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Advance Medical Directive: Patients' Dilemma

Arahan Perubatan Awal: Dilema Pesakit

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ABSTRACT

An Advance Medical Directive (AMD) is an individual's instructions concerning his decision for future treatment. AMD was developed because of medical technologies' growing complexity and widespread acceptance. There is a concern relating to AMD. While implementing AMD, there is a dilemma about the law that will bind it. Thus, this paper aims to analyse the law and ethical aspects concerning AMD in Malaysia. This paper adopts a qualitative methodology. The authors analyse the kinds of literature from primary and secondary sources on AMD, medical law and ethics. This article discovered that while discussing AMD in Malaysia, Articles 17 and 18 of the Malaysian Medical Council's Consent for Treatment of Patients by Registered Medical Practitioners (MMC) can be relied on. These provisions are seen as too general and need further clarification. The laws regarding AMD vary from state to state. For example, in the United States, the 1990 Patient Self-Determination Act (PSDA) encourages everyone to make decisions ahead of time about the sorts and extent of medical care they want to accept or decline if they become unable to do so due to illness. As a result, this paper concludes that it is critical for Malaysia to have clearer AMD guidelines.

Keywords: Advance Medical Directive; consent; hospital; patient autonomy; treatment

ABSTRAK

Arahan Perubatan Awal (AMD) ialah arahan individu tentang keizinannya terhadap rawatan masa hadapan. AMD dibangunkan kerana kerumitan teknologi perubatan yang semakin meningkat dan penerimaan yang meluas. Terdapat kebimbangan terhadap AMD. Semasa melaksanakan AMD, timbul dilema tentang undang-undang yang akan mengikatnya. Justeru, manuskrip ini bertujuan untuk menganalisis undang-undang dan aspek etika berhubung dengan AMD di Malaysia. Manuskrip ini menggunakan metodologi kualitatif. Penulis menganalisis jenis kesusasteraan daripada sumber primer dan sekunder tentang AMD, undang-undang perubatan dan etika. Manuskrip ini mendapati Perkara 17 dan 18 Consent for Treatment of Patients by Registered Medical Practitioners daripada Majlis Perubatan Malaysia (MMC) boleh dirujuk apabila membincangkan AMD di Malaysia. Peruntukan ini dilihat terlalu umum dan memerlukan penjelasan lanjut. Undang-undang berkisar AMD adalah berbeza dari sesebuah negera dengan negara yang lain. Sebagai contoh, di Amerika Syarikat, Patient Self-Determination Act (PSDA) 1990 menggalakkan setiap individu untuk membuat keputusan lebih awal tentang jenis dan tahap rawatan perubatan yang mereka terima atau tolak jika mereka tidak dapat membuat keputusan tersebut disebabkan oleh penyakit yang dihidapinya. Oleh itu, manuskrip ini mencadangkan bahawa adalah sangat penting untuk mempunyai garis panduan yang lebih jelas berkaitan dengan AMD di Malaysia.

Kata kunci: Arahan Perubatan Awal; keizinan; hospital; autonomi pesakit; rawatan

INTRODUCTION

Medical law is a developing field. Even though medical law is now broadly offered, it contradicts early adopters' efforts to protect its legitimacy as an aspect of legal study (Rebekah McWhirter & Margaret Brazier, 2024). It has been simple to classify medical law as a new field of academic study because of its propensity to concentrate on the difficulties posed by emerging technologies, and because research tends to focus on the present and future rather than the lessons learnt from the past (Rebekah McWhirter & Margaret Brazier, 2024).

The adoption of the Advance Medical Directive (AMD) demonstrates the concept of autonomy. AMD can be defined as written or vocal statements that govern the patient's healthcare decision-making, if the outcome is positive or unfavourable (Goffin, 2012). Thus, AMD is an oral (verbal) or written direction about a patient's future medical treatment and health care if he loses his ability to communicate or becomes incapable. Whereas implementing AMD, there is a problem about the law that will bind it.

Everyone in Malaysia has the right to witness and appreciate the development of the law. According to Article 5(1) of Malaysia's Federal Constitution, it is crucial to see the implication of the right to life. Thus, as well as the context of the importance of taking care of life and further the health and freedom to choose what they want and do not want in terms of health care and treatment. People in a dilemma about what to choose and what they need or want in terms of health care and treatment.

AMD is a tool that empowers individuals to outline their healthcare preferences if they lose the capacity to make decisions. These directives are pivotal in supporting patient autonomy and ensuring clarity in medical decision-making. This article examines the systems governing AMD in Malaysia, the United States, and the United Kingdom, focusing on their legal, cultural, and ethical dimensions. We are referring to the United States and the United Kingdom because they have clear legal frameworks that promote individual liberty and healthcare planning, whereas Malaysia has substantial hurdles due to a lack of explicit legislation with regard to AMD contextual. Therefore, it is important to discuss and refer to these two countries for the benefit of Malaysia in this paper.

METHODOLOGY

This paper adopts a qualitative research approach. Every piece of data is gathered and then thoroughly examined (Noraisah Yusop & Kartini Aboo Talib @ Khalid, 2024). The authors analyse the kinds of literature from primary and secondary sources on AMD, medical law and ethics. The data for this paper was analysed using content analysis and critical analysis approaches (Ramalinggam Rajamanickam et al., 2019). Data were primarily gathered from original sources, such as Malaysian and foreign laws and papers (Mohd Zamre Mohd Zahir et al., 2021; Mohd Zamre Mohd Zahir et al., 2019). Data gathering is important (Ramalinggam Rajamanickam et al., 2019) for the study and the review phase (Nurul Hidayat Ab Rahman et al., 2023; Nurul Hidayat Ab Rahman et al., 2022). The authors describe the results of the analysis in the concluding section of this study.

RESULTS AND DISCUSSION

It is a fundamental human right for the patient, who is mature and rational enough to comprehend the nature of the treatment, to make their own decision about whether or not to accept it (Brazier et al., 2023). Ethicists support patient autonomy, or the right to self-rule instead of being ruled by others (Brazier et al., 2023). The law has evolved dramatically in recent years, restricting medical paternalism and encouraging patient-centered treatment, according to Margaret Brazier, Emma Cave, and Rob Heywood (Brazier et al., 2023).

The patient finds it difficult to decide whether he is terminally ill. Making decisions for a patient who has a poor prognosis and is very sick can be difficult (Ministry of Health Malaysia, 2024). Unrealistic expectations, pain, and the use of incorrect treatments are the results of a failure to detect serious, life-threatening illnesses. Clinicians must act in the best interests of all patients and make ethical decisions, even though the sanctity of life principle is the top priority in critical care medicine (Ministry of Health Malaysia, 2024). Individuals with progressive terminal illnesses who cannot survive for more than three to six months, for instance:

- end stage respiratory disease on long term home oxygen therapy with severe community acquired pneumonia;
- end stage cardiac, respiratory, liver disease with no options for transplant
- metastatic cancer unresponsive to treatment (Ministry of Health Malaysia, 2024).

In Malaysia, research indicates that there is currently no formal guideline or rule regarding AMD (Shaikh Mohd Saiffuddeen Shaikh Mohd Salleh, 2015). Shaikh Mohd Saiffuddeen of the Malaysian Institute of Islamic Development (IKIM) stated in his paper "Islamic Bioethics on the Issue of Advance Medical Directive (AMD)" that there is no specific guideline issued by Malaysia's Ministry of Health (MoH) for implementing AMD. This dilemma will leave patients with no clear direction if they wish to have an AMD.

According to Fadhlina Alias, Puteri Nemie Jahn Kassim, and Muhammad Najib Abdullah, while AMD is a relatively new concept in Malaysia, certain sectors have recently called for increased public awareness and the incorporation of such measures into healthcare service delivery (Fadhlina Alias et al., 2020). Article 17 of the Consent for Treatment of Patients by Registered Medical Practitioners addresses the refusal to give consent for treatment. In general, everyone has the freedom to refuse medical treatment. A legally competent individual has the right to determine what happens to him or her. Such people have the right to refuse medical treatment, whether their reasons are rational, irrational, or unknown, or even nonexistent. Forcing therapy on a competent patient who has lawfully denied it may constitute assault or violence.

Nevertheless, if the patient's situation has change significantly, any past refusal of medical care may no longer be valid and should be brought up with the patient. Similar to consent to medical treatment, denial of treatment can be expressed or implied, in writing or verbally. A patient's refusal to receive treatment should also be documented in full and in writing in the medical record or the medical practitioner's case notes, and the patient should sign and date it if possible. In circumstances where patients decline some life-saving therapies (such as blood transfusion) based on religious beliefs or cultural custom, and if the chance of such emergency life-saving procedures getting essential is high in the course of therapy, the practitioner may seek a court's decision to protect himself from future action (Article 17 of the Consent for Treatment of Patients by Registered Medical Practitioners, Malaysian Medical Council (MMC) Guideline).

On the same message, the Malaysian Medical Council (MMC) issued a general AMD guideline titled "Consent for Treatment of Patients by Registered Medical Practitioners" under Articles 17 and 18. Article 18 states that, among other things, "a medical practitioner should refrain from providing treatment or performing any procedure where there is an unequivocal written directive by the patient that such treatment or procedure is not to be provided in the situations which now apply to the patient." Even while some private hospitals publish a broad guideline on AMD on their websites (Harriet Berliner, 2012), it is clear that no specific guideline or standard for AMD is employed in Malaysian local government hospitals.

THE PRINCIPLE OF AUTONOMY IN BIOETHICS

Autonomy has long been recognized as a foundational principle in bioethics, deeply intertwined with human nature and an individual's capacity to experience quality of life and spiritual well-being. Historically, many societies practiced significant degrees of paternalism within families, where decisions were often made on behalf of individuals without their explicit consent. However, modern societal standards have shifted to prioritise respect for human autonomy and the right to self-determination, particularly for individuals deemed competent and of legal age to agree. Competence also relates to someone's knowledge and understanding (Widad Ma et al., 2024). This shift emphasizes the importance of people accepting responsibility for their own decisions and actions.

Autonomy, derived from the Greek words autos (self) and nomos (law), refers to the capacity of an individual to make informed, uncoerced decisions (Ebbesen & Pedersen, 2008). In bioethics, it is considered a key value, ensuring that individuals have the freedom to make choices aligned with their personal values and beliefs. The principle of autonomy is sometimes regarded as a cornerstone of the requirement for informed consent in medical ethics, building an essential component of the patient-physician interaction (Varelius, 2006).

However, the application of autonomy in medical ethics is not without challenges. For instance, the concept of relational autonomy highlights that individuals' decisions are often influenced by their relationships and social contexts. This perspective suggests that autonomy should not be viewed in isolation but rather in conjunction with the individual's social environment (Buchanan & Brock, 1989).

PATIENT'S AUTONOMY IN MEDICAL DECISION-MAKING

In medical practice, the principle of autonomy manifests prominently through the process of informed consent. This method emphasises that patients receive thorough information regarding their diagnosis, treatment options, potential risks, and benefits, allowing them to make decisions that are consistent with their values and preferences. Informed consent is a practical implementation of the bioethics principle of respecting patient autonomy and self-determination, as well as a patient's legal right to control what occurs to their body (American College of Obstetricians and Gynaecologists, 2021).

Despite the emphasis on autonomy, there are instances where its application becomes complex. For example, in the context of assisted dying, debates arise regarding the extent to which individual autonomy should be honored, especially when considering potential societal implications. Foster (2023) argues that decision-making should consider relational and societal impacts, not just individual autonomy. He suggests that laws permitting assisted dying could lead to irreversible societal harm, including coercion and degradation of doctor-patient trust.

CHALLENGES TO AUTONOMY IN HEALTHCARE

While autonomy is a fundamental principle, its implementation in healthcare settings can be fraught with challenges. One significant concern is the potential for healthcare providers to unduly influence patients' decisions. Reports from Canada indicate instances where patients felt pressured by medical professionals to consider Medical Assistance in Dying (MAID), raising ethical questions about the balance between providing information and exerting influence (Lee, 2024).

Moreover, healthcare providers themselves may experience moral distress when patients' autonomous choices conflict with the providers' personal or professional values. For instance, some Canadian doctors and nurses have reported discomfort administering euthanasia under permissive laws, especially when patients' requests are driven by factors like poverty or social isolation (Associated Press, 2023).

AUTONOMY AND VULNERABLE POPULATIONS

The principle of autonomy becomes particularly complex when considering vulnerable populations, such as individuals with disabilities or intersex individuals. The United States Department of Health and Human Services (2023) issued a study denouncing nonconsensual surgery on intersex youths and promoting their bodily autonomy. The report emphasises the trauma and injustices that intersex people suffer in the healthcare system and proposes policy changes to preserve their rights.

Similarly, the disability rights movement emphasizes autonomy through the slogan "Nothing about us without us," calling for self-determination and empowerment. This perspective challenges traditional notions of autonomy by highlighting the importance of social relationships and support systems in decision-making processes (Charlton, 1998).

1. Advance Medical Directive in Malaysia

Malaysia lacks a specific legislative framework for AMDs, with related principles derived from common law and the Mental Health Act 2001. In Malaysia, the absence of a dedicated legislative framework for Advance Medical Directives presents a significant gap in the country's healthcare laws. Currently, the principles and guidelines related to AMDs are drawn mainly from common law, which evolves through judicial decisions rather than through codified statutes. Additionally, the Mental Health Act 2001 does address some aspects of medical decision-making, but it is primarily concerned with the treatment of individuals suffering from mental disorders. This means that while certain provisions may relate to the autonomy of patients and their rights to make medical decisions, there is no specific law that formally recognizes or governs Advance Medical Directives.

An AMD usually addresses situations such as the withdrawal of life support or the refusal of certain medical treatments, especially when the person is terminally ill or in a persistent vegetative state. Without a specific legal framework in Malaysia, the use and enforcement of such directives are not as clear-cut as they could be. As a result, healthcare providers may be hesitant to follow AMDs, and patients may feel uncertain about whether their wishes will be respected.

The absence of clear laws also leads to confusion around the rights of individuals to make advance decisions about their medical care. It might lead to the difficulty in protecting someone's right and upholding justice from the other angle (Haslida Isamail et al., 2024). In many countries with well-established frameworks for AMDs, patients can explicitly outline their preferences in advance, knowing that their wishes will be honored even if they are incapacitated. The AMD system in the United States is well-established. For example, the Patient Self-Determination Act of 1990 in the United States, which requires healthcare practitioners to inform patients about AMD options for treatment (Meisel & Cerminara, 2022). While in the United Kingdom, the Mental Capacity Act of 2005, which permits the appointment of a lasting power of attorney (LPA) for health decisions or advance decisions to refuse treatment (ADRTs), defines the AMD framework. Without such a framework in Malaysia, however, patients and their families may not be confident that their wishes will be respected, and healthcare providers may not have clear guidelines on how to act in these situations.

Malaysia is a multi-ethnic and multi-religious country, and its diverse population has a wide range of cultural and religious views that significantly influence medical decision-making. Among the major religions in Malaysia, Islam is practiced by the majority of the population, and its teachings are particularly influential when it comes to decisions about life and death. Islamic principles place a strong emphasis on the sanctity of life, which means that many Muslims may view decisions like withdrawing life support or refusing medical treatment with caution.

For instance, Islamic teachings generally prohibit euthanasia and assisted suicide. However, Islamic scholars have also recognized the importance of preserving dignity and reducing unnecessary suffering, which can allow for exceptions in certain circumstances, such as when a patient is terminally ill or in a persistent vegetative state. This nuanced approach to end-of-life care presents a challenge in the context of AMDs, as the decision to withdraw life support may be seen as contrary to Islamic beliefs, depending on the individual's interpretation of religious texts.

In addition to religious beliefs, cultural norms play a significant role in medical decision-making in Malaysia. In many traditional Malaysian families, decisions regarding healthcare are made collectively by the family, rather than by the individual alone. Family members, especially elders, are often considered to have the ultimate authority over medical decisions. In this context, the concept of an AMD, which empowers individuals to make their own decisions about medical care ahead of time, may be unfamiliar or even uncomfortable for some Malaysians.

The importance of family in medical decision-making means that discussions about end-of-life care or the withdrawal of life support are often informal. These conversations may take place within the family unit without involving healthcare professionals or formal legal documents. This informal approach can sometimes lead to misunderstandings or disagreements, especially when family members have differing views on what is best for the patient. In such situations, the lack of a formalized system for AMD can exacerbate tensions and ethical conflicts in the healthcare setting.

Given the complex interplay between legal, cultural, and religious factors, it is essential for Malaysia to develop a culturally inclusive policy framework for the introduction and implementation of AMD. A well-designed framework would not only address the legal and ethical aspects of AMD but also ensure that the cultural and religious values of the Malaysian population are respected.

One of the key challenges in implementing AMD in Malaysia is ensuring that the legal framework is flexible enough to accommodate the diverse beliefs and practices of the population. For instance, some Malaysians may prefer a directive that allows for the withdrawal of life support in certain situations, while others may see such a decision as contrary to their religious beliefs. A culturally inclusive policy would allow for these differences by providing a clear and respectful process for patients to make their wishes known while taking into account the values of their families and communities.

Such a policy should also aim to increase public awareness about AMD and educate Malaysians about their rights and options when it comes to medical decision-making. Public education campaigns could help demystify the concept of AMD and provide individuals with the information they need to make informed decisions about their healthcare. These campaigns should be sensitive to the cultural and religious diversity of Malaysia and should aim to build trust and understanding between healthcare providers, patients, and their families.

In addition, healthcare providers in Malaysia should be trained in how to discuss AMD with patients and their families in a culturally sensitive manner. This could involve providing healthcare professionals with guidelines on how to navigate complex ethical and cultural dilemmas related to end-of-life care. By promoting open and respectful communication, healthcare providers can help ensure that patients' wishes are honored while minimizing the potential for conflict and misunderstanding.

2. Advance Medical Directive in the USA

The United States has a well-established AMD system, supported by instruments like living wills and durable powers of attorney for healthcare (DPAHC). The Patient Self-Determination Act of 1990 requires healthcare practitioners to inform patients about AMD options for treatment (Meisel & Cerminara, 2022). A DPAHC appoints a trusted person, called a healthcare proxy or agent, to make medical choices on the patient's behalf if they are unable to do so. This legal tool provides an additional layer of security for patients, ensuring that someone they trust will make healthcare decisions in line with their wishes when they can no longer express them themselves. These instruments work together to create a robust system that prioritizes individual choice and autonomy in healthcare decision-making.

The legal foundation for AMDs in the United States was further strengthened by the passage of the Patient Self-Determination Act of 1990. This federal law requires healthcare providers, including hospitals, nursing homes, and other medical institutions, to inform patients of their rights to create and implement AMD. The law ensures that patients are educated about their selections for end-of-life care, giving them the opportunity to make informed decisions ahead of time. Healthcare providers are also required to ask patients whether they have an AMD in place and to honor the directives if they exist, subject to state laws and regulations.

Government initiative has a significant relation to society (Siti Nur Husna Tukiran et al., 2024). Normally, whatever the government wants to do it will give benefit to the society. While the federal government has set certain standards, individual states have the authority to establish their own laws regarding AMDs. This leads to variations in how these directives are implemented across the country. For example, some states may have specific forms for living wills or DPAHCs, while others may allow for broader, more flexible documentation. Additionally, some states may have laws that require healthcare providers to follow certain procedures when a patient's AMD conflicts with medical judgment, while others may leave these decisions up to the discretion of the healthcare provider. These variations can create challenges, particularly for patients who move between states or seek care from providers in different jurisdictions.

In the USA, AMDs prioritize individual choice, allowing clear specifications regarding interventions such as resuscitation or artificial ventilation. Enforcement is robust, though variations in state laws can create challenges. Efforts to digitize and standardize AMDs, like the National POLST program, aim to improve accessibility and compliance (National POLST, 2023). The principle of autonomy also extends to the right to appoint a healthcare proxy through a Durable

Power of Attorney for Healthcare (DPAHC). By choosing someone they trust to make medical decisions on their behalf, patients can ensure that their preferences are respected even when they are unable to advocate for themselves. The DPAHC allows individuals to maintain control over their healthcare decisions, even in the absence of direct communication, thus reinforcing the fundamental notion of personal autonomy in medical care.

Ethical debates arise when directives conflict with medical judgment or a physician’s personal beliefs. Nevertheless, the system’s emphasis on autonomy remains its defining feature. While the USA system for Advance Medical Directives is built on the foundation of patient autonomy, it is not without its ethical challenges and debates. One of the main ethical issues arises when a patient’s AMD conflicts with medical judgment or the personal beliefs of a physician or healthcare provider. In some cases, a healthcare provider may feel that following a patient's directive to withdraw life-sustaining treatment is contrary to their medical obligations or professional ethics, particularly if they believe the patient could recover with appropriate intervention. This can create a moral dilemma for the physician, who may be torn between respecting the patient's wishes and providing care that they believe could be beneficial. For example, if a patient has specified in their living will that they do not want to receive life-sustaining treatments such as artificial ventilation or resuscitation in the event of terminal illness, a physician may find themselves in a difficult position if the patient's condition is not immediately clear or if there is a possibility that the patient could recover. In such cases, healthcare providers must carefully navigate the legal and ethical considerations involved, balancing the need to respect the patient's wishes with their professional obligations.

Another ethical concern arises when the patient’s AMD conflicts with the personal beliefs of family members or healthcare proxies. In some cases, family members may disagree with the decisions outlined in an AMD, particularly if they have a different understanding of the patient's wishes or feel that the patient would have wanted to pursue every possible treatment option. These disagreements can lead to conflicts within families, and healthcare providers may be forced to mediate these disputes to ensure that the patient's wishes are ultimately respected.

Despite these challenges, the USA system’s emphasis on autonomy remains its defining feature. The ability for patients to make their own decisions about their healthcare, even in the face of medical uncertainty or family disagreements, is a cornerstone of the American healthcare system. The ongoing debates about the ethical implications of AMDs reflect the broader tension between individual rights and medical professionalism, but the system continues to prioritize patient autonomy as the fundamental guiding principle.

3. Advance Medical Directive in the UK

The United Kingdom’s AMD framework is defined by the Mental Capacity Act 2005, which allows advance decisions to refuse treatment (ADRTs) or the appointment of a lasting power of attorney (LPA) for health decisions. Legally binding ADRTs must meet specific criteria, such as being documented and witnessed.

In the United Kingdom, under the Mental Capacity Act 2005, relevant provisions can referred such as sections 24, 25, and 26. As a result, under that Act and English law, if a person has made an effective advance directive saying that he does not consent to treatment, it would be illegal for a doctor to provide that treatment, as stated in section 24 of the Mental Capacity Act 2005. In *Re T (Adult)* [1992] 4 All ER 649, it is apparent that a competent person has the right to refuse treatment even if it may result in death. However, the decision must not be influenced by external pressures. Forcing such treatment on someone could be battery or tort. According to Jonathan Herring and Jesse Wall, bodily integrity is the integration of the self with the rest of the objective environment around us (Herring & Wall, 2017). A violation is vastly different from interfering with bodily decisions. This explains why interference with bodily integrity requires a higher level of justification than interference with autonomy. It also examines how the concept of physical integrity aids in understanding disability, gender, and split bodily material (Jonathan Herring & Jesse Wall, 2017). A competent patient has the ultimate right to refuse treatment.

UK policies emphasize refusal of treatment rather than explicit medical requests. Healthcare professionals must respect valid directives unless they pose significant ethical or public health concerns. Plus, cultural diversity in the UK influences perceptions of AMDs. Campaigns by organizations like Compassion in Dying aim to improve understanding and utilization. However, barriers such as limited public knowledge and reluctance to discuss end-of-life choices remain significant (Thompson et al., 2019).

COMPARATIVE ANALYSIS WITH REGARD TO AMD

Firstly, from the legal framework's context, the USA and the UK have codified AMD with clear legal backing, while Malaysia lacks specific legislation. The centralised UK system contrasts with the USA's state-specific approach, which allows tailored regulations. In the USA, the legal landscape surrounding AMD is framed by state laws. Each state has the autonomy to develop its own regulations regarding Advance Medical Directives, making the legal system highly decentralized (Harris, 2017). These directives are often formalized through documents such as a "living will" or a "durable power of attorney for healthcare" (Miller & Keeling, 2021). This state-specific approach allows for tailored regulations that reflect the unique healthcare needs and values of different communities. Additionally, the Patient Self-Determination Act of 1990 mandates healthcare providers to inform patients about their rights to execute such directives, further strengthening the legal infrastructure supporting AMD (Perry, 2020). In the UK, the legal framework for AMD is more centralized and regulated through the Mental Capacity Act (2005). This act provides a clear framework for individuals to make decisions about their medical treatment in advance, ensuring that their wishes are respected in the event of incapacity (British Medical Association, 2019). The UK also emphasizes the use of "Advance Decisions" (living wills) and "Lasting Powers of Attorney," which empower individuals to make decisions about their medical care (Buckley, 2020). The centralized nature of the UK system ensures that the legal standing of these directives is uniformly applied across the country. In contrast to the USA and the UK, Malaysia does not yet have a specific law governing Advance Medical Directive. While Malaysia has some regulations in place that address end-of-life care, such as the National Organ Donation Act 1997, there is no dedicated legal framework for AMD (Ng & Lee, 2019). The solution and a component and development that can support the efficacy and efficiency of the organisation is crucial in good governance (Nadirah Zabidi et al, 2024). The absence of specific legislation complicates the ability of patients to ensure their medical preferences are honored, particularly when healthcare providers lack clear guidelines on how to handle such situations. This gap in the legal system places the burden on healthcare professionals to navigate decisions about medical treatment based on general ethical principles rather than codified law.

Secondly, from the cultural influences, Malaysian norms emphasize family input, while the USA and UK prioritize individual autonomy. Religious and cultural considerations are more prominent in Malaysia and the UK than in the USA. In Malaysia, the concept of family-centered care is deeply ingrained in the healthcare system. Family members are often seen as the primary decision-makers, and their input is considered essential, especially when it comes to life-and-death situations (Chong & Goh, 2021). Cultural norms, influenced by Malaysian society's strong emphasis on collectivism and filial piety, often result in healthcare decisions being made by family members rather than individuals themselves. This practice contrasts with the Western ideals of individual autonomy and can create complications in the absence of formal AMD laws. When individuals are unable to communicate their wishes, family members often find themselves in the difficult position of making decisions that may not align with the patient's true preferences (Tan & Lee, 2018). In the USA, individual autonomy is a cornerstone of healthcare decision-making. The legal system strongly supports the rights of individuals to make their own healthcare decisions, as evidenced by the widespread use of Advance Directives (Miller & Keeling, 2021). The cultural emphasis on personal freedom and individual rights means that patients in the USA are encouraged to make their own decisions about their medical care, even if it involves difficult or life-altering choices. This cultural influence supports the legal backing for AMD, ensuring that patients' wishes are respected and followed by healthcare providers. However, this focus on individualism can sometimes lead to ethical dilemmas, especially when patients' wishes conflict with the recommendations of healthcare professionals or family members (Harris, 2017). In the UK, there is a balance between respecting individual autonomy and the role of healthcare professionals in making decisions for patients who are unable to do so themselves. While the UK's centralised legal framework encourages individuals to make advance decisions, there is also a cultural and legal tradition of paternalism in medicine, where doctors are seen as guiding patients toward the best outcomes (Buckley, 2020). The role of family members in healthcare decisions is also significant, though not as dominant as in Malaysia. The cultural blend of autonomy and paternalism in the UK means that advance medical directives are respected, but healthcare professionals may still intervene if they believe that the patient's choices are not in their best interests (British Medical Association, 2019).

Thirdly, from the aspect of public awareness and accessibility, public understanding of AMD is highest in the USA, followed by the UK. Malaysia faces significant challenges in raising awareness, particularly in rural areas. In the USA, public awareness of Advance Medical Directives is relatively high, primarily due to extensive campaigns and educational programs that emphasize the importance of planning for end-of-life care (Perry, 2020). Organizations such as the American Bar Association and the National Hospice and Palliative Care Organization have played a significant role in promoting the use of Advance Directives. Additionally, the legal requirement under the Patient Self-Determination Act ensures that individuals are informed about their right to create an AMD when they enter healthcare facilities. Despite this, there are still disparities in understanding among different socioeconomic groups, with some individuals, particularly in rural areas or from minority communities, lacking knowledge about the benefits and processes of creating Advance Directives (Harris, 2017). In the UK, public awareness of Advance Medical Directives is also relatively moderate, though it lags behind the USA. The National Health Service (NHS) provides information about Advance Decisions, and there is growing recognition of the importance of planning for end-of-life care. However, despite this, there remains a lack of widespread understanding of the legal implications and the process of creating such directives (British Medical Association, 2019). Public campaigns are more focused on organ donation and general healthcare planning, with less emphasis placed on Advance Medical Directives, which may limit their accessibility to the general public. In Malaysia, public awareness of Advance Medical Directives is low, and there are significant challenges in educating the public, particularly in rural areas. The lack of specific legislation further complicates the issue, as many people are unaware of the possibility of creating such directives or may not see the need for them. Cultural factors, including a reluctance to discuss death and end-of-life care, also contribute to the low uptake of Advance Directives in Malaysia (Ng & Lee, 2019). While urban areas may have more resources and educational campaigns, rural communities often face greater obstacles in accessing information and understanding the importance of making healthcare decisions in advance.

Furthermore, ethical challenges across all three countries involve balancing personal autonomy with cultural, familial, and professional values. In Malaysia, the absence of formal AMD complicates decision-making for healthcare providers. In the USA and UK, conflicts may arise when directives appear inconsistent with medical ethics or professional guidelines. In Malaysia, the absence of formal AMD laws creates ethical challenges for healthcare providers who must navigate situations where patients' wishes are unclear. In cases where family members are heavily involved in decision-making, healthcare professionals may find themselves caught between respecting family input and ensuring that the patient's autonomy is honored. The cultural practice of deference to family authority can lead to situations where medical decisions are made based on family preferences rather than the individual's wishes, potentially causing moral distress for healthcare providers (Chong & Goh, 2021).

Thus, there are several suggestions for these three countries:

TABLE 1. Suggestions for Improvement (illustration given by the authors)

For Malaysia	For the USA	For the UK
• Establish a legal framework for AMDs. • Launch educational initiatives to increase public and professional awareness. • Tailor policies to reflect Malaysia's multicultural and religious landscape.	• Address accessibility gaps, especially among underserved populations. • Standardize digital tools to simplify AMD documentation. • Harmonize state laws for greater consistency.	• Increase public awareness through targeted campaigns. • Provide training for healthcare professionals on handling ADRTs and LPAs. • Develop culturally sensitive approaches to meet diverse patient needs.

The legal, cultural, and ethical dimensions of Advance Medical Directives differ significantly between Malaysia, the USA, and the UK. While the USA and the UK have clear legal frameworks that support individual autonomy and healthcare planning, Malaysia faces significant challenges due to the absence of specific legislation. Cultural influences also shape the way healthcare decisions are made, with Malaysia emphasizing family involvement, while the USA and UK focus more on individual rights and autonomy. Public awareness and accessibility of AMD are also key factors in each country, with the USA leading in terms of education and outreach. Ethical challenges in all three countries involve balancing personal autonomy with the preferences of families and healthcare professionals, highlighting the complex nature of end-of-life decision-making.

CONCLUSION

Medical professionals, academics, lawyers, religious leaders, and pertinent government agencies should all be involved in any attempt to address AMD in Malaysia. This is because they can offer their skills, knowledge, and expertise to the creation of a workable and sustainable AMD model in Malaysia. AMD might be viewed as an important tool in a patient's ability to function independently. Even while AMD is still relatively unknown in Malaysia and lags behind other developed countries such as the United Kingdom, it cannot be denied that patients are becoming more aware of the possibility of developing their own AMD. The Malaysian Institute of Islamic Development (IKIM) brought together academics and medical professionals to examine the current state of AMD in Malaysia, patients' rights to prepare an AMD, and the necessity for a step forward in regulating its practice. It is suggested that the evolution of Malaysian laws corresponds to the country's economic, social, and political growth.

AMD plays a vital role in ensuring dignified and patient-centered end-of-life care. Malaysia's journey involves foundational steps toward a structured system, while the USA continues refining its robust framework, and the UK evolves within its established legislative context. By sharing insights and tailoring strategies to local needs, these nations can enhance their AMD systems to benefit patients and caregivers alike.

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