International Journal of Asian Social Science
ISSN(e): 2224-4441
ISSN(p): 2226-5139
DOI: 10.55493/5007.v15i7.5492
Vol. 15, No. 7, 150-155.

URL: www.aessweb.com

Medical negligence, workforce migration, and the sustainability crisis in Malaysia's public healthcare system

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Article History
Received: 14 May 2025
Revised: 23 June 2025
Accepted: 10 July 2025
Published: 25 July 2025

Keywords
Burnout
Delegable
Ex gratia
Migration
Outpatient
Reports
Takaful.

ABSTRACT

This study explores the increasing strain on Malaysia's public healthcare system resulting from rising medical malpractice cases, physician migration to the private sector, and long-term sustainability issues. It focuses on the legal, institutional, and workforce challenges contributing to physician burnout and clinical negligence. A doctrinal legal research method and thematic analysis were applied to examine selected Malaysian case law from LexisNexis and relevant academic literature. This approach assesses how courts interpret negligence in overloaded healthcare environments and evaluates the scope of indemnity protections available to public healthcare professionals. Key court rulings reveal that public sector physicians remain personally liable for negligence despite government legal aid, incentivizing migration to private practice. However, private sector employment is not risk-free, as courts increasingly hold private hospitals liable under non-delegable duty principles, challenging assumptions of legal immunity. The evolving legal landscape affects both public and private healthcare practitioners, underscoring the need for clearer liability frameworks and more equitable protections. The study recommends reforming indemnity laws, improving working conditions, and adopting shared liability models. It also calls for stronger intersectoral collaboration and sustainable funding strategies to ensure a resilient, fair, and future-ready public healthcare system in Malaysia.

Contribution/ Originality: This study uniquely examines Malaysian case law to highlight legal risks driving physician migration and proposes reforms linking liability with healthcare sustainability, an area rarely explored.

1. INTRODUCTION

The Malaysian public healthcare system is facing several urgent issues, such as increasing medical malpractice cases, a rising number of doctors moving to private practice, and concerns about long-term sustainability (Wah & Ng, 2024). These problems developed as a result of chronic understaffing, job insecurity, and poor pay, and have left public hospital doctors overburdened (Soomro & Ramendran, 2024). This pressure has the potential not only to increase clinical errors but also to bring healthcare professionals under legal and professional scrutiny. The costs of malpractice litigation have led many doctors to seek less volatile and more satisfying jobs in the private sector (Khor, Chua, & Fried, 2024).

This research investigates the intricate interaction between the migrant workforce, medical malpractice suits, and the systemic shortcomings of Malaysia's public healthcare sector. It examines these and other conditions,

including insufficient indemnity protection, inadequate resources, and legal exposure, which lead to poor outcomes for patients and high turnover among healthcare professionals, citing case law and scholarly literature. Using policy analysis and legal research, this article explores the impact of the current institutional and legal environment on workforce stability and medical practice. It concludes with a series of structural reforms to advocate for better working conditions and legal protections for workers, as well as to safeguard the ailing healthcare system in Malaysia.

Through a qualitative research design, this study explores the entanglement of medical neglect, labour migration, and sustainability in Malaysia's public health system. Primarily utilizing case law analysis and literature review, primary data were derived from published case law findings in selected court decisions accessible via LexisNexis Malaysia to consider the trends in clinical negligence, liability, and the extent of state indemnity in the public sector for doctors.

They illustrate the ways courts consider fault in a system that is stretched to its breaking point and lacks adequate investment. Additional sources, such as peer-reviewed journal articles, policy papers, and health law literature, also provide a fuller background of the wider systemic issues driving doctors out of the public sector. The approach yields insights into how legal liability, job dissatisfaction, and organizational sustainability impact Malaysia's concurrent healthcare sectors.

1.1. Strained Workforce and Rising Risk of Error

Chronic understaffing and rising patient loads are contributing to burnout, depression, and an increased risk of mistakes in public hospitals in Malaysia, where postgraduate doctors have reported for years that time for rest and meals is a luxury, and their workload consists of the patients they handle. Work conditions are generally unfavorable in Malaysian public hospitals, as reported by Ching et al. (2024). Continued understaffing and the increasing number of patients attending hospitals are the main factors contributing to doctors' work overload (Roslan, Yusoff, Asrenee, & Morgan, 2021). Healthcare workers with these diseases are prone to burnout, high stress, and exhaustion (Shaharul, Ahmad Zamzuri, Ariffin, Azman, & Mohd Ali, 2023).

Burnout increases the likelihood that doctors will experience depressive symptoms, attempt suicide, and struggle to meet patient expectations (Wieclaw et al., 2008). Since doctors play a vital role in society, their ailments and hardships may cause delays in the provision of care, which could affect their patients (Kay, Mitchell, & Del Mar, 2004). According to Yusof and Razali (2024), in such a pressured environment, the probability of inadvertent medical errors naturally increases. Sadly, the public and patients frequently hold doctors accountable for these incidents, calling their errors "negligence" even when they were unintentional and caused by tremendous pressure (Garcia et al., 2019). For overworked physicians who may already feel unsupported by the system, both institutionally and socially, this blame culture can be extremely disheartening.

1.2. Legal Exposure and Institutional Safeguards

Although the Ministry of Health provides legal counsel and ex gratia compensation to manage medico-legal risks, public scrutiny and litigation anxiety continue to weigh heavily on healthcare workers. Fortunately, the Ministry of Health Malaysia has developed internal processes that grant medical officers the right to legal help and counsel in every medico-legal issue. The Ministry has also implemented an ex-gratia compensation system for victims of medical injury as part of its broader risk management plan, particularly in cases where legal proceedings are avoided.

While the primary policy goal is to protect medical practitioners from such unfair and overly uncharitable claims of negligence, the researcher believes that many of these doctors are feeling fragile due to increased public oversight and a litigious atmosphere. The compensation awarded from ex-gratia settlements and court awards has been inconsistently determined in recent years (Ministry of Health Malaysia, 2022). During 2021, the total sum in

compensation received was RM30,456,754.70. The figure decreased in 2022 to RM4,752,469.20 and increased again to RM6,891,879.28 in 2023. These figures, which comprise both court-ordered payments and ex gratia settlements, demonstrate the Ministry's commitment to managing medical malpractice cases and related issues. Table 1 shows the amount of compensation paid by court order and Ex Gratia payment.

Table 1. Amount of compensation paid by court order and out of court (Ex gratia payment), 2019-2023.

Year	Ex Gratia		Litigation		Total	
	Amount (RM)	Case	Amount (RM)	Case	Amount (RM)	Case
2023	2,073,591.7	61	4,818,287.58	12	6,891,879.28	73
2022	1,694,258.07	25	4,193,506.64	10	5,887,764.71	35
2021	2,740,822.43	46	27,715,932.27	15	30,456,754.70	61
2020	3,909,087.89	55	14,427,784.37	18	18,336,872.26	73
2019	4,471,603.29	70	18,449,560.91	36	22,921,164.20	106

The Ministry's compensation strategy aims to balance the provision of high-quality healthcare services with accountability. The Ministry seeks to ensure that patients receive appropriate compensation while maintaining the integrity of the healthcare system by managing claims through both ex-gratia payments and legal processes. Although government indemnity provides public hospital physicians with a certain level of legal protection, it is contingent upon their adherence to legal limits and professional standards. In cases of gross negligence, misconduct, or criminal activity, they remain personally accountable (Kaur, Chin, & Aziz, 2022).

1.3. Individual Accountability despite Government Backing

Multiple high-profile cases such as *Rohgetanaa v Dr Navin Kumar*, *Nur Syarafina v Kerajaan Malaysia*, and *Dato' Stanley Isaacs v Government of Malaysia* demonstrate that even with Ministry support, healthcare providers are not immune from liability. The case of Rohgetanaa a/p Mayathevan (an infant suing through her father and litigation representative, Mayathevan A/L Mayandi) v Dr Navin Kumar & Ors and other appeals can be referenced where the infant plaintiff was born at Malacca Hospital and subsequently diagnosed with cerebral palsy, a condition attributed to negligence during delivery. The court found both attending doctors liable, alongside the hospital under vicarious liability, and awarded over RM4.8 million in damages.

In the same vein, in the case of Kerajaan Malaysia v Nur Syarafina Binti Sa'ari & Ors, the plaintiff at Hospital Bentong suffered a serious perineal tear during childbirth. An anovaginal fistula complication and issues with young ladies were created by misdiagnosis. The court found the defendants negligent and awarded damages in excess of RM291,000.

In Dato' Stanley Isaacs v. Government of Malaysia, the deceased, who was once a medical practitioner herself, was misdiagnosed and mistreated at Hospital Kuala Lumpur. Holding the government and two individual doctors liable, the court awarded RM735,000, taking into account indirect evidence of misconduct, such as interference with records and providing false expert evidence.

In Muhammad Zulkarnain v Hospital Sultan Ismail, the 12-year-old boy who was subjected to amputations due to negligent treatment was awarded more than a million Malaysian Ringgit. The court emphasized that the child's act of driving an unlawfully operating a motorcycle without a permit was "not the proximate cause of the harm," and "did not mitigate the duty" for his injury.

These cases demonstrate that even with institutional support from the Ministry of Health, such as ex gratia payments and legal assistance, doctors can still be held personally accountable if their actions are deemed irresponsible. When a patient is harmed by substandard care, legal protection does not absolve the provider of responsibility. Additionally, it highlights the broader systemic problems that contribute to such outcomes, along with the financial and legal repercussions for physicians and organizations.

1.4. Migration to Private Sector and the Myth of Legal Immunity

The exodus of experienced doctors to the private sector, motivated by better pay and conditions, threatens the sustainability of public healthcare. Because of this, Amir and Ezat (2020) opined that a large number of highly qualified and experienced medical professionals are choosing to leave the public sector in pursuit of higher pay, a better work-life balance, and more secure jobs in the private healthcare industry. If this movement is not addressed, there is a chance that the public healthcare system will be weakened and that inequities in access to high-quality care will worsen, particularly for lower-income groups who depend significantly on government institutions (Fadzil, Wan Puteh, Aizuddin, & Ahmed, 2022).

However, moving to the private sector does not provide protection from claims of medical malpractice. Private hospitals have historically functioned as non-profit organizations that only housed independent doctors, protecting them from responsibility for the carelessness of those doctors (Samah, 2022). But as private hospitals developed to offer all-inclusive medical care comparable to that of public hospitals, courts began to hold them more responsible for the conduct of their medical staff. Historic rulings like *Gold v Essex County Council* and *Roe v Minister of Health* confirmed that hospitals cannot avoid accountability by assigning responsibility to third parties and have an obligation to provide competent treatment.

Later, this idea was used in Malaysia, where courts started adopting the common law view of the non-delegable duty of care. Imposing this theory on private healthcare institutions has the important advantage of guaranteeing accountability, even in situations where a staff member's negligence cannot be immediately linked to systemic failures or third-party injuries that occur while a patient is in the facility. According to the theory, the obligation is to guarantee that care is given correctly as well as to provide care. Regardless of whether the healthcare provider is a permanent employee, a visiting consultant, or an independent specialist, this guarantees patient protection and encourages greater standards of institutional responsibility.

This is demonstrated in the seminal Malaysian case of *Dr. Hari Krishnan & Anor v. Megat Noor Ishak*. The Federal Court finally decided that the hospital nevertheless had a non-delegable duty of care to ensure that anaesthetic treatments were provided with appropriate skill and care, even if the doctors engaged were not direct hospital employees. The court based its ruling on the obligation resulting from the hospital-patient connection, distinguishing this from vicarious liability. The ruling supports the UK case *Woodland v. Swimming Teachers' Association*, which states that Malaysian healthcare facilities are required to protect patients regardless of how services are organized or contracted out.

While public hospitals serve as critical safety nets for the nation's healthcare, they are disproportionately exposed to liability, particularly when patients are transferred from private hospitals at advanced stages of illness. The legal and reputational consequences often fall on public healthcare providers, even in situations where earlier interventions or mismanagement in private care played a significant role in the final outcome.

Such practices are not only unjust to overburdened public healthcare professionals but also erode public confidence in the healthcare system. They highlight the urgent need for a more integrated framework of shared responsibility and accountability across both sectors, with clear guidelines for inter-facility patient transfers and transparency in medical decision-making. Without such reforms, the public sector will continue to bear an unfair share of the blame, both in courts and in public discourse, while private institutions remain largely protected from scrutiny.

2. CONCLUSION AND RECOMMENDATION

In conclusion, it is imperative to consider increasing the costs of healthcare, especially outpatient services in public hospitals, as a strategic measure to ensure better compensation for medical professionals. Underpayment of healthcare workers hampers the retention of skilled personnel in the public sector, leading to a continuous outflow of talent to the more lucrative private healthcare industry. Adjusting the public healthcare cost structure would not

only lead to more equitable remuneration but could also encourage those with financial means to opt for private services, thereby alleviating patient overload in public facilities.

More significantly, rather than mainly depending on contract-based employment, the government would have more money to provide doctors with permanent jobs as a result of increased revenue. This change would foster a stronger and more sustainable public healthcare system, boosting job security and morale for healthcare workers. With a well-staffed workforce, tasks can be more evenly distributed, reducing the risk of burnout and allowing doctors to perform their duties more effectively and confidently. This, in turn, leads to better patient care.

By developing a more integrated healthcare system between the public and private sectors, it would inadvertently accelerate growth in the private healthcare sector as well (Hanif, et al., 2023). Yet, the rates should not be raised uniformly for everyone. A just solution may be to develop a targeted subsidy scheme where the wealthy pay in full, but poor people continue to access free or heavily subsidized care. It would be a system that is fiscally sustainable so that no one goes without health care because their wallet is thin.

Another proposed healthcare financing model for Malaysia is a mixed system of social health insurance with specific government subsidies based on the socioeconomic profile of the country. With that national health insurance scheme—akin to Thailand's Universal Coverage Scheme (UCS) or Indonesia's Jabatan Kesehatan Nasional (JKN)—enforced for companies and citizens, there would be guaranteed funding for basic public healthcare services. Muslims could invest in Shariah-compliant takaful health policies that would be inclusive and compatible with religion. A new system of targeted subsidies would also ensure that care for low-income individuals and households is free or heavily subsidized. The middle- and upper-income groups would be responsible for contributing to these funds, either through co-payments or an insurance-type arrangement.

Restoring the Goods and Services Tax (GST) could also increase revenue that could be utilized to support infrastructure, new technology, and human resources in public healthcare. Political figures and policymakers will need to make tough decisions that favor public health over short-term political considerations. Politicians and policymakers need to be ready to think boldly and progressively, even if those ideas are not immediately popular, but when lives are on the line, long-term structural change must take precedence over immediate political advantage. It is also important to remember that increased funding will allow the public healthcare system to hire more physicians and support personnel, which will help to address the long-standing problems of overwork and understaffing that many government hospitals currently face.

Funding: This study received no specific financial support.
Institutional Review Board Statement: Not applicable.
Transparency: The authors state that the manuscript is honest, truthful, and transparent, that no key aspects of the investigation have been omitted, and that any differences from the study as planned have been clarified. This study followed all writing ethics.
Competing Interests: The authors declare that they have no competing interests.
Authors' Contributions: All authors contributed equally to the conception, design, analysis, interpretation of data, and writing of the manuscript. All authors have read and approved the final version of the manuscript.

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