ORIGINAL ARTICLE

Medical negligence adjudication in Malaysia: A retrospective analysis of law cases in 2025

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ABSTRACT

Introduction: Medical negligence litigation in Malaysia is rising, making judicial decisions vital for defining contemporary duties of care and clinical governance. This study presents a retrospective document-based analysis of medicolegal cases adjudicated in 2025 to systematically identify and categorise the core clinical and systemic issues driving liability.

Materials and Methods: A retrospective document search was conducted on reported Malaysian medical negligence judgments published between January 1 and December 31, 2025, across the LexisNexis and Current Law Journal databases. From 51 initial records, 22 non-relevant disputes were excluded, yielding 29 clinically relevant medicolegal cases for analysis. A descriptive, quantitative and demographic profiling of the dataset was conducted to map the structural landscape of the litigation. To systematically analyse the evolving standards of medical accountability and clinical governance in Malaysia, a retrospective, document-based thematic analysis using a structured three-stage qualitative coding framework was conducted.

Results: Litigation was heavily concentrated in the High Court (22 cases), clustered in urban centres, and dominated by public hospitals (15 cases). Surgical domains were the most frequently litigated: Orthopaedics (10 cases), Obstetrics & Gynaecology (8 cases), and Other Surgical Specialities (6 cases). The qualitative analysis synthesised five dominant areas of judicial scrutiny: 1) Negligence in Timely Intervention and Diagnosis, 2) Breach of Informed Consent and Patient Autonomy, 3) Medical Records and Documentation Evidence, 4) Systemic Liability, and 5) Legal and Procedural Issues. Liability was consistently driven by critical delays in time-sensitive interventions, such as emergency Caesarean sections resulting in severe birth injuries and delayed vascular treatment leading to limb loss. Diagnostic failures, including the inability to order essential radiological investigations or misdiagnosing acute conditions like Deep Vein Thrombosis and fatal septic shock, were also key findings. Furthermore, the judiciary showed a consistent judicial emphasis on protecting patient autonomy, penalising doctors for insufficient disclosure of material risks and failure to advise on alternative treatments. Judicial severity was notably demonstrated against healthcare professionals operating beyond their credentialed boundaries, confirming that practice must strictly adhere to regulatory standards. A significant trend identified is the increased focus on corporate accountability, with hospitals being held corporately liable under the principle of non-delegable duty for systemic failures. Inadequate referral systems and a lack of qualified standby personnel led to hospital liability even where individual treating doctors were absolved of direct clinical negligence. Additionally, the integrity of medical records proved pivotal, as issues of tampering, fabrication, and post-incident insertion of notes were treated as severe aggravating factors that profoundly undermined the defence's credibility.

Conclusion: The 2025 retrospective case law analysis indicates that the Malaysian medicolegal environment is evolving toward a standard of total accountability. The courts demand strict adherence to clinical best practices, respect for patient autonomy, robust institutional systems, and honest professional conduct. For healthcare professionals and institutions, mitigating legal risk now necessitates not just technical competence, but also absolute integrity in documentation and unwavering professional transparency.

KEYWORDS:
Negligence, malpractice, jurisprudence, clinical governance, informed consent

INTRODUCTION

Medical negligence claims are of serious global concern in Malaysia, increasing pressure on healthcare providers to maintain high standards of care.[1-2] Judicial decisions serve as vital markers that define duties of care, clinical governance, and professional accountability. The legal landscape depends heavily on complex judicial tests, such as the transition from the traditional Bolam test to the Foo Fio Na standard and relies fundamentally on expert evidence.[2-3] Systematic analysis of recent outcomes is therefore essential for risk management, legal reform, and professional education.

The historical evolution of Malaysian medical negligence jurisprudence began with Chin Keow v Kerajaan Malaysia.[4] Over subsequent decades, claims have steadily increased due to heightened public awareness of patient rights, expanding medical specialisation, and growing healthcare complexity.

Historically, judicial assessment was grounded in the Bolam principle, which defines negligence as a failure to act in accordance with the standards of reasonably competent

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medical men at the time.[5] This benchmark recognises that medicine is not an exact science. Similarly, Hunter v Hanley clarified that negligence only arises when a clinician exhibits a failure that "no doctor of ordinary skill would be guilty of acting with ordinary care".[6] The law demands conduct consistent with a reasonably competent practitioner, not perfection.

This reluctance to equate adverse outcomes with negligence is reflected in the Malaysian case of Payremalu Veerappan v Dr Amarjeet Kaur & Ors.[7] Referencing M Shoba v Dr Mrs Rajakumari Unnithan case, the court emphasised that "a doctor is never presumed to be infallible" and negligence cannot be inferred merely because treatment goes wrong. A positive finding that the practitioner fell below ordinary standards is required. This principle is vital when analysing rare complications, high-risk surgeries, or rapidly evolving emergencies, demonstrating that Malaysian courts remain cautious against imposing retrospective perfectionism.

This paper undertakes a retrospective document-based analysis of Malaysian medical negligence cases adjudicated in 2025. The primary objective is to identify, synthesise, and categorise prevailing issues and judicial trends by examining clinical circumstances, legal debates, liability findings, and damages. This analysis provides a vital snapshot of the evolving medicolegal environment, offering essential insights for clinicians, administrators, and legal professionals to mitigate risk and ensure compliance with contemporary standards of care.

MATERIALS AND METHODS

To systematically examine the evolving standards of medical accountability and clinical governance in Malaysia, this study employed a retrospective document-based analysis, a rigorous qualitative method involving the systematic evaluation of textual records to develop empirical knowledge. A comprehensive electronic search was conducted across the LexisNexis and Current Law Journal (CLJ) databases, which house authoritative records from all levels of the Malaysian judiciary, using the explicit keyword phrase "medical negligence" OR "medical malpractice" OR "clinical negligence" for cases published or decided between January 1 and December 31, 2025. This initial search yielded 51 raw records, which were then subjected to a strict multi-stage screening process. Inclusion criteria required cases from any level of the Malaysian judiciary involving a patient against a healthcare practitioner or assistant across any delivery site, including public hospitals, private centres, and standalone clinics. Conversely, exclusion criteria eliminated non-medical negligence, purely commercial or employment disputes, road traffic accidents lacking central medical mismanagement, and out-of-court settlements. Following screening, 22 cases were excluded, resulting in a final sample of 29 cases. For each selected case, a structured data extraction protocol recorded baseline descriptive variables, including jurisdictional level, geographic registry distribution, healthcare sector, and the specific clinical speciality under scrutiny. The core textual data within the written judgments, comprising the judges' ratios decidendi, obiter dicta, cited expert testimonies, and established case facts, were then analysed.

First, open coding was conducted to isolate and label specific clinical failures and legal disputes. Next, axial coding cross-examined these raw codes, mapping their conceptual relationships and clustering them into broader categories based on shared clinical or legal vulnerabilities. Data analysis followed a thematic qualitative approach combining inductive coding with deductive categorisation. The initial coding framework was mapped deductively into established medicolegal and ethical domains (e.g., duty of care in intervention, informed consent, documentation, systemic liability, and procedural/legal issues). Using these standard ethical and legal frameworks ensured a rigorous, domain-appropriate analysis tailored to judicial case law review. Finally, selective coding integrated and refined these categories into five distinct, overarching thematic domains that encapsulate the primary drivers of contemporary Malaysian medicolegal liability. This comprehensive approach ensured the study's conclusions were grounded entirely in objective legal texts, providing a transparent, rigorous, and reproducible framework for evaluating modern healthcare accountability.

RESULTS

Demographic

The systematic database search identified 29 medical negligence cases in Malaysia meeting the inclusion criteria for 2025. A descriptive baseline profiling was performed to map out the structural and clinical characteristics of the litigation dataset. As comprehensively detailed in Table I, litigation was heavily concentrated within the High Court's jurisdiction (n = 22), with the remaining 5 in the Court of Appeal and another two in the Session Court, and geographically clustered in the major urban centres of the Klang Valley (Kuala Lumpur and Shah Alam) and Ipoh. Public sector hospitals accounted for more claims (n = 15), followed by private facilities (n = 13). The patient cohort primarily comprised adults, though key vulnerable populations, including newborns (n = 4) and children (n = 3), were represented. Surgical-based domains emerged as the most frequently litigated sectors, led by Orthopaedics (n = 10), Obstetrics & Gynaecology (n = 8), and Other Surgical Specialities (n = 6). Notably, several cases overlap; this frequently manifested as clinical boundary intersections between orthopaedics and other surgical subspecialties (spine and vascular surgery), and O&G and paediatrics specialities.

[Table I: Demographic and Legal Profile of Included Medical Negligence Judgments (N = 29)]

Key Thematic Findings

Thematic analysis of the 29 selected cases identified five major themes. Refer to Table II for case summary and details.

[Table II: Summary of 2025 Medical Negligence Cases in Malaysia according to Key Issues, Decisions, and Damages]

Under the first theme, Negligence in Timely Intervention and Diagnosis, delays in emergency intervention were prominently identified in obstetric and vascular management. Delayed emergency Caesarean sections resulting in severe birth injuries were litigated in A (a child...)[8] and Nitin Sharma[21], while vascular-related delays leading to

Table I: Demographic and legal profile of included medical negligence judgments (N = 29)

No.	Demographic	Classification	Frequency (n)	Case Citation
1	Judicial Jurisdiction	Session Court	2	35, 36
		High Court	22	8-29
		Court of Appeal	5	30-34
		Federal Court	0	-
2	Geographic Registry	Kuala Lumpur	5	8,11,16,21,25
		Shah Alam	5	14,15,23,24,27
		Ipoh	4	17, 18, 26, 31
		Seremban	2	12,23
		Georgetown	1	9
		Taiping	1	10
		Penang	1	19
		Alor Setar	1	20
		Kota Bahru	1	13
		Melaka	1	28
3	Health Sector	Public Hospital	15	8, 10, 12–14, 16, 17, 19–21, 23, 24, 26, 29, 32
		Private Hospital	10	19, 27, 28, 30, 31, 33, 34, 36
		Private Outpatient Clinics	3	9,22,35
		University Hospital	1	25
4	Patient Age Cohort	Adult	22	Remaining cases
		Child	4	8, 20, 21, 33
		Newborn	3	16, 29, 36
5	Main Speciality Involved	Orthopaedics	10	9, 12, 14, 17, 19, 23, 24, 27, 28, 34
		Obstetrics & Gynaecology	8	8, 11, 12, 20, 21, 25, 32, 33
		Other Surgical Specialities	6	10, 13, 15, 16, 19, 25
		Paediatrics	4	20, 21, 29, 36
		Emergency Medicine	1	30
		Otorhinolaryngology	1	31
		Anaesthesiology	1	14
		Ophthalmology	1	18
		General Practice	1	22
		Aesthetic Medicine	1	35
6	Specialty Distribution	Multidisciplinary Overlap	9	12, 14, 16, 17, 19, 20, 21, 25, 26
		Single Speciality Case	20	Remaining cases

*Note: Frequencies across clinical specialities exceed N = 29 due to multidisciplinary overlap in several cases.

ischemic gangrene and amputation were evaluated in Fairuz Fahmy[12] and Wee You Kheong.[28] Diagnostic failures were also recurring, such as the failure to perform radiological investigations for a spinal giant cell tumour in Daniel Lee Eng Wern,[9] alongside missed diagnoses of vascular injury in Wee You Kheong,[28] Deep Vein Thrombosis in Thavani a/p Kaliaperummal,[26] and septic shock in Zuasnita bt Baharudin.[29] Substandard perioperative management was further identified, including unmanaged postoperative ischemia resulting in amputation[14], negligent peripheral administration of inotropes,[16] and premature sinus surgery.[31] Conversely, Tan Sri Datuk Seri Mohd Hussein case saw no negligence found for a rare arthroscopic vascular complication.[34]

The second theme is Breach of Informed Consent and Patient Autonomy. Insufficient disclosure of material risks, alternatives, or conservative treatment pathways was scrutinised in Dr Chandran a/l Gnanappah,[31] Evelyn Sharmini,[11] and Tan Sri Datuk Seri Mohd Hussein,[34] whereas Siti Arbaiyah bt Umar[25] was dismissed due to adequate disclosure. This theme also captured practitioners operating beyond their credentialed scope, including a general practitioner using unapproved filler substances[35] and a gynaecologist performing bowel repair.[11]

The third theme is Medical Records and Documentation Evidence. Allegations of altered or post-incident inserted records arose in Loganathan a/l Thiagarajan[18] and Evelyn Sharmini,[11] while the suppression or total absence of evidence was noted in Nitin Sharma[21] and Muhammad Aiman bin Mohd Hisham.[20] Documentation and system-related deficiencies were similarly central to Nur Fuziatun bt Mohd Fadzli[33] and Mohammad Nabill Sajid.[19]

Systemic liability formed the fourth theme. Nur Fuziatun involved hospital liability stemming from inadequate referral networks and absent standby personnel.[33] Dr Chandran a/l Gnanappah[31] addressed corporate liability alongside indemnity against the doctor, and A (a child...)[8] scrutinised institutional compliance with Decision-to-Delivery Interval (DDI) guidelines.

The final theme encompassed legal and procedural issues. Claims were dismissed due to statutory limitation periods under the Public Authorities Protection Act 1948,[13] while contributory negligence was argued in Daniel Lee Eng Wern[9] and Bukit Tinggi Hospital.[30] Lastly, substantial aggravated and exemplary damages were awarded for egregious misconduct in Loganathan,[18] Thavani,[26] Hasmani,[14] and Rafianee.[35]

Table II: Summary of 2025 medical negligence cases in malaysia: Key issues, decisions, and damages

No	Case Name (Date of Judgment)	Date of incident	Summary of Case	Issues	Liability	Damages Awarded (RM)
1	A (a child suing through his mother and litigation representative, Noor Shahizan bt Ajmi) v Kerajaan Malaysia & Ors[8] (6 May 2025)	11 Feb 2010 (filed 11 Jan 2023)	Plaintiff suffered severe brain damage (cerebral palsy) due to a delay in performing an emergency caesarean section. The court found negligence in the delay.	The court held that the 30-minute decision-to-delivery interval is a guideline, not a strict rule, and is contingent on hospital feasibility. Aggravated damages were denied due to the plaintiff's 12-year delay in filing the suit, noting the defendants did not pursue a limitation defence. Lastly, the court determined the plaintiff's maximum life expectancy as 29 years, rejecting the claimed 44 years.	Yes (against D1, D3, D4).	RM2,286,490.00 (Total)(Includes Gen: RM300k, Special: RM458k, Future: RM1.47m).
2	Bukit Tinggi Hospital Sdn Bhd & Anor v Navin Sharma a/l Karam Chand[30] (23 September 2025)	13 May 2019	Appeal on quantum for a patient's death (septicaemia/ruptured cyst).	- contributory negligence of the patient (deceased) & husband in AOR discharge. - The appellants argued that the deceased's estate could not claim for aggravated damages as that was a claim that was personal to a 'living plaintiff'.	Yes (Liability upheld) 6.	RM173,000.00 (approx.)(Reduced from ~RM1.08m. P&S: RM50k, Special: ~RM33k, Costs: RM75k).
3	Daniel Lee Eng Wern v Aaron Lim Boon Keng[9] (19 February 2025)	19 & 26 February 2019, 3 & 13 December 2019 (Clinic visits), 11 Jan 2020 (fracture diagnosis), 14 Jan 2020 (tumour diagnosis)	An orthopaedic surgeon failed to order appropriate investigations for persistent back pain, delaying diagnosis of a giant cell tumour on the spine.	- Failure to conduct a proper physical examination on the patient's spine led to failure to diagnose the tumour after several visits to the clinic -There is no revision of the provisional diagnosis conducted by the Defendant on pt repeated visits & he failed to provide a conclusive diagnosis - the injuries suffered and/or losses incurred by the Plaintiff were caused by or substantially contributed to by the negligence of the Plaintiff himself (refusal for MRI & failure to come to appointments)	Yes (75% liable; 25% contrib. neg.).	RM126,204.23
4	Dato Dr Gengatharan @ Jeganathan s/o Venkatesan v Dr Shanker Sathappan & Anor[10] (25 December 2025)	19/12/2014 (First admission) 8/1/2015 (transfer hospital) 10/1/2015 (Fall incident)	Claim by the husband of a deceased patient alleging she died after falling off a hospital bed post-surgery. The court found no negligence in management.	The court examined whether the patient fell from her hospital bed due to the defendants' negligence. Additionally, the plaintiff alleged that IV Mannitol and Phenytoin were administered without proper consent, causing the confusion and disorientation that ultimately led to the fall	No (Dismissed).	Nil (Costs RM50k to each Defendant).
5	Dr Chandran a/l Gnanappah v Gan See Joe[31] (19 May 2025)	27 March 2014	The patient died after sinus surgery. The doctor proceeded prematurely without waiting for the antibiotics to work. The hospital was liable for a non-delegable duty.	-failure to provide informed consent prior to surgery(advice) & perform surgery which is not indicated at that time (failure to treat). -adjustment of indemnity between doctor and hospital.	Yes (D1 liable; D2 liable but indemnified).	~RM900,000+(Gen: RM100k, Loss of Contrib: RM288k, Special: RM143k, Aggravated: RM350k).
6	Dr Jerilee Mariam Khong & Ors v Yusnita bt Johari3[2] (30 July 2025)	11/11/2013 (referred to hospital) 12/12/2013 (admitted for delivery) High Court judgment (15/4/2021)	The plaintiff suffered severe and irreversible brain damage secondary to amniotic fluid embolism following an emergency Caesarean section.	The main issues determined in this case were whether the plaintiff's pre-existing health condition triggered the "Egg-Shell Skull" rule affecting the defendants' liability, and whether the trial court made factual errors in finding certain medical staff liable for negligence that materially contributed to the plaintiff's brain damage. The Court of Appeal upheld the liability of the hospital and specific medical staff while dismissing claims against several other doctors, and significantly reduced the overall quantum of damages awarded	Yes (D2, D3, D7-D17).	RM585,829.60 (approx.) (Gen: RM400k, Special: ~RM34k, Future care awards varied).

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No	Case Name (Date of Judgment)	Date of incident	Summary of Case	Issues	Liability	Damages Awarded (RM)
7	Evelyn Sharmini a/p Mariasoosay Nathan v Dr Yogaraj Ramanathan & Anor1[1] (21 November 2025)	10 July 2018	Gynaecologist liable for bowel perforations during surgery and failure to advise on conservative options. Hospital not vicariously liable.	- failure to advise (informed consent) & treat (complications, bowel injuries) - D1 undertook bowel repair, though did not credential to perform it. - documentation of outpatient notes - appears to have been inserted later.	Yes	RM967,710.40(Gen: RM420k, Aggravated: RM50k, Future: RM121k, Costs: RM200k).
8	Fairuz Fahmy bin Harun lwn Sivanathan a/l Jeyaramu & Anor[12] (23 December 2025)	8 December 2017	Defendant in a road accident suit brought 3rd party proceedings against the hospital for the delay in vascular treatment leading to amputation.	- whether the delay in referring to the vascular hospital was intentional, leading to negligence.	No (3rd Party Claim dismissed).	Nil (against 3rd Party).
9	Hamzan bt Hamzah v Dr Ahmad Zul Fikri B Mohamad & Ors[13] (7 August 2025)	15 May 2021 (admit), 3 August 2022 (final treatment received), 2 August 2025 (cause of action ended)	Negligence claim struck out as time-barred under the Public Authorities Protection Act 1948.	- Plaintiff did not name any doctors in the suit -exceeded the limitation period of 36 months	No.	Nil.
10	Hasmani bin Tahir v Kerajaan Malaysia dan lain-lain[14] (20 December 2025)	22 January 2019 (Admission) 21 February 19 (plan for surgery), postponed to 4 Mac 19	Negligence leading to amputation of the right leg. Liability was found against the government and doctors. The court awarded exemplary damages.	- Whether the use of a tourniquet during surgery was according to the standard of care - Failure to advise: to explain complications of vascular injury - Failure to treat within golden hour (6 hours of ischaemic time)	Yes.	RM300,000 (General) + RM300,000 (Exemplary) + Special Damages.
11	Juwariyah bt Sal Hamid @ Ahmad v Dato' Dr Shahrudin bin Mohd Dun[15] (14 April 2025)	25 May 2017 (1st surgery) 7 June (2nd surgery)	Plaintiff claimed negligence for biliary stricture following gallbladder surgery.	Whether the defendant breached the standard of care by prioritising an ERCP over an MRCP and discharging the plaintiff without a post-stent removal cholangiogram or scheduled follow-ups, the court found that stricture was a known risk and that management was proper.	No (Dismissed).	Nil (Costs RM35k).
12	Krishnasamy a/l Jayaraman & Anor v Kementerian Kesihatan Malaysia & Ors[16] (7 November 2025)	14 Jan 2019	Assessment of damages for a minor who suffered multiple amputations due to the negligent administration of inotropes. Liability conceded.	The plaintiff alleged medical negligence involving highly inconsistent diagnoses and the improper administration of inotropes through a peripheral vein, which caused severe gangrene necessitating multiple amputations. Furthermore, a breach of confidentiality occurred when doctors openly discussed the patient's unconfirmed diagnosis with relatives.	Yes (Conceded).	RM7,400,883.19(Prosthetics, future care, Gen damages, etc.).
13	L/Kpl Naraayanan Nair a/l Subramaniam v Kerajaan Malaysia & Ors17 (9 January 2025)	13 Mac 2018 (Admission), 14 Oct 2021 (Admission of liability)	Assessment of damages for arm amputation. Liability admitted. The court awarded significant aggravated damages due to the conduct.	The assessment of various heads of damages following the defendants' admission of liability for medical negligence that resulted in the amputation of the plaintiff's left arm	Yes (Admitted).	~RM2,256,981(Gen: RM150k, Aggravated: RM200k, Prosthetics: ~RM1.8m).
14	Loganathan a/l Thiagarajan v Dr Lee Mun Toong18 (28 March 2025)	6 July 2011 (Admission), 7 July 2011 (Surgery)	Ophthalmologist negligent for failing to detect a foreign body in the eye. Aggravated damages were awarded due to the fabrication of records.	The court rejected the defendant's claim that the patient refused a CT scan, citing the absence of a signed waiver and contradictory nurses' notes. Significant discrepancies also emerged regarding the injury's mechanism, and a 3cm scleral tear was only documented post-operatively	Yes.	RM1,032,870.59(Gen: RM200k, Aggravated: RM500k, Future income: ~RM253k).

Table II: Summary of 2025 medical negligence cases in malaysia: Key issues, decisions, and damages

No	Case Name (Date of Judgment)	Date of incident	Summary of Case	Issues	Liability	Damages Awarded (RM)
15	Mohammad Nabill Sajid bin Mohammad Aslam Sajid v Government of Malaysia & Ors19 (22 April 2025)	11 July 2020 (Admission) 15 July 2020 (Surgery)	Claim for paralysis due to delayed spinal surgery dismissed. The court found the delay was to stabilise the patient and did not alter the outcome.	The plaintiff alleged a four-day delay in spinal decompression surgery caused his permanent paralysis. Conversely, the defendants maintained this delay was medically necessary to stabilise his severe lung and spine injuries safely. The treating specialist strongly denied claims that surgery was delayed for financial approvals, while the plaintiff further alleged incorrect documentation and refusal of neurosurgical treatment.	No (Dismissed).	Nil (Assessed at RM400k+ if liable).
16	Muhammad Aiman bin Mohd Hisham v Kerajaan Malaysia 20 (30 June 2025)	24/03/2009 (Admission), 20/03/2009 (Discharge at own risk), 31/3/2009 (Second presentation), 2/4/2009 (date of delivery)	Medical negligence suit involving a child suing through the mother.	The plaintiff failed to prove that the defendants' negligence caused the birth defect. The court highlighted alternative causes, including premature delivery, four episodes of antepartum haemorrhage, intra-uterine growth restriction, and the mother's consumption of traditional medicine. Furthermore, an adverse inference was drawn against the plaintiff for suppressing crucial prenatal records, including the "pink book."	No.	Nil (cost of RM 50,000)
17	Nitin Sharma s/o Ram Krishen v Kerajaan Malaysia & Ors 21 (3 June 2025)	31 Dec 2000 (First presented), 14 Jan 2001 (delivery date)	Plaintiff suffered cerebral palsy/Erb's palsy due to negligence at birth. Defendants failed to produce rebuttal expert evidence [66]67.	The 22-year-old plaintiff's high-risk pregnancy involved an unstable lie and cord prolapse risk. Despite recognising the need for an elective caesarean on 31 December, the defendants inexplicably delayed the delivery. Furthermore, the defendants failed to call the material treating doctors and the CT scan assessor.	Yes.	~RM5,684,991.98(Gen: RM450k, Aggravated: RM100k, Future Care: RM4m+, Costs: RM300k) 69.
18	Nur Fuziatun bt Mohd Fadzli v Gombak Medical Centre Sdn Bhd & Ors33 (12 November 2025)	17 June 2014 (delivery)	The court allowed an appeal against the hospital and Person in Charge regarding the non-delegable duty/system failure but dismissed the appeal against the delivering doctor.	The plaintiff alleged negligence in diagnosing fetal distress, performing a vacuum delivery, and lacking an adequate specialist referral system. The hospital and its person-in-charge were initially absolved because the treating doctor was found not liable. Key issues involved the person-in-charge's duty of care, delayed early-morning transfers, handwritten note discrepancies, and post-2016 specialist standby requirements	Yes.	Remitted to the High Court for assessment.
19	Punitha a/p Padathaly v Salam Alliance Sdn Bhd & Anor22 (24 November 2025)	22 June 2018 (clinic visit) 28 June 2018 (referral letter written)	Claim regarding a psychiatric referral letter issued without consent/exam. The application by the defendants to strike out the application is dismissed.	The plaintiff alleged professional negligence against the doctor for issuing a psychiatric referral letter diagnosing her with bipolar disorder without conducting any clinical examination or consultation. Furthermore, she claimed a breach of confidentiality and misuse of medical information when the doctor wrongfully disclosed this letter to her husband without her lawful authorisation.	To proceed to full trial.	To be decided.
20	Radha a/p Sekar v Pengarah Hospital Port Dickson23 (21 July 2025)	27 Nov 2017 (Admission), 14 December 2017 (Surgery for debridement)	Appeal against dismissal of the claim for the death of a patient. The High Court affirmed the lower court decision dismissing the claim.	The plaintiff failed to prove that the improper insertion of an IV drip caused the deceased's thrombophlebitis. The court found no negligent delay in the orthopaedic referral or surgical debridement, as appropriate antibiotic treatment had already commenced. Ultimately, the cause of death was sepsis with multiorgan failure exacerbated by pre-existing conditions.	No.	Nil (Costs RM10k).

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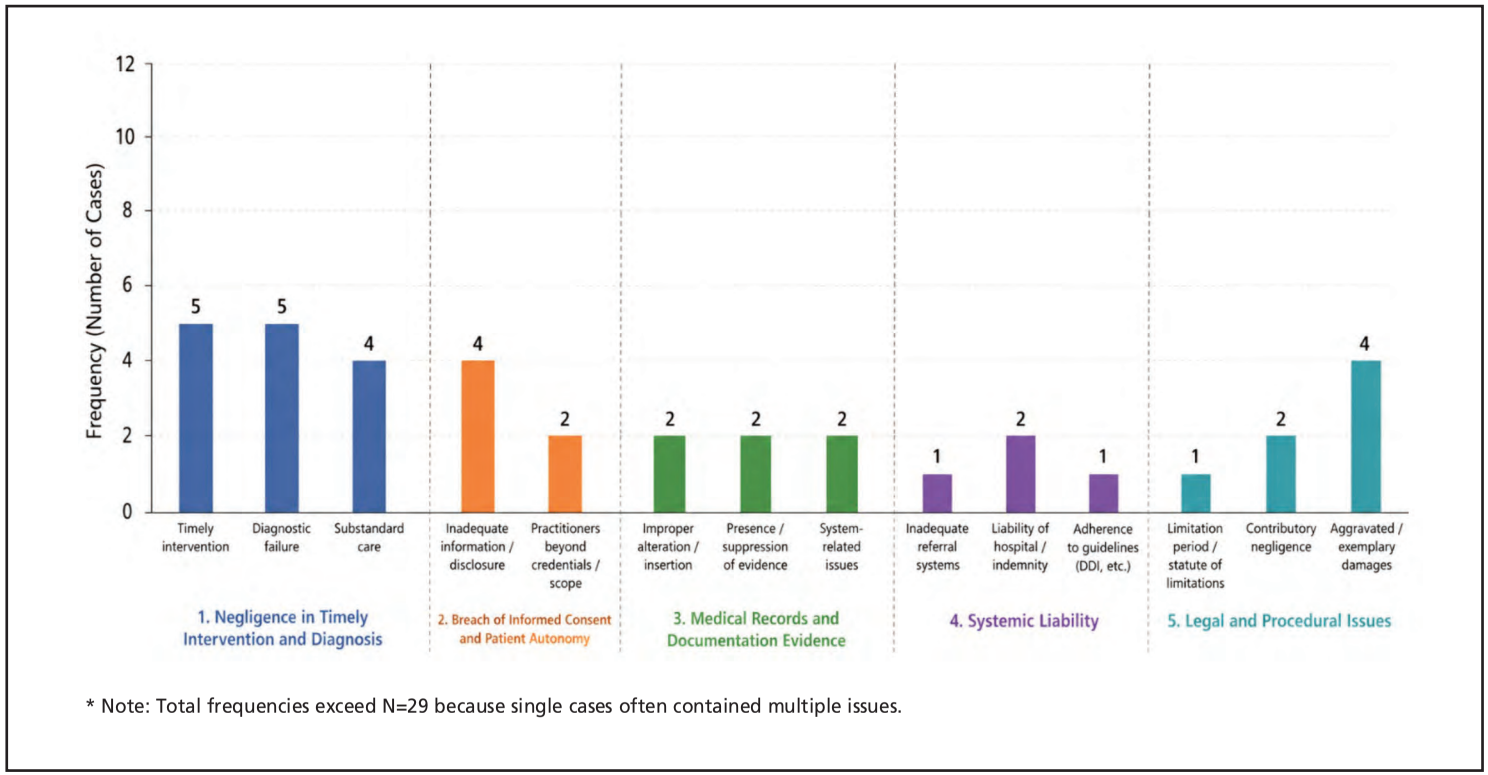
No	Case Name (Date of Judgment)	Date of incident	Summary of Case	Issues	Liability	Damages Awarded (RM)
21	Rafianee bt A Razak v Dr Suffia Hany bt Mohamad Amin & Ors35 (29 July 2025)	26 Oct 2020 (contacted through phone), 28 October, 9 & 11 November 2020 (Surgery/procedure).	Breast filler procedure by a general practitioner using an unapproved product.	The plaintiff alleged negligence against the doctor for performing an aesthetic breast filler procedure without the mandatory Letter of Credentialing and Privileging. Furthermore, the injected filler was primarily composed of silicone, contrary to the consented 100% hyaluronic acid. Additionally, the clinic was operating illegally without the required Ministry of Health license under the applicable healthcare laws.	Yes.	~RM919,009.60(Gen: RM85k, Exemplary: RM800k, Special: RM34k).
22	Selvaraju a/l Ponniah v Pengarah Hospital Tengku Ampuan Rahimah & Ors24 (1 April 2025)	15 March 2018 (Admission), 25th March 2018 (Deceased)	Claim for death due to Fat Embolism. Alleged delay in surgery/implant application.	Whether the delay of surgery causes death (fat embolism), and whether the delay was due to the payment process for the implant.	No (Dismissed).	Nil (Costs RM10k).
23	Shahrul Izam bin Mat Desa v Dr Mohamad Shahbodin bin Sarik36 (3 March 2025)	1 April 2014	Suit regarding the death of a child from pneumonia.	Failure to prove that negligence was committed during the 4 days of treatment before transfer to the government hospital.	No (Dismissed).	Nil (Costs RM6,825).
24	Siti Arbaiyah bt Umar v UKM Kesihatan Sdn Bhd & Anor25 (13 August 2025)	31/10/2014 - first surgery 21/05/2015 - second surgery	Plaintiff alleged the surgeon failed to advise on an alternative surgical approach. The court found the plaintiff was properly advised and consented.	The plaintiff failed to prove a breach of the doctor's duty to advise on surgical risks. The court held the doctor adequately advised on the anterior approach, deemed the safest option, and reasonably relied on another specialist to advise the patient on the less common posterior approach.	No.	Nil (Costs RM38k).
25	Tan Sri Datuk Seri Mohd Hussein bin Abd Hamid v. Gleneagles Hospital (Kuala Lumpur) Sdn Bhd & Anor34 (20 June 2024)	27 December 2013 (the date the arthroscopic debridement surgery was performed)	The patient suffered a popliteal artery tear following an arthroscopic knee surgery.	Whether the surgeon was negligent in causing the popliteal artery injury during the arthroscopy and in failing to inform the patient of this specific material risk. Whether the private hospital was vicariously liable for the surgeon's negligence, and if the hospital owed and breached a non-delegable duty of care to the patient. Both the surgeon and the hospital were found liable, overturning the High Court's dismissal.	Yes (by 2-1 Court of Appeal majority).	To be assessed. The Court of Appeal remitted the case back to the High Court for the assessment of damages
26	Thavani a/p Kaliaperummal v Kerajaan Malaysia & Ors 26 (14 January 2025)	4 May 2018 (Accident), 5 July 2018 (Deceased)	Assessment of damages for death due to an undiagnosed deep-vein thrombosis.	Following the defendants' admission of liability, the primary issue determined was the assessment of various damages arising from the fatal misdiagnosis and mismanagement of the deceased's deep-vein thrombosis. The court examined whether the medical personnel's prolonged neglect warranted these compensations	Yes (Admitted).	~RM682,176.00(Gen: RM100k, Aggravated: RM500k, Dependency: RM45k).
27	Vasanthi a/p B Balakrisnan v Sunway Medical Centre Sdn Bhd 27 (23 May 2025)	27 Jan 2017	Plaintiff alleged negligence in wrist fracture surgery (implant placement). The court found treatment was within standard medical practice.	The plaintiff alleged the defendant operated only on her radius fracture and failed to disclose a concomitant ulna fracture, causing her persistent wrist pain. Ten months later, another hospital operated on the unhealed ulna. Ultimately, the court dismissed the suit, ruling that the plaintiff failed to prove the defendant was negligent in his treatment.	No (Dismissed).	Nil.

Table II: Summary of 2025 medical negligence cases in malaysia: Key issues, decisions, and damages

No	Case Name (Date of Judgment)	Date of incident	Summary of Case	Issues	Liability	Damages Awarded (RM)
28	Wee You Kheong v Hasbullah bin Azhar & Ors[28] (14 February 2025)	25 August 2015	Plaintiff suffered a severe leg injury in a road traffic accident (RTA). The 4th Defendant (Orthopaedic surgeon) was at the 3rd Defendant hospital.	The 1st and 2nd defendants were found liable for the road traffic accident, resulting in the dismissal of their third-party claim. However, the court ruled there was a break in the chain of causation regarding the plaintiff's leg amputation, attributing this specific injury entirely to the subsequent medical negligence of the 3rd and 4th defendants. It was concluded as a misdiagnosis of a vascular injury leading to compartment syndrome, causing a delay in treatment that resulted in ischemic gangrene and an above-knee amputation.	Yes (3rd & 4th Defendants liable for medical negligence; 1st & 2nd Defendants liable for the accident).	~RM782,917 (Includes Future Prosthetic: RM512k, General Damages: RM125k, Special Damages: ~RM135k). Plus ~RM101k against RTA defendants.
29	Zuasnita bt Baharudin & Anor v Government of Malaysia & Ors[29] (24 April 2025)	5 April 2018 (Admission), 21 May 2018 (Deceased)	Assessment for the death of a child (septic shock). The court awarded aggravated damages for prolonged suffering/neglect and a lack of urgency.	Delays in medical intervention: treatment administered was inadequate and lacked proper escalation to a specialist facility.	Yes.	RM822,180.00(Gen: RM300k, Aggravated: RM500k, Special: RM22k).



* Note: Total frequencies exceed N=29 because single cases often contained multiple issues.

Fig. 1: Frequency of medical negligence issues according to thematic categories in 29 selected cases

DISCUSSION

An important methodological observation is that the keyword "medical negligence" captures a broader range of healthcare disputes than direct clinical malpractice alone. Of 51 initially retrieved cases, 23 were excluded because they involved insurance disputes, employment conflicts, corporate litigation, product liability, and regulatory issues rather than negligent patient care. This demonstrates the value of using a broader search term initially to avoid prematurely excluding relevant medicolegal cases. The findings also illustrate how modern litigation extends beyond bedside care into wider issues involving healthcare systems, manufacturers, and medical technology. This is reflected in cases like Johnson & Johnson v Vijayakumar, which concerned liability from a defective medical implant, shifting focus to product safety and manufacturer responsibility.[37]

Continuing the analysis of administrative oversight, Ramani a/p Visvanathan involved a judicial review against the Malaysian Medical Council (MMC) regarding disciplinary proceedings, indicating that professional negligence can be contested through administrative law.[38] While these cases were excluded from the final clinical negligence analysis, their initial retrieval indicates that medicolegal risk encompasses commercial, administrative, and regulatory compliance, necessitating a holistic approach to risk management.

Surgical specialities such as orthopaedics, neurosurgery, vascular surgery, and O&G represented the most frequently litigated domains, a pattern consistent with international data. Steele et al. (2015), analysing United Kingdom National Health Service Litigation Authority (NHSLA) data, identified 617 neurosurgical claims, with 46% being successful, totalling a litigation burden of £67.4 million.[39] Similarly, Li et al. reported that orthopaedics and O&G accounted for 11.3% and 10.0% of malpractice claims in Chinese tertiary hospitals, respectively.[40] The present findings challenge the perception that O&G exclusively dominates disputes in Malaysian government hospitals. Although obstetric litigation remains prominent, the highest damages awarded in the 2025 cases were associated with surgical specialities due to the long-term financial implications of severe surgical injuries, particularly limb loss requiring lifelong prosthetic replacements and revisions.

The number of defendants differed remarkably between public and private hospital cases. For example, the Muhammad Aiman,[20] Nitin Sharma,[21] and Nur Fuziatun[33] public hospital cases involved more than 30 defendants, including house officers, medical officers, registrars, consultants, administrators, and government entities. This contrasts with private litigation, which commonly involves fewer individually named practitioners or specialist teams. This discrepancy reflects differing organisational structures. In public hospitals, patient management involves multiple clinical teams across different specialities and levels of seniority. Conversely, private hospital consultants often function under an "independent contractor" model. The increased number of defendants in public-sector litigation underscores the complexity of assigning accountability within highly layered systems. Many disputes arose from breakdowns in shared responsibility, supervision, escalation pathways, and institutional communication across multiple clinical tiers. While multidisciplinary management theoretically strengthens patient care, fragmented responsibility within large healthcare systems may create ambiguity in decision ownership and delay decisive intervention.

Negligence in Timely Intervention and Diagnosis

This observation is reflected in the broader thematic findings of the present study, where medical negligence litigation remained heavily centred on failures involving timely intervention, diagnostic judgment, and perioperative clinical management. Across multiple cases, liability frequently arose not merely from rare complications but from delays in escalation, inadequate reassessment, failure to investigate evolving symptoms, and breakdowns in clinical decision-making during time-sensitive situations. The courts consistently treated delays in intervention seriously where they resulted in irreversible neurological injury, limb loss, or death. The courts consistently treated delays in intervention seriously where they resulted in irreversible neurological injury, limb loss, or death.

A recurring pattern involved emergency and acute care settings where deterioration required urgent intervention within a limited therapeutic window. In obstetric litigation, delays in performing emergency Caesarean Sections in A (a child...)8 and Nitin Sharma[21] resulted in severe hypoxic injury and cerebral palsy. Similarly, in vascular and postoperative settings, the courts scrutinised whether clinicians acted promptly once signs of ischaemia, vascular compromise, or deterioration became apparent. Wee You Kheong illustrates the compounded consequences of delayed intervention and diagnostic error, where misdiagnosis of a vascular injury as compartment syndrome ultimately resulted in ischemic gangrene and above-knee amputation.[28] The analysis suggests that the judiciary increasingly recognises the practical importance of the "golden hour" principle in emergency medicine, namely the critical therapeutic window during which rapid assessment, diagnosis, escalation, and intervention are necessary to prevent irreversible physiological damage. In many acute conditions, such as fetal distress, vascular compromise, sepsis, ischemia, or major trauma, delays beyond this period may transform a potentially reversible condition into permanent disability, organ failure, limb loss, or death. Rather than viewing delay as a secondary issue, the findings demonstrate that courts increasingly regard failure to intervene within this critical period as a direct breach of the standard of care where earlier action could reasonably have altered the clinical outcome. The significance of the "golden hour" therefore lies not merely in speed alone, but in the expectation that healthcare systems and clinicians must recognise deterioration early, communicate effectively, escalate promptly, and initiate decisive management before the opportunity for meaningful recovery is lost.

The cases also demonstrate that diagnostic reasoning remains central to the professional duty of care. Several judgments involved failures to pursue appropriate investigations, reconsider provisional diagnoses, or

adequately interpret persistent clinical signs. In Daniel Lee Eng Wern,[9] the orthopaedic surgeon's failure to order radiological imaging despite repeated complaints of back pain delayed the diagnosis of a giant cell tumour of the spine. Similar issues arose in Thavani a/p Kaliaperummal[26] involving undiagnosed DVT, and Zuasnita bt Baharudin,[29] where septic shock was not recognised in time. Collectively, these cases indicate that courts increasingly view diagnosis as a continuous and dynamic clinical obligation rather than a single isolated event. Clinicians are expected not only to initiate treatment but also to continuously reassess the patient's evolving condition, revisit differential diagnoses, and escalate investigations when the clinical trajectory deviates from expectations.

The findings further suggest that contemporary negligence litigation increasingly scrutinises perioperative judgment and postoperative monitoring. In Hasmani bin Tahir,[14] failure to recognise and manage postoperative ischaemia within the accepted six-hour therapeutic window directly resulted in limb amputation. In Krishnasamy a/l Jayaraman, negligent administration of inotropes through a peripheral line caused multiple amputations in a minor.[16] Similarly, in Dr Chandran a/l Gnanappah, liability arose from proceeding with sinus surgery before adequate infection control had been achieved.[31] These cases demonstrate that courts are not merely examining technical procedural performance, but also evaluating the broader clinical judgment surrounding the timing, justification, and safety of surgical intervention and postoperative care.

At the same time, the findings demonstrate that Malaysian courts continue to distinguish between genuine negligence and recognised medical complications. In Tan Sri Datuk Seri Mohd Hussein, the Court of Appeal accepted expert evidence that the popliteal artery injury sustained during arthroscopy was an exceptionally rare avulsion injury that could occur despite the exercise of reasonable care and skill.[34] The court therefore rejected allegations that excessive force had been used and found no negligence in the diagnosis, surgical execution, or postoperative management, particularly given the prompt referral to vascular specialists once the complication was identified. The decision reinforces the principle that adverse outcomes alone do not establish negligence. Nevertheless, the surgeon was ultimately found liable for failure to adequately advise the patient regarding material risks, illustrating the judiciary's increasing separation between technical competence and the independent duty to secure informed patient autonomy.

Breach of Informed Consent and Patient Autonomy

The findings indicate a growing judicial emphasis on informed consent and patient autonomy within Malaysian medical negligence litigation. Liability increasingly extends beyond technical treatment errors to include failures in disclosure, counselling, and patient communication. Several cases demonstrate that courts now expect clinicians to provide patients with sufficient information regarding material risks, alternative treatments, and conservative management options before obtaining consent for intervention.

In Dr Chandran a/l Gnanappah, the lack of adequate informed consent was considered alongside the doctor's decision to proceed prematurely with surgery.[31] Similarly, in Evelyn Sharmini, the court criticised the failure to advise the patient regarding conservative management alternatives prior to surgery.[11] These cases suggest that courts increasingly regard disclosure obligations as part of the substantive standard of care rather than a purely administrative formality.

The Court of Appeal decision in Tan Sri Datuk Seri Mohd Hussein further illustrates the evolving judicial approach toward material risk disclosure.[34] The majority held that the surgeon failed to warn the patient about the specific risk of popliteal artery injury prior to arthroscopy, thereby depriving the patient of the opportunity to make a fully informed decision. However, the dissenting judgment by Azimah Omar demonstrates the continuing legal tension regarding the scope of disclosure obligations for exceptionally rare complications. Her Ladyship opined that the rare and unforeseeable vascular injury was not sufficiently material to require disclosure and further argued that such a warning would not have altered the patient's decision to proceed with surgery. The differing judicial approaches reflect the continuing evolution of Malaysian informed consent jurisprudence from traditional professional-centred disclosure toward a more autonomy-based standard.

The analysis also demonstrates that courts are prepared to reject informed consent claims where adequate counselling is established through evidence. In Siti Arbaiyah bt Umar, the court dismissed allegations that alternative approaches had not been discussed after finding that the doctor had adequately advised the patient regarding the selected surgical plan.[25] The contrasting outcomes across these cases suggest that liability in informed consent disputes frequently turns on the adequacy, materiality, and documentation of the advice provided rather than merely the occurrence of complications themselves.

Another significant issue identified involves practitioners operating beyond their credentials, training, or regulatory approval. In Rafianee bt A Razak v Dr Suffia Hany, a general practitioner performed breast filler procedures using unapproved substances, raising both credentialing and regulatory concerns.[35] Likewise, in Evelyn Sharmini, the defendant gynaecologist undertook bowel repair despite lacking the appropriate credentials to perform such procedures.[11] These findings indicate that courts increasingly view professional boundaries, credentialing, and regulatory compliance as integral components of the standard of care. Negligence, therefore, extends beyond technical incompetence to include undertaking procedures outside the practitioner's recognised expertise or authorised scope of practice.

Medical Records and Documentation Evidence

The findings demonstrate that medical records increasingly function not merely as clinical communication tools, but as central evidentiary instruments in medical negligence litigation. Across several cases, the integrity, completeness, and reliability of documentation significantly influenced judicial findings on credibility, liability, and damages.

Courts responded particularly severely to allegations involving altered or fabricated records. In Loganathan a/l Thiagarajan, the court awarded substantial aggravated damages after identifying serious concerns regarding tampering with medical records and inconsistencies in the defendant's account of events.[18] Similar concerns arose in Evelyn Sharmini, where outpatient notes appeared to have been retrospectively inserted.[11] These cases suggest that documentation irregularities are viewed not merely as administrative deficiencies, but as conduct affecting professional honesty and the integrity of the judicial process itself.

The findings also highlight the evidentiary significance of witness presentation and disclosure during litigation. In Nitin Sharma, the defence's failure to call relevant witnesses or rebuttal experts weakened its position regarding the delay in the emergency Caesarean Section.[21] Conversely, in Muhammad Aiman, although concerns were raised regarding withheld evidence, the claim nevertheless failed because causation was not established.[20] These contrasting outcomes indicate that deficiencies in documentation or evidentiary presentation alone do not automatically establish negligence unless they materially affect proof of breach or causation.

The analysis further suggests that documentation failures may also reflect broader systemic deficiencies within healthcare institutions. In Nur Fuziatun, issues relating to illegible handwriting formed part of the wider system failures identified by the court.[33] However, Mohammad Nabill Sajid demonstrates that flawed documentation does not invariably result in liability where the underlying clinical management remains justified, and causation cannot be established.[19] Overall, the findings indicate that courts increasingly regard accurate documentation as an essential component of professional accountability, continuity of care, and medicolegal defensibility.

Systemic Liability

The findings demonstrate an increasing judicial willingness to impose liability upon healthcare institutions in addition to individual clinicians. Modern medical negligence litigation in Malaysia increasingly examines failures involving systems of care, institutional preparedness, staffing arrangements, escalation pathways, and multidisciplinary coordination rather than focusing solely on isolated acts of individual negligence.

A central issue identified is the concept of non-delegable duty. In Nur Fuziatun, the hospital and Person in Charge were found liable because of system failures involving inadequate referral arrangements, lack of standby specialists, and insufficient intensive care support.[33] Importantly, liability arose despite the delivering doctor not being personally negligent. The case illustrates judicial recognition that hospitals owe independent corporate duties to ensure that appropriate systems, staffing, and facilities are available for safe patient care.

The relationship between institutional liability and individual practitioner negligence is further demonstrated in Dr Chandran a/l Gnanappah.[31] Although the hospital was held liable under a non-delegable duty, the court ultimately granted indemnity against the treating doctor because the primary negligence arose from his clinical decisions and inadequate informed consent process. This reflects the judiciary's attempt to balance institutional accountability with personal professional responsibility within modern healthcare systems.

The findings also demonstrate that courts continue to treat clinical guidelines as influential but non-binding standards. In A (a child...), the court clarified that the Decision-to-Delivery Interval (DDI) guideline for emergency Caesarean Sections was not a strict mandatory rule but a feasibility-dependent recommendation.[8] Nevertheless, liability was still imposed because the delay was not adequately justified under the circumstances. The decision illustrates that courts may permit flexibility in guideline application while still requiring clinicians and institutions to provide reasonable explanations for departures from accepted standards where adverse outcomes occur.

Legal and Procedural Issues

The findings additionally highlight several recurring procedural and legal issues influencing the outcome of medical negligence litigation, particularly limitation periods, contributory negligence, and punitive damages.

In Hamzan bt Hamzah, the claim was struck out after exceeding the limitation period prescribed under the Public Authorities Protection Act 1948, illustrating the procedural barriers faced by plaintiffs pursuing claims against government healthcare institutions.[13] The case demonstrates that even potentially arguable negligence claims may fail if statutory procedural requirements are not satisfied.

The findings also indicate that Malaysian courts remain willing to reduce liability where patient conduct contributed to the adverse outcome. In Daniel Lee Eng Wern, damages were reduced by 25% due to the plaintiff's refusal to undergo an imaging investigation and failure to attend follow-up appointments.[9] Similarly, Bukit Tinggi Hospital involved arguments relating to contributory negligence following an Against Own Risk (AOR) discharge.[30] These cases demonstrate that courts assess patient compliance and decision-making alongside professional duties when determining liability and quantum.

Finally, the analysis demonstrates a clear judicial willingness to impose substantial aggravated and exemplary damages in cases involving particularly serious professional misconduct. High aggravated damages were awarded in Loganathan a/l Thiagarajan,[18] Thavani a/p Kaliaperummal,[26] and Zuasnita bt Baharudin,[29] while exemplary damages featured prominently in Hasmani bin Tahir[14] and Rafianee bt A Razak.[35] These awards indicate that Malaysian courts increasingly utilise punitive damages not only to compensate plaintiffs, but also to condemn dishonest conduct, gross neglect, regulatory breaches, and serious departures from acceptable professional standards.

LIMITATIONS

This study has several limitations. First, relying solely on cases published in the LexisNexis and CLJ databases, retrieved using the keyword "medical negligence," inherently excludes undocumented decisions or cases catalogued under different legal terms. The sample size of 29 reflects only fully adjudicated cases published in law reports during the study period. It does not encompass the broader spectrum of medical negligence claims that were settled out of court, dismissed prior to full hearing, or managed internally through institutional or Ministry of Health grievance mechanisms. Consequently, these findings illustrate trends in judicial adjudication and legal reasoning rather than the absolute incidence or epidemiology of medical malpractice in Malaysia.

Second, restricting the analysis to the single calendar year of 2025 provides only a temporal snapshot; it reflects the year of judgment rather than the year in which the actual clinical incidents occurred, limiting real-time clinical trend analysis. Additionally, the lack of 2025 Federal Court cases leaves out recent authoritative interpretations from Malaysia's apex court.

Finally, focusing exclusively on reported judicial decisions introduces a selection bias toward high-severity, high-value, and complex litigations. The vast majority of medical errors, patient disputes, and complaints are resolved outside the formal judicial system through private negotiations, out-of-court settlements, alternative dispute resolution (ADR), or internal institutional disciplinary processes (such as by the MMC). Consequently, this study cannot analyse the frequency or nature of these lower-severity or pre-court disputes. The findings, therefore, represent the most severe legal precedents rather than the complete, everyday landscape of medical errors and healthcare disputes in Malaysia. Future research incorporating administrative data directly from hospitals and regulatory bodies is recommended to capture a comprehensive, system-wide picture. To establish broader longitudinal shifts in judicial attitudes toward patient rights, future studies should conduct multi-year comparative analyses of case law and integrate administrative data from health authorities and institutional risk management registries.

CONCLUSION

This study maps the contemporary 2025 Malaysian legal landscape of medical negligence, establishing a sophisticated judicial standard that demands technical proficiency, system resilience, and absolute integrity.

At the core of judicial scrutiny are critical delays in time-sensitive interventions and diagnostic failures regarding acute conditions. These issues represent primary drivers of liability when resulting in catastrophic harm. Furthermore, the judiciary showed a judicial emphasis on protecting patient autonomy and informed consent, penalising practitioners for inadequate risk disclosure, withholding information on conservative alternatives, and practising beyond credentialed or regulatory boundaries.

The most significant shift identified is the increased focus on hospital systemic liability and documentation integrity. Under the principle of non-delegable duty, hospitals face corporate liability for operational failures, such as inadequate referral networks or a lack of qualified standby personnel, even when individual doctors are absolved. Crucially, the integrity of medical records proved pivotal; issues of tampering, fabrication, or post-incident note insertions were treated as severe aggravating factors that profoundly undermined defence credibility.

In conclusion, the 2025 case law indicates an evolution toward total accountability. The courts demand adherence to clinical best practices, respect for patient autonomy, auditable institutional systems, and honest conduct. For healthcare professionals and institutions, preventing negligence requires strict clinical standards, but mitigating legal risk demands absolute transparency and documentation integrity.

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