From Professional Deference to Patient-Centered Accountability: Medical Negligence Litigation, High-Value Compensation and Evolving Medico-Legal Responsibilities in Malaysia — A Critical Narrative Review

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ABSTRACT

Background

Medical negligence lies at the intersection of patient safety, professional accountability, individual autonomy and distributive justice. Internationally, malpractice litigation has evolved alongside increasing recognition of patients' rights, institutional responsibility and the long-term economic consequences of catastrophic healthcare-related injury. Malaysia is undergoing a comparable transformation. Ministry of Health (MOH) data demonstrate that medico-legal complaints increased from 211 in 2020 to 336 in 2024, while litigation cases increased from 68 to 118 over the same period. Concurrently, Malaysian courts have delivered increasingly important judgments concerning informed consent, standards of clinical care, institutional responsibility, causation and aggravated damages.

Main text

This critical narrative review examines the evolution of medical negligence and medico-legal accountability in Malaysia within its international and Asian context. Particular attention is given to the landmark decisions of *Foo Fio Na v Dr Soo Fook Mun & Anor*, *Zulhasnimar Hasan Basri & Anor v Dr Kuppu Velumani P & Ors*, *Dr Hari Krishnan & Anor v Megat Noor Ishak Megat Ibrahim & Anor*, *Yusnita Johari v Dr Jerilee Mariam Khong & Ors*, and *Prince Court Medical Centre Sdn Bhd v Lim Yoke Har & Ors*, together with subsequent appellate developments. Collectively, these cases demonstrate a movement away from undifferentiated professional deference towards a more nuanced framework in which clinical judgment, disclosure of material risks, patient autonomy, institutional responsibility and post-event conduct are scrutinised separately.

The Malaysian evidence nevertheless requires careful interpretation. Rising claims cannot be equated automatically with rising negligence, and higher awards in catastrophic cases should not be interpreted simply as increasing judicial generosity. Contemporary compensation increasingly reflects lifetime nursing care, rehabilitation, assistive technology, inflation, loss of earnings and loss of amenities. Increasing patient awareness, greater healthcare complexity, changing societal expectations, stronger recognition of autonomy and improved access to legal remedies may also contribute to increasing litigation.

Conclusions

Malaysia is entering a more demanding phase of medico-legal accountability. The appropriate response is

neither defensive medicine nor restriction of legitimate claims. A sustainable framework requires meaningful informed consent, open disclosure after adverse events, institutional learning, stronger medico-legal education, accessible dispute resolution and systematic national surveillance of claims. Medical negligence litigation should ultimately function not merely as a mechanism for assigning blame and compensation but as part of a broader ethical architecture of accountability, learning and prevention.

Keywords: medical negligence; medical malpractice; medico-legal litigation; patient safety; informed consent; medical ethics; compensation; healthcare law; Malaysia; patient autonomy

BACKGROUND

Healthcare is inherently associated with uncertainty. An undesirable clinical outcome does not, by itself, constitute negligence. Yet uncertainty cannot extinguish professional responsibility. Medical negligence therefore presents one of the most difficult ethical problems in healthcare: how should society distinguish unavoidable harm from preventable harm, and where harm was preventable, how should responsibility be distributed between individual practitioners, healthcare institutions and the wider health system?

The scale of avoidable healthcare-associated harm makes this question more than a matter of private litigation. The World Health Organization estimates that approximately one in ten patients' experiences harm in healthcare and that more than three million deaths annually are associated with unsafe care. More than half of patient harm is considered preventable [1]. Patient safety is therefore simultaneously a clinical, ethical, public-health and economic concern.

Medical negligence litigation captures only a small and highly selected proportion of this burden. Not all adverse events result from negligence; not all negligent care causes compensable injury; and not all injured patients initiate claims. Litigation rates should consequently never be treated as epidemiological proxies for the incidence of medical error.

Nevertheless, litigation provides important information. Claims and judgments expose points of friction between what patients reasonably expect from healthcare and what healthcare systems deliver. They may reveal recurrent failures involving diagnosis, treatment, monitoring, communication, informed consent, equipment, documentation, escalation of care and institutional governance.

The international history of medical negligence law has also reflected a broader transformation in healthcare ethics. Earlier jurisprudence tended towards professional deference. Contemporary law increasingly recognises patient autonomy, shared decision-making and institutional responsibility. The result is not the displacement of medical expertise but a reconsideration of where professional expertise ends and patient autonomy or judicial responsibility begins.

Malaysia provides a particularly important setting in which to examine this transformation. Its mixed public-private healthcare system operates within a common-law legal tradition, while Malaysian medical negligence jurisprudence has been influenced by English and Australian developments but has evolved distinctive principles of its own.

More than a decade ago, Hambali and Khodapanahandeh identified indications of an upward trend in Malaysian malpractice claims and criticised the tort system for difficulties relating to accessibility, delay, compensation and accountability [2]. Contemporary MOH data now provide stronger evidence of increasing medico-legal activity within public healthcare facilities.

Between 2020 and 2024, MOH medico-legal complaints increased from 211 to 336, representing an increase of approximately 59%. Litigation cases increased from 68 to 118, an increase of approximately 74% [3].

These developments demand analysis beyond the simplistic proposition that "patients are suing doctors more frequently". The more important ethical questions are why medico-legal disputes appear to be increasing, what Malaysian courts now regard as unacceptable clinical or institutional conduct, how the balance between professional judgment and patient autonomy has changed, and whether medical negligence litigation ultimately

promotes safer healthcare.

This article critically examines these questions by situating contemporary Malaysian medico-legal developments within their international and Asian context and analysing landmark Malaysian judgments that have reshaped the law governing standards of care, informed consent, causation, institutional responsibility and compensation.

Review approach and source selection

This article is a critical narrative review, not a systematic or scoping review. It provides an illustrative, purposively selected examination of Malaysian judicial decisions, Ministry of Health administrative reporting and relevant international and regional scholarship. The literature and case authorities cited in the original manuscript constitute the documentary basis of the synthesis; the authors have not maintained a reproducible database-search log, screening register or formal quality-appraisal record. Accordingly, no comprehensive database coverage, search date, search period, search strings, inclusion/exclusion counts or independent screening is claimed.

Judgments were discussed for their relevance to distinct doctrinal questions: diagnosis and treatment, disclosure of material risks, causation, institutional responsibility and damages. The analysis prioritises reported appellate holdings where identified, distinguishes first-instance awards from appellate modification, and does not treat selected judgments as a representative sample of Malaysian claims. Official MOH annual-report figures are presented descriptively, without inferring incidence of negligence or trends in compensation values. The authors should complete and document a reproducible supplementary source search before representing the review as comprehensive or stating specific database search dates.

From medical paternalism to patient-centred accountability

The international evolution

For much of the twentieth century, medical negligence law was dominated by professional deference. The classic English decision in *Bolam v Friern Hospital Management Committee* established that a clinician would generally not be negligent when acting in accordance with a practice accepted as proper by a responsible body of medical professionals [4].

The principle was understandable. Judges are not clinicians, and courts should be cautious about retrospectively substituting judicial opinion for legitimate medical judgment exercised under clinical uncertainty. Yet unrestricted professional deference creates its own ethical problem. If the medical profession itself determines the standard against which its conduct is judged, professional custom can become self-validating.

The House of Lords subsequently qualified this position in *Bolitho v City and Hackney Health Authority*, recognising that professional opinion relied upon to justify clinical conduct must withstand logical analysis [5]. Professional support therefore became important but not necessarily conclusive.

A still more fundamental transformation occurred in relation to informed consent. In *Rogers v Whitaker*, the High Court of Australia rejected the proposition that disclosure of treatment risks should be determined solely according to customary medical practice [6]. The UK Supreme Court later adopted a strongly autonomy-centred approach in *Montgomery v Lanarkshire Health Board*, emphasising a patient's entitlement to information concerning material risks and reasonable alternatives [7].

These cases reflect a deeper ethical transition. The physician possesses expertise concerning disease and treatment. The patient possesses authority over the values, risks and consequences that he or she is prepared to accept. Technical expertise and decisional authority are therefore related but not identical.

Medical malpractice in Asia: common pressures, different responses

Asian healthcare systems have not followed a uniform medico-legal trajectory. Rapid healthcare development,

rising expectations, expanding access to information and changing perceptions of professional authority have produced different patterns of litigation and dispute resolution.

China provides evidence that medical litigation can become a significant healthcare-system phenomenon. A study of 1,086 malpractice cases from 1998 to 2011 found that 76% of adjudicated claims received compensation, with medical-technical errors accounting for a substantial proportion of paid judgments [8]. A much larger recent study of 5,052 first-trial Chinese malpractice cases found compensation in 85% of cases and demonstrated substantial differences in compensation according to injury severity, specialty and allegation type [9].

Importantly, the highest compensation does not necessarily occur following death. Severe permanent disability can create greater long-term financial consequences because the patient continues to require healthcare, rehabilitation, assistive equipment and personal support for many years [9].

Japan demonstrates a different trajectory. Taniguchi and colleagues analysed 13,340 closed malpractice claims between 2006 and 2021. More than half ended in settlement, while approximately three quarters of cases proceeding to judgment favoured the medical profession. Overall closed malpractice claims declined, with a particularly marked decline in obstetric and gynaecological claims following introduction of Japan's obstetric compensation system [10].

This comparison is important for Malaysia. Litigation volume is not determined exclusively by the prevalence of negligent care. It is influenced by the architecture through which societies respond to injury. Compensation mechanisms, mediation, accessibility of courts, patient expectations, professional communication and no-fault schemes can all influence whether an adverse event eventually becomes litigation.

The ethical challenge is consequently broader than determining how to defend lawsuits. It is to design a system in which injured patients can obtain explanation, accountability and appropriate compensation without requiring every dispute to pass through prolonged adversarial litigation.

The Malaysian medico-legal trajectory

Evidence of increasing medico-legal activity

The strongest contemporary evidence of increasing Malaysian medico-legal activity comes from MOH administrative data as shown in Table 1.

Table 1. Medico-legal activity in Ministry of Health Malaysia facilities, 2020–2024

Year	Medico-legal complaints	External inquiry committees	Ex-gratia cases	Litigation cases
2020	211	108	107	68
2021	165	76	54	82
2022	234	138	117	81
2023	283	104	121	86
2024	336	76	125	118

Source: Ministry of Health Malaysia Annual Report 2024 [3].

The MOH administrative series documents increased recorded complaints and litigation between 2020 and 2024. It contains no longitudinal award amounts and therefore cannot establish a national increase in compensation values.

Yet three cautions are essential. First, these are MOH data and therefore should not be presented as the complete epidemiology of Malaysian medical negligence. Private-sector claims are not comprehensively captured. Second, a medico-legal complaint is not equivalent to proven negligence.

Third, increasing litigation does not demonstrate that the quality of Malaysian healthcare has deteriorated proportionately. This distinction is fundamental. The number of lawsuits is a product of both the occurrence of injury and the probability that an injured or dissatisfied patient will seek legal redress. Changes in awareness, access to lawyers, patient expectations, healthcare complexity and willingness to challenge professional authority can therefore increase litigation independently of changes in underlying clinical quality.

Malaysia may thus be experiencing not simply a rise in negligence but a rise in medico-legal accountability.

Landmark Malaysian jurisprudence

Table 2. Selected landmark cases shaping Malaysian medical negligence law

Case	Principal issue	Broader significance
Foo Fio Na v Dr Soo Fook Mun & Anor [2007]	Applicability of *Bolam*	Rejected universal professional control over the legal standard; strengthened patient-centred disclosure
Zulhasnimar Hasan Basri & Anor v Dr Kuppu Velumani P & Ors [2017]	Diagnosis/treatment versus advice	Clarified differentiated standards: *Bolam-Bolitho* for diagnosis/treatment and patient-centred approach for disclosure
Dr Hari Krishnan & Anor v Megat Noor Ishak Megat Ibrahim & Anor [2018]	Clinical negligence, expert evidence, hospital responsibility	Further clarified the Malaysian standard and addressed hospital responsibility and non-delegable duty
Yusnita Johari v Dr Jerilee Mariam Khong & Ors [2023], appellate decision [2025]	Catastrophic injury, causation and damages	Important treatment of material contribution, pre-existing vulnerability and lifetime consequences
Prince Court Medical Centre v Lim Yoke Har & Ors [2024]	Patient fall, equipment/institutional failure and aggravated damages	Highlights organisational responsibility and significance of institutional post-event conduct
Bukit Tinggi Hospital v Navin Sharma Karam Chand [2025]	Aggravated damages	Further clarifies compensatory character and boundaries of aggravated damages

Analytical separation of legal questions

The applicable standard of care in diagnosis and treatment is analytically distinct from the duty to disclose material risks. The former concerns reasonable professional clinical conduct and expert evidence; the latter concerns the information necessary for an autonomous treatment decision. Neither breach alone establishes compensable negligence without the required causation and damage. Hospital liability also requires its own legal basis, whether direct fault, vicarious responsibility or an applicable non-delegable duty. Aggravated damages are a separate question from the valuation of medical care and other compensatory losses. These distinctions prevent a general narrative of patient-centred accountability from obscuring case-specific holdings.

***Foo Fio Na*: the patient enters the centre of the legal relationship**

The Federal Court decision in *Foo Fio Na v Dr Soo Fook Mun & Anor* represents one of the most consequential developments in Malaysian medical negligence law [11]. The central question was whether the *Bolam* test should apply to all aspects of medical negligence. The Federal Court rejected an unrestricted application of *Bolam* and drew substantially upon the Australian reasoning in *Rogers v Whitaker*. Its importance extends beyond doctrinal classification. At an ethical level, *Foo Fio Na* challenged the proposition that the medical profession should possess exclusive authority to determine what information patients ought to receive. Such an approach risks conflating expertise with autonomy.

A surgeon is qualified to explain the probability and clinical consequences of a complication. The surgeon

cannot, however, determine how much that complication matters to the particular patient's life. A relatively uncommon complication may be profoundly material to a concert pianist, professional driver, surgeon, athlete or parent even if many other patients would accept the same risk. The legal evolution therefore reflects a fundamental ethical principle: materiality cannot always be defined statistically.

This also explains why a signed consent form cannot be treated as synonymous with informed consent. A signature proves that something was signed. It does not necessarily establish that material risks, reasonable alternatives and the patient's concerns were adequately discussed. The practical consequence for Malaysian medicine is significant. Consent must increasingly be understood as a process of communication rather than a defensive document.

Zulhasnimar: recalibrating professional expertise

A possible difficulty following *Foo Fio Na* was whether rejection of universal *Bolam* reasoning meant that courts should independently determine all questions of clinical diagnosis and treatment. The Federal Court addressed this uncertainty in *Zulhasnimar Hasan Basri & Anor v Dr Kuppu Velumani P & Ors* [12]. The Court distinguished between diagnosis and treatment, on one hand, and the duty to advise patients of risks, on the other. For diagnosis and treatment, the *Bolam* approach remained applicable, subject to the logical scrutiny associated with *Bolitho*. For disclosure of risk, the patient-centred reasoning associated with *Rogers* and *Foo Fio Na* remained applicable. This distinction represents a sensible compromise.

Medical expertise should receive substantial weight when determining whether one technically complex clinical strategy was reasonably preferred over another. Courts cannot practise medicine retrospectively. But whether a patient should have been informed of a material risk is not exclusively a medical question. It involves autonomy, values and reasonableness. Malaysia therefore did not simply replace doctor-centred medicine with judge-centred medicine. Instead, its jurisprudence gradually allocated different questions to the actors institutionally and ethically best positioned to answer them.

Dr Hari Krishnan: expertise, institutions and non-delegable responsibility

The Federal Court revisited these issues in *Dr Hari Krishnan & Anor v Megat Noor Ishak Megat Ibrahim & Anor and another appeal* [13]. The litigation arose after retinal surgery and involved an ophthalmologist, anaesthetist and private eye hospital. The case required consideration not only of the standard of clinical care but also of hospital responsibility where doctors practised as independent contractors. The judgment reinforced the differentiated Malaysian approach to medical negligence and addressed the circumstances in which institutional responsibility may extend beyond conventional vicarious liability.

This development is ethically important because contemporary healthcare is rarely delivered by an isolated physician. Hospitals control or influence staffing, equipment, credentialling, operating theatres, nursing systems, emergency responses, medication systems, information technology and institutional protocols. Even where particular specialists are legally characterised as independent contractors, the patient's experience is often one of receiving integrated care from the hospital. A medico-legal framework that attributes every failure exclusively to the individual practitioner therefore risks misunderstanding how modern healthcare actually operates.

The growing recognition of institutional responsibility aligns Malaysian jurisprudence with contemporary patient-safety science: unsafe outcomes often arise not from a single incompetent individual but from interactions between human behaviour and organisational conditions. This does not eliminate personal accountability. Rather, it prevents organisational accountability from disappearing behind contractual arrangements invisible to the patient.

Yusnita Johari: causation in the catastrophically vulnerable patient

The litigation in *Yusnita Johari v Dr Jerilee Mariam Khong & Ors* presents an especially difficult intersection between negligence, pre-existing clinical risk, causation and catastrophic disability [14,15]. The patient was a

high-risk obstetric patient with placenta praevia who ultimately suffered severe irreversible brain damage. The litigation required the courts to determine whether alleged failures in her management materially contributed to the catastrophic neurological outcome. The Court of Appeal's 2025 decision is particularly important because it considered the relationship between causation and the "thin skull" or "egg-shell skull" principle [15]. This case exposes a common misunderstanding surrounding medical negligence.

A seriously ill patient can be negligently treated. But serious illness can also cause a disastrous outcome despite appropriate treatment. The existence of negligence therefore cannot be inferred from the magnitude of harm. Conversely, a defendant cannot necessarily escape responsibility merely because the patient was already vulnerable. Once actionable negligence has materially caused the relevant injury, the defendant generally encounters the patient as that patient actually exists, including relevant vulnerabilities.

These principles become extraordinarily difficult to apply where underlying disease and negligent treatment operate simultaneously. The ethical challenge is to avoid both extremes: compensating every tragic outcome because the result evokes sympathy, and denying compensation merely because the patient was already clinically fragile. Causation is the mechanism through which negligence law attempts to maintain this boundary.

Catastrophic injury and the apparent rise in compensation

High-value medical negligence awards frequently attract public attention because the headline figure can appear enormous. This can be misleading. A multi-million-ringgit award to a young patient requiring lifelong care is economically different from a multi-million-ringgit commercial award. It may have to fund decades of nursing care, rehabilitation, medication, specialist reviews, consumables, assistive devices, wheelchairs, home modifications and replacement equipment. Permanent severe disability may therefore produce a larger economic claim than death.

These selected cases illustrate the potentially substantial costs of catastrophic disability, but do not demonstrate a national temporal trend in damages. Comparisons must identify the level of court, the specific head of damages, and any appellate variation.

***Prince Court v Lim Yoke Har*: when the institutional response becomes part of the ethical wrong**

The High Court decision involving *Prince Court Medical Centre Sdn Bhd v Lim Yoke Har* provides perhaps the clearest recent illustration that medico-legal accountability extends beyond the initial clinical event [16]. The patient, aged 75, suffered catastrophic brain injury following a fall from a hospital bed. The litigation focused substantially on the circumstances of the fall, including the hospital bed and cot-side mechanism. The court found the hospital liable and made a substantial award, including RM1 million in aggravated damages. However, the most important aspect of the case is not the figure itself.

The judgment addressed concerns regarding the hospital's handling of the incident, the availability of incident reports and internal nursing review material, the explanation of the fall and the conduct of the defence. This raises an issue of profound ethical importance: What happens after an adverse event may influence the medico-legal consequences of what happened during the adverse event.

Healthcare institutions sometimes assume that the safest response to a potentially negligent event is immediate defensiveness: disclose little, admit nothing and contest everything. That strategy may protect against premature admission of liability, but taken too far it can create a second injury. Families frequently seek an explanation before they seek money. Where an institution appears evasive, dismissive or unwilling to acknowledge obvious failures, distrust can transform an adverse event into prolonged conflict. The case therefore highlights the potential importance of open disclosure, incident investigation, preservation of evidence and respectful communication. It also provides a warning that medico-legal risk management and ethical transparency are not necessarily opposing objectives. In some circumstances, ethical transparency may itself be good risk management.

Table 3. Selected reported judgments illustrating compensation heads and appellate status (not a longitudinal trend)

Decision / court	Injury / issue	Verified reported amount or head	Interpretive qualification
Dr Jerilee Mariam Khong & Ors v Yusnita Johari [2025] 6 MLRA 299; Court of Appeal	Severe obstetric brain injury; causation and lifetime need	RM400,000 general damages for pain, suffering and loss of amenities affirmed; RM31,500 pre-trial family-care value affirmed; RM5,320 wheelchair affirmed.	Appeal allowed in part: several damages heads reduced or set aside, interest and costs varied; these are components, not the total final award.
Prince Court Medical Centre Sdn Bhd v Lim Yoke Har & Ors [2024] MLJU 2699; High Court	Brain injury after hospital-bed fall; aggravated damages	RM1,000,000 aggravated damages reported; approximately RM4.2 million aggregate reported by case commentary.	First-instance figures; aggregate and appellate finality not independently confirmed. Do not treat as final appellate award.
Bukit Tinggi Hospital Sdn Bhd v Navin Sharma a/l Karam Chand (2025); Court of Appeal	Aggravated damages and scope of remedy	Not entered: amount and final disposition require authenticated judgment.	Illustrative legal authority only pending verification of full report.

Sources: Dr Jerilee Mariam Khong & Ors v Yusnita Johari [2025] 6 MLRA 299, Court of Appeal, paras 45–51; Prince Court Medical Centre Sdn Bhd v Lim Yoke Har & Ors [2024] MLJU 2699, as reported in case commentary. Monetary figures are non-comparable across cases and procedural stages.

Does Malaysia truly have a medical negligence epidemic?

The available evidence does not justify that conclusion. MOH statistics demonstrate increasing medico-legal complaints and litigation, but these are not equivalent to proven negligent events. Several mechanisms could explain the trend.

Greater patient awareness

Patients today have greater access to medical and legal information. The asymmetry of knowledge between doctor and patient remains substantial but is smaller than in previous generations.

Changing expectations

Patients increasingly expect explanations, participation in decisions and transparency following unexpected outcomes. This should not automatically be characterised as unreasonable consumerism. Some of the change reflects legitimate maturation of patient autonomy.

Increasing complexity of medicine

Modern medicine treats older and more medically complex patients, performs increasingly sophisticated procedures and saves individuals who previously might not have survived. Paradoxically, better medicine can generate more complicated negligence claims because survival following catastrophic injury can create decades of care needs.

Increasing visibility rather than increasing incidence

Improved reporting and complaint systems can increase recorded events even if the underlying incidence remains unchanged. A system in which complaints increase because patients finally feel able to report concerns may initially appear statistically worse while becoming institutionally healthier.

Greater willingness to challenge authority

Traditional medical relationships were frequently paternalistic. Changing educational, social and legal expectations have altered the balance. The rise in claims may therefore reflect, at least partly, a transition from unquestioned professional authority towards accountable professional authority.

The critical conclusion is consequently: Malaysia has evidence of increasing medico-legal activity, but currently available data do not establish a proportional increase in the underlying incidence of negligent medical care. That distinction should remain explicit in both scholarship and policy.

Litigation as patient-safety surveillance

Medical negligence litigation is usually conceptualised as a contest between plaintiff and defendant. From a public-health perspective, this is incomplete. A lawsuit is also a data point. Repeated litigation involving delayed diagnosis, failure to monitor deterioration, inadequate informed consent, medication error, defective equipment or poor escalation of care should be treated as a surveillance signal.

Healthcare institutions routinely analyse infection rates, mortality, readmission and adverse drug events. There is no principled reason why medico-legal claims should be excluded from the same learning framework. The crucial question should therefore not end with:

"Did the hospital successfully defend the claim?" It should continue: "What does this claim reveal about how the next patient could be harmed?"

A hospital can win a lawsuit because causation cannot be established on the balance of probabilities while still uncovering a genuine safety weakness. Conversely, losing litigation should trigger more than financial settlement. It should generate organisational learning. The adversarial courtroom is an exceptionally expensive place to discover a patient-safety problem. It becomes ethically indefensible if the same problem is allowed to injure another patient.

The unintended consequence: defensive medicine

Greater accountability can improve healthcare, but excessive fear of liability can distort it. Defensive medicine encompasses behaviours undertaken principally to reduce medico-legal exposure rather than maximise patient benefit. A 2023 systematic review and meta-analysis encompassing 64 studies, approximately 35,900 physicians and 23 countries estimated an overall pooled prevalence of defensive medicine of 75.8%. Previous experience of medico-legal litigation was associated with increased defensive behaviour [18].

Defensive medicine takes two broad forms. Assurance behaviour includes excessive investigations, referrals, consultations, documentation or admission. Avoidance behaviour includes reluctance to undertake high-risk procedures or manage patients perceived to carry elevated litigation risk. Both have ethical consequences.

Unnecessary investigation consumes resources and may expose patients to radiation, invasive procedures, false-positive findings and further interventions. Avoidance may be still more troubling. If clinicians decline difficult cases primarily because bad outcomes may generate lawsuits, the patients most in need of expertise may have the greatest difficulty accessing it. The goal of medico-legal reform therefore cannot simply be to maximise accountability. It must achieve accountability without paralysing clinical judgment.

Reconsidering informed consent

The jurisprudential evolution beginning with *Foo Fio Na* has important implications for everyday Malaysian clinical practice. Consent should not be reduced to a signature immediately before a procedure. A defensible and ethically meaningful consent process should ordinarily address:

- the nature and purpose of the intervention;

- material risks;
- reasonable alternatives;
- consequences of declining treatment;
- significant uncertainties; and
- concerns that are particularly important to the individual patient.

The phrase "material risk" deserves emphasis. Materiality is relational. A risk may be numerically uncommon but highly important to a particular patient's occupation, responsibilities or values. Medical education should therefore move beyond teaching students to "take consent". Clinicians should be taught how to conduct a consent conversation. This requires communication skills, understanding of risk, appreciation of uncertainty and documentation that reflects an actual discussion.

The ethics of apology and open disclosure

One of the most difficult moments in healthcare occurs after a serious adverse event. Clinicians may themselves be distressed. Institutions may immediately anticipate litigation. Families want answers before investigations are complete. Silence can appear protective. It can also be devastating.

An ethically mature open-disclosure process should distinguish between acknowledgement and premature attribution of legal fault. Healthcare organisations should be capable of saying:

- an unexpected event occurred;
- the patient's suffering is recognised;
- an investigation is being undertaken;
- known facts will be shared;
- uncertainties will be identified honestly; and
- appropriate measures will be taken to prevent recurrence.

An apology should not be viewed merely as a litigation tactic. It is part of preserving the moral relationship between healthcare institutions and patients after harm. The lesson from cases such as *Lim Yoke Har* is that opacity may carry its own legal and ethical cost. Malaysia should consider whether clearer statutory or regulatory guidance concerning open disclosure and appropriately framed apologies could encourage candour without converting every humane expression of regret into an admission of negligence.

Alternative dispute resolution: beyond the courtroom

Traditional tort litigation has important strengths. It provides independent adjudication, procedural protections and the possibility of substantial compensation. But it also has profound limitations. Medical negligence litigation can require years of expert evidence, cross-examination, appeals and substantial legal expenditure. For catastrophically injured patients and their families, delayed compensation may arrive precisely when financial needs are most urgent.

Alternative dispute resolution should therefore occupy a larger place within Malaysian medico-legal policy. Mediation can permit outcomes unavailable through conventional judgments, including explanation, acknowledgement, apology and negotiated arrangements for future care. However, alternative dispute resolution is ethically defensible only if it remains fair. It should not become a mechanism through which powerful institutions pressure vulnerable patients into accepting inadequate compensation. Meaningful

safeguards include independent advice, voluntary participation, transparency and access to expert evidence where required.

Should Malaysia consider limited no-fault compensation?

The Japanese experience deserves careful consideration. Following implementation of Japan's obstetric compensation system, obstetric/gynaecological malpractice claims declined significantly [10]. Malaysia should not simply transplant a foreign model. Healthcare financing, litigation culture and institutional arrangements differ. Nevertheless, catastrophic birth injury presents a particularly compelling case for policy examination. Traditional negligence litigation attempts simultaneously to answer two questions:

Was somebody legally at fault? And **how will this severely disabled person receive lifelong care?**

Those questions need not always depend upon one another. A carefully designed limited no-fault scheme for defined catastrophic injuries could provide earlier financial support while preserving separate mechanisms for investigation, professional accountability and serious misconduct. The central ethical insight is simple: A child requiring lifelong care needs that care regardless of whether lawyers can prove precisely which clinical event crossed the legal threshold of negligence.

A proposed Malaysian framework for medico-legal reform

Malaysia should move from a predominantly reactive model towards an integrated system of prevention, accountability and learning.

1. Establish national medico-legal surveillance

Malaysia needs systematic national data encompassing both public and private healthcare.

At minimum, surveillance should record:

- specialty;
- type of allegation;
- severity of injury;
- clinical and institutional contributing factors;
- litigation outcome;
- settlement mechanism;
- compensation components; and
- recurrence of similar events.

The purpose should not be to produce rankings of "dangerous doctors". The purpose should be to identify dangerous systems.

2. Integrate claims data with patient-safety systems

Medico-legal claims, incident reports and mortality reviews should not exist in separate organisational silos.

Repeated patterns should trigger clinical governance review even where individual lawsuits are successfully defended.

3. Strengthen medico-legal education

Medical curricula should teach:

- negligence principles;
- informed consent;
- documentation;
- communication after adverse events;
- capacity;
- confidentiality;
- causation;
- professional accountability; and
- the distinction between adverse outcome and negligent care.

Medico-legal literacy should be viewed as a patient-safety competency rather than merely protection against litigation.

4. Strengthen institutional accountability

Hospitals must recognise responsibility for the systems through which care is delivered.

Credentialling, equipment maintenance, nursing systems, escalation protocols, staffing and incident investigation are not peripheral administrative matters. They are components of the institution's ethical duty to patients.

5. Develop open-disclosure frameworks

Malaysia should develop clearer national standards governing communication following serious adverse events. Candour should become a component of professional practice rather than an exceptional response after litigation has begun.

6. Expand mediation and early resolution

Clearly meritorious claims should not require years of litigation merely because institutional processes default to denial. Conversely, early neutral expert assessment may help identify claims lacking evidential foundation. Both patients and healthcare professionals' benefit when legitimate disputes can be distinguished from unsustainable claims earlier.

7. Study compensation rather than relying on headline awards

Malaysia requires empirical research examining compensation over time, adjusted for inflation and stratified by injury severity, age, future-care needs, sector and specialty. Without such data, statements that compensation is "rising" risk confusing exceptional catastrophic awards with overall trends.

Ethical implications: what should medical negligence law ultimately achieve?

A functioning medical liability system has at least four purposes: compensation, accountability, deterrence and learning.

A system that compensates patients but fails to prevent recurrence is incomplete. A system that deters negligence by frightening clinicians away from high-risk patients is also incomplete. A system that protects professional reputation by making legitimate claims practically inaccessible is unjust. And a system that treats every adverse outcome as evidence of negligence misunderstands medicine.

The challenge is balance. Doctors require sufficient professional space to make difficult decisions under uncertainty. Patients require protection from unreasonable care. Institutions require incentives to develop safer systems. Injured patients require fair and timely compensation. Society requires mechanisms through which failures generate learning. The development of Malaysian jurisprudence suggests that these interests are gradually being recalibrated.

DISCUSSION

The contemporary Malaysian medico-legal landscape cannot adequately be described as a simple increase in malpractice. What is occurring is more complex. There is measurable evidence of increasing medico-legal complaints and litigation within MOH facilities. Between 2020 and 2024, complaints increased approximately 59% and litigation approximately 74% [3]. At the same time, Malaysian jurisprudence has progressively refined the relationship between medical expertise, judicial scrutiny and patient autonomy. *Foo Fio Na* challenged universal professional deference. *Zulhasnimar* restored appropriate space for clinical expertise while maintaining patient-centred standards for disclosure. *Dr Hari Krishnan* further clarified clinical standards and confronted institutional responsibility. *Yusnita Johari* illustrates the extraordinary complexity of causation and compensation where negligent conduct intersects with severe pre-existing clinical vulnerability. *Lim Yoke Har* demonstrates that institutional conduct after an adverse event may itself become ethically and legally consequential.

Recent jurisprudence concerning aggravated damages further requires courts to distinguish legitimate defence of contested negligence claims from conduct that causes additional compensable injury. Collectively, these cases reveal a transition from a predominantly doctor-centred liability model towards a broader patient- and system-centred accountability model. That transition should be welcomed, but cautiously. The objective should not be to make doctors afraid.

Fear is a poor patient-safety strategy. Neither should policy attempt to suppress litigation simply because compensation is expensive. Compensation is expensive because catastrophic disability is expensive. The better strategy is prevention. Every recurrent negligence claim should prompt the healthcare system to ask whether an earlier patient experienced the same failure and whether the lesson was missed. Malaysia therefore needs to move beyond the language of "risk management". The goal should be risk learning. This distinction is subtle but important. Risk management asks: *"How do we reduce the institution's exposure?"* Risk learning asks: *"Why was the patient exposed in the first place?"* The second question is ultimately more consistent with medical ethics.

STRENGTHS AND LIMITATIONS OF THIS REVIEW

This review integrates contemporary Malaysian MOH medico-legal statistics with landmark Malaysian jurisprudence and international and regional evidence. Its principal contribution is conceptual: rather than interpreting rising claims solely as evidence of worsening medical practice, it analyses the phenomenon as a transition in patient autonomy, institutional accountability, compensation and patient-safety governance.

Several limitations should nevertheless be acknowledged. First, comprehensive nationwide Malaysian malpractice data remain unavailable. MOH statistics primarily describe public-sector medico-legal activity and cannot be assumed to represent the entire healthcare system.

Second, reported judgments represent a selected subset of disputes. Many claims settle privately or through other mechanisms and never produce reported judicial decisions. Third, compensation comparisons across cases are inherently difficult because injuries, life expectancy, future-care requirements and heads of damages differ substantially.

Fourth, this is a purposive critical narrative review without a prospectively documented search protocol, formal screening or critical-appraisal process. Case selection is illustrative, and the completeness of case coverage cannot be established. Fifth, selected judgments cannot support an inference of rising compensation amounts; appellate changes and unreported settlements prevent reliable comparisons.

CONCLUSION

Malaysia's medico-legal landscape is undergoing a significant transformation. Official statistics demonstrate a substantial recent increase in medico-legal complaints and litigation involving MOH facilities. At the same time, Malaysian courts have progressively refined the boundary between professional clinical judgment and patient autonomy, expanded scrutiny of institutional responsibility and confronted increasingly complex questions involving catastrophic injury, causation and damages.

However, increasing litigation should not be interpreted simplistically as evidence that Malaysian medicine is becoming proportionately more negligent. Nor should high-value judgments be characterised merely as increasingly generous compensation. The evidence instead suggests a convergence of several forces: greater patient awareness, changing expectations of professional accountability, increasingly complex healthcare, stronger recognition of autonomy, institutional responsibility and the enormous lifetime cost of catastrophic disability.

Malaysia now faces a choice. One response is defensive medicine: more investigations, more referrals, more documentation, less willingness to treat high-risk patients and increasingly adversarial relationships between clinicians and patients. The alternative is to treat medico-legal change as an opportunity to strengthen patient safety. That requires meaningful informed consent, transparent communication, open disclosure, organisational learning, accessible dispute resolution, fair compensation, stronger medico-legal education and systematic national surveillance of claims.

The ultimate purpose of medical negligence law should not be to make medicine risk-free. That is impossible. Neither should it punish every adverse outcome. Its legitimate purpose is to distinguish unreasonable care from unavoidable misfortune, compensate those who have suffered legally actionable harm, hold individuals and institutions appropriately accountable and convert the lessons of failure into safer healthcare. The most meaningful measure of a mature medico-legal system is therefore not how many cases patients win, how many cases hospitals successfully defend or how much compensation is paid. It is whether the healthcare system learns enough from today's injured patient to prevent tomorrows.

DECLARATIONS

Abbreviations

ADR: Alternative dispute resolution; MOH: Ministry of Health Malaysia; WHO: World Health Organization

Ethics approval and consent to participate

Not applicable. This article analyses published literature, publicly available judicial decisions and official government reports and did not involve recruitment of human participants or collection of identifiable individual-level research data.

Clinical trial number: not applicable.

Consent for publication

Not applicable.

Availability of data and materials

All data discussed in this article are derived from publicly available published literature, judicial decisions and official reports cited in the manuscript.

Competing interests

The authors declare that they have no competing interests.

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Authors' contributions

LSH conceptualised the article, critically reviewed the literature and medico-legal jurisprudence, developed the analytical framework, and reviewed and approved the final manuscript. SFJ, NRS, TAJJ and RN contributed to the literature review and manuscript preparation. All authors reviewed and approved the final manuscript.

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REFERENCES

1. World Health Organization. Patient safety. Geneva: World Health Organization; 2023.
2. Hambali SN, Khodapanahandeh S. A review of medical malpractice issues in Malaysia under tort litigation system. *Glob J Health Sci*. 2014;6(4):76–83. doi:10.5539/gjhs. v6n4p76.
3. Ministry of Health Malaysia. *Annual Report 2024*. Putrajaya: Ministry of Health Malaysia; 2025.
4. *Bolam v Friern Hospital Management Committee* [1957] 1 WLR 582; [1957] 2 All ER 118.
5. *Bolitho v City and Hackney Health Authority* [1998] AC 232.
6. *Rogers v Whitaker* (1992) 175 CLR 479.
7. *Montgomery v Lanarkshire Health Board* [2015] UKSC 11; [2015] AC 1430.
8. Li H, Wu X, Sun T, et al. Claims, liabilities, injuries and compensation payments of medical malpractice litigation cases in China from 1998 to 2011. *BMC Health Serv Res*. 2014; 14:390. doi:10.1186/1472-6963-14-390.
9. Li N, Wang Z. Medical malpractice compensation in China: a retrospective study of litigation cases from 2010 to 2015. *Risk Manag Healthc Policy*. 2026; 19:565182. doi:10.2147/RMHP.S565182.
10. Taniguchi K, Watari T, Nagoshi K. Characteristics and trends of medical malpractice claim in Japan between 2006 and 2021. *PLoS One*. 2023;18(12). doi: 10.1371/journal.pone.0296155.
11. *Foo Fio Na v Dr Soo Fook Mun & Anor* [2007] 1 MLJ 593; [2007] 1 CLJ 229; Federal Court of Malaysia.
12. *Zulhasnimar bt Hasan Basri & Anor v Dr Kuppu Velumani P & Ors* [2017] 5 MLJ 438/441; [2017] 8 CLJ 605; Federal Court of Malaysia.
13. *Dr Hari Krishnan & Anor v Megat Noor Ishak Megat Ibrahim & Anor and another appeal* [2018] 3 MLJ 281; [2018] 1 MLRA 535; Federal Court of Malaysia.
14. *Yusnita Johari v Dr Jerilee Mariam Khong & Ors* [2023] 4 MLRH 263; High Court of Malaya at Johor Bahru.
15. *Dr Jerilee Mariam Khong & Ors v Yusnita Johari* [2025] 6 MLRA 299; Court of Appeal of Malaysia.
16. Prince Court Medical Centre Sdn Bhd v Lim Yoke Har & Ors and another suit [2024] MLJU 2699 (High Court of Malaya).
17. *Bukit Tinggi Hospital Sdn Bhd v Navin Sharma a/l Karam Chand*. Court of Appeal of Malaysia; 2025.
18. Zheng J, et al. Prevalence and determinants of defensive medicine among physicians: a systematic review and meta-analysis. *Int J Qual Health Care*. 2023;35(4). doi:10.1093/intqhc/mzad096.