Medical Negligence in Malaysia: Rising Claims, Structural Gaps, and the Case for Reform

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Abstract

This paper examines the rise in medical negligence claims in Malaysia and argues that this trend reflects underlying structural gaps within the medico-legal framework. Adopting a doctrinal legal research methodology complemented by analytical and comparative approaches, the study analyses legislation, judicial decisions, government reports, and relevant academic literature to assess the adequacy of Malaysia's existing medico-legal framework. It examines the interaction between common law principles, statutory provisions, and regulatory oversight. It further evaluates the impacts of evolving legal standards, judicial developments, institutional challenges in healthcare delivery, and increasing patient awareness.

The findings indicate that although the existing framework provides flexibility through common law, it is characterised by inconsistency, fragmented accountability, regulatory limitations, and inadequate patient-centred mechanisms. In particular, the regulatory scope of the Medical Act 1971 does not adequately address modern medico-legal challenges, resulting in a disconnect between professional regulation and civil liability.

The paper concludes that targeted reforms, including clearer standards of care, improved reporting mechanisms, enhanced regulatory oversight, and the institutionalisation of alternative dispute resolution, are necessary to Malaysia's medico-legal framework while balancing patient protection with the practical realities of medical practice.

Keywords: Malaysia, Medical Negligence, Medico-legal Framework, Standard of Care, Medical Act 1971, Law Reform.

[1] Acknowledgements: This article did not receive any specific funding from public, commercial, or not-for-profit organisations. The author wishes to acknowledge that this paper originated from a group assignment and extends appreciation to Dr Thuraikumar A/L Kanniah and Dr Amir Ghadaffi bin Patawari for their collaboration, insights, and contributions during the initial stages of the work. Any revisions, analysis and views expressed in this article are solely those of the author.

1. Introduction

Medical negligence, also known as medical malpractice, arises from a breach of duty of care and a failure to provide the required standard of care, resulting in harm or injury to the patient.[2] Traditionally, such claims were viewed as isolated failures of individual practitioners. However, medical negligence is increasingly understood as a reflection of broader systemic strain within modern healthcare systems. As patient expectations rise alongside increasing medical complexity, even minor lapses may escalate into legal disputes. This has likely contributed to a noticeable increase in medical negligence claims. In Malaysia, this trend raises critical questions about whether existing legal and regulatory frameworks remain adequate to balance patient protection with the realities of clinical practice.

1.1 Conceptualising Structural Gaps in Malaysia's Medico-Legal Framework

For the purposes of this paper, the term "structural gaps" refers to systemic deficiencies within the Malaysian medico-legal framework that impede the effective alignment of legal accountability, professional regulation, institutional governance, and patient protection. These gaps are not limited to deficiencies in statutory law, but include disciplinary and civil mechanisms, inconsistencies in standards of care, limited integration between healthcare regulation and negligence litigation, inadequate institutional accountability mechanisms, and the absence of comprehensive reporting systems capable of generating reliable medico-legal data.

This conceptual framework underpins the analysis throughout the paper. The rise in medical negligence claims is therefore examined not merely as an increase in litigation, but as a manifestation of broader structural weaknesses affecting the interaction between legal institutions, healthcare providers, regulatory bodies, and patients.

Against this backdrop, this paper has three primary objectives. First, it examines the existing medico-legal framework governing medical negligence in Malaysia, including the role of common law, statutory provisions, and regulatory oversight. Second, it aims to identify and analyse the key factors contributing to the rise in medical negligence claims, including legal, judicial, institutional, and societal influences. Third, it evaluates whether the current framework is sufficient to address contemporary challenges in medical practice.

1.2 Research Methodology

This study adopts a doctrinal legal research methodology, supplemented by an analytical and policy-oriented inquiry, to examine the adequacy of Malaysia's existing medico-legal framework in addressing the increasing incidence of medical negligence claims. Doctrinal legal research is appropriate because the principal objective of this article is to analyse the development and application of legal principles governing medical negligence through judicial decisions, statutory provisions, and regulatory instruments, while critically evaluating their effectiveness in contemporary healthcare practice.

[2] B Sonny Bal, 'An Introduction to Medical Malpractice in the United States' (2009) 467 Clinical Orthopaedics & Related Research 339.

The primary sources examined include Malaysian legislation such as the Medical Act 1971[3], the Civil Law Act 1956[4], the Limitation Act 1953[5], together with relevant subsidiary regulations and professional guidelines issued by the Malaysian Medical Council (MMC) and the Ministry of Health Malaysia (MOH). Judicial authorities from Malaysian courts constitute the principal source of doctrinal analysis, particularly decisions concerning standards of care, informed consent, institutional liability, and professional accountability. In addition, comparative reference is made to selected Commonwealth jurisdictions, namely Singapore, the United Kingdom (UK), Australia, Canada, and New Zealand, due to their shared common law heritage and the development of significant medico-legal reforms that may offer persuasive guidance for the Malaysian context.

In addition to doctrinal analysis, the study incorporates a limited empirical review of publicly available governmental reports, academic literature, and medico-legal policy documents to contextualise recent trends in medical negligence claims and healthcare governance. Rather than conducting quantitative empirical research, these materials are utilised to support the broader policy analysis concerning the interaction between legal doctrine, regulatory institutions, judicial practice, and healthcare administration.

The scope of this article is confined to civil medical negligence under Malaysian law and does not extend to criminal liability, contractual disputes, or Islamic medical jurisprudence. Similarly, while comparative jurisdictions are discussed, they are intended to provide illustrative examples of possible regulatory approaches rather than direct models for legal transplantation.

The study is subject to certain limitations. Malaysia presently lacks a comprehensive national database on medical negligence litigation, settlements, and medico-legal complaints, resulting in reliance upon publicly available judicial decisions, MOH reports, MMC publications, and academic research. Consequently, observations concerning the increase in medical negligence claims should be understood as based on available institutional indicators rather than complete nationwide empirical statistics. Nevertheless, these materials provide sufficient evidence to facilitate a critical evaluation of structural issues within Malaysia's current medico-legal framework.

1.3 Empirical Trends in Medical Negligence Claims in Malaysia

Although Malaysia does not maintain a comprehensive national database recording all medical negligence claims, settlements, disciplinary actions, and indemnity payouts, available evidence from government reports, professional bodies, academic studies, and judicial developments collectively suggests that medico-legal disputes are becoming increasingly significant within the Malaysian healthcare landscape.[6]

[3] Medical Act 1971.
[4] Civil Law Act 1956.
[5] Limitation Act 1953.
[6] Siti Naaishah Hambali and Solmaz Khodapanahandeh, 'A Review of Medical Malpractice Issues in Malaysia under Tort Litigation System' (2014) 6 Global Journal of Health Science 76.

The most direct evidence comes from MOH. Financial data from the MOH Annual Report 2023 indicates that compensation for medico-legal cases rose from RM5.8 million in 2022 to RM6.8 million in 2023, indicating an upward trajectory in medico-legal liability.[7] Available institutional data suggest that medico-legal complaints and litigation involving public healthcare facilities have become increasingly prominent over recent years. According to the MOH Annual Report 2024, a total of 336 medico-legal complaints and 118 litigation cases were registered against MOH healthcare facilities during the year, while 41 cases resulted in recommendations for ex gratia payments.[8] The report further notes that Independent Inquiry Committees were convened for 76 complex cases involving compensation claims, reflecting the increasing complexity of medico-legal dispute management within the public healthcare sector.[9]

Longitudinal data published by the MOH similarly indicate an upward trend in medico-legal complaints over recent years.[10] MOH statistics recorded 211 medico-legal complaints in 2020, increasing to 234 complaints in 2021, 283 complaints in 2023, and 336 complaints in 2024. Litigation cases also increased from 68 cases in 2020 to 118 cases in 2024.[11] Although these figures relate only to MOH facilities and exclude private healthcare institutions, they suggest increasing medico-legal activity within Malaysia's largest healthcare provider.

Table 1. Medico Legal Statistics (2020 to 2024)[12]

Year	MOH Medico-Legal Complaints	Litigation Cases	Ex Gratia Cases
2020	211	68	107
2021	234	76	108
2022	283	81	117
2023	283	86	121
2024	336	118	125

The observed increase should, however, be interpreted cautiously. Rising complaint numbers do not necessarily indicate declining standards of medical practice. Instead, they may reflect multiple interacting factors, including greater patient awareness of legal rights, improved institutional complaint mechanisms, increasing healthcare utilisation, demographic changes, expansion of specialised medical services, and greater willingness to pursue legal or administrative remedies following adverse clinical outcomes. Thus, numerical increases in complaints should not automatically be equated with increasing medical negligence or declining professional competence.

[7] Ministry of Health Malaysia, *Annual Report 2023* (MOH/S/RAN/275.24(AR) - e, 2024).
[8] Ministry of Health Malaysia, *Annual Report 2024* (MOH/S/RAN/304.25(AR) - e, 2025).
[9] Ibid.
[10] Ibid.
[11] Ibid.
[12] Ibid.

Academic literature similarly supports the existence of a growing medico-legal trend. Puteri Nemie Jahn Kassim observed that Malaysia was experiencing a gradual increase in both the number of medical negligence claims and the size of compensation awards over past decades.[13] Subsequent research continued to identify medical negligence litigation as an expanding area of legal practice, driven by greater patient awareness, increased healthcare consumerism, and evolving judicial approaches towards professional accountability.[14] Hambali and Khodapanahandeh similarly noted that increased public awareness, easier access to information, rising healthcare expectations, and dissatisfaction with healthcare outcomes may have contributed to a greater willingness among patients to challenge clinical decisions through legal mechanisms.[15]

Further illustrating this trajectory are recent Malaysian judicial developments. Malaysian courts have, over the past two decades, delivered a growing body of jurisprudence addressing informed consent, institutional liability, delayed diagnosis, specialist standards of care, and hospital accountability. Landmark decisions between 2023 and 2024, such as *Siow Ching Yee v Columbia Asia Sdn Bhd*[16], *Syazwani binti Drani v Government of Malaysia & Ors*[17], and *Prince Court Medical Centre Sdn Bhd v Lim Yoke Har*[18], demonstrate the courts' increasing willingness to scrutinise medical conduct and impose substantial liability. This trend continued into 2026, as seen in *AF (a child suing through his mother) v Putra Medical Centre Darul Aiman Sdn Bhd*[19], where both medical practitioners and the hospital were held liable for failures in timely diagnosis and treatment, reinforcing the expanding scope of institutional accountability. The emergence of such litigation reflects the increasingly complex nature of contemporary healthcare delivery and demonstrates that medical negligence disputes now extend beyond allegations of individual professional error to encompass broader issues of organisational governance and systemic patient safety.

Importantly, none of the foregoing sources should be interpreted in isolation. MOH data capture only the public healthcare sector, judicial decisions represent only a small proportion of disputes that proceed to reported litigation, disciplinary proceedings pursue objectives distinct from civil liability, and empirical studies are necessarily shaped by their respective institutional contexts. However, the convergence of evidence across these independent sources supports the broader conclusion that medical negligence has become an increasingly significant component of Malaysia's healthcare governance framework. Thus, the central argument advanced in this article is not that litigation has increased solely because medical care has deteriorated, but rather that evolving legal standards, institutional transformation, technological change, and heightened patient awareness have collectively increased the visibility, complexity, and frequency of medico-legal disputes.

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[13] Puteri Nemie Jahn Kassim, *Medical Negligence in Malaysia: Cases and Commentary* (2nd edn, Thomson Reuters Asia 2021).

[14] Margaret Brazier and Emma Cave, *Medicine, Patients and the Law* (7th edn, Manchester University Press 2023).

[15] Hambali and Khodapanahandeh (n 6).

[16] [2024] 3 MLRA 208.

[17] [2023] 1 LNS 2261.

[18] *Prince Court Medical Centre Sdn Bhd v Lim Yoke Har (bertindak melalui anak lelaki dan wakil litigasinya, Goh Seng Cha) & Ors and another suit* [2024] MLJU 2699.

[19] *AF (a child suing through his mother 'parents ad litem' Isrul Hasmah bt Ismail) & Anor v Putra Medical Centre Darul Aiman Sdn Bhd & Anor* [2026] 8 MLJ 349.

2. Medico-Legal Framework in Malaysia

2.1 Elements of Medical Negligence

Under Malaysian law, a successful medical negligence claim requires the claimant to establish a duty of care, breach of duty, and causation.[20] These elements constitute the legal threshold that must be satisfied before compensation can be awarded.[21]

2.1.1 Duty of Care

The existence of a duty of care is generally established once a doctor–patient relationship is formed.[22] This duty requires medical practitioners to exercise reasonable care and skill when providing treatment.[23] In medical negligence claims, this element is typically straightforward, as courts readily recognise that healthcare providers owe patients a legal obligation once treatment is undertaken. Although the existence of the duty is seldom disputed in Malaysian medical negligence litigation, its practical significance lies in determining the scope of accountability within increasingly complex healthcare systems.

Importantly, modern Malaysian jurisprudence has extended this duty beyond individual practitioners to include healthcare institutions, particularly private hospitals.[24] This expansion increases the scope of potential defendants in medical negligence claims, enabling claimants to pursue both individual and institutional liability where appropriate. This judicial development reflects a broader recognition that patient safety increasingly depends upon organisational governance, multidisciplinary care, and institutional systems rather than solely on the conduct of individual practitioners. Consequently, this expansion of the duty of care reinforces the article's central argument that structural gaps arise not merely from individual professional failures but also from evolving institutional responsibilities that existing regulatory frameworks do not fully address.

2.1.2 Breach of Duty

Breach of duty is often the central issue in most medical negligence claims, as it requires the court to determine whether the medical practitioner's conduct fell below the accepted standard of care. This assessment is inherently fact specific and relies heavily on expert evidence. However, determining what constitutes the applicable standard has become increasingly complex as medical practice evolves beyond traditional doctor–patient interactions into multidisciplinary and technology-assisted healthcare delivery.

In practice, establishing breach largely determines whether a claim succeeds, as courts must evaluate whether the practitioner acted in accordance with accepted medical practice. Where the standard of care is interpreted more strictly, particularly in areas such as risk

[20] Jahn Kassim (n 13).
[21] *Shalini a/p Kanagaratnam v Pusat Perubatan Universiti Malaya (formerly known as University Hospital) & Anor* [2016] 3 MLJ 742.
[22] *R v Bateman* [1925] 19 Cr App R8.
[23] *Foo Fio Na v Dr Soo Fook Mun & Anor* [2007] 1 MLJ 593.
[24] *Siow Ching Yee* (n 16).

disclosure, the likelihood of establishing breach increases, thereby contributing to the rise in medical negligence claims.

2.1.3 Causation

Causation requires the claimant to prove that the breach of duty caused the injury suffered. If the injury would have occurred regardless of the breach, liability will not follow, although liability may still arise where the breach materially contributed to the harm.[25] Malaysian courts generally apply the "but for" test, supported by expert medical evidence.[26] In medical negligence claims, causation often presents a significant hurdle due to the complexity of medical conditions and the presence of multiple contributing factors. This difficulty has become increasingly pronounced within modern healthcare, where patient outcomes frequently involve multidisciplinary treatment, pre-existing medical conditions, and complex clinical pathways that complicate the attribution of legal responsibility. Even where a breach of duty is established, a failure to prove causation may result in the claim being dismissed. Thus, the complexity of proving causation therefore reinforces the need for clearer institutional accountability and more comprehensive documentation, both of which constitute recurring structural issues examined throughout this article.

2.2 Standard of Care in Malaysia

The standard of care is a critical determinant in medical negligence claims, as it defines the threshold against which a practitioner's conduct is assessed. Malaysian law reflects an evolving approach that balances professional expertise with patient rights.

2.2.1 The Bolam Test

Traditionally, Malaysian courts have applied the Bolam test, under which a medical practitioner is not negligent if their conduct is supported by a responsible body of medical opinion.[27] This approach places considerable weight on professional consensus and has made it more difficult for claimants to succeed in medical negligence claims, as courts defer to medical expertise.

Although the Bolam test provides flexibility, it has been criticised for limiting patient protection, particularly where professional standards may not adequately reflect patient expectations or evolving norms of care. Excessive judicial deference to professional opinion may also reduce transparency and hinder meaningful external scrutiny of clinical decision-making, particularly where institutional practices rather than individual errors contribute to patient harm.

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[25] Wu Siew Ying t/a Fuh Lin Bud-Grafting Centre v Gunung Tunggal Quarry & Construction Sdn Bhd 2 MLJ 1; Nur Fuziatun binti Mohd Fadzli v Gombak Medical Centre Sdn Bhd & Ors MLJU 4319.

[26] *Cork v Kirby Maclean Ltd* [1952] 2 All ER 402; *Barnett v Chelsea Kensington Hospital Management* [1967] 1 QB 428.

[27] Mah Weng Kwai & Associates, 'Approach to Medical Negligence Claims by Malaysian Courts' (*MahWengKwai & Associates*, 10 January 2013) <https://mahwengkwai.com/approach-to-medical-negligence-claims-by-malaysian-courts/> accessed 15 March 2026.

2.2.2 Post-Foo Fio Na Developments

The Federal Court decision in *Foo Fio Na v Dr Soo Fook Mun & Anor*[28] marked a significant shift in Malaysian law, particularly in relation to informed consent. The case involved a patient who suffered paralysis following surgery and alleged inadequate disclosure of risks. The Court held that the duty to disclose material risks should be assessed from the perspective of a reasonable patient, rather than solely by reference to medical opinion. This development aligns Malaysian law with the approach in *Rogers v Whitaker*[29] and reflects a move towards patient-centred care.

In the context of medical negligence claims, this shift has important implications. It lowers the threshold for establishing breach in cases involving non-disclosure and enhances patient autonomy. Consequently, claims based on inadequate communication or failure to disclose material risks have become more viable, contributing to the overall increase in litigation.

2.3 Statutory Regulation and Emerging Challenges

Although medical negligence claims are primarily governed by common law, statutory provisions play an important role in shaping the regulatory environment, procedural requirements, and institutional responsibilities that influence such claims. The Medical Act 1971[30] establishes the framework for the registration and regulation of medical practitioners in Malaysia, while other legislation, including the Civil Law Act 1956[31], the Limitation Act 1953[32], and the Private Healthcare Facilities and Services Act 1998[33], collectively provides the broader statutory context within which negligence claims operate.

The Civil Law Act 1956[34] provides the legal basis for the application of common law principles in Malaysia, including those governing negligence. It provides the statutory foundation for the application of established tort principles in medical negligence claims. The Limitation Act 1953[35] imposes time limits on the filing of claims, which directly affects access to justice in medical negligence cases. Delays in diagnosis or the discovery of harm may complicate compliance with limitation periods, potentially barring otherwise valid claims.

As for the Private Healthcare Facilities and Services Act 1998[36], it regulates private healthcare providers and imposes statutory obligations relating to patient safety, quality of care, and institutional governance. In medical negligence claims, this Act has assumed increasing importance as courts recognise that healthcare institutions owe independent duties of care to patients. This development supports claims against hospitals for systemic

[28] *Foo Fio Na* (n 23).
[29] [1992] 175 CLR 479.
[30] Medical Act 1971.
[31] Civil Law Act 1956.
[32] Limitation Act 1953.
[33] Private Healthcare Facilities and Services Act 1998.
[34] Civil Law Act 1956.
[35] Limitation Act 1953.
[36] Private Healthcare Facilities and Services Act 1998.

failures, such as inadequate supervision or poor clinical governance, thereby expanding the scope of liability beyond individual practitioners.

The Medical Act 1971[37] has served Malaysia's healthcare system for more than five decades by establishing professional standards and empowering the MMC to oversee professional conduct. While the Act does not directly determine civil liability, it plays an indirect evidentiary role in medical negligence claims. Courts may refer to professional standards, ethical guidelines, and disciplinary findings when assessing whether a practitioner has met the required standard of care. Nevertheless, significant developments in healthcare delivery raise legitimate questions regarding whether the Act remains sufficiently responsive to contemporary medico-legal challenges. At the time of its enactment, healthcare delivery in Malaysia was predominantly centred upon individual practitioners operating within comparatively simple institutional structures. Modern healthcare, by contrast, is characterised by multidisciplinary treatment teams, complex corporate healthcare organisations, technological innovation, and increasing reliance upon digital healthcare services.

The rapid expansion of private healthcare illustrates this transformation. Contemporary medical care increasingly involves institutional decision-making rather than isolated professional judgment, with hospitals exercising substantial control over staffing arrangements, clinical governance, administrative systems, and patient safety mechanisms. Recent judicial decisions recognising non-delegable duties owed by private hospitals demonstrate that institutional responsibility has become an increasingly important aspect of medical negligence litigation. However, the existing statutory framework remains principally focused upon regulating individual practitioners rather than healthcare institutions as integrated systems of care.

The emergence of telemedicine, electronic health records, artificial intelligence-assisted diagnosis, and remote healthcare delivery further exposes limitations within the current legislative framework. Although Malaysia enacted the Telemedicine Act 1997[38], one of the earliest telemedicine statutes globally, questions remain regarding the practical integration of telemedicine regulation with the broader professional framework established under the Medical Act 1971.[39] Increasing reliance on remote consultations, digital prescribing platforms, electronic medical records, and cross-border healthcare services has generated novel issues relating to standards of care, informed consent, continuity of treatment, and professional accountability. These developments require regulatory responses that extend beyond traditional models of face-to-face clinical practice.

Thus, the issue is not whether the Medical Act 1971[40] remains relevant, but whether its current regulatory framework has evolved sufficiently to respond to contemporary healthcare delivery. The increasing complexity of healthcare services suggests a need for ongoing legislative review to ensure that professional regulation remains capable of

[37] Medical Act 1971.
[38] Telemedicine Act 1997.
[39] Medical Act 1971.
[40] Ibid.

responding to institutional liability, technological innovation, and evolving patient expectations.

2.4 Institutional Limitations of Malaysian Medical Council (MMC)

The MMC, established under *section 3* of the Medical Act 1971[41], is responsible for regulating professional conduct and maintaining standards within the medical profession. Its functions include receiving complaints, conducting disciplinary proceedings, and issuing professional guidelines. In relation to medical negligence claims, the MMC plays a complementary but limited role. MMC findings and guidelines may influence negligence claims by informing the court's assessment of professional standards.

A recurring challenge concerns the availability of publicly available information regarding disciplinary proceedings and complaint outcomes. While the MMC possesses extensive disciplinary powers under the Medical Act 1971[42], comprehensive annual data relating to complaint volumes, investigation outcomes, disciplinary sanctions, and case-processing timelines are not routinely published in a consolidated format. This limits opportunities for independent assessment of regulatory performance and makes it difficult for policymakers and researchers to evaluate broader trends in professional misconduct and patient complaints.

Another challenge concerns procedural efficiency. Effective professional regulation requires complaints to be investigated and resolved within reasonable timeframes. Delays in disciplinary proceedings may undermine both practitioner confidence and public trust, particularly where complainants perceive that accountability mechanisms are inaccessible or ineffective. Although procedural reforms introduced through the Medical (Amendment) Act 2012[43] and Medical Regulations 2017[44] were intended to strengthen disciplinary processes and improve the functionality of the MMC, ongoing evaluation of complaint-handling efficiency remains necessary.

Furthermore, the MMC's jurisdiction is inherently limited. The Council's processes focus on misconduct rather than civil liability, and the MMC does not fully address the needs of claimants seeking civil redress. Consequently, disciplinary proceedings, civil negligence claims, hospital complaint mechanisms, and MOH investigations frequently operate in parallel rather than as components of a coordinated accountability system. This institutional fragmentation reinforces the broader structural issue that medical negligence claims in Malaysia are resolved primarily through the courts, with regulatory mechanisms serving only a supporting function.

[41] Ibid, s3.
[42] Ibid.
[43] Medical (Amendment) Act 2012.
[44] Medical Regulations 2017.

3. Factors Contributing to the Rise in Medical Negligence Claims

3.1 Legal Factors

Legal developments have significantly expanded the scope and accessibility of medical negligence claims in Malaysia. In the Malaysian context, the position evolved through judicial refinement, particularly in relation to informed consent and disclosure obligations. *Foo Fio Na v Dr Soo Fook Mun & Anor*[45] made it clear that courts are not strictly bound by medical opinion in all circumstances. Instead, in cases involving risk disclosure, the courts may independently assess whether a practitioner has disclosed material risks that a reasonable patient would consider significant. The Bolam test was replaced in favour of the test set out in *Rogers v Whitaker.*[46] Because of this, doctors must now ensure that patients understand all major risks related to their medical care. As a result of this judgement, patients gain more control over their treatment and doctors may be held more accountable and are required to be more open when describing their management plans.

Subsequent jurisprudence has reinforced this shift. In *Dr Hari Krishnan & Anor v Megat Noor Ishak Bin Megat Ibrahim & Anor*[47], the Federal Court held that failure to disclose material risks, particularly where a patient has expressed specific concerns, constitutes a breach of duty. The case involved a patient becoming permanently blind in one eye following retinal detachment surgeries. He alleged that he was not properly informed of the specific risks of the second procedure, including blindness, and was denied further diagnostic testing before the operation. The Court emphasised that informed consent must be meaningful and tailored to the patient's understanding, rather than limited to generalised warnings.

Importantly, the court drew a distinction between the standards for advice, diagnosis, and treatment. It affirmed that while the *Rogers v Whitaker* test governs the duty to inform patients of risks, the *Bolam* test, with the *Bolitho* qualification, still applies to diagnosis and treatment. In other words, courts will assess medical decisions based on whether they are supported by a responsible body of opinion, but they also reserve the right to reject illogical or unreasonable professional views. This case reaffirmed that informed consent must go beyond generic warnings and address risks that a reasonable patient would consider significant.

At the same time, statutory frameworks have strengthened the regulatory environment surrounding medical practice. The Private Healthcare Facilities and Services Act 1998[48] imposes obligations on private healthcare providers to maintain standards of safety and quality, effectively broadening institutional responsibility. thereby extending responsibility beyond individual practitioners to healthcare institutions themselves. This reflects the increasing institutionalisation of healthcare delivery, where hospitals and private healthcare facilities are expected to implement effective governance systems, clinical protocols, and risk

[45] *Foo Fio Na* (n 23).
[46] *Rogers* (n 29).
[47] *Dr Hari Krishnan & Anor v Megat Noor Ishak Bin Megat Ibrahim & Anor and Another Appeal* [2018] 3 MLJ 281.
[48] Private Healthcare Facilities and Services Act 1998.

management measures to safeguard patient safety. Although the Act does not create an independent cause of action for medical negligence, breaches of its statutory obligations may provide persuasive evidence that a healthcare institution has failed to exercise reasonable care, particularly in cases involving inadequate staffing, poor clinical governance, or systemic failures in patient management. Consequently, the Act reinforces the growing recognition that medical negligence may arise not only from individual clinical errors but also from organisational shortcomings within healthcare institutions.

The Medical Act 1971[49] further establishes professional registration requirements and disciplinary mechanisms, ensuring that practitioners meet minimum competency standards. While these statutes do not create civil liability directly, it provides a regulatory framework that promotes professional competence and ethical practice. Courts may refer to statutory requirements, the MMC's Code of Professional Conduct, and other professional guidelines as persuasive evidence when assessing whether a medical practitioner has exercised the standard of care expected of a reasonably competent practitioner in similar circumstances. These serve as normative benchmarks that assist the court in evaluating whether the common law standard of care has been satisfied alongside expert evidence and established legal principles.

These legal developments collectively expand both the grounds for liability and the ease with which claims can be substantiated, thereby contributing to the rise in medical negligence litigation.

3.2 Judicial Factors

The increasing number of medical negligence claims in Malaysia is partly due to how courts have evolved in applying standards of care, not only in technical treatment but also in communication, timeliness, and institutional responsibility. The judiciary's willingness to hold both individuals and healthcare systems accountable for procedural lapses has possibly contributed to a more rights-conscious litigation environment. Rather than deferring entirely to professional opinion, courts increasingly examine whether medical decisions are logically defensible, adequately documented, and aligned with reasonable clinical expectations.

A notable example is *Dr Hari Krishnan & Anor v Megat Noor Ishak Bin Megat Ibrahim & Anor and Another Appeal*[50], where the court not only addressed the failure to disclose risks but also scrutinised the adequacy of communication between doctor and patient. The judgment emphasised that informed consent is not a mere procedural formality but a substantive requirement grounded in patient autonomy.

Another relevant case is *Ahmad Thaqif Amzar bin Ahmad Huzairi v Kuala Terengganu Specialist Hospital Sdn Bhd & Ors*[51], where the plaintiff, a child represented by his mother, suffered irreversible brain damage after multiple doctors failed to respond urgently to a

[49] Medical Act 1971.
[50] *Dr Hari Krishnan* (n 47).
[51] *Ahmad Thaqif Amzar bin Ahmad Huzairi v Kuala Terengganu Specialist Hospital Sdn Bhd & Ors* [2021] 9 MLJ 10.

progressively enlarging neck swelling that obstructed his airway. The court found both private and public healthcare providers liable for delays in referral, diagnosis, and specialist intervention. Importantly, liability was apportioned, with the courts recognising both individual negligence and institutional responsibility, while also considering contributory negligence on the part of the patient's guardians.

This case illustrates how Malaysian courts no longer focus solely on the competence of individual doctors but increasingly interrogate institutional procedures and documentation. In comparison, in *Foo Fio Na v Dr Soo Fook Mun & Anor*[52], although the Federal Court significantly expanded the doctrine of informed consent by emphasising patient autonomy, the court's inquiry remained centred on the conduct and professional obligations of the treating doctor rather than the wider organisational systems within which healthcare was delivered. Similarly, in *Shalini a/p Kanagaratnam v Pusat Perubatan Universiti Malaya*[53], the court's assessment largely focused on whether the treating clinicians had breached the applicable standard of care, with comparatively limited examination of broader institutional governance or systemic failures. By contrast, the decision in *Ahmad Thaqif*[54] demonstrates an increasingly holistic judicial approach. Delayed scans, failure to escalate to specialists, and poor communication were all treated as breaches of the standard of care, even when the patient had initially presented to a private facility and was later transferred to a public one.

More recently, in *Siow Ching Yee v Columbia Asia Sdn Bhd*[55], the Federal Court clarified that private hospitals owe a direct and non-delegable duty of care to patients. In this case, the hospital was held liable for the negligence of an independent anaesthetist who failed to detect hypoxia. The Court held that private healthcare facilities are also healthcare providers and that they are legally required to take responsibility for their patients' care, emphasising that hospitals cannot avoid liability merely by structuring contractual relationships with independent practitioners. This decision significantly strengthens institutional liability and expands the avenues through which patients may pursue claims.

Collectively, these cases demonstrate that Malaysian courts have progressively shifted from a predominantly profession-centred conception of medical negligence towards a more patient-centred model of accountability. Malaysian courts now may be more willing to interrogate the logic of medical decisions and the sufficiency of communication. This shift not only strengthens patient protections but also increases the likelihood of findings of liability and encourages more claimants to bring actions.

3.3 Institutional Factors

Along with updated laws, certain aspects within the institution are also responsible for the rise in medical litigation claims due to negligence. Modern healthcare systems involve complex coordination between multiple practitioners, departments, and administrative

[52] *Foo Fio Na* (n 23).
[53] *Shalini a/p Kanagaratnam* (n 21).
[54] *Ahmad Thaqif Amzar* (n 51).
[55] *Siow Ching Yee* (n 16).

processes, which increases the risk of communication breakdowns, delayed responses, and procedural lapses.

As seen in the case of *Ahmad Thaqif Amzar*[56] institutional shortcomings, such as failure to escalate care and delays in diagnosis, can result in severe patient harm and subsequent legal liability. These issues are often linked to weaknesses in clinical governance, inadequate adherence to standard operating procedures, and insufficient interdepartmental coordination.

In the landmark case of *Foo Fio Na*[57], the hospital's inaction on a patient clearly getting worse was considered negligent by the Federal Court. It was clear that the system's problems included poor communication between teams in charge and not having urgent plans to escalate the situation. Such failures demonstrate that the hospital's standard operating procedures (SOPs) were not followed and there was no framework for clinical governance. These warnings from the institution suggest that judges are now paying closer attention to details that can lead to harm which could prompt more people to file medical lawsuits because of negligence.

Statutory obligations under the Private Healthcare Facilities and Services Act 1998[58] further reinforce the expectation that healthcare institutions must maintain safe operational standards. Courts have increasingly interpreted these obligations alongside common law duties, effectively holding institutions accountable for systemic failures that contribute to patient harm. The recognition of non-delegable duties means that hospitals are responsible for ensuring that all care provided within their facilities meets acceptable standards, regardless of whether services are rendered by employees or independent contractors.

In recognising these emerging challenges and concerns, policy-level responses such as MOH's *2022 Guideline on the Management of Medico-Legal Complaints*[59], which serves as an internal administrative guideline to standardise the management of medico-legal complaints across Ministry of Health facilities. Although the Guideline does not have the force of legislation and does not create independent legal obligations or causes of action, it is intended to guide MOH healthcare institutions in ensuring timely, consistent, and transparent complaint management. Its goal is to ensure that institutions are more open, accountable and that complaints in the public healthcare system are handled promptly. While such frameworks aim to improve internal resolution and reduce litigation, they also increase formal documentation and reporting, which may indirectly contribute to the visibility and traceability of potential negligence incidents.

3.4 Social factors

Social changes in Malaysia have influenced the evolving medico-legal landscape by increasing public awareness of patient rights and facilitating greater access to health-related

[56] *Ahmad Thaqif Amzar* (n 51).
[57] *Foo Fio Na* (n 23).
[58] Private Healthcare Facilities and Services Act 1998.
[59] Ministry of Health Malaysia, *Guideline on the Management of Medico-Legal Complaints in Ministry of Health* (Medical Practice Division, 2022).

information. However, these developments should not be interpreted as direct causes of increased medical negligence litigation. Instead, they likely contributed to an environment in which patients are better informed about healthcare standards, legal rights, and available avenues for seeking redress.

One contributing social factor is the widespread use of online health platforms and communities. As Malaysians increasingly rely on the internet for health information, their eHealth literacy, defined as the ability to seek, understand, and use digital health information-has improved significantly. Platforms such as online health communities, health blogs, and reputable sites like WebMD and Mayo Clinic empower patients to self-educate about symptoms, treatments, and medical standards. This access enables patients to better recognize when their experiences may constitute substandard care or negligence, making them more likely to pursue legal action. Research shows that higher eHealth literacy is associated with more proactive patient behaviour and a greater willingness to question or challenge healthcare providers.[60] While these developments do not necessarily translate into increased litigation, they may enhance patients' ability to recognise potential instances of substandard care and make informed decisions regarding available complaints or legal mechanisms.[61]

Similarly, social media has transformed the way healthcare experiences are shared and discussed. Platforms like Facebook, TikTok, X (formerly Twitter), and online discussion forums provide spaces for patients to recount personal healthcare experiences, exchange information, and discuss issues relating to patient safety and professional accountability. Viral posts and threads foster empathy, provoke public outrage, and inform others about their legal rights and potential legal recourse. Existing research suggests that social media can increase public awareness of patient rights, healthcare quality, and complaint mechanisms by facilitating the rapid dissemination of information and peer experiences.[62] However, empirical evidence directly linking social media exposure to an increase in medical negligence litigation remains limited, particularly within the Malaysian context. Thus, social media should therefore be viewed as one of several contributing factors that may shape public awareness and healthcare expectations, rather than as an independent driver of litigation.

Social media also facilitates the rapid dissemination of information and advice, potentially normalizing litigation as an accessible and reasonable response to unsatisfactory medical care.[63] In addition, courts and legal practitioners increasingly recognize social media posts as evidence in medical negligence litigation, as illustrated in cases such as *Wye Valley NHS Trust*

[60] Xinyi Lu and Runtong Zhang , 'Association between eHealth Literacy in Online Health Communities and Patient Adherence: Cross-Sectional Questionnaire Study' (2021) 23 Journal of Medical Internet Research.
[61] Samantha R Paige and others, 'eHealth Literacy in Health Care' (2018) 20(10) Journal of Medical Internet Research e36.
[62] Judith H Hibbard and Jessica Greene, 'What the Evidence Shows About Patient Activation' (2013) Health Affairs 207.
[63] Maizatul Farisah Mohd Mokhtar , 'Medical Negligence Dispute in Malaysia: Choosing Mediation as the Best Constructive Approach to Address the Paradoxes in Medical Negligence Claims' (2024) 7(1) European Journal of Medicine and Natural Sciences 147.

v Murphy.[64] In this case, the defendant, Mr. Murphy, claimed damages for a rugby injury but was found to have deliberately exaggerated his incapacity. The Trust presented video evidence from social media showing Mr. Murphy lifting heavy weights and engaging in physical work, contradicting his claims. The court found him in contempt for knowingly providing false information to medical experts and the court, leading to dismissal of his claim and a committal order for contempt. Although this case does not demonstrate that social media increases medical negligence claims, it illustrates the expanding role of digital evidence in modern medico-legal proceedings and highlights how online content may influence the conduct and adjudication of healthcare-related disputes.

Mainstream media also reinforces this trend. High-profile reports about hospital errors or fatal medical outcomes regularly make headlines in Malaysia. Such reports, often featured in newspapers and broadcast media, draw attention to institutional failures and legal proceedings, including investigations by the MMC and court settlements.[65] While news coverage may influence public perceptions of healthcare quality and accountability, there is insufficient empirical evidence to conclude that media exposure alone leads to increased medical negligence litigation. Instead, it is more accurate to regard mainstream media as an important source of public information that contributes to broader societal expectations regarding transparency, professional accountability, and patient rights. [66]

3.5 Synthesis

In summary, the rise in medical negligence claims in Malaysia is the result of an interplay between evolving legal standards, increasingly interventionist judicial approaches, institutional complexities within healthcare delivery, and heightened social awareness among patients. Legal reforms and statutory frameworks have expanded the scope of liability, judicial decisions have strengthened patient-centred protections, institutional realities have exposed systemic vulnerabilities, and social developments have empowered patients to act on perceived grievances.

Rather than reflecting any single causal factor, the increase in claims is better understood as a cumulative outcome of these interacting forces. Collectively, these developments have reshaped both the expectations placed on healthcare providers and the willingness of patients to seek legal redress, thereby contributing to the observable rise in medical negligence litigation in Malaysia.

4. Consequences of Rising Medical Negligence Claims

4.1 Defensive Medicine and Clinical Practice

One important consequence of increasing negligence litigation is the practice of defensive medicine, whereby healthcare practitioners modify their clinical decision-making primarily

[64] [2024] EWHC 1912 (KB).
[65] C Lee Ventola, 'Social Media and Health Care Professionals: Benefits, Risks, and Best Practices' (2014) 39(7) PT <https://pubmed.ncbi.nlm.nih.gov/25083128/> accessed 17 May 2025.
[66] Hambali and Khodapanahandeh (n 6)

to minimise potential legal liability rather than optimise patient care. Defensive medicine generally takes two forms: positive and negative defensive medicine. Positive defensive medicine involves ordering additional diagnostic investigations, referrals, or procedures primarily to document clinical diligence, whereas negative defensive medicine involves avoiding high-risk patients or complex procedures altogether.

Although comprehensive Malaysian empirical evidence remains limited, international literature consistently demonstrates that fear of litigation influences clinical decision-making and contributes to increased healthcare utilisation and expenditure.[67] Excessive diagnostic testing and unnecessary referrals may increase costs for both patients and healthcare providers without necessarily improving clinical outcomes. Moreover, defensive practice may undermine clinical efficiency while exacerbating resource allocation challenges within an already strained healthcare system.[68]

4.2 Medical Indemnity and Healthcare Costs

The financial consequences of medical negligence litigation beyond compensation awards to professional indemnity arrangements and institutional healthcare expenditure. Increasing compensation awards and litigation costs may contribute to higher professional indemnity premiums borne by medical practitioners and healthcare institutions. These additional costs may ultimately be passed on to patients through higher healthcare charges or absorbed by public healthcare expenditure.

Across many jurisdictions, escalating medical malpractice litigation has been associated with rising insurance costs and greater institutional investment in legal risk management. While Malaysia lacks publicly available national data regarding medical indemnity expenditure, the increasing number of medico-legal complaints and compensation payments reported by the MOH suggests that negligence claims impose measurable financial burdens on healthcare providers and public resources.[69]

4.3 Professional Pressure and Workforce Sustainability

Increasing medico-legal exposure may adversely affect professional morale and workforce retention within the healthcare sector. Medical practitioners practising in high-risk specialties such as obstetrics, emergency medicine, surgery, and anaesthesiology may experience greater professional anxiety arising from potential litigation. Fear of legal liability may contribute to occupational stress, burnout, and reduced willingness to undertake high-risk procedures or manage medically complex cases.

Existing research suggests that medico-legal pressures may influence workforce migration and specialist retention, particularly where practitioners perceive increasing legal exposure without corresponding institutional support or regulatory certainty. Although litigation

[67] David M Studdert and others, 'Defensive Medicine Among High-Risk Specialist Physicians in a Volatile Malpractice Environment' (2005) 293(21) Journal of the American Medical Association 2609.
[68] Ibid.
[69] MOH Annual Report 2024 (n 8).

serves an important accountability function, an overly adversarial medico-legal environment may inadvertently discourage innovation and appropriate clinical risk-taking that are often essential components of effective clinical practice.[70]

4.4 Public Confidence and Healthcare Governance

Rising medical negligence claims may also affect public confidence in the healthcare system. Increased litigation can reflect greater patient awareness and stronger accountability mechanisms, but persistent negligence disputes may simultaneously undermine trust in healthcare institutions if systemic failures remain inadequately addressed. Transparency, effective complaint resolution, and timely institutional responses therefore become increasingly important elements of healthcare governance.

Conversely, an effective medico-legal framework that promotes accountability, early dispute resolution, and institutional learning may strengthen rather than diminish public confidence by demonstrating that healthcare providers are committed to patient safety and continuous quality improvement. The objective of reform should therefore not be to reduce litigation at all costs but to create mechanisms that prevent avoidable harm while providing fair and efficient avenues for patient redress.

4.5 Implications for Structural Reform

These consequences demonstrate that medical negligence litigation affects the healthcare system as a whole rather than only the parties involved in individual disputes. Rising claims may increase healthcare expenditure, encourage defensive medicine, place additional pressure on healthcare professionals, and expose institutional weaknesses in governance and patient safety. Accordingly, reforms aimed at strengthening regulatory oversight, promoting alternative dispute resolution, improving institutional accountability, and encouraging early error disclosure should be viewed not only as legal reforms but also as broader healthcare governance initiatives designed to enhance patient safety while maintaining the sustainability of Malaysia's healthcare system.

5. Existing Non-Legislative Responses

5.1 Communication

Effective communication remains a cornerstone of the healthcare provider–patient relationship and is widely recognised as one of the primary factors influencing patient satisfaction and litigation risk.[71] Transparent and empathetic communication enables patients to make informed decisions regarding their treatment while aligning expectations with clinical realities. This is particularly significant in medical negligence contexts, where

[70] Redwan Yasin and others, 'Medical Negligence, Workforce Migration, and the Sustainability Crisis in Malaysia's Public Healthcare System' (2025) 15 International Journal of Asian Social Science 150.
[71] John M Travaline , Robert Ruchinskas and Gilbert E D'Alonzo Jr, 'Patient-Physician Communication: Why and How' (2005) 105 The Journal of the American Osteopathic Association 13.

many claims are triggered not solely from adverse outcomes, but from dissatisfaction arising from inadequate explanations or perceived failures of disclosure.

Transparent communication may help defuse anger, frustration, and mistrust, which are common precursors to complaints and legal action. When patients feel adequately informed and heard, they may be less likely to pursue costly and time-consuming negligence claims. This aligns with medico-legal risk management principles emphasised in professional guidance and clinical governance frameworks, where communication is recognised as both an ethical obligation and a preventive risk-management strategy.

In practice, effective communication includes obtaining informed consent, explaining risks and alternatives in clear terms, and ensuring that patients understand the proposed treatment. Judicial approaches to informed consent in Malaysia have reinforced the expectation that material risks must be disclosed in a manner that supports patient autonomy. Although communication alone cannot prevent all disputes, it significantly reduces the likelihood of misunderstandings escalating into formal claims.

Importantly, the role of communication is further amplified by Malaysia's status as a multiracial and multicultural society, comprising diverse ethnic, linguistic, and religious groups. Differences in language proficiency, health literacy, cultural expectations, and attitudes toward authority may create barriers to effective doctor–patient communication. Miscommunication in such contexts may lead to misunderstandings regarding diagnosis, treatment risks, or consent, thereby increasing the likelihood of dissatisfaction and subsequent legal claims.[72] As such, culturally competent communication, tailored to the patient's background and level of understanding, is not merely desirable but essential in mitigating medico-legal risk within the Malaysian healthcare setting.

5.2 Robust Documentation

Comprehensive and accurate medical documentation represents another non-legislative safeguard against medical negligence claims. Although Malaysia already imposes documentary obligations through various legislative, regulatory, and professional instruments, there are inconsistencies in the quality, completeness, and implementation of documentation across different healthcare settings.[73]

Medical records provide a contemporaneous account of patient history, clinical findings, diagnostic reasoning, treatment decisions, and follow-up care. These records are often central in litigation, as courts rely extensively on contemporaneous documentation to assess whether the standard of care was met.

Robust documentation requires maintaining detailed records of all procedures, consultations, investigations, and communications with patients. This documentation not only serves as evidentiary support in the event of a dispute but also enables healthcare

[72] Kate E. Humphrey and others, 'Frequency and Nature of Communication and Handoff Failures in Medical Malpractice Claims' (2022) 18(2) Journal of Patient Safety 130.
[73] Jahn Kassim (n 13).

providers to evaluate and improve their clinical practice. Proper records facilitate continuity of care, improve coordination among practitioners, and reduce the likelihood of medical errors.[74]

From a medico-legal perspective, incomplete or inconsistent documentation may weaken a practitioner's defence in negligence proceedings. Conversely, well-maintained records can demonstrate adherence to accepted standards of practice and support the credibility of the practitioner's account. In this way, documentation functions as both a clinical tool and an important medico-legal safeguard, directly influencing the outcome of negligence claims.[75]

5.3 Malaysian Medical Council Complaint Mechanism

The MMC provides a formal avenue for patients to lodge complaints against medical practitioners under the Medical Act 1971.[76] This disciplinary mechanism operates independently from civil litigation and focuses on professional misconduct, ethical breaches, and deviations from accepted standards of practice. This allows for feedback and constructive criticism, enabling the MMC to assess whether a practitioner's conduct falls below expected professional standards and providing patients with an avenue to raise concerns without immediately resorting to litigation. Where necessary, the MMC may initiate disciplinary proceedings, which can result in sanctions such as warnings, suspension, or removal from the medical register.[77]

In the context of medical negligence claims, the MMC plays a preventive and corrective role. By addressing complaints at an early stage, the MMC may reduce the likelihood of patients pursuing civil action, particularly where grievances are resolved through explanation, acknowledgement of errors, or corrective measures.[78] Additionally, disciplinary findings and recommendations often encourage practitioners to engage in Continuous Professional Development (CPD), thereby strengthening clinical competence and reducing the recurrence of similar incidents.

Although MMC proceedings do not determine civil liability or award damages, they complement the tort system by reinforcing professional accountability.[79] In medico-legal disputes, MMC findings may indirectly influence perceptions of credibility and standard of care, even though they are not binding on civil courts. As such, the MMC operates as part of a broader medico-legal regulatory framework that supports both patient protection and professional self-regulation.

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[74] Peter Chiu-Leung Chow , 'Keeping good documentation: the ethical and legal issues in medical records' (2025) 66(9) Singapore Med J 517 <https://doi.org/10.4103/singaporemedj.SMJ-2025-042>accessed 17 March 2026.

[75] Ibid.

[76] Medical Act 1971.

[77] Mahmud Mohd Nor, 'Proceedings in a Disciplinary Action at the Malaysian Medical Council' (2005) 60(Supp D) Med J Malaysia 32.

[78] Puteri Nemie Jahn Kassim, 'Medical Negligence Litigation in Malaysia: Current Trend and Proposals for Reform' (Ahmad Ibrahim Kulliyyah of Laws, International Islamic University Malaysia) <https://mdm.org.my/downloads/dr_puteri_nemie.pdf> accessed 15 March 2026.

[79] Mohd Nor (n 77).

5.4 Alternative Dispute Resolution (ADR)

ADR, including mediation and negotiation, has emerged as an increasingly significant mechanism for resolving medical negligence disputes outside the formal court system. In Malaysia, mediation services are facilitated through institutions including the MMC, which provide structured, neutral platforms for parties to negotiate settlements.

ADR offers several advantages in the context of medical negligence claims. Mediation allows patients to express their grievances in a non-adversarial environment, which can be particularly valuable in cases where emotional distress or communication breakdown has likely contributed to the dispute. Through facilitated negotiation, parties may reach resolutions that include apologies, explanations, corrective actions, or financial compensation, depending on mutual agreement.[80]

From a practical standpoint, ADR is significantly faster and more cost-effective than litigation.[81] While court proceedings may extend over several years, mediation processes can often resolve disputes within a considerably shorter timeframe, sometimes within a few months.[82] Empirical studies indicate that mediation has a high success rate of approximately 80 to 90 per cent and is generally less costly than full litigation, in some cases even falling below the value of the compensation claimed.[83]

However, ADR is not without limitations. Its effectiveness depends on the willingness of both parties to engage in good faith, and outcomes are not guaranteed unless a settlement is reached.[84] There may also be concerns regarding power imbalances between individual patients and institutional healthcare providers, particularly where legal representation is uneven.

Furthermore, the absence of publicly available data on mediation outcomes presents a further structural challenge. Without systematic reporting on the number of disputes referred to ADR, settlement rates, resolution times, or participant satisfaction, it is difficult to evaluate whether existing ADR mechanisms effectively reduce litigation or improve access to justice. Greater transparency in ADR reporting would therefore facilitate empirical evaluation, while also informing future medico-legal policy development. Despite these challenges, ADR remains a valuable complement to litigation, offering a more flexible, efficient, and less adversarial means of resolving disputes while potentially reducing the overall volume of medical negligence claims.

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[80] Siti Farahiyah Ab Rahim and Anggraeni Endah Kusumaningrum, 'Tort Litigation Versus Mediation in Medico-Legal Disputes: Evaluating The Limits Of Mediation and Proposals for Reform' (2025) 30(2) Journal of Fatwa Management and Research 176.
[81] Mohd Mokhtar (n 63).
[82] Azmi Izhar Azmi and others, 'Medical Negligence Dispute Resolution in Malaysia: The Role of Mediation' (2021) 6(16) Environment-Behaviour Proceedings Journal 191, 195.
[83] Ibid.
[84] Rahim and Kusumaningrum (n 80).

6. Proposed Reforms

6.1 Codified Standards of Care

One proposed reform is the statutory codification of the standard of care. This would involve enacting legislation that defines key aspects of medical negligence, particularly those relating to professional conduct and risk disclosure.

Such codification could establish clear benchmarks for medical practice, enabling both practitioners and courts to assess conduct against objective criteria. It would also support more consistent legal outcomes and reduce reliance on conflicting expert testimony. Importantly, codified standards could incorporate clinical guidelines and best practices, thus enhance patient safety and promote evidence-based care.

Despite its potential advantages, codification is not without limitations. One commonly identified concern is the risk of regulatory rigidity.[85] Medical practice continues to evolve rapidly in response to scientific developments, technological innovation, and changing clinical standards. Statutory provisions that are drafted too narrowly may become outdated and fail to accommodate emerging treatment or evolving standards of care.[86] In contrast, common law principles possess greater flexibility and may adapt more readily to new clinical circumstances through judicial interpretation.

A further concern is that overly prescriptive statutory standards may inadvertently encourage defensive medicine practice.[87] Where healthcare practitioners perceive codified legal requirements as rigid rules rather than guiding principles, clinical decision-making may become overly cautious and compliance-oriented. This may discourage the exercise of professional clinical judgment and reduce flexibility in responding to individual patient circumstances, particularly where patients present with complex or atypical conditions.[88] Consequently, any statutory codification should provide sufficient flexibility to accommodate evolving medical knowledge and individualised patient care, rather than prescribing exhaustive or inflexible standards of clinical practice.

6.2 Mandatory Error Reporting

Another proposed reform is the introduction of mandatory medical error reporting. Currently, Malaysia does not have legislation requiring systematic disclosure of medical errors to patients or regulatory authorities.

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[85] Paula Giliker, 'Codification, Consolidation, Restatement? How Best to Systemise the Modern Law of Tort' (2021) 70(2) International and Comparative Law Quarterly 271.

[86] Angela Campbell and Kathleen Cranley Glass, 'The Legal Status of Clinical and Ethics Policies, Codes, and Guidelines in Medical Practice and Research' (2001) 46 McGill Law Journal 473.

[87] Vera Lúcia Raposo, 'Defensive Medicine and the Imposition of a More Demanding Standard of Care' (2019) 39(4) Journal of Legal Medicine 401.

[88] Johan Christiaan Bester, 'Defensive Practice Is Indefensible: How Defensive Medicine Runs Counter to the Ethical and Professional Obligations of Clinicians' (2020) 23 Medicine, Health Care and Philosophy 413.

Mandatory reporting could enhance transparency and trust, which are critical in reducing patient dissatisfaction and litigation. Early disclosure of errors allows for prompt resolution, potentially reducing both the duration and cost of disputes. It also fosters a culture of learning, enabling healthcare institutions to identify underlying systemic weaknesses and implement preventive measures.

One concern is that compulsory reporting requirements may inadvertently foster a culture of blame if healthcare professionals perceive that disclosures will automatically expose them to disciplinary action or civil liability. Such perceptions may discourage open communication, encourage defensive documentation, or lead to underreporting of incidents, thereby undermining the very objective of improving patient safety. Thus, any mandatory reporting framework introduced in Malaysia should seek to balance transparency and accountability with a supportive, learning-oriented approach that encourages honest disclosure while safeguarding patient interests and ensuring procedural fairness for healthcare professionals.

6.3 Expanded Malaysian Medical Council Jurisdiction

Reform may also involve expanding the jurisdiction and powers of the MMC. Currently, the MMC's role is largely disciplinary and reactive. By broadening its mandate, the Council could adopt a more proactive and preventive approach to medical regulation.

Potential enhancements include strengthening investigatory powers, promoting adherence to clinical guidelines, and ensuring ongoing competency through structured oversight and Continuous Professional Development (CPD).[89] Expanding the MMC's jurisdiction to address a wider range of negligence-related issues could help bridge the gap between professional regulation and civil liability. However, such expansion would require careful design to maintain fairness, independence, and procedural integrity, particularly in distinguishing between disciplinary action and civil adjudication.

However, expanding the MMC's powers also raises important concerns. While broader investigatory and enforcement powers may strengthen professional accountability, they also raise concerns regarding procedural fairness, institutional capacity, and the appropriate scope of professional regulation. Disciplinary proceedings are intended to regulate professional conduct rather than determine civil liability, and care should therefore be taken to avoid unnecessary overlap between disciplinary processes and negligence litigation.[90] Moreover, any expansion of the Council's functions must be accompanied by adequate staffing, expertise, funding and administrative resources to ensure timely complaint resolution and maintain public confidence in the regulatory process.

In *Pengarah Tanah dan Galian Wilayah Persekutuan v Sri Lempah Enterprise Sdn Bhd*[91], Raja Azlan Shah FCJ emphasised the fundamental constitutional principle that "every legal power must have legal limits," reinforcing that administrative discretion is never unfettered and

[89] Jahn Kassim (n 78).
[90] Medical Act 1971 (Act 50), ss 29–30.
[91] [1979] 1 MLJ 135.

must be exercised within the bounds of fairness and reasonableness.[92] Any expansion of MMC's powers should therefore be accompanied by appropriate safeguards, including procedural transparency, independent oversight mechanisms, clearly defined jurisdictional boundaries, and adequate institutional resources.

6.4 Institutionalised ADR

Finally, the formal integration of ADR mechanisms into the medico-legal framework may provide a more efficient and patient-centred approach to resolving disputes. While ADR is already available in Malaysia, it is not systematically embedded within medical negligence processes.

Institutionalising mediation, for example through mandatory pre-litigation mediation schemes, could facilitate earlier resolution of disputes. ADR allows patients to express their grievances in a less adversarial setting and may result in remedies such as apologies, explanations, or corrective actions. ADR is also significantly faster and more cost-effective than litigation, with typical resolution timelines of months rather than years.

However, mandatory pre-litigation mediation may inadvertently delay access to the courts if mediation becomes an additional procedural hurdle rather than a genuine opportunity for early resolution.[93] As mentioned before, the effectiveness of ADR depends heavily on the willingness of both parties to participate in good faith. [94] Significant power imbalances may also arise where patients, who often possess limited medical knowledge and financial resources, negotiate against well-resourced healthcare institutions or insurers. Without appropriate procedural safeguards, there is a risk that vulnerable claimants may feel pressured into accepting settlements that do not adequately reflect the merits of their claims. Additionally, mediation outcomes are generally confidential and non-precedential, meaning that recurring systemic issues or unsafe clinical practices may remain hidden from public scrutiny, thereby limiting opportunities for broader institutional learning and legal development.

Thus, ADR should complement rather than replace judicial mechanisms. Any mandatory mediation framework should therefore incorporate safeguards such as voluntary informed participation, access to independent legal advice, qualified mediators with medico-legal expertise, and clear exceptions permitting direct recourse to litigation where mediation is inappropriate or unlikely to succeed.

7. Comparative Framework and Jurisdictional Selection

Comparative legal analysis serves an important function in medico-legal research by providing insights into alternative regulatory approaches that may assist domestic legal development. The jurisdictions examined in this article—Singapore, the UK, Australia,

[92] *R Rama Chandran v Industrial Court of Malaysia* [1997] 1 MLJ 145 (FC).
[93] *Halsey v Milton Keynes General NHS Trust* [2004] EWCA Civ 576.
[94] Rahim and Kusumaningrum (n 80).

Canada, and New Zealand—have been selected because they share historical and doctrinal connections with Malaysia through the common law tradition while adopting distinct responses to challenges arising from medical negligence litigation. Their experiences provide persuasive rather than binding guidance and illustrate different approaches to balancing patient protection, professional autonomy, and healthcare governance.

Accordingly, comparative analysis does not suggest that Malaysia should replicate foreign legal models in their entirety. Instead, selective adaptation of specific institutional mechanisms, such as targeted statutory clarification, enhanced transparency obligations, strengthened institutional accountability, and expanded alternative dispute resolution, offers a more realistic and context-sensitive approach. Such incremental reform preserves the strengths of Malaysia's common law tradition while addressing structural gaps exposed by contemporary healthcare practice and increasing medical negligence litigation.

7.1 Singapore

Singapore offers perhaps the most relevant comparator for Malaysia due to similarities in legal heritage, regional context, and mixed public-private healthcare delivery. Following the decision in Hii Chii Kok v Ooi Peng Jin London Lucien[95], Singapore introduced *section 37* of the Civil Law Act 1909[96], providing statutory guidance on medical advice and informed consent while preserving judicial flexibility. Rather than comprehensively codifying medical negligence, the legislation clarifies specific aspects of professional responsibility. This targeted codification may enhance legal certainty and consistency. However, as mentioned before, there is a risk that statutory provisions could become overly prescriptive or fail to keep pace with developments in medical science, healthcare technology, and evolving clinical practices. Unlike common law, which develops incrementally through judicial interpretation, legislation may require frequent amendment to remain relevant.

Furthermore, Malaysia's healthcare system differs from Singapore's in terms of institutional capacity, regulatory structure, and the scale of public healthcare delivery. A reform that functions effectively within Singapore's relatively centralised healthcare system may therefore not produce the same outcomes in Malaysia without corresponding institutional support, clear implementation guidelines, and periodic legislative review. Consequently, any move towards codification should be confined to clearly defined areas, such as informed consent and disclosure obligations, while preserving judicial discretion to ensure that the law remains sufficiently flexible to respond to the complexities of individual clinical cases.

7.2 United Kingdom

The UK provides a useful example of institutional transparency through the statutory Duty of Candour introduced under *section 20* of the Health and Social Care Act 2008.[97] The obligation requiring healthcare providers to disclose significant patient safety incidents promotes openness, organisational learning, and patient trust. While Malaysia's healthcare

[95] [2017] SGCA 38.
[96] Civil Law Act 1909, s37.
[97] Health and Social Care Act 2008, s20.

system differs structurally from the National Health Service, introducing statutory obligations encouraging early disclosure and communication following medical errors could strengthen accountability and reduce adversarial disputes.

Unlike the UK, where the duty operates within the institutional framework of the National Health Service (NHS) alongside established patient safety reporting systems and regulatory oversight, Malaysia's dual public-private healthcare system presents a more fragmented regulatory landscape. Without clear legislative guidance and institutional support, mandatory disclosure obligations may inadvertently encourage defensive medical practice, increase concerns over self-incrimination, or discourage open reporting if healthcare practitioners fear that disclosed information could subsequently be used against them in disciplinary proceedings or civil litigation.

Furthermore, implementing such a duty would require robust legal safeguards, standardised reporting protocols, adequate practitioner training, and alignment between the MOH, the MMC, and private healthcare regulators to ensure that disclosure promotes organisational learning rather than merely creating an additional compliance burden. Thus, while the underlying principles of transparency and patient-centred communication are highly relevant to Malaysia, any statutory duty should be carefully adapted to the local healthcare and regulatory context rather than directly replicating the UK model.

7.3 Canada

Canada offers valuable lessons regarding patient safety and disclosure practices through its emphasis on systemic learning rather than individual blame when responding to patient safety incidents. This is reflected in the Canadian Disclosure Guidelines[98], developed by the former Canadian Patient Safety Institute (now Healthcare Excellence Canada), which encourages healthcare providers to engage in open disclosure with patients and their families following adverse events while simultaneously promoting organisational learning and quality improvement. Rather than viewing every adverse event solely through the lens of professional fault, the Canadian framework recognises that patient harm may arise from a combination of organisational processes, communication failures, human factors, and system design. Accordingly, disclosure is intended not merely to facilitate accountability, but also to identify underlying causes and prevent similar incidents from recurring.[99] This systems-based approach encourages healthcare providers to report patient safety incidents without fear that every error will automatically result in disciplinary or legal sanctions. Such an environment facilitates earlier identification of systemic risks, strengthens institutional learning, and supports continuous quality improvement alongside patient-centred transparency.

However, Canada's disclosure framework operates within a mature patient safety infrastructure characterised by established incident-reporting systems, multidisciplinary

[98] Healthcare Excellence Canada, *Canadian Disclosure Guidelines: Being Open with Patients and Families* <https://www.healthcareexcellence.ca/resources/canadian-disclosure-guidelines> accessed 30 June 2026.
[99] Health Canada, *Resources on Patient Safety* <https://www.canada.ca/en/health-canada/services/health-care-system/quality-care/patient-safety/resources.html> accessed 30 June 2026.

quality improvement programmes, statutory protections for apologies in many provinces, and a healthcare culture that increasingly embraces organisational learning over individual blame. Malaysia's current medico-legal framework remains more divided, with professional regulation, hospital governance, civil litigation, and complaint mechanisms operating largely as separate processes. Without comparable institutional capacity, mandatory disclosure initiatives may inadvertently increase practitioners' concerns regarding legal exposure, discourage candid reporting of adverse events, or impose additional administrative burdens on already resource-constrained healthcare institutions. While Canada's experience offers valuable lessons for strengthening patient safety and accountability, any Malaysian adaptation should be implemented incrementally and accompanied by broader institutional reforms rather than adopted as a standalone regulatory measure.

7.4 New Zealand

New Zealand provides a more useful comparative model through its no-fault compensation scheme, administered by the Accident Compensation Corporation (ACC) since 1974. Patients receive compensation for treatment-related injuries without proving negligence.[100] This system shifts the focus away from adversarial fault-finding toward accessibility, efficiency, and rehabilitation.[101]

Despite its strengths, the New Zealand model should be approached cautiously in the Malaysian context. The ACC scheme operates within a unique legal, economic, and institutional environment supported by substantial public funding and long-standing policy commitments. The present article[102] does not undertake a detailed assessment of the financial, administrative, or legislative implications of introducing a comparable no-fault compensation system in Malaysia.

Yet, the New Zealand experience remains valuable because it demonstrates that compensation and patient support need not always depend upon traditional fault-based litigation. While such a model may not be directly transferable to Malaysia, it highlights an alternative approach focused on accessibility and efficiency rather than fault-based litigation. Elements of this approach, such as simplified claims processes or administrative compensation schemes, may inform future reforms in Malaysia.

7.5 Towards a Hybrid Malaysian Model

Rather than adopting comprehensive legislative reform or preserving the existing framework unchanged, Malaysia may benefit from a hybrid model combining the strengths of common law flexibility with targeted statutory and institutional reform. Judicial development should continue to govern evolving medical practice while legislation should address specific areas

[100] Ken Oliphant, 'Beyond Misadventure: Compensation for Medical Injuries in New Zealand' (2007) 15 Medical Law Review 357.
[101] Katharine A Wallis, 'No-fault, no difference: no-fault compensation for medical injury and healthcare ethics and practice' (2017) 67(654) British Journal of General Practice 38.
[102] Ibid.

requiring greater legal certainty, including informed consent, institutional accountability, digital healthcare governance, and early dispute resolution mechanisms.
Similarly, stronger regulatory oversight, enhanced transparency, mandatory error disclosure, and greater use of mediation should complement rather than replace civil litigation. Such an integrated approach would preserve the adaptability of Malaysia's common law tradition while addressing the structural gaps identified throughout this article, thereby promoting patient safety, professional accountability, and sustainable healthcare governance in an increasingly complex medical environment.

8. Conclusion

The rise in medical negligence claims in Malaysia should be viewed as an indicator of deeper systemic issues within the medico-legal and healthcare framework. As this paper has demonstrated, the increasing trend in claims is shaped by a convergence of legal developments, evolving judicial approaches, institutional shortcomings, and heightened patient awareness. Together, these factors indicate a shifting landscape in which expectations of accountability, transparency, and quality of care have significantly intensified.

This highlights a structural gap within the existing medico-legal framework, particularly under the Medical Act 1971.[103] While the Act continues to play a crucial role in regulating professional conduct and maintaining standards within the medical profession, its scope remains largely limited to registration and disciplinary control. It does not directly address civil liability, nor does it provide comprehensive mechanisms for patient redress or integrated dispute resolution. As healthcare delivery becomes increasingly complex through the expansion of private healthcare, multidisciplinary practice, digital health technologies, and institutional care, these structural gaps have become more apparent and have exposed the limitations of a framework that was developed for a markedly different healthcare environment.

Addressing the rise in medical negligence claims requires more than isolated legislative amendments or institutional reforms. Rather, it requires an integrated and context-sensitive approach that strengthens the coherence of Malaysia's medico-legal framework by aligning legal standards, regulatory oversight, institutional accountability, and patient-centred healthcare governance. The comparative analysis in this article demonstrates that jurisdictions sharing Malaysia's common law heritage have responded to similar challenges through targeted reforms, combining judicial flexibility with carefully designed statutory and institutional measures.

Ultimately, the increase in medical negligence claims highlights the need for a more cohesive and responsive medico-legal framework. While the flexibility of the common law remains a valuable strength, it must be complemented by targeted reforms that address gaps in regulation, enhance accountability, and promote preventive mechanisms within healthcare practice. The challenge moving forward is not to replace the existing system entirely, but to refine it in a manner that better aligns legal standards, regulatory oversight, and patient

[103] Medical Act 1971.

expectations within Malaysia's evolving healthcare landscape. By addressing these structural gaps through evidence-based and context-sensitive reform, Malaysia can develop a more responsive and sustainable medico-legal framework that safeguards patient rights while supporting professional autonomy, public confidence, and the continued delivery of high-quality healthcare.

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AF (a child suing through his mother 'parents ad litem' Isrul Hasmah bt Ismail) & Anor v Putra Medical Centre Darul Aiman Sdn Bhd & Anor [2026] 8 MLJ 349

Ahmad Thaqif Amzar bin Ahmad Huzairi v Kuala Terengganu Specialist Hospital Sdn Bhd & Ors [2021] 9 MLJ 10

Azmi AI and others, 'Medical Negligence Dispute Resolution in Malaysia: The Role of Mediation' (2021) 6(16) Environment-Behaviour Proceedings Journal 191.

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