other non-communicable diseases are all contributing to increased healthcare spending, as well as the susceptibility to more persistent and potentially pandemic infectious diseases. This pattern indicates a growing need for improved healthcare systems in AMS, and suitable policies must be put in place to ensure that more people have access to safe, affordable,

quality, and holistic care (ASEAN, 2017).

Through three areas of emphasis, the ASEAN Health Cluster 3 aims to promote health systems and access to care. (a) Developing national policies and regulations for ASEAN people, including vulnerable groups, to increase access to safe, affordable, and appropriate services, technology, essential drugs and vaccines, traditional and complementary medicine; (b) advocating for appropriate levels of health resources including human resources for health (HRH) and health financing; and (c) improved communication, knowledge management, and information exchange, as well as Research and Development (R&D) and innovations (ASEAN, 2017).

For instance in Singapore, Consultants Jeremy Lim and Manav Saxena also reported that “in an analysis of admissions to a large restructured hospital by the Department of Economics at National University of Singapore, it was found that nearly half the elderly had tapped into their children’s Medisave accounts to pay for their hospitalisation expenses” (Lim, J. & Saxena, M., 2015). According to a Mindshare survey conducted in 2012, 72 percent of Singaporeans say they “cannot afford to become sick these days due to hefty medical costs” (One Singapore, 2021). Singapore's healthcare system is world-class (One Singapore, 2021). However, cost is a concern, and access to medical subsidies can be difficult.

Given how badly the pandemic has damaged businesses in Indonesia, the involvement of non-state actors such as the private sector is difficult to foresee. However, the pandemic should not be used as a reason to abandon efforts to meet SDG targets by 2030. COVID-19, on the other hand, gives us the option to do more to meet our goals. For one thing, the health crisis has taught us how to live a healthy lifestyle, as well as how to care for and share with others - a mindset shift that is critical to achieving SDG targets. The pandemic has also demonstrated that everyone is on an equal footing. COVID-19 affects both men and women, young and elderly, wealthy and poor; the epidemic has thrown us all into the same boat. Other benefits of the pandemic include increased global cooperation and strengthened science-based decision-making, both of which offer states with a great opportunity to meet their SDG targets (Zuzy Anna, 2020).

In Malaysia, it is critical to safeguard patient autonomy, particularly in situations where the patient wishes to make decisions about his or her medical treatment. Medical experts in Malaysia have warned that the rising number of COVID-19 cases in the country could lead to a serious shortage of health resources, putting lives at risk (Tharanya Arumugam, 2020). As a result, it's critical to boost the Ministry of Health's resources, which include COVID-19 test kits and personal protective equipment (PPE) to protect workers from infection. Advanced cancer patients who are fragile and disabled should be given aggressive medical treatments near the end of life (Amy Case, 2020). These aggressive medical treatments often include Intensive Care Unit (ICU) and mechanical ventilation for the patients that have a low (and often zero) chance of survival.

The Millennium Development Goals were focused on a small set of disease-specific health targets for 2015, whereas the Sustainable Development Goals are far broader in scope and look to 2030. For instance, the SDGs take account of a broad health goal, “Ensure healthy lives and promote well-being for all at all ages”, and call for achieving universal health coverage.

World Health Statistics 2020, WHO’s annual snapshot of the world’s health, states

among others:

- The world's population is living longer and healthier lives. Between 2000 and 2016, global life expectancy and healthy life expectancy (HALE) both grew by over 8%, and income continues to have a significant role.
- Between 2000 and 2017, overall access to critical health care improved, with the greatest gains in low- and lower-middle-income nations. Nonetheless, service coverage in low- and middle-income countries remains well below coverage in wealthier ones.
- In comparison to advances in communicable disease prevention and control, there has been inadequate progress in preventing and controlling non-communicable diseases (NCD), particularly in low and middle-income countries, where delivery of effective NCD interventions remains a vast challenge to health systems;
- Investing in country health information systems to increase data timeliness could have the biggest impact and is critical for governments to track progress toward the SDGs. For almost a fifth of countries, over half of the indicators have no recent primary or direct underlying data;
- Major infectious disease prevention and treatment coverage, as well as maternity, neonatal, and child health care, have all improved significantly in the last two decades, resulting in a continuous drop in disease incidence and mortality. The current rate of change, however, is insufficient to meet the 2030 SDG targets, and COVID-19 risks putting the world even more off track to meet the SDGs.

Result And Discussion

It is very important to preserve the autonomy on the basis of protecting the principle of autonomy. An awareness that patient autonomy is especially fragile underpins the inclusion of compliance with autonomy in biomedical ethics as a core concern (Beauchamp, TL & Childress, 2009). Compliance with autonomy in healthcare environments tends to rely upon situations where decision making relating to medical care treatments is required. A theory of maintaining autonomy is also used in debates on confidentiality, faithfulness, privacy and truth-telling (Beauchamp, TL & Childress, 2009), however, it is most closely linked to the notion of enabling or authorizing a patient to make autonomous and independent health care decisions (Walker RL., 2009). The influential concept of Beauchamp and Childress defines independent decisions as those taken consciously and with significant awareness and independence from influences (Beauchamp, TL & Childress, 2009).

However, the following questions are of crucial in terms of autonomy application in practice: What are a person's limits? Will there be any external criteria set around these boundaries or must there be? Can we consider the relationship's aspect towards autonomy are only relationships relating to the patients' families, friends and others, or does healthcare professional (such as doctor, nurse) or the researcher also count? If that is so, what in reality does this look like? In addition, can autonomy be operationalized in legislation that at least in the East or West, has formed one body, one mind, and one person through methodological individualism? Simply put, as research participants, patients, doctors, academics, politicians and as people, what will autonomy do for us? In medical practice and research, very few attempts were made to transform individualist conceptions of autonomy into new decision-

making methods and techniques in rich and nuanced theoretical critique.

In the UK Supreme Court decision of **Montgomery v Lanarkshire Health Board** [2015] UKSC 11 recognizes that it is the responsibility of doctors to take adequate care so that the patient knows about any “material risks” involved with any treatment. “Material risks” can apply either to (a) risks expected to be attached as a reasonable individual in the patient’s role, or (b) to risks reasonably aware that the particular patient is expected to have importance (Herring, J., 2016). The **Montgomery case’s** decision still gives rise to the question of consent with regard to the individual patient and his decision-making ability, in spite of greater judicial acceptance of subjective notions of risk. As observed by McLean:

The autonomy of decision-making dominates in law. Decision-making skills (legally defined) foreseen the competence status and therefore the right to function independently. The person is supreme; if considered competent he or she has the right to take decisions in accordance with his or her own concerns and desires, so that the third parties are not affected. This individualistic autonomy model has nothing to do with what the decision is, but is interested in the right to make it (McLean, 2010).

Autonomy is important because we need to ensure that the patient is fully involved in understanding their diagnosis and treatment, and not just the doctor is involved in this situation (The Medic Portal, 2021). Autonomy means that a patient has responsibility for their own care for the final decision-making (The Medic Portal, 2021). According to the Malaysian Medical Association (MMA), there are eight patient’s rights that needs to be protected (Malaysian Medical Association (MMA), 2017). First, the right to health care and humane treatment. Second, the right to choice of care. Third, the right to acceptable safety. Fourth, the right to adequate information and consent. Fifth, right to redress of grievances. Sixth, the right to participation and representation. Seventh, right to health education. Eighth, the right to a healthy environment (Malaysian Medical Association (MMA), 2017). This guideline can be seen that there is an effort to protect the right of the health of the patients in private and public hospitals in Malaysia. However, this effort seems insufficient.

The issue of whether patients are able to practice their autonomy is very subjective. There is no clear mention, so far, that the patients have adequate autonomy. But, according to the literature, autonomy and rights to health, which arguably are stated under the right to life and human rights, must be respected. It seems that the right to health of the people appears to be secured in a very general way by the capacity of a person residing in Malaysia to exercise his or her autonomy with regard to medical treatment and health care. In Malaysia, the right to health is protected indirectly under the Malaysian Federal Constitution (Razak & Nordin, 2017). Their rights should be protected as they have human rights and the right to life as human being. Plus, according to Zahir et al. (2019a: 2019b) individuals have rights towards health care and medical treatment (Zahir et al., 2019a; Zahir et al., 2019b; Zahir, 2021). Malaysia’s Ministry of Health has launched numerous health initiatives over the years to improve patient safety and the welfare of the population (has an along with the private healthcare system (Health Care in Malaysia, 2010).

Therefore, in Malaysia there is important to ensure that the principle of autonomy is protected. The said principle is limited as to individual cannot harm the others as to fulfil his desire. Autonomy is significant since we need to guarantee that the patient is completely involved in understanding their risk, diagnosis and treatment, and not the doctor is involved in this situation.

Autonomy In The Context Of Covid-19

A small percentage of patients infected with COVID-19 will require hospitalisation, but this is unlikely if they are young and healthy. The elderly and those with critical health conditions are at a higher risk of severe or critical infections (Milly Evans, 2021). Some medicines and therapies used to treat colds and flu can also be used to treat coronavirus symptoms (Milly Evans, 2021). Cough medicines or cough suppressants can comfort shrink their cough. Previously, the World Health Organisation (WHO) had announced on 11 March 2020 that the outbreak of the virus COVID-19 (Coronavirus Disease) which first discovered in Wuhan in December 2019 entered a global pandemic. COVID-19 is a new infectious disease caused by a new coronavirus that was first identified in December 2019 and is believed to cause respiratory infection in humans. By mid-May 2020, more than 150 countries, including Malaysia, have reported COVID-19 cases, and WHO's have recorded over 200,000 cases worldwide. According to statistics, over 7,000 people had died from the virus and there is still a worrying rise in the figure. By early 2021, there are 219 countries and territories across the world affected by COVID-19. The list of countries and their regional classification is based on the United Nations Geoscheme. There are 109,140,311 coronavirus cases, 2,406,371 deaths and 81,182,759 recovered global cases have actually been registered (Worldometers, 2021). Quoting trepidations with "the alarming levels of spread and severity," the WHO urged the governments to implement critical and aggressive steps to stop the virus spread (Human Rights Watch, 2020).

In any hospital, the numbers of ICU beds are usually relatively small and well-occupied. Due to the expensive and limited services and facilities required to provide sustainable treatment, economic considerations play an essential role in providing end-of-life care (Fadhlina Alias & Puteri Nemie Jahn Kassim, 2019). Therefore, healthcare providers need to deal with problems justifying resource distribution among patients (Fadhlina Alias & Puteri Nemie Jahn Kassim, 2019). The obvious solution to the shortage of facilities like beds is to raise the number of beds for critically ill patients in some way (Jean-Louis Vincent & Jacques Creteur, 2020).

With regards to the danger to human rights aspect around the World posed by coronavirus, the UN calls on countries to take a more supportive and global approach to the pandemic (United Nations, 2020). Everybody has the right to health (United Nations, 2020). For instance, Advance Medical Directive (AMD) (also known as "Arahan Perubatan Awal" (APA) in the Malay language) makes an individual has a voice as to demonstrate his autonomous power relating to his or her health in circumstances when he or she no longer has control over what is being done to him or her (Zahir et al., 2017a; Zahir et al., 2017b; Zahir, 2017c; Zahir et al., 2019a). As a consequence, AMD is a guideline that empowers a patient to maintain his or her right to make a decision as to what he or she wishes to do in respect of health care before he or she loses the opportunity to do so (Sommerville, 1996). However, he or she must be competent before making a decision regarding his or her health (Zahir et al., 2019b; Zahir et al., 2021). This right to health shows that the individual plays a significant role relating to his or her health care using his or her autonomy (Zahir et al., 2021; Zainudin et al., 2021).

Jaafar et al. (2007) found that the right to health and principle of autonomy corresponds with Sustainable Development Goals 3 (SDG) for maintaining a safe life and encouraging well-

being for all, as it takes healthcare as close as possible to where people live and work, which is a key part of the ongoing healthcare cycle (Jaafar et al., 2007). With the rapid spread of COVID-19, the Malaysian government is monitoring closely the chain of positive cases and at the same time trying to uphold the principle of patient's autonomy. Thus, contacts with positive cases are quickly screened while the public must keep a safe distance from one other and stay home as much as possible to break the chain of the virus to prevent it from spreading (Prime Minister's Office of Malaysia, 2020). Every individual has the right to health and medical care based on the autonomy principle (Zahir, 2020). Every individual is entitled to treatment including treatment if he or she suffers from COVID-19 (Zahir, 2020; Zahir, 2021).

The Malaysian Medical Council (MMC) allows all registered doctors to protect the confidentiality of patients' personal information under its Code of Professional Conduct (Code) (Milton Lum, 2020). Any allegation of breach of patient confidentiality must be decided by the MMC in a disciplinary investigation, according to the Medical Act of 1971 (Act 50). The doctor's duty to protect patient confidentiality is not absolute (Milton Lum, 2020). Patient information may be revealed if the patient gives their permission, either indirectly or directly, for their own treatment or for other purposes; it is required by law, such as in the case of infectious disease notification; or it is in the public interest. In the private sector, the Personal Data Protection Act governs the protection of personal information. There is, however, no law governing protection of personal information for the public sector which includes its healthcare facilities (Milton Lum, 2020). There is no law governing protection of patient autonomy and consent for the public sector including the usage of healthcare facilities and medical treatment neither. Not only that, there is no clear guideline and law pertaining to principle of autonomy with regard to this matter towards patients in Malaysia who suffered COVID-19 to make his or her decision whether to proceed or discontinue with the medical treatment.

In the case of COVID-19's situation, autonomy is important because we need to ensure that the patient is fully involved in understanding their treatment. It is because the fact is, every individual plays a significant role relating to his or her health care using his or her autonomy. Every person plays a significant role relating to his or her health care using his or her autonomy. He and she should understand his or her risk, diagnosis and treatment before making his or her decision pertaining to medical treatment. It is important to the individual to make decision for his treatment without harming the others. Handling COVID-19's patient, require careful care. It is because COVID-19 is easily spreading to others through air. Plus, there is not currently a cure for COVID-19. The aim of treatment is to manage and reduce symptoms until the patients have recovered. In our community, stay safe by maintaining a proper distance, wearing a face mask, keeping rooms well ventilated, avoiding crowds, washing your hands properly, and coughing into a bent elbow or tissue are highly recommended. Therefore, in short, every COVID-19 patients have a right towards his autonomy towards their medical treatment as long as they did not harming others. It is important to have clear guideline and law with regard to this matter towards patients in Malaysia who suffered COVID-19.

Conclusion

The literature shows that health is a fundamental part of the enjoyment of human rights, and it is usually attached to the right to life. Autonomy is important because a patient needs to make sure that he or she is actively involved in the medical treatment, and not just follow his or her doctor without understanding his or her actual situation with regard to his or her medical treatment. For the COVID-19's situation, it calls for the highest standard of health protection.

Even for an individual who suffered from COVID-19, he or she is still has a basic rights to health and autonomy. This autonomy may inherit either internalism or motivational externalism, as stated by Robert Audi, in the corresponding practical judgment. Respect of the personal autonomy of a patient is considered one of many basic concepts of ethics in medicine. Autonomy is the most basic way of not harming others. It is therefore important to establish values concerning the idea of patient autonomy not to hurt others. Consequently, we can see here that there is always a room for autonomy in medical practice. Fundamentally, autonomy is the pivotal healthcare notion. This must be done when that patient still has the capacity to give consent and it must be given voluntarily without intervention by any individual. This narrates the rights of an individual patient to make decisions independently whether to give consent or to refuse to give consent. In view of this legal position, the issue that will be the point of discussion in this medium is whether a patient who has the right to give consent also has the same right to refuse treatment in Malaysia. Patient autonomy must always be considered as the starting point for measures aimed at improving patients' dignity. Beyond that, the problems must be addressed by appropriate moral reasoning, clear communication and comprehensive assessment of the situation, empathy, and personal judgment. It is important to have clear guideline and law about the matter pertaining principle of autonomy to make the decision for medical treatment towards patients in Malaysia since the guideline and law regarding the principle of autonomy is still vague including those who suffered COVID-19. Yet, the introduction of the COVID Act and the previous Prevention and Control of Infectious Diseases Act 1988 are still a step in the right direction in these unprecedented times and should promote the principle of autonomy too. Not only that, but it is also necessary to ensure that the distribution of justice in this context, which offers sufficient, equal and adequate facilities for society including to the consumers, is carried out by making a proper and just policy.

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