Bridging the Gap: Effective Communication and Disclosure in Halal Pharmaceutical Practices

Mimi Sofiah Ahmad Mustafa, Nasihah Naimat, Yuhanza Othman, Marziana Abd Malib, Ida Rahayu Mahat, Mohd Ab Malek Md Shah

Department of Law, University Technology MARA, Cawangan Melaka,78000 Melaka, Malaysia

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ABSTRACT

The Halal status of pharmaceutical goods for the Muslims is inevitably necessary. The laws of Malaysia do not impose any sanctions for the non-compliance of this status for the producers of pharmaceutical goods but there exists an obligation on the part of medical practitioners to disclose the Halal status of the medicine used for the purpose of the patient's treatment albeit no direct mandatory requirement made by the law. This article explores the extent of effective communication in the light of disclosure made by medical practitioners to their Muslim patients of the Halal status of the medicines used for their treatment. In addition, the law regarding duty to inform is looked at to determine its adequacy with regard to the disclosure of the medicines Halal status. This writing was a qualitative study focusing on the duty to inform and ordinary practice by medical practitioners to reveal the Halal status of the medicines applied to the patients. Seventeen doctors, three dentists and four registered pharmacists from several hospitals and other health institutions in several states in Malaysia were interviewed to reach the objectives of this paper. Doctrinal research was also applied to gather data from library research and internet resources. The finding showed that all doctors admitted that there are no guidelines from Ministry of Health to mandatorily disclose of the Halal status of the medicines. The hospitals were also seen to have different approaches to reveal the medicine Halal status to their Muslim patients. This study is hoped to contribute to the existence of a specific rule to regulate the practice of disclosure of Halal status of the medicines in the Malaysian health institutions.

Keywords: Halal Pharmaceuticals, Medicine, Duty to Inform, Medical Practitioners, Regulation.

INTRODUCTION

Malaysia has a Muslim population of 25.1 million which caters for 75% of the whole Malaysian population of 33.4 million people in 2023 (Pew Research Centre, 2023). This fact necessitates the government of Malaysia to take into consideration Islamic law into many of the country's policies and regulations that govern its day-to-day activities. To give some examples are the banking system, the hire purchase regulation, industries such as food, drink, health, clothing, shoes and others. The banking system has several Islamic products available for their Muslim customers such as Mudharabah (profit sharing), Wadiah (safekeeping), Musharakah (joint venture), Murabahah (cost plus finance), Ijar (leasing), Hawala (an international fund transfer system), Takaful (Islamic insurance), and Sukuk (Islamic bonds) (Del Baldo, 2023).

The global halal pharmaceutical industry has experienced remarkable growth in recent years, driven by the increasing demand from Muslim consumers for products that comply with Islamic principles (Razak, 2020). As the industry expands, ensuring transparency, trust, and compliance with halal standards has become a critical challenge. In Malaysia, food and drink manufacturers are encouraged to acquire the halal certificate from the respective authorities to ensure that their Muslim consumers are confident in consuming their products. The same goes to personal care products where Muslims will prefer to buy bath, shampoo, toothpaste, face and body care, lotion and others that have the halal logo attached to them.

Malaysia's halal pharmaceutical sector, together with that of food and personal care industries, is governed

by a comprehensive regulatory framework, spearheaded by the Department of Islamic Development Malaysia (JAKIM). JAKIM's Halal Certification and Standards ensure that pharmaceutical products meet stringent halal requirements, covering every stage of the supply chain from sourcing raw materials to manufacturing, packaging, and distribution (Ali & Suleiman, 2016). The Malaysian government has also introduced the Halal Industry Master Plan 2030, which aims to position the country as a global halal hub, including in the pharmaceutical sector (Mohd Yusoff, 2019).

As of today, there is no specific Halal law in Malaysia that makes it mandatory for producers of food and any other consumer goods to be Halal certified but the food and consumer goods must fulfil the trade descriptions as provided by the Trade Descriptions Act 1972 (Amendment 2011) (TDA 2011). If the food and goods are found to be not in accordance with the halal trade descriptions under the Act, then they are not halal certified.

With regard to pharmaceutical product, the halal certification is apparently nothing to be shout about because according to the information gathered by the author from a practicing private pharmacist, whatever drugs the retailers receive for sale are not mostly accompanied with the halal logo. The private sectors rely totally on whatever conferred by the National Pharmaceutical Regulatory Agency (NPRA) from the Ministry of Health. The retailed drugs are those already disclosed to the NPRA in terms of registration. NPRA is a regulatory body that registers all medicine and cosmetic that are going to be sold in shops in Malaysia. NPRA thus does not verify whether any medicine or cosmetic is halal compliant or not. But the applicants that submit their products for registration at the NPRA must disclose any animal components in their products. If there is Halal certificate attached to the product, this must also be disclosed in the application (https://www.npra.gov.my/index.php/en/about.html).

Although TDA 2011 does not directly mention any provision regarding halal, Sections 28 and 29 of this said Act have conferred power to the minister to make orders and regulations for effective halal enforcement. For instance, Trade Description (Definition of Halal) Order 2011 provides definition of halal, service in relation to food and goods along with punishments for offence for deceitful or misleading use of halal (Asa, 2018). Again, where pharmaceutical product is concerned, it is not mandatory for it to be halal certified but if it is not fit with the trade description as being halal, then technically it is non-halal. From the preceding paragraph, the author has mentioned that most of the retailed medicines are not marked as halal and are explicitly sold in our market. We do not see any sign in the shops that indicate the halal status of the medicines sold. Hence, it is suggested that probably the medicines sold in the shops did not go through the process to be halal certified. It can be said the same for medicines used in hospitals in Malaysia since all medicines go through the process of registration only at NPRA. It was also said by one of the respondents that most of the medicines registered at the NPRA are imported and hence are most likely not to have any Halal marking on them.

Ab Halim et. al (2015) mentioned in their study that apart from herbal and organic health food supplements, majority of pharmaceuticals and medicines available in Malaysia were not halal compliant. As of today, the position is still the same because the author had managed to speak with one of the assistant directors in the Halal Malaysian Council from JAKIM by telephone to confirm about this on 13 December 2023 at 4.40pm.

Halal Pharmaceutical was also defined by Akashah (2013) as pharmaceutical products that contain ingredients permitted under the Shariah law & fulfil the conditions outlined in the Trade Description (Definition of Halal) Order 2011. According to Akashah, MS 2424 2012 is the Malaysian Standard that expresses the general guidelines in the manufacturing and handling of halal pharmaceuticals. It serves as a basic requirement for halal pharmaceuticals in Malaysia. MS 2424 2012 has expressly required that all pharmaceutical products must comply to the principles of Good Manufacturing Practice (GMP) in order to obtain the product requisite quality and to be in accordance with the standard imposed by the manufacturing or marketing authorizations.

LITERATURE REVIEWS

Effective communication

It is noteworthy to have a look at effective communication to establish the need for disclosure of halal pharmaceutical because a successful communication could definitely reach targets and objectives smoothly. Effective communication is the cornerstone of successful interactions, whether in personal relationships, professional environments, or academic settings. It involves the exchange of information, ideas, and emotions in a way that fosters understanding and collaboration (Adler et.al, 2022). In today's fast-paced world, the ability to communicate effectively is more important than ever, as it helps build trust, resolve conflicts, and achieve shared goals (Guffey & Loewy, 2021).

Effective communication and disclosure are essential to bridge the gap between pharmaceutical companies and consumers, fostering trust and ensuring adherence to halal principles (Abdul Rahim, 2021). Nowhere is this more evident than in Malaysia, a global leader in halal certification and regulation, where robust frameworks and proactive policies have set a benchmark for the industry. Despite the initiatives mentioned earlier that highlight Malaysia's commitment to maintaining the integrity of halal products and building consumer confidence, challenges remain. Miscommunication, lack of awareness, and inconsistent disclosure practices can undermine consumer trust (Abdul Rahim, ibid). For example, while JAKIM's halal logo is widely recognized, some consumers remain skeptical due to incidents of counterfeit certifications or insufficient information about product compliance (Razak, 2020). This underscores the need for effective communication strategies that go beyond certification to educate consumers, address their concerns, and foster transparency.

In Malaysia, the role of communication is further amplified by the diverse and multicultural nature of its population. Pharmaceutical companies must ensure that their messaging is not only accurate but also culturally sensitive and accessible to all stakeholders (Ali & Suleiman, 2016). For instance, clear labelling, multilingual packaging, and proactive engagement with consumers through digital platforms can enhance trust and compliance (Mohd Yusoff, 2019). Moreover, non-verbal communication, such as the prominent display of halal logos and certifications, plays a crucial role in building consumer confidence (Abdul Rahim, 2021).

The Malaysian regulatory framework also emphasizes the importance of stakeholder collaboration. JAKIM works closely with industry players, academic institutions, and international bodies to develop and enforce halal standards (Razak, 2020). This collaborative approach ensures that the regulatory framework remains dynamic and responsive to emerging challenges, such as technological advancements and global market trends (Mohd Yusoff, 2019). By prioritizing effective communication and disclosure, Malaysia's halal pharmaceutical industry can serve as a model for other countries seeking to build trust and ensure compliance with halal principles.

This article explores the role of effective communication and disclosure in halal pharmaceutical practices, with a focus on Malaysia's regulatory framework. It examines the challenges, strategies, and opportunities for bridging the gap between industry standards and consumer expectations, drawing on insights from academic research and industry practices. By highlighting Malaysia's leadership in this field, the article aims to provide a roadmap for enhancing transparency, trust, and compliance in the global halal pharmaceutical industry.

Duty to inform by doctors

According to Kurniawati & Kusumawati (2023), an essential and fundamental patient right is the right to consent to medical treatment. The ethical principle of autonomy protects this fundamental right. This principle provides the basis for the belief that patients are given the authority to evaluate medical treatment choices. According to the theory of informed consent, doctors must provide patients with adequate information to enable them to make an "informed" decision in order to avoid legal action. Therefore, a doctor who performs a procedure that a patient has not consented to is infringing on the patient's legal rights

and could face medical malpractice lawsuits, removal from preferred provider lists, or loss of hospital privileges (Murray, 2012). However, doctors may find it helpful to know what they are generally required to disclose, as informed consent legislation and principles do not specify the quantity of information that must be disclosed.

The first legal concept of informed consent can be seen from the Nuremburg Code, which was created after World War II to make sure that unethical "medical" experiments were no longer conducted in the name of science. The code was created after the Nazi physicians experimented and tortured the prisoners during the World War 2 without their consent. Since then, patients' consent was absolutely required before any medical experiments are to be conducted on them.

The right to consent was historically protected through common law decisions (Rock, 2014). These early court decisions gave some guidance to health care providers about how to comply with the requirements of consent. Later, this common law right of consent was broadened and extended by mandating that medical professionals fulfil their obligation to notify patients of all pertinent details essential to their comprehension of the process prior to obtaining consent.

The broad idea that a person of majority age and sound mind has the legal right to decide what can be done to their body is the foundation of the theory as mentioned by Benjamin Cardoza J. in the leading case of Schloendorff v Society of New York Hospital (1914). This case established and solidified the principle of patient autonomy that ultimately formed the basis of the requirement for informed consent in medicine and research (Bazzano et. al, (2021). An Anglo-American law as included in Natanson v. Kline (1960) mentioned that each patient is considered to be the master of his or her own body. A patient of sound mind may prohibit medical treatment expressly even if it is lifesaving. Even if the physician believes the medical treatment is desirable or lifesaving, the law does not permit him or her to substitute personal judgment for that of the patient. The court in DiFilippo v Preston (1961) decided that a doctor's duty to disclose information to the patient depended upon community disclosure standards which customarily imposes the question as to whether the majority of doctors within a particular community would customarily make such a disclosure.

In an earlier case of Mohr v Williams (1905), the plaintiff, Mrs Anna Mohr, consented to an operation on her right ear; however, once she had been anesthetized, the defendant physician changed the plan of surgery from the right ear to the left after determining that the right ear was not as severely affected by disease as had been expected. Mrs Mohr's hearing was further impaired by the operation, and she sued the surgeon for assault and battery in changing the laterality of the operation without consent. The Supreme Court of Minnesota agreed that the surgeon should have obtained consent before performing surgery on the opposite ear. The decision was reiterated in another 1905 case, Pratt v Davis, the respondent sued her surgeon for abuse after the latter conducted a hysterectomy without getting her permission. The doctor acknowledged not getting permission for the second procedure and not telling the respondent that he planned to conduct a hysterectomy to treat her epileptic episodes, even though he had gotten permission for an earlier operation. The appellant admitted purposefully misrepresenting the operation's goal to the plaintiff, arguing that the respondent's epilepsy rendered her incapable of giving her consent or thinking critically about her circumstances. The court found for the respondent saying that the citizen's right to self-determination, or the fight for his inviolability, is the subject of universal acquiescence. This right inevitably prohibits any doctor or surgeon, no matter how talented or distinguished, who has been asked to examine, diagnose, advise, and prescribe (which are at least the essential first steps in treatment and care) from violating his patient's bodily integrity without authorization.

The famous Bolam's case (Bolam v Friern Hospital Management Committee [1957]) established that a doctor is not negligent if their actions are consistent with a practice accepted as proper by a responsible body of medical professionals skilled in that particular art. While this case primarily addressed the standard of care, it implicitly covered the extent of disclosure. At the time, the focus was on what other professionals would deem necessary to disclose rather than patient autonomy. The House of Lords held in Sidaway v Board of Governors of the Bethlem Royal Hospital [1985] that the Bolam test applied to the duty of disclosure, meaning a doctor could decide what risks to disclose, provided it was in line with standard

medical practice. However, this case has been criticized for not adequately respecting patient autonomy, as it allowed medical professionals significant discretion in deciding what information to provide. In a landmark decision in the case of Montgomery v. Lanarkshire Health Board [2015] the court had significantly redefined the duty to inform in English law. It was held that doctors must take reasonable steps to ensure that patients are aware of any material risks involved in a proposed treatment and of reasonable alternatives. A risk is material if a reasonable person in the patient's position would likely attach significance to it, or if the doctor knows that the particular patient would likely attach significance to it. This case shifted the focus from a doctor-centered approach (Bolam) to a patient-centered approach, emphasizing patient autonomy and the right to make informed decisions.

Hence, the extent of a doctor's liability in the duty to inform can vary depending on several factors, including jurisdictional laws, professional standards, and the specific circumstances of the case. However, in general terms, doctors have a duty to provide patients with sufficient information to make informed decisions about their medical care (Murray, ibid).

This duty typically includes disclosing relevant information about the patient's condition, diagnosis, prognosis, and treatment options, explaining the potential risks, benefits, and alternatives to the proposed treatment, ensuring that the patient understands the information provided and has the opportunity to ask questions and documenting the informed consent process in the patient's medical records. Failure to fulfil this duty could result in liability for the doctor, especially if the patient suffers harm as a result of not being properly informed. The specific legal standards for determining liability may vary, but in many jurisdictions, doctors can be held accountable for negligence if they fail to meet the standard of care expected of a reasonable and prudent healthcare provider. It is essential for doctors to stay up-to-date with legal and ethical standards regarding informed consent to minimize the risk of liability and ensure that patients are adequately informed about their medical treatment options. Thus, it is the scope of the law of tort to deal with this standard.

RESEARCH METHODOLOGY

This study employs a qualitative methodology, chosen for its effectiveness in investigating legal complexities and challenges associated with communicating the halal status of pharmaceutical products. By adopting a doctrinal, library-based approach, the research engages critically with primary legal sources, particularly analyzing common law precedents and statutory provisions governing the duty to inform within Malaysia's jurisdiction. This framework enables a comprehensive examination of the interplay between healthcare practitioners' obligation to disclose information and the necessity for transparent communication of halal compliance. To supplement this legal analysis, secondary data, which includes scholarly articles, case reports, monographs, and digital resources, are synthesized to contextualize findings and strengthen the study's theoretical foundation.

Additionally, insights from semi-structured interviews with medical professionals, pharmacists, and healthcare administrators enrich the empirical dimension of the research, drawing on their practical experiences in handling pharmaceutical products for diverse patient populations. Twenty respondents (R1-R20) were contacted to respond on questions relating to their practice of communicating the halal status of medicines given to patients and sold to the customers at their retail outlets. All necessary responses are partly recorded and displayed at Table 2 below. All interviews conducted for this study were transcribed verbatim to ensure accuracy and preserve the original language and expressions of the respondents. This approach allowed for a rich, authentic representation of participants' perspectives, especially given the cultural and ethical sensitivity surrounding halal pharmaceutical disclosure. The transcriptions were then analyzed using thematic analysis, following the six-step framework by Braun and Clarke (2006). These steps included familiarization with the data, generating initial codes, searching for themes, reviewing themes, defining and naming themes, and producing the final report. Coding was done inductively, meaning themes were derived directly from the data rather than guided by a pre-determined framework. Manual coding was used to assist in organizing data and identifying patterns across stakeholder responses. This method facilitated a comprehensive understanding of the current practices, ethical considerations, and institutional variations in disclosing halal status within the healthcare and pharmaceutical sectors.

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This study employed a purposive sampling method to select participants who possess relevant knowledge and experience regarding pharmaceutical practices, patient communication, and halal-related concerns in healthcare settings. The sampling aimed to ensure diversity across roles and institutions to gain a broad understanding of disclosure practices. A total of 20 participants were interviewed, comprising medical doctors, pharmacists (both from hospital and retail settings), dentists, and pharmaceutical retailers. Participants were selected based on their professional roles, direct engagement with patients or pharmaceutical products, and their ability to reflect on practices concerning halal status disclosure.

The sample included individuals from both government and private healthcare institutions, as well as those from urban and suburban areas, to capture variations in policy implementation and ethical practices. Efforts were made to include both Muslim and non-Muslim practitioners to explore different perspectives on religious and ethical obligations. Participation was voluntary, and informed consent was obtained prior to each interview. The sample size was considered sufficient as data saturation was reached; no new themes emerged toward the later stages of data collection.

By integrating primary legal analysis with secondary literature and stakeholder perspectives, the study identifies ambiguities and gaps within current regulatory frameworks that may impede effective communication of halal status in pharmaceuticals. The findings aim to inform recommendations for enhancing legal clarity and ethical practice in this critical area of healthcare disclosure.

Table 1 List of Respondents

RESPONDENT	**DESIGNATION**	**ORGANISATION/ AFFILIATION**
R1	Consultant Obstetrician & Gynaecologist & Gynae Oncologist	Hospital Tengku Ampuan Afzan, Kuantan
R2	Professor in Obstetrics & Gynaecology	International Medical University (IMU)
R3	Head of Department of Shariah Compliance	Sultan Ahmad Shah Medical Centre @ IIUM, (SASMEC @IIUM), Kuantan, Pahang
R4	Consultant Obstetrician & Gynaecologist	Darul Aman Specialist Clinic
R5	Associate Professor/ Consultant Orthopaedic Surgeon	Sultan Ahmad Shah Medical Centre IIUM, Kuantan
R6	Medical Officer	UiTM
R7	Consultant Orthopaedic Surgeon	Putra Specialist Hospital
R8	Medical Officer	Muar General Hospital
R9	Family Medicine Consultant	Health Ministry
R10	General Practitioner	Private Clinic in Trengganu
R11	Medical Officer (Obstetrician & Gynaecologist department)	Sungai Buloh General Hospital
R12	Registered Pharmacist	Hospital Tengku Ampuan Afzan, Kuantan Pahang
R13	Consultant Obstetrician & Gynaecologist	Columbia Asia Hospital, Taiping.
R14	Registered Pharmacist	Pharmacy Bentong

R15	Head of Pharmacy Department	Parit Buntar Hospital, Perak.
R16	Registered Pharmacist (Managing Director)	Farmasi Al Arif Sdn Bhd
R17	Registered Pharmacist	Temerloh General Hospital
R18	Consultant Periodontist	Periodontic Unit Dental Clinic, Klang
R19	Dentist	Health Ministry
R20	Dentist	Health Ministry

DISCUSSION AND ANALYSIS

Several respondents gave their opinions on the issue of whether there is a need to communicate the halal status of pharmaceutical products to the public or patients treated in hospitals and clinics, and to customers who buy medicines from retail outlets. Their responses vary according to the normal practice at their respective organization and place of work. The following table summarizes each one of their understandings of disclosure necessity in their field of work.

Table 2 Responses Retrieved from Respondents (R1-R20)

RESPONDENT	**DISCLOSURE OF HALAL STATUS OF MEDICINE TO PATIENTS/CUSTOMERS**		**REMARKS**
	Yes	No	
R1		√	Has in-house pharmacist to assist doctors to explain to patients.
R2	√		Will disclose whenever necessary and refer to any fatwas from the Mufti for guidelines. Will balance between benefits and harm.
R3		√	Have colour-coding for non-halal drugs. Patients must give consent after being explained of the non-halal status.
R4		√	Asked suppliers to provide the halal certificates. Those with no certificates but no available alternatives, will get informed consent from patients.
R5		√	Syariah Department available to advise doctors on the halal status of drugs.
			The information will be

R6	√		given to patients ethically based on the principles of maqasid syariah.
R7	√		Will try best possible not to give Muslim patients non-halal drugs unless no other drugs are available.
R8	√		Have in-house pharmacist for every ward in the hospital.
R9	√		Most drugs used are halal based. If there are non-halal drugs, patients must give verbal consent.
R10		√	Has own guideline which is not available online. Claimed that patients do not have to sign any written consent.
R11	√		Gave example of a medicine named Clexane that is non-halal but necessary to be used after surgery. There are available halal drugs but the after-effect risk is higher compared to the non-halal.
R12	√		Hoping for JAKIM to collaborate with drug control authorities to issue halal certificates before drugs are released to the public.
R13		√	Not disclosed because not many drugs have the halal status. Will only disclose if the drugs are porcine based.
R14		√	Most drugs do not have halal certificates. Retailers receive as they are from suppliers.
R15		√	Enlightened of NPRA's role in this respect and stated that NPRA will only know of the halal status of drugs if registration holders disclose about them during registration. Procedurally, applicants must inform NPRA if the drugs have animal origin or not.
R16		√	Retailers are not obliged to inform customers. Guidelines only available in

			government hospitals. NPRA makes it mandatory to declare the non-halal status at the labelling.
R17		√	Mentioned that all drugs that have animal origin whether halal or not, must have consents from patients as prescribed by the standard accreditation. Respective pharmacies should prepare a list of such drugs for references. (see table 1.1)
R18		√	Never thought of disclosing since all the drugs come from the pharmacy. But knew of some tools used for treatment are imported and non-halal.
R19	√		Will ask patients to decide if known non-halal drugs are to be applied to them.
R20		√	Assumed all drugs prescribed by the Pharmacy at the hospital are halal unless stated otherwise. Patients must sign written consent if agreed to be treated with non-halal medications after disclosing the risks attached to them.

Most doctors interviewed by the author admitted that they were not required by their profession to disclose the halal status of any medications used to their patients. Same goes to the pharmacists who have to encounter with patients at the medicine counter to advise them about the drugs they take when leaving the clinics or hospitals. The retailers whom the author had the opportunity to interview also admitted the same when selling medicines to their customers. Many doctors admitted that if they did so, it was a sheer moral responsibility as they each understand the necessity not to upset Muslim patients if the latter knew about the non-halal status of the drugs used for their treatment. Retailers on the other hand confessed that they will not disclose the non-halal status unless asked by the customers. It is opined that this relates to the fact that the customers may decide not to buy the medicines if they know of the non-halal status of the medicines.

In another perspective, it is fortunate for most government hospitals to have guidelines released by the Ministry of Health regarding this matter albeit not being forced to disclose the halal status of medicines to patients. For the time being, there is no legal implication if such disclosure is not carried out by medical practitioners. Some hospitals apparently have in-house pharmacists to advise doctors on drugs used for treatment as disclosed by R1, R5, R8 and R9. R2 mentioned that not all private hospitals have in-house pharmacists as a standard discipline but established private hospitals do. In our opinion, this is an admirable act by the hospitals because it facilitates the doctors in their job by not having had to explain the status of the drugs and let the experts do it. This will secure the trust of patients being treated and will subsequently ease the process of treatment.

R3 shared the colour-coding methodology in their practice where drugs are tagged with different colours to

identify the status of the medicine at the hospital he served. According to R3, the hospital he was attached to is a syariah compliant hospital and it is vital that they identify upfront the non-halal medicines to be labelled with red marks and placed in a separate cabinet. Secondly, the hospital will first explain the non-halal status of the medicine to Muslim patients before asking them to sign a consent form for the treatment. It is quite interesting because R3 also revealed that such procedure is also practiced to the non-Muslim patients because some of them also inquired about the halal status of the medicines used on them. Most respondents admitted that the consent form is an indicator that the patients are informed beforehand about the non-halal medicines to be employed on them. R3 did enlighten about drugs which have non-halal capsules although the contents are halal. For this issue, they have a good joint venture with the army who apparently has a viable list of all non-halal drugs which facilitate the hospital to act upon. For example, a drug named vitriol used for knee problems is an imported drug but the capsules are non-halal although hyaluronic acid (HA) in it is halal. So,

a similar drug is made in Malaysia with halal capsules made from bovine. According to R3, when patients disagree to have non-halal drugs used on them, the doctors will advise the alternatives such as drugs that have lesser effect on them or any other products like medical socks that help prevent leg swelling and, to a lesser extent, blood clots especially after surgery.

Another respondent, R4 declared that suppliers of drugs to his hospital are required to attach halal certificates for drugs used at their hospital but if the certificates are not available for any particular drugs, the Muslim patients are required to sign the written consent form. R2, R6 and R7 clarified that they will ethically inform patients of the non-halal drugs based on the principles of maqasid syariah where this is the underlying Islamic principle to prevent harm by considering the benefits and well-being it confers on human beings. R2 specifically stressed upon the need to refer to guidelines given by the religious department and the Mufti for confirmation before the drug is used but will balance between the benefits and the harm to the patients. R6 felt that all doctors either Muslim or not will disclose the non-halal status of the drugs used to Muslim patients based on ethics. R6 also believed that the definition of halal can have different meanings depending on Islamic scholars. R11 claimed that there is a necessity to give Muslim patients non-halal drugs especially after surgery such as Clexane although there are alternatives but the after-effect risk is higher compared to the non-halal drugs.

R13 declared that it is not a practice to disclose the halal status of drugs in their private hospital unless there is porcine contained in them. Surprisingly, R10 who has a private clinic for thirty years claimed that the clinic has its own guidelines but they were not available online. No disclosure has ever been made to patients and no written consent is required from them. R10 revealed that where halal matters are concerned, there are Muslim doctors' groups that will highlight and update on them and R10 will just refer to the information available in those groups.

Several registered pharmacists also gave their invaluable opinions on this matter. For a start, R15 enlightened the author on NPRA's role in this respect and stated that NPRA will only know of the halal status of drugs if registration holders disclose about them during registration. Procedurally, applicants must inform NPRA if the drugs have animal origin or not. But NPRA is not the valid authority to issue the halal certificate. Hence, there must be communications between the drug suppliers and JAKIM for NPRA to record the halal status of drugs registered with them. According to R15, most are drugs are imported and hence it is difficult to identify whether the components are halal or not. If the drug is halal certified from its country of origin, then JAKIM will not certify anymore. What NPRA can do is just to make it mandatory for applicants to expose the type of animal used in the drugs. R14 and R16 are both working in outlets selling medicines and they both divulged that drugs received from suppliers do not have any halal status. If drugs contain non-halal substances, they must be clearly labelled on the packaging. This is to indicate that the pharmacists in private outlets will base their knowledge on what is labelled on the packaging of the medicines. To add, most customers do not inquire about the halal status of any medicines that they buy from their outlets. A registered pharmacist working at a government hospital, R17 concurred with R14 and R16 and added that all drugs that have animal origin whether halal or not, must have consents from patients as prescribed by the standard accreditation. Consistent with R17's opinion, respective pharmacies should prepare a list of such drugs for references as prepared by the hospital R17 is working at as displayed partly

at table 1.1. Unquestionably, the author observes this as a remarkable initiative by the hospital and hopefully, other hospitals whether government or private do some way or another partake to furnish this list for their own references. R12, another registered pharmacist, is hoping for JAKIM to collaborate with drug control authorities to issue halal certificates before drugs are launched and released to the public by carrying out drug pharmaceutical audits. This certainly is the objective of this paper in order to establish a good communication to bridge the gap for any disclosure issues on halal pharmaceutical.

The last group that the author was able to get information for this study is the dentists. All three dentists admitted that they have never come across any issues on the halal status in their practice and they have never received any instructions to disclose the halal status of drugs used to patients before applying them to patients. Each one of them assumed the drugs are halal since they come from the hospital's pharmacy. But R20 mentioned that patients will be asked to sign a consent form if there are any drugs identified as non-halal after explaining the risks attached to them and R19 would ask patients to decide themselves when encountering such a situation. R18 however raised a relevant issue on the non-halal status of the equipment used during treatment because it was discovered that some of them are not halal since they are made from non-halal components. The author found that this is apparently an important and significant area to be researched on and will perhaps extend the research area to cover equipment used in medical treatment in the future.

Theoretical Framework

This study adopts a dual-theoretical framework, integrating the Theory of Planned Behaviour (TPB) by Ajzen (1991) with the Islamic ethical framework of *Maqasid al-Shariah*, to explore the disclosure practices and communication strategies of healthcare practitioners regarding the halal status of pharmaceutical products.

The Theory of Planned Behaviour (TPB) speculates that individual behaviour is driven by three primary factors:

1. Attitude – the degree to which a healthcare professional views the act of disclosing halal status as ethically important or beneficial,

2. Subjective norms – the influence of perceived social and institutional expectations (such as from patients, religious authorities, hospital management), and

3. Perceived behavioural control – the individual's perceived ability to perform the behaviour, taking into account barriers such as lack of information, training, or policy support.

Applying TPB to this study allows an examination of how practitioners' ethical beliefs, cultural awareness, and institutional norms shape their willingness and capacity to disclose information about the halal status of drugs.

In parallel, the study also draws upon the principles of *Maqasid al-Shariah* (Objectives of Islamic Law), which emphasize the protection of essential human values namely religion (*din*), life (*nafs*), intellect (*aql*), lineage (*nasl*) and property (*mal)* (Auda, 2008).

In the context of pharmaceutical ethics, disclosure of non-halal substances aligns with the protection of *din* (faith) and *nafs* (life), enabling Muslim patients to make informed choices that align with both their health needs and religious obligations (Kamali, 2008). This framework also supports the concept of *maslahah* (public interest) and *darurah* (necessity), helping healthcare providers ethically justify certain decisions when alternatives are unavailable or when health risks outweigh religious concerns (Kamali, 2010).

The integration of TPB and *Maqasid al-Shariah* thus provides a culturally sensitive and ethically grounded lens through which to interpret practitioner behaviour, institutional policies, and communication challenges in halal pharmaceutical contexts. It also supports the development of recommendations that are both practically and religiously appropriate, especially in Muslim-majority healthcare settings.

SUGGESTIONS AND RECOMMENDATIONS

Based on the discussions and practices outlined, the following recommendations can enhance transparency, ethical responsibility, and patient trust in the disclosure of halal status in pharmaceuticals.

First, there is a need to establish clear legal and ethical guidelines on halal disclosure, a National Policy on Halal Pharmaceutical Disclosure is perhaps indispensable. While current practices are based largely on personal ethics and moral responsibilities, there is a pressing need for formalized legal and regulatory frameworks that require healthcare providers including doctors, pharmacists, and retailers to disclose the halal status of medicines, especially in predominantly Muslim societies. This could be spearheaded by the Ministry of Health (MOH) in collaboration with religious authorities such as JAKIM (Department of Islamic Development Malaysia) and NPRA. Such a development for mandatory guidelines under the MOH and JAKIM to standardize these halal disclosure practices across all healthcare institutions (public and private) should include protocols for labelling, consent forms, and alternatives for non-halal medications. An example has been given by R3 above to adopt the color-coding system (e.g., red labels for non-halal drugs) and consent procedures used by syariah-compliant hospitals as a national model.

Second, communication channels between pharmaceutical stakeholders and halal certifying bodies must be strengthened. The current gap between NPRA and JAKIM should be bridged through formalized protocols and continuous communication. Suppliers, especially for imported drugs, should be mandated to disclose the source of animal ingredients, and a fast-track halal certification system could be introduced to expedite drug approval processes while upholding religious sensitivities. to ensure halal certification is integrated into drug registration processes. R12's suggestion for pre-market halal audits by JAKIM to certify drugs before public release should be implemented.

Third, it is necessary to implement mandatory labelling of halal status on medicine packaging through the passing of a new legislation or subsidiary legislation. Pharmaceutical companies (drug manufacturers and importers) should be required to label drugs with clear halal status indicators. This transparency would aid pharmacists, retailers, and consumers in making informed choices and reduce ambiguity at the point of purchase or prescription. This requirement of clear labelling of animal-derived ingredients on all medication packaging, as noted by R14 and R16 would encourage proactive disclosure, rather than relying on patient inquiries. For instance, adopt R3's approach of explaining non-halal components to all patients, regardless of religion, given growing interfaith awareness. Private pharmacies and hospitals should maintain updated lists of non-halal drugs (as done by R17's hospital) for patient reference. This leads to the critical creation and maintenance of a centralized halal drug database. A publicly accessible and regularly updated database listing the halal status of medications should be developed. This would empower both practitioners and patients with reliable information and reduce dependency on informal sources like WhatsApp groups.

Next, standard operating procedures (SOPs) for consent and disclosure need to be developed especially by hospital administrators and healthcare institutions. Hospitals and clinics should introduce standardized consent forms and clear disclosure procedures regarding the halal status of drugs, applicable to both Muslim and non-Muslim patients who request such information. These SOPs could be tailored to include color-coding systems and in-house pharmacist verification, as demonstrated by some hospitals. Staff training on effective communication is necessary to realize this recommendation.

Also, it is high time to create a centralized Public Database of Halal Medicines to build a publicly accessible digital platform listing the halal status of approved medications in Malaysia, updated regularly by MOH, NPRA, and JAKIM (with possible support from academic institutions). In order to make this possible, mandatory disclosure requirement during the drug registration process can ensure the necessary data is collected.

Healthcare providers should be trained on Halal Awareness and Ethical Disclosure carried out by medical and pharmacy training institutions, MOH, and professional boards. Integration of modules on religious and cultural sensitivity, including halal-related pharmaceutical ethics, into CPD (Continuing Professional Development) programs is highly applauded.

In addition, it is essential to encourage the use of halal alternatives where available. Doctors and pharmacists should actively offer halal-certified alternatives to non-halal medications when feasible, particularly when they do not compromise treatment efficacy. Collaborations with local pharmaceutical producers can help expand the availability of halal medications.

It is also elemental to introduce legal safeguards to protect practitioners and healthcare providers who disclose non-halal status, ensuring they are not penalized for reduced sales or patient refusal (a concern raised by retailers) as ethical and legal frameworks. Likewise, Islamic ethical principles (*maqasid* syariah) should be incorporated into institutional policies, as practiced by R2 and R6, to prioritize patient well-being while respecting religious requirements. Continuous education programs should be introduced for healthcare professionals to understand the significance of halal concerns in medical treatment. These programs should cover the above concept of *maqasid* syariah, ethical disclosure practices, and communication skills tailored to patient beliefs to encompass cultural and religious sensitivities.

Needless to say, since issues surrounding the halal status of dental and surgical equipment were highlighted, future research should delve deeper into this underexplored area, potentially guiding policy development for halal-compliant medical tools (highlighted by R18). This could be carried out by research institutions, MOH, and JAKIM. To add, studies on alternatives to non-halal materials in devices and drugs (such as Malaysian-produced halal capsules, as mentioned by R3) should be supported.

Limitations

The study was conducted based on interviews with a selected group of doctors, pharmacists, dentists, and retailers, which may not represent the full spectrum of healthcare professionals across the country. As such, the findings may not be generalizable to all healthcare settings, particularly in rural or underserved areas. It also focused primarily on healthcare providers and stakeholders, but did not directly include the views and experiences of patients, particularly Muslim patients who are directly affected by the non-disclosure of halal pharmaceutical information. Including patient perspectives would have offered a more comprehensive understanding of communication gaps and expectations. Much of the data collected was based on self-reported interviews, which may be subject to personal bias, selective memory, or social desirability. Some respondents may have downplayed shortcomings in disclosure practices or overstated their ethical compliance.

CONCLUSION

To conclude, the findings of this study reveal that while there is growing awareness among medical practitioners, pharmacists, and retailers regarding the religious sensitivities of Muslim patients, the disclosure of halal status in pharmaceuticals remains inconsistent and largely informal. Most healthcare providers rely on personal ethics rather than established policy to inform patients of non-halal components, and there exists a notable absence of legal obligations or standardized procedures to guide this practice.

Notably, hospitals with syariah-compliant frameworks have made commendable efforts through the use of color-coding, written consents, and dedicated pharmacist consultations. However, the lack of a cohesive national strategy or enforceable regulation has resulted in disparate practices across the healthcare system, with some practitioners unaware or unconcerned about disclosure responsibilities.

Given the importance of transparency in maintaining patient trust and ensuring culturally respectful healthcare delivery, this paper recommends stronger policy interventions, improved inter-agency coordination, and standardized communication strategies to promote ethical and effective disclosure. The incorporation of halal considerations into mainstream pharmaceutical governance is not only a matter of religious compliance but also a reflection of respect for patient autonomy, cultural diversity, and ethical medical practice.

Ultimately, bridging the communication gap in halal pharmaceutical disclosure will not only enhance the quality of healthcare but also uphold the integrity of Malaysia’s commitment to inclusive and patient-

centered care.

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