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Litigation, Labor and Law: Rethinking Workforce and Liability Structures in Malaysia's Public Healthcare Sector

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Abstract: This article explores the link between medical negligence litigation, workforce migration, and structural weaknesses in Malaysia's public healthcare system. Adopting a case study approach, it categorizes legal decisions into three areas: (A) Hospital and Doctor Liability, Surgical/Procedural Negligence; (B) Birthing-Related Negligence and Women's Health; and (C) Diagnosis-Related, Follow-up, and Causation Issues. The analyzed cases reveal recurring themes, such as inadequate supervision, diagnostic errors, and under-resourced facilities, which have led to serious harm and an increasing legal liability. These institutional failings compromise patient care and contribute to the departure of skilled medical professionals from the public sector in search of better prospects. The article recommends strategic reforms, including introducing a national health insurance model with targeted subsidies, improving doctor remuneration through revised public service fees, and shifting toward more secure, long-term employment for healthcare workers. A progressive tax policy, such as reintroducing GST, could provide sustainable funding.

Keywords: *Burnout, outpatient, reports, ex gratia, migration, delegable, takaful*

1. Introduction

Malaysian public healthcare faces several urgent issues, namely skyrocketing medical negligence cases, increasing exodus of medical professionals to private practice, and worries over the longevity of public health services (Wah & Ng, 2024). Underlying these challenges are structural factors, including low staff levels, job insecurity, inadequate pay, and lack of professional indemnity cover (Soomro & Ramendran, 2024). In consequence, public hospital doctors are overworked and legally exposed, leading to errors and dissatisfaction. The financial and reputational risks involved in malpractice litigation have thus driven healthcare professionals to seek alternative sources of employment and remuneration in recent years, outside the public system (Khor, Chua & Fried, 2024).

This paper examines the intricate relationship between labour migration, medical malpractice lawsuits, and institutional shortcomings in Malaysia's public healthcare system. It considers how inadequate legal protection, insufficient institutional support, and poorly resourced working environments adversely affect both patient care and the retention of healthcare professionals. This paper adopts a case study approach to deepen the analysis, focusing on selected Malaysian medical negligence cases to illustrate the systemic pressures faced by public healthcare providers.

By integrating case law analysis with academic sources, the paper explores the legal, ethical, and policy dimensions of this growing crisis. Through a combination of legal research and policy analysis, it evaluates the consequences of the current institutional framework on workforce stability and professional accountability. The paper concludes by offering recommendations for structural reform aimed at improving working conditions, strengthening legal protections for healthcare workers, and ensuring the long-term sustainability of Malaysia's public healthcare sector.

2. Contextual Background: Workforce Strain, Litigation and Systemic Failures

Malaysia's healthcare system is embattled with systemic deficiencies, including a lack of funding, an understaffed system, and an inflexible contract-based employment setup for junior doctors (Rassip et al., 2023). With the institutions particularly overwhelmed and understaffed, overworked medical professionals, especially in crowded government hospitals, are unable to cope with the workload (Supian & Ibrahim, 2024).

Daud, Abd Ghani & Zahid (2022) believe that career stagnation, job insecurity, and poor wages have driven many health workers to look for employment in the private sector or to move out of the country for greener pastures. It is more than just this financial exhaustion." This shift in the workforce's mobility could not be attributed to lower wages or working conditions- Apathy and disillusionment are fueling the migration (Omar, 2022). And the loss of the experienced staffers means that the staff that remain behind become even more overworked, and the cycle of burnout and stress, and bad patient outcomes continues (Jinah et al., 2023).

These stressed conditions are largely to blame for the increase in medical malpractice lawsuits (Metzner, 2022). Understaffed and underfunded doctors are much less likely to make mistakes but are more likely to be holding the legal bag when the shit hits the fan (Ahmad et al., 2021). The spectre of litigation is an additional level of psychological and professional stress that is rendering the public sector unappealing to many doctors (Kassim & Najid, 2013). Thus, if private providers experience less legal risk (since insurance and support arrangements are superior), the lack of systemic protection contributes further to migration from a more into a less protective legal environment. For another, this leads to a reinforcing feedback loop: Systemic deficits induce the loss of workers, which worsens other deficits and escalates the risk of poor charging decisions and the number of lawsuits. Without real reform, the cycle of abuse seen in these examples of negligence will undermine the sustainability and credibility of Malaysia's public health infrastructure.

3. Methodology

This study is based on a qualitative research design that unravels the interconnectedness of medical neglect, labour migration and sustainability within the Malaysian public health system. This research employs a case study review technique where ten cases in the Malaysian courts are analyzed as the main units of study. These cases, sourced from the LexisNexis Malaysia database, serve to discern trends in judicial reasoning, determination of liability, and the cap on indemnity for public healthcare providers. Predominantly through case law analysis and literature searching, the researchers have formulated secondary data extracted from law reports in several sample cases available through LexisNexis Malaysia in an actuarial review of the trends of clinical negligence, responsibility, and degree of state indemnity in the public sector of doctors. These cases are grouped into three categories: Category A: Hospital and Doctor Liability – Surgical/Procedural Negligence; Category B: Birthing-Related Negligence and Women's Health; and Category C: Diagnosis-Related, Follow-up and Causation Issues.

Category A: Procedural Negligence and Vicarious Liability

In this group of cases, the courts addressed allegations of negligence arising from surgeries or medical procedures, with particular focus on hospital responsibility, informed consent, and clinical errors. In *Rohgetanaa a/p Mayathevan v. Dr Navin Kumar & Ors*, 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.

Meanwhile, in *Muhammad Zulkarnain v. Hospital Sultan Ismail*, the 12-year-old boy who was subjected to amputations for negligent treatment was awarded more than a million Malaysian Ringgit. The court underscored that the kid's act of driving unlawfully, operating a motorcycle with no permit, was "not the proximate cause of the harm," and "did not mitigate duty" for his injury. Collectively, these cases highlight how institutional strain and procedural oversights contribute to clinical errors and legal liability that ultimately burden both medical professionals and healthcare institutions.

These cases underscore the broader institutional crisis within the Malaysian public healthcare system, where overstretched resources, insufficient staffing, and weak risk management systems contribute to avoidable errors and escalating legal liability. The recurrence of such outcomes points not only to individual failings but also to structural weaknesses, such as poor clinical governance, lack of legal training among healthcare workers, and institutional reluctance to invest in patient safety mechanisms. This legal and financial exposure fuels dissatisfaction among public healthcare professionals, contributing to workforce migration and instability. Consequently, these case studies reinforce the argument that medical negligence litigation is not

merely a matter of personal fault, but also a symptom of deeper systemic inadequacies that endanger the sustainability of Malaysia's public healthcare sector.

While procedural negligence cases expose the legal impact of operational and communication failures, obstetric and childbirth-related cases reveal another layer of vulnerability, where lapses during labour and delivery not only endanger lives but also reflect gendered risks and systemic gaps in maternal care.

Category B: Childbirth Negligence

This set of cases reveals systemic weaknesses in obstetric care, including inadequate supervision and diagnostic failure, which often result in long-term harm to mothers. In *Kerajaan Malaysia & Ors v. Norfazlin Zamani*, in this medical negligence case, the plaintiff, an aesthetician, sued the Government of Malaysia and attending doctors at Selayang Hospital after suffering bladder injuries and complications during childbirth. She had opted into the Full Paying Patient (FPP) scheme and selected a senior consultant, but he was unavailable during her emergency C-section. A junior doctor performed the surgery and negligently injured her bladder. The injury went undetected for two days, requiring a laparotomy, followed by a second surgery after a drain broke and was left in her abdomen. The plaintiff also developed psychiatric trauma due to her suffering.

The Government admitted liability, and the High Court awarded her general, aggravated, and special damages. The defendants appealed the quantum. The Court of Appeal allowed the appeal in part, upholding the liability but adjusting the quantum of damages awarded by the High Court.

In *Kerajaan Malaysia & Anor v. Nurul Rabihah Abdul Rahman*, the respondent gave birth at Taiping Hospital and suffered a serious injury (OASI) during delivery. Despite surgery and treatment, her condition worsened—she lost control of her bowels and needed a stoma (a bag to collect waste). Later tests showed severe muscle and nerve damage. She had another surgery at a different hospital, but it didn't help. She sued the hospital for medical negligence. The hospital admitted fault, and the court awarded her RM1457,500.00, which includes, but is not limited to, pain and suffering, treatment, and aggravated damages. The hospital appealed, saying the amount was too high. The respondent also appealed, asking for more money to cover stoma-related costs. The court reduced some of the compensation (appeal allowed in part) and rejected the respondent's request for extra money.

In another case, *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 of over RM291,000. These childbirth-related cases expose how a lack of supervision, inexperience among junior medical staff, and persistent systemic resource limitations directly compromise maternal healthcare and elevate institutional legal risk.

Collectively, they reveal how systemic failures, including the lack of senior oversight, limited training, and under-resourced maternity wards, expose both patients and hospitals to preventable harm. They are also an indication of the double whammy facing an overstretched healthcare workforce, and for the most part, junior doctors are forced to perform complex operations without sufficient support. These trends, not only jeopardise patient safety, but also further the proliferation of litigation, institutional reputation erosion, professional burnout and attrition – collectively perpetuating declines in the health care workforce and sustainability of Malaysia's public health care system on the horizon.

Beyond surgical and maternal care negligence, a third category of litigation focuses on diagnostic errors and failures in follow-up treatment. These cases further highlight structural breakdowns in continuity of care and underscore the broader challenges faced by an underfunded and overstretched system.

Category C: Misdiagnosis, Follow-Up Failures, and Systemic Risk

The final category encompasses cases involving diagnostic errors, poor follow-up, and administrative failures, all of which reflect deeper systemic issues. 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 made the award of RM735,000 by taking into

account indirect evidence of misconduct, like interfering with records and providing false expert evidence. These cases collectively underscore the medico-legal challenges associated with diagnostic accuracy, continuity of care, and the integrity of medical documentation within Malaysia's public healthcare system.

This case is proof that there is an increasing focus on the credibility of medical notes, which is a platform for both clinical governance and legal protection in the face of malpractice litigation. Combining with a longer list of case misadventures elsewhere because of inadequate clinical oversight, procedural failure - in diagnosis in case-management - and institutional unaccountability, it all shows how the lack of systemic protections in diagnostics, case management and institutional accountability exposes patients and providers alike to real dangers, erasing public confidence in care and facilitating the growing litigious burden on health care.

The cumulative effect of these negligence cases reveals a healthcare system grappling with legal scrutiny. To mitigate this, the Malaysian government has implemented institutional safeguards such as indemnity schemes and ex gratia settlements. The following section evaluates the effectiveness of these legal protections.

4. Legal Exposure and Institutional Safeguards

Despite the Ministry of Health's provision of legal representation and ex gratia compensation for risk management of medico-legal risk, public exposure and fear of litigation still drag the healthcare workers down. Fortunate for us, the Ministry of Health Malaysia has had its internal legal processes, which provide medical officers entitlement to get legal help and advice on all medico-legal cases! Also, as part of a more comprehensive policy of risk management, the Ministry has established an ex gratia compensation mechanism for patients injured in medical treatment, in those cases in which action is initiated or legal procedures evaded.

Although the stated purpose of such standing is to shield their profession from unjust and overly uncharitable allegations of negligence, the authors maintain that many of these doctors are feeling quite fragile in the face of heightened public scrutiny and a litigious climate. The compensations paid from ex gratia settlements and court-adjudged damages have been fluctuating in recent years (Ministry of Health Malaysia's Annual Reports, 2023). For the year ended 31 March 2021, aggregate remuneration was RM30,456,754.70. The picture dropped in 2022 to RM4,752,469.20 and rose again to RM6,891,879.28 in 2023. Those numbers include both court-ordered payments and ex gratia settlements, a testament to how serious the ministry is in managing medical malpractice cases and related matters. Below is the amount of Compensation Paid by Court Order and Out of Court (Ex Gratia Payment), 2019-2023

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	2,073,591.70	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 government's policy, through the Ministry of Health, aims to balance the delivery of quality healthcare with accountability. The Ministry is working to ensure patients are not compensated inappropriately, at the same time as protecting the interests of the health system by settling claims through a combination of ex gratia payments and litigation. While civil servant compensation arrangements provide public hospital doctors with some legal immunity, it is attached to the legal boundary and professional ethics. They are, however, personally responsible in case of gross negligence, wrongdoing, and criminal offence (Kaur, Chin & Aziz, 2022).

But legal protection by itself cannot keep talent or rebuild morale. Increasing medical-legal risk, as well as flat remuneration and systemic fatigue, are driving a rapid shift of doctors into the private system. This trend is examined in the following section and challenges the assumption that the private sector provides complete legal immunity.

Migration to the Private Sector and the Myth of Legal Immunity

A wave of experienced doctors leaving for the private sector in search of higher pay and better working conditions is undermining the public health system. Due to this fact, Amir & Ezat (2020) believed that many well-respected and experienced medical practitioners are inclined to depart from the public sector to clinch better remuneration, better work-life balance, and a stable job in the private health care sector. If this trend is not curtailed, the public sector might be further eroded, and disparities in access to higher-quality care might grow, especially among marginalized populations, who rely heavily on the public sector (Fadzil et al., 2021).

But working in the private world doesn't shield one from medical malpractice claims in the private world. For a long time, private hospitals have played the role of not-for-profit entities that serve as homes for independent doctors, shielding them from liability for those doctors' negligence (Samah, 2022). But as private hospitals grew and started providing all-inclusive medical care on a scale to the public hospitals, courts started increasingly holding them culpable for the actions of their doctors. In landmark cases such as *Gold v Essex County Council* and *Roe v Minister of Health,* it was established that hospitals cannot "contract out" of their duty of care and have a duty to provide adequate treatment.

The concept was later applied in Malaysia, where courts initially began to adopt the common law approach to a non-delegable duty of care. Applying this theory to a private hospital has the significant benefit of ensuring accountability in a case in which the negligence of an employee cannot be directly traced to systemic problems, either negligence caused the victim of a third party being injured after entering as a patient of the facility. The obligation, so the theory goes, is to ensure that care is administered properly in addition to providing care. It does not matter if the healthcare provider is an employee, a visiting consultant, or an independent specialist; it is insured for the protection of the patient and must bear up to the expectations of higher standards of institutional accountability.

The test has been affirmed in the landmark Malaysian case of *Dr. Hari Krishnan & Anor v. Megat Noor Ishak.* The Federal Court ultimately found that the hospital did nonetheless owe a non-delegable duty of care to ensure that the anaesthetic treatment was administered with the requisite skill and care, notwithstanding that the doctors in question were not employees of the hospital. The court predicated the obligation on the hospital-patient relationship, and not on vicarious liability. The ruling supports the landmark UK case *Woodland v Swimming Teachers' Association*, which holds that Malaysian health facilities must protect patients irrespective of the way services are implemented or tendered out.

In addition to that, a considerable number of medical negligence cases falling under these three categories above have also arisen within the private healthcare sector in Malaysia. For instance, Several cases involving private hospitals demonstrate how issues of surgical negligence, informed consent, and institutional responsibility continue to arise in the private sector. In *Tan Sri Datuk Seri Mohd Hussein Abd Hamid v. Gleneagles Hospital*, the appellant sued an orthopaedic surgeon and the hospital after sustaining a popliteal artery injury during knee surgery. Although the High Court dismissed the claim, the Court of Appeal reversed the decision, finding that surgical negligence and failure to warn warranted further scrutiny.

In *Siow Ching Yee v. Columbia Asia Sdn Bhd***,** the Federal Court held the hospital liable for hypoxic brain damage suffered by the plaintiff due to an anaesthetist's negligence, affirming the hospital's non-delegable duty of care despite the anaesthetist being an independent contractor. The plaintiff was awarded over RM2 million in damages. Similarly, in *Datin Dr Teoh Su Lin v. Arjun Gopal Subramaniam*, a 14-year-old boy suffered severe eye damage following steroid treatment prescribed without adequate follow-up. The appellate court upheld partial liability against the treating ophthalmologist, addressing causation and expert evidence issues.

In *Ahmad Zubir v. Datuk Dr Zainal Abidin & Ors*, the plaintiff's claim for negligence and breach of contract over his wife's death was dismissed, with the courts finding that the doctors acted reasonably and the absence of a

post-mortem undermined causation. These cases underscore the legal risks faced by private healthcare providers, reinforcing the need for consistent standards of care, proper documentation, and patient communication across all healthcare settings.

Public hospitals are vital safety nets for the nation's health care system, but they are often unfairly held liable for patients who are transferred from private hospitals already in critical condition. Public healthcare – often where the legal and reputational costs are to be had – finds them in their lap, even when it could be the case that early intervention (and mismanagement) in private care were responsible for whatever the result was. These are not only unfair for hard-pressed public health workers, but they also damage public trust in the health service. They underscore the importance that the two sectors work together in a more cohesive approach of shared responsibility and accountability based on clear inter-facility patient transfer protocols and transparency of the medical decision-making process.

Without those reforms, the public sector will continue to be held disproportionately accountable, in courts and public debate, while private entities operate in relative secrecy. This analysis has demonstrated that the legal and institutional importunities surrounding public health care are both causes and effects of systemic strain. Solving departures and litigation risk demands comprehensive reform, not just in the law and how it's administered, but in financing and infrastructure. The following fairly pre-cut strategic policy response offers some recommended strategies.

5. Conclusion and Recommendations

There is an urgent need to increase the cost of health services, particularly outpatient care in public hospitals, as a strategic approach to enable better remuneration of healthcare providers. Health workers are underpaid, and the underpayment makes it difficult to keep skilled professionals in the public sector, as there is an unrelenting amount of talent leaving for a more lucrative private health sector. Making the public health cost slightly higher to achieve parity would not only see more fair renumeration, but it would also divest wealthier Malaysians of an incentive to use private services at the same time as reducing the queue at the public hospital.

Even more important, instead of relying primarily on contract-based jobs, more revenues mean the government would have more money to give doctors long-term jobs. Such a shift would serve to provide more durable support for a public healthcare system and ease the stress of job insecurity on those who work in health. By having a well-staffed workforce, work responsibilities are shared more evenly, and doctors can perform their job more effectively and confidently without the fear of burning out. This results in improved patient care.

Another option for the financing of healthcare in Malaysia is a combination of a social health insurance with targeted government subsidies according to the country's socio-economic profile. Under that national health insurance scheme, which would be similar to Thailand's Universal Coverage System (UCS) or Indonesia's Jabatan Kesehatan Nasional (JKN), imposed on companies and individuals, there would be assured support for serious funding for basic public healthcare services. Muslims would be able to take out Sharia-compliant takaful health policies that are all-encompassing and religion-friendly. Healthcare for low-income individuals and families would also become free, or heavily subsidized, under a new system of targeted subsidies. Neither the very low nor the very high income individuals were called upon to pay into these funds, which would be based on the ability to pay, with the middle- and upper-income people contributing to them by co-payments or in an insurance contribution manner.

Reintroduction of the Goods and Services Tax (GST) could also enhance revenue, and the income so generated could then be utilized to develop infrastructure, new technology, and human resources in the public healthcare system. Politicians and decision-makers will have to make difficult decisions when choosing public health over political expedience. Articulate politicians and policy makers must be prepared to think boldly and progressively, even if those ideas are not initially popular; but when lives are at stake, the politics must follow the policy, and long-term structural change must precede short-term political expediency. Also, let's not forget that more money will enable the public healthcare system to employ more doctors and support staff to address

the long-standing complaints of overburden and understaffing that plague many government-run hospitals today.

References

Amir, A.M.N.; Ezat, W.S. (2020). Physician's intention to leave Malaysian government hospitals with the existing retention strategy. *J. Public Health Policy Plan* 2020, *4*, 30–37.

Ahmad, M. A. H., Abd Jalil, I. J., Isa, N. A. B. M., Nizamani, S. M., & Mohd, N. (2021). Legal Issues in Medical Practice in Malaysia. *International Journal of Ethics, Trauma & Victimology*, *7*(01), 29-34.

Ahmad Zubir v. Datuk Dr Zainal Abidin & Ors, [2019] 5 MLJ 95.

Ching, S. M., Cheong, A. T., Yee, A., Thurasamy, R., Lim, P. Y., Zarina, I. I., ... & Ramachandran, V. (2024). Prevalence and factors associated with burnout among healthcare providers in Malaysia: a web-based cross-sectional study. *Irish Journal of Medical Science (1971-)*, *193*(2), 851-863.

Daud, F., Abd Ghani, N. F., & Zahid, S. N. A. (2022). Job satisfaction among specialists in the Ministry of Health Malaysia and its associated factors. *Malaysian Journal of Public Health Medicine*, *22*(3), 1-8.

Datin Dr Teoh Su Lin v. Arjun Gopal Subramaniam [2024] 3 MLJ 679 [CA]

Dato' Stanley Isaacs v. Government of Malaysia [2018] MLJU 1672

Dr. Hari Krishnan & Anor v. Megat Noor Ishak. [2018] 3 CLJ 427

Fadzil, M. M., Wan Puteh, S. E., Aizuddin, A. N., & Ahmed, Z. (2022). Specialists' Dual practice within a public hospital setting: evidence from Malaysia. *Healthcare,* 10(10), 2097). MDPI.

Garcia, C. D. L., Abreu, L. C. D., Ramos, J. L. S., Castro, C. F. D. D., Smiderle, F. R. N., Santos, J. A. D., & Bezerra, I. M. P. (2019). Influence of burnout on patient safety: systematic review and meta-analysis. *Medicina*, 55(9), 553.

Gold v Essex County Council *and* Roe v Minister of Health [1942] 2 KB 293, 301, CA.

Jinah, N., Lee, K. Y., Zakaria, N. H., Zakaria, N., Ismail, M., & Mohmad, S. (2023). Contract Doctors' strike in Malaysia: A content analysis of the perception of the medical fraternity and stakeholders on Facebook. *Plos one,* 18(9), e0292213.

Kassim, P. N. J., & Najid, K. M. (2013, January). Medical negligence disputes in Malaysia: Resolving through hazards of litigation or community responsibilities?. In *Proceedings of World Academy of Science, Engineering and Technology,* 78, 1607. World Academy of Science, Engineering and Technology (WASET).

Kaur, S., Chin, C. A., & Aziz, M. F. B. A. (2022). Medical Negligence in Malaysia: Selected Issues of Liabilities and Damages? *Medical Liability in Asia and Australasia*, 163-175.

Kay MP, Mitchell GK, Del Mar CB (2004). Doctors do not adequately look after their physical health. *Med J Aust* 181(7), 368.

Kerajaan Malaysia & Anor v. Nurul Rabihah Abdul Rahman [2024] 5 MLJ 88 [CA]

Kerajaan Malaysia v. Nur Syarafina Binti Sa'ari & Ors [2019] 12 MLJ 41

Kerajaan Malaysia & Ors v. Norfazlin Zamani [2024] 8 AMR 687, CA

Khor, S. K., Chua, E. P. W., & Fried, C. (2024). Sustainability and Resilience in the Malaysian Health System.

Metzner, J. L., & Gendel, M. H. (2022). The stress of being sued. *Malpractice and liability in Psychiatry*, 79-84.

Mohd Yusof, A. N., & Haji Razali, H. Y. (2024). Moving Away from the Blame Culture: The Way Forward to Manage Medical Errors. *Malaysian Journal of Medical Sciences*, *31*(6).

Muhammad Zulkarnain Bin Mohamed Rokani & Ors V Pengarah Hospital Sultan Ismail Johor Bahru & Ors [2020] Mlju 133

Nur Syarafina Binti Sa'ari v Kerajaan Malaysia & Ors [2018] MLJU 1158

Omar, N. F. B. (2022). *The Effects Of Job Demands And Resources Variables On Health Status of Medical Doctors From Public Hospitals In Malaysia: The Role Of Job Burnout As A Mediator* (Doctoral dissertation).

Rassip, M. N. A. B. A., Zakaria, N. H. B., Baki, P. A., Haron, M. A., Sibert, M. Y., Bidin, N. B., ... & Ibrahim, N. H. B. (2023). Resource management for full-paying patient service in Malaysia: issues and challenges. *International Journal of Healthcare Technology and Management*, *20*(1), 53-73.

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 [2017] 4 MLJ

Roslan, N. S., Yusoff, M. S. B., Asrenee, A. R., & Morgan, K. (2021). Burnout Prevalence and its associated factors among Malaysian healthcare workers during the COVID-19 pandemic: an embedded mixed-method study. In *Healthcare,* 9(1), 90. MDPI.

Samah, A. A. (2022). Benefits and Drawbacks of Imposing a Non-Delegable Duty of Care on Private Healthcare Facilities in Malaysia: Comparative Analysis on the Common Law and the Malaysian Law Approach. *KDU LJ*, *2*, 1.

Shaharul, N. A., Ahmad Zamzuri, M. A. I., Ariffin, A. A., Azman, A. Z. F., & Mohd Ali, N. K. (2023). Digitalisation of medical records: improving efficiency and reducing burnout in healthcare. *International Journal of Environmental Research and Public Health*, *20*(4), 3441.

Siow Ching Yee v. Columbia Asia Sdn Bhd, [2024] CLJU 404

Soomro, A., & Ramendran, C. (2024). Workplace Stress and Burnout Among Healthcare Workers in Malaysia: HRM Interventions A Review. *Asia Pacific Journal of Business, Humanities and Education*, *9*(1), 22-40.

Supian, N. S., & Ibrahim, M. I. (2024). Factors influencing sleep quality among nurses in Tertiary hospitals in Kelantan, Malaysia: a cross-sectional study. *BMC nursing*, *23*(1), 1-10.

Tan Sri Datuk Seri Mohd Hussein Abd Hamid v. Gleneagles Hospital, [2024] MLJU 3690.

Wah, K., & Ng, J. (2024). Can Malaysia Tackle the Cancer Crisis? Addressing the Oncologist Shortage and Shaping Healthcare Innovations for a Healthier Future Over the Next Decade. *Addressing the Oncologist Shortage and Shaping Healthcare Innovations for a Healthier Future Over the Next Decade (June 26, 2024)*.

Wieclaw, J., Agerbo, E., Mortensen, PB., Burr, H., Tuchsen, F. & Bonde, JP, (2008). Psychosocial Working conditions and the risk of depression and anxiety disorders in the Danish workforce. *BMC Public Health* 8(1), 280.

Woodland v. Swimming Teachers' Association [2013] 3 WLR 1227.