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Medical Negligence in Malaysian Hospitals: A Qualitative Thematic Analysis of Organisational and Governance Failures

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Abstract

This study adopts a qualitative research design using thematic analysis to examine Malaysian medico-legal court decisions. Traditionally, negligence has been examined through legal constructs such as duty of care, breach, causation, and damage (Hatta et al., 2024). However, contemporary research increasingly recognises that adverse patient outcomes arise from complex interactions within healthcare systems rather than isolated acts of misconduct (Reason, 2021). The study employs a qualitative research design that involves the use of thematic analysis to investigate the Malaysian medico-legal court decisions to determine underlying organisational and systemic factors that contribute to medical negligence. Data analysis was done through the six-phase thematic approach by Braun and Clarke with a focus on patterns across the selected cases involving misdiagnosis, surgical error, consent issues, and post-treatment complications. This study is based on three medico-legal court cases in Malaysia and utilises Braun and Clarke's thematic analysis framework to explore the organisational and governance-related causal factors identified by these cases in relation to medical negligence. The results show that there are four common themes: communication breakdown, documentation failure, weak governance structures, and risk factors that exist at the system level. These themes show that latent organisational conditions are the main factor in medical negligence in Malaysian hospitals, which is in line with the systems theory and the Swiss Cheese Model of accident causation. This study contributes to the literature by offering a contextualised interpretation of medical negligence in the Malaysian healthcare institutions. It also provides practical implications in enhancing risk management structures, governance structures and patient safety systems. These results are in line with the need to change the blame-based strategies to the system-based accountability in healthcare organisations.

Keywords

Medical negligence; Malaysia; healthcare governance; patient safety; qualitative research; organisational risk

1. Introduction

Medical negligence has become a critical concern in contemporary healthcare systems, not merely in terms of clinical issues, but also in terms of broader organisational and governance concerns. Historically, legal constructs like duty of care, breach, causation, and damage have been used to understand medical negligence (Hatta et al., 2024). Nevertheless, contemporary

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research increasingly recognises that the negative outcomes in patients are the result of complex and interdependent interactions in healthcare systems instead of a single act of individual misconduct (Reason, 2021).

The healthcare sector across the globe has experienced significant change, which is marked by heightened awareness by patients, technological changes, and more thorough scrutiny of standards of healthcare delivery. Such developments have also helped to increase the number of medical negligence claims, which has made both the legal and healthcare communities reassess their traditional approaches to accountability (Slawomirski & Klazinga, 2022). Specifically, there has been an increasing trend in transitioning individual blame to systemic analysis with organisational factors, communication processes, and governance structures being the primary factors of patient safety (Dahlawi et al., 2021).

The growing focus on patient safety can be seen as a more general paradigm shift in the management of healthcare, where the occurrence of errors is no longer perceived as an isolated event but as a symptom of the underlying weakness of the system (Jin et al., 2022). This systems-based approach has become prominent in both research and policy-making, with the need to ensure that healthcare organisations adopt proactive risk management strategies (Mohd Zulkefli et al., 2021).

This shift is increasingly evident in the Malaysian healthcare context. This has resulted in a significant rise in medico-legal disputes due to the expansion of healthcare services, the growth of patient expectations and information access (Abd Samah & Say, 2022). Another development in the approach of Malaysian courts towards medical negligence is the shift towards a more institutional approach to responsibility (Hatta et al., 2024). The new judicial trends have highlighted the idea of the non-delegable nature of the duty of care, which reaffirms the concept of ultimate responsibility of healthcare organisations in regard to ensuring patient safety.

Regardless of these changes, the study on medical negligence in Malaysia is still mostly restricted to the legal study. The current research is mostly preoccupied with court cases, legal principles, and doctrinal interpretations, considering organisational culture and healthcare management principles (Zainal et al., 2020). This leaves a strong gap in the knowledge of how systemic factors in hospitals play a role in leading to adverse outcomes and legal liabilities.

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Healthcare organisations have complex, interdependent systems, where the outcomes are influenced by relationships among human factors, clinical processes, and institutional governance (Jin et al., 2022). The failures of these mechanisms can hardly be traced to one cause; they are the result of a complex of latent factors, and active mistakes. This school of thought is consistent with the systems theory, which underlines the interrelatedness of the organisational elements and the significance of understanding how failures spread across the various levels of the system (Reason, 2021).

Moreover, communication failures and poor documentation have been revealed as the major causes of medical errors in the healthcare environment that may lead to a compromised state of patient safety and exposure to legal liabilities (Webb et al., 2025). These risks are further enhanced by weak governance structures and ineffective incident reporting systems, thus limiting the ability of organisations to learn by mistakes made and prevention mechanisms (Mohd Zulkefli et al., 2021).

This research fills the gap in the current body of research by adopting a qualitative, management-oriented approach to the research issue, to explore the medical negligence in Malaysian hospitals. This study aims to reveal the underlying organisational flaws and systemic failure leading to negligence by analysing the medico-legal court judgements. This method is in contrast to the traditional legal studies where the emphasis is made on the identification of patterns and themes that represent the broader institutional issues.

This research has three objectives:

(1) To establish major organisational and systemic issues that lead to medical negligence in Malaysian hospitals;

(2) To examine these aspects using the systems theory and the governance of healthcare; and

(3) To make practical recommendations on how to improve risk management and patient safety.

Combining legal analysis with the organisational theory, this paper presents a more detailed insight into the issue of medical negligence. It is part of the expanding literature that recommends patients should be approached with a system-based approach towards patient safety and the need to introduce proactive risk management strategies as adopted by healthcare organisations (Dahlawi et al., 2021).

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2. Literature Review

2.1 International Tendencies regarding Medical Negligence and Patient Safety.

Medical negligence is an increasingly significant global issue, as healthcare systems are becoming more complex and the rising expectations of patients in terms of safety increase. Historically, negligence has been theorised through a legal framework, which places an emphasis on personal responsibility and professionalism. Nevertheless, recent studies have been shifting to a wider conception including organisational, systemic and institutional factors as the key determinants of poor healthcare outcomes (Dahlawi et al., 2021).

Bibliometric reviews of the medical negligence literature show that the number of scholarly outputs has increased significantly over the last 20 years, which means that the academic and policy interest in patient safety and accountability in healthcare is growing (Dahlawi et al., 2021). This body of work points to a shift in the perception of medical errors as sporadic cases to the idea that they are the symptoms of systemic failures that are inherent to healthcare organisations. In this way, there has been an extension of interest to interdisciplinary perspectives that are integrated law, medicine, public health and healthcare management.

One of the themes in the discussion of global patient safety is the understanding that often preventable harm in healthcare is caused by system failures and not necessarily by individual negligence. These changes in the international healthcare policy can be described as a paradigm shift: the focus has shifted to safety culture, risks management, and continuous quality improvement (Slawomirski and Klazinga, 2022). According to these strategies, risks are to be proactively identified, and organisational safety nets are to be put in place to reduce the risk of the occurrence of adverse events.

In addition, the healthcare globalisation has enhanced the necessity of standardisation of safety practices and governance structures. Healthcare facilities are now more than ever before under the pressure to embrace evidence-based practices, enhance the communication system, and ensure accountability on all levels of operation. These changes help highlight the need to analyze the issue of medical negligence through a systems-based approach, especially in highly structured healthcare settings.

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2.2 Medical Negligence in Malaysia.

In Malaysia, the traditional method of investigating medical negligence has been through legal principles based on common law principles. The only distinction between the determination of negligence and the determination of causation is in establishing whether: (a) a duty of care existed; (b) there was a breach of the duty of care; and (c) an event causally linked to the harm resulted from the breach of the duty of care (Hatta et al., 2024). Although this legal system continues to be of central focus in the judicial decision-making processes, recent events have shown that there is a shift towards appreciating the broader institutional responsibility.

The Malaysian healthcare system has experienced tremendous growth over the past few years due to the population growth, increased healthcare demand and the growth of both the public and the private healthcare sectors. The growth has been concomitant with an increase in the number of medico-legal claims, which show an increase in patient awareness and their readiness to seek legal redress (Abd Samah & Say, 2022). This has seen more and more cases being brought before the courts that not only point to individual clinical malpractices but also systemic failure in the organisation.

There are recent trends in the judicial system in Malaysia which point towards the courts shifting to a governance-based approach to medical negligence. This can be seen in situations where health care facilities are held responsible for failures in supervision, communication and compliance in procedures. The identification of non-delegable duty of care further supports the role that hospitals should play in ensuring that patients receive safe and competent treatment, whether services are delivered by individual practitioners.

Nevertheless, legal developments in Malaysia have not changed the situation significantly since academic studies in the country are mainly oriented to doctrinal research and understanding the case law (Zainal et al., 2020). Little is done to examine how organisational variables like governance systems, communication systems and resource constraints contribute to medical negligence. This disjuncture underscores the importance of interdisciplinary studies that translate the legal scholarly perspective into the healthcare management interpretations.

2.3 Systems Theory and Swiss Cheese model.

The systems theory can be used as a starting point to the complex nature of medical negligence in healthcare settings. This view holds that healthcare organisations consist of

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interrelated systems, such as human resources, clinical processes, technological systems, and governance systems. The way these components interact with each other affects the system performance, and the failure of such interactions is often the cause of failures (Jin et al., 2022).

Among the most widely recognised models in this framework is the Swiss Cheese Model of accident causation that conceptualises errors as the product of multiple layers of system failure instead of a single location of breakdown (Reason, 2021). In this model, every layer of defence in an organisation has potential vulnerabilities or holes and unfavourable events happen when holes coincide to allow errors to grow through the system.

These latent conditions, in the context of healthcare, may comprise an inadequate training, inadequate staffing, inadequate communication protocols, as well as, weak organisational policies. Active failures, like clinical errors or misjudgements, can be the last onset of these underlying issues. The Swiss Cheese Model changes the emphasis of organisational responsibility and not on the individual blame.

The use of systems theory in the issue of medical negligence has far-reaching consequences to the healthcare management. It highlights how organisations should assume a holistic perspective of risk management, not focusing on the immediate errors but the underlying factors that allow the errors to happen. This view is consistent with the global efforts to enhance patient safety, which focus on system enhancement and not individual responsibility (Dahlawi et al., 2021).

2.4 Organisational Failure and Communication in Healthcare.

The communication is a key factor in determining the safety and quality of care provided to the patient. In healthcare settings with a high level of complexity and interdependence, correct and prompt communication is crucial to the coordination of clinical activities, as well as ensuring continuity of care. Communication breakdowns may be associated with severe outcomes, such as delayed treatment, incorrect diagnosis, and medication errors (Webb et al., 2025).

Communication breakdown has always been found to be a major cause of medical negligence in research. This is especially seen during patient handovers where the transfer of information, whether incomplete or erroneous, may negatively affect clinical decision-making. Interdisciplinary communication is also essential, since healthcare delivery may often imply collaboration of various specialists in different domains of expertise.

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In the context of determining communication practices in healthcare institutions, organisational factors play a crucial role. Hierarchy, such as, may hinder open communication especially when junior staff members are hesitant to question senior clinicians. Moreover, time restrictions and workload pressures may also negatively affect the effective communication, which can further increase the probability of errors.

Both structural and cultural intervention is needed to address communication failures. Information transfer and ambiguity can be enhanced by the use of structured communication methods, including standardised handover procedures. Simultaneously, establishing a culture of transparency and cooperation is crucial toward motivating employees to disclose issues and engage in decision-making activities.

2.5 Risk Management and Healthcare Governance.

Risk management is an essential part of healthcare systems, whose goal is to detect, assess, and eliminate possible risks to patient safety. The key to risk management is the adoption of procedural ways of identifying hazards, analysing risks and developing strategies to mitigate the occurrence of negative events. This involves clinical audits, incident reporting systems, and real-time monitoring of performance indicators in a healthcare setting (Mohd Zulkefli et al., 2021).

Healthcare governance is a set of rules, practices and processes by which organisations are guided and regulated. Good governance frameworks are needed in the delivery of accountability, transparency, and quality of care. Governance mechanisms in the context of medical negligence are vital in eliminating any errors and responding effectively in situations when they occur.

Nonetheless, there is a common problem of establishing sound systems of governance in many healthcare organisations. Such challenges can be low financial resources, lack of training, and organisational resistance to change. In addition, a blame-focused culture may deter the reporting of mistakes, and this may restrict the organisational learning and improvement.

Risk management and governance are crucial components of patient safety improvement. With the assistance of identifying the organisational goals and objectives with the safety priorities, healthcare institutions can establish the environment facilitating the continuous improvement and minimising the chances of negligence. This strategy aligns with the

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healthcare management trends in the world, which focus on proactive risk prevention and system-wide responsibility (Slawomirski & Klazinga, 2022).

2.6 Research Gap

Even though the literature on the topic of medical negligence is growing tremendously, there are still some gaps in the literature, especially as far as the Malaysian healthcare environment is concerned. First, the current literature is largely legal-oriented, focusing on the liability, judicial reasoning, and doctrinal analysis (Zainal et al., 2020). Although this can help us to gain some insight into the legal accountability in negligence, the information offered is limited in providing us with insight into the underlying factors that contribute to negligence, which are organisational and systemic.

Second, worldwide research, such as bibliometric analysis, offers generalized summaries of the research trends without providing deep contextualized insights and case-based findings (Dahlawi et al., 2021). These studies emphasize the significance of systems-based approaches but do not comprehensively address how such approaches are manifested healthcare contexts.

Third, qualitative studies that investigate actual medico-legal cases in organisations to establish the common patterns of organisational failure are lacking. These studies are crucial to comprehend how negligence occurs in practice and to design specific interventions to enhance patient safety. This paper fills in these gaps by incorporating a qualitative thematic design to analyse Malaysian medico-legal cases. It offers a contextualised perspective on medical negligence, as well as contributes to the synthesis of legal and management approach in medical research.

3. Methodology

3.1 Research Design

The research design adopted in this study is a qualitative interpretive research design in an attempt to investigate the organisational and systemic aspects of medical negligence in Malaysian hospitals. A qualitative approach is especially suitable to the study as it allows an in-depth analysis of complex phenomena, such as human behaviour, institutional practices, and organisational failures that cannot be completely covered by quantitative methods (Braun and Clarke, 2021).

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In contrast to the more conventional approaches to legal analysis, which focus on the doctrinal interpretation of law, this work is based on the more fundamental approach to the legal analysis, which is concerned with the analysis of patterns of organisational risk and governance failures ingrained within the medico-legal cases. The study aims to identify recurring themes in the judicial decisions studied as rich sources of qualitative data by analyzing the judicial decisions as a rich source of qualitative data.

The interpretive paradigm that the research is based on presupposes that the reality is socially constructed and that the meaning is obtained with the help of the contextual analysis. In this regard, the medico-legal cases are not just the legal final results but the stories, which reveal the functioning of healthcare systems under the conditions of stress, uncertainty, and failure.

3.2 Data Sources

To give a thorough analysis of the study, both primary and secondary sources of data are used.

Primary Data

The primary data comprised Malaysian medico-legal court decisions involving allegations of medical negligence. These cases were selected due to their detailed accounts of clinical events, organisational processes, and judicial reasoning, making them credible sources of qualitative data. The main cases, which have been analysed, are:

Siow Ching Yee v Columbia Asia Sdn Bhd (2024).

Nur Arissa Naura v Dr Abirami Kunaseelan (2024)

Dr Jerilee Mariam Khong v Yusnita Johari (2025).

These cases were selected because it is relevant in illuminating the problems associated with communication breakdown, clinical decision-making, documentation practices, and institutional accountability.

Secondary Data

Academic literature, policy reports, and previous research on the topic of medical negligence, patient safety, and healthcare governance are all examples of secondary data. These were the sources, which were used to support the theoretical framing and to contextualise the findings in terms of broader scholarly discourse (Dahlawi et al., 2021; Mohd Zulkefli et al., 2021).

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3.3 Sampling Strategy

The sampling strategy that has been used is purposive sampling strategy in order to specify the information rich cases that are relevant to the research objectives. This strategy is typically employed in qualitative research to make sure that the selected sources of data would offer valuable information about the phenomenon under investigation (Braun and Clarke, 2021).

The criteria used to include cases consisted in the following:

Cases: those dealing with a proved or suspected case of medical negligence.

Cases that contain extensive judicial reasoning.

Cases- Reflecting organisational or systemic problems.

Cases that are representative of the various types of clinical scenarios.

According to such criteria, it was possible to select cases in four major categories:

- Surgical negligence
- Misdiagnosis
- Informed consent issues
- Post-treatment complications

This heterogeneity made sure that a broad scope of organisational failures and healthcare risks is covered in the analysis.

3.4 Data Analysis Procedure

The thematic analysis was employed to analyse the data, and the six-step framework, created by Braun and Clarke (2021), was followed. It is a very common method of carrying out qualitative research to identify, analyse, and report data patterns. The first stage of open coding was to identify common issues in the organisational context, and codes were then organized into larger thematic groups.

The process of analysis included the following phases:

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Phase 1: Familiarisation

In order to get a deep insight on the content, context and critical issues that each judgment entails, the researcher read the selected cases several times.

Phase 2: Initial Coding

Significant portions of text were systematically coded to reflect meaningful characteristics pertaining to medical negligence, organisational processes and patient safety. The first stage of open coding was to identify common issues in the organisational context, and codes were then organized into larger thematic groups.

Phase 3: Theme Development

The codes were then put under larger categories to determine common themes found in the different cases. These categories then evolved into initial themes.

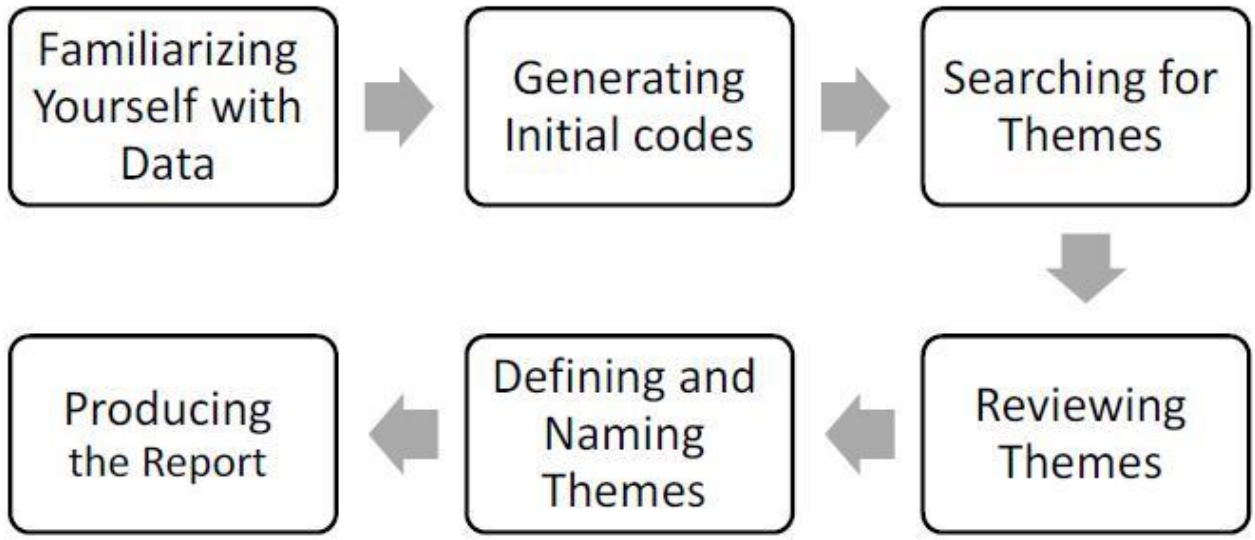


Figure 1 Thematic Analysis Process Adapted from Braun and Clarke (2021)

This figure illustrates how organisational factors including communication breakdown, documentation failure, governance weaknesses, and system-level risks interact to create latent conditions that lead to medical negligence, consistent with systems theory and the Swiss Cheese Model.

Phase 4: Theme Review

Themes were checked and narrowed down to assure uniformity, coherence and pertinence to the research purposes.

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Phase 5: Theme Definition

The themes were well spelled out, and each was supported by the evidence in the data to ensure conceptual clarity and analytical depth.

Phase 6: Reporting

The last themes were consolidated into an orderly narrative that clarifies how organisational and systemic issues cause medical negligence.

This intensive analytical measure adds credibility and transparency of the findings.

3.5 Validity and Reliability

To achieve research rigour, several measures were used.

To begin with, triangulation was obtained through the comparison of results in various cases, which made it possible to identify some common trends and diminish the threat of bias. Second, the results were discussed based on the available literature on patient safety and systems theory, which ensured the consistency of the results (Reason, 2021; Jin et al., 2022). Third, a clear coding procedure was upheld, which allowed tracing the process of raw data to the final themes.

Also, judicial decisions used as data sources help to increase the level of reliability, as the documents are subject to strict legal examination and give validated reports on the events.

4. Findings

4.1 Background of Case-Based Evidence.

The case study analysis of Malaysian medico-legal cases shows that there are recurrent patterns of negligence that go beyond the individual clinical mistakes and reflect more overall failures of the organisation. In the chosen cases, breakdowns in communication, inadequate documentation, weak governance structures, and systemic constraints within healthcare institutions were frequently connected to negligence in the chosen cases.

Critically, the cases show an increasing judicial awareness of the institutional accountability in which hospitals are not only held responsible of the conduct of individual practitioners but also in failures in organisational systems and processes. This is in line with the trends in other parts of the world to adopt a governance-based accountability in healthcare (Dahlawi et al., 2021).

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4.2 Theme 1: Communication Breakdown

Communication breakdown turned out to be one of the most evident factors contributing to medical negligence in all the cases analysed. Communication failures were reported in many forms such as lack of interdisciplinary coordination, incomplete communication, and failure to communicate with patients appropriately.

Critical clinical details could not be effectively shared between the healthcare providers in several cases leading to lags in diagnosis and treatment. To give an example, a lack of effective handover processes resulted in incidents where new medical teams did not have any information about the condition of patients, which further contributed to the risk of adverse outcomes. In the case of Siow Ching Yee v Columbia Asia, there was a delay in communication between the departments that resulted in treatment delay.

The interdisciplinary failure of communication was also observed, especially in situations where several specialists were involved. Lack of coordinated decision making could often lead to fragmented care where key clinical considerations are missed.

These results correspond with prior studies, which have noted communication failure as a major contributor to medical errors and patient harm (Webb et al., 2025). Systems-wise, breakdowns in communication are indicative of shortcomings in the organisational processes and not of personal negligence.

4.3 Theme 2: Documentation Failures

Another key element that led to medical negligence was documentation failures. The analysis showed that there were prevalent problems that were associated with incomplete, inaccurate or missing medical records.

In several instances, the inadequacy of documentation undermined clinical decision-making since health professionals could not access the necessary information about the patient. Not only did it have an impact on the quality of care but also undermined the legal defense of healthcare institutions.

The accurate documentation plays a crucial role in ensuring continuity of care, supporting clinical decisions and providing evidence in legal proceedings. Nevertheless, the results confirm that documentation habits of certain hospitals in Malaysia are still unsatisfactory and reflect the overall organisational deficiencies.

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Such challenges underscore the need to have proper knowledge management systems within healthcare organisations. In the absence of credible documentation, patient safety and accountability of the institution are jeopardized.

4.4 Theme 3: Weak Governance Structures.

The poor governance structures became one of the major factors that contributed to medical negligence. The analysis demonstrated lack of oversight, accountability systems and leadership in organisations. In some instances, clear responsibility to attend to the patient was lacking and resulted in gaps in supervision and decision making. Also, there were no strong systems of clinical governance, which restricted the capability of organisations to oversee performance and implement standards.

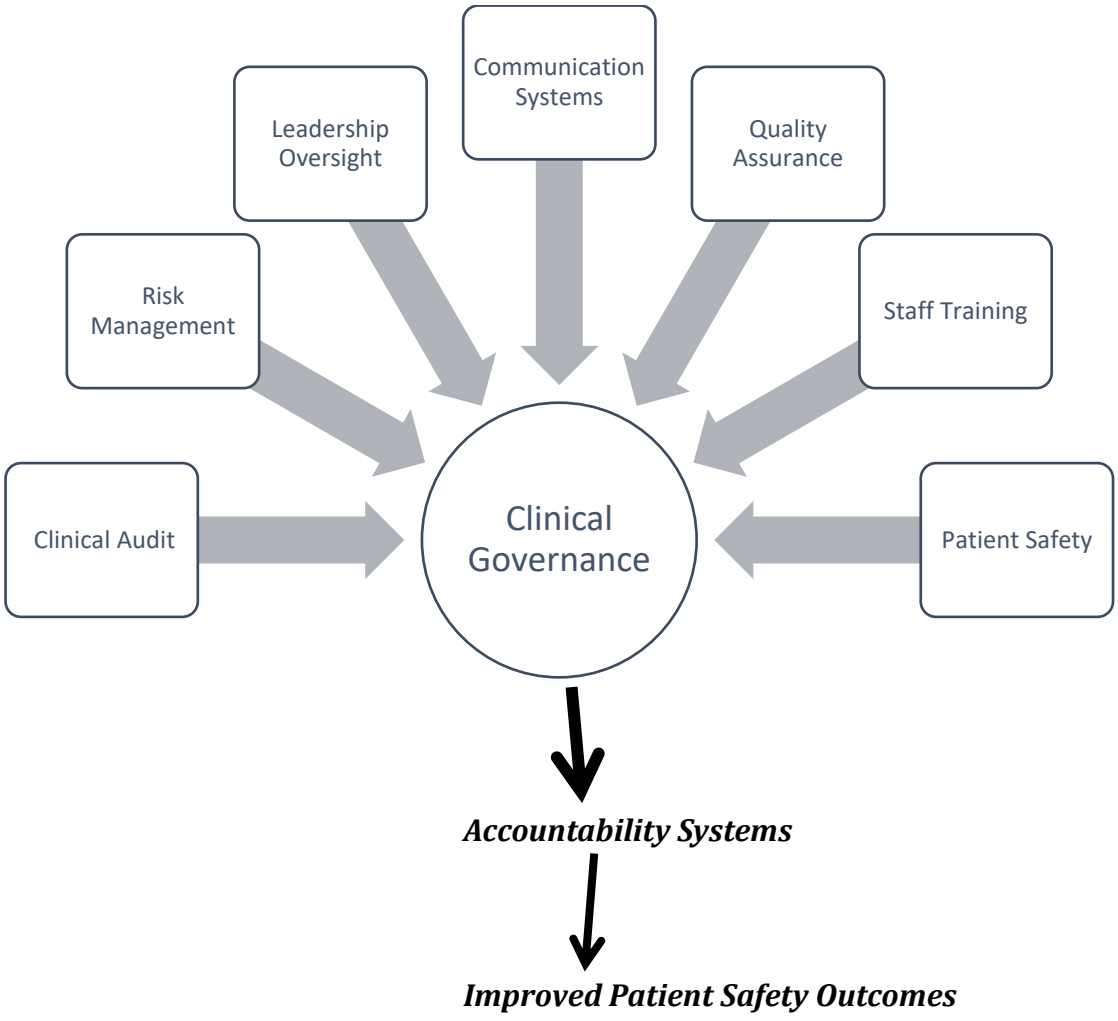


Figure 2: Adapted Clinical Governance Framework for Malaysian Healthcare Organisations Adapted from Slawomirski and Klazinga (2022) and Mohd Zulkefli et al. (2021).

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This figure illustrates the key components of clinical governance, including accountability structures, risk management processes, quality assurance mechanisms, and leadership oversight, which collectively influence patient safety outcomes.

The results indicate that healthcare organisations that have poor governance structures are more susceptible to negligence, since they do not have the mechanisms required to identify and respond to risks. This is in line with the studies that focus on the importance of governance in ensuring patient safety and organisational effectiveness (Slawomirski & Klazinga, 2022).

4.5 Theme 4: System-Level Risk Factors.

The final theme pertains to larger-system-wide risk factors that provide conditions under which medical negligence may be found. These are staffing, insufficient training, absence of a standard protocol, and resource limitations. In a few instances, the healthcare providers were working under a lot of workload pressures thus more likely to make mistakes. Training deficiency and non-compliance with clinical guidelines also led to the poor patient outcomes. These results indicate how latent organisational conditions influence the quality of healthcare. The Swiss Cheese Model states that these conditions provide gaps in the system, which can result in negative outcomes in case of active failures (Reason, 2021).

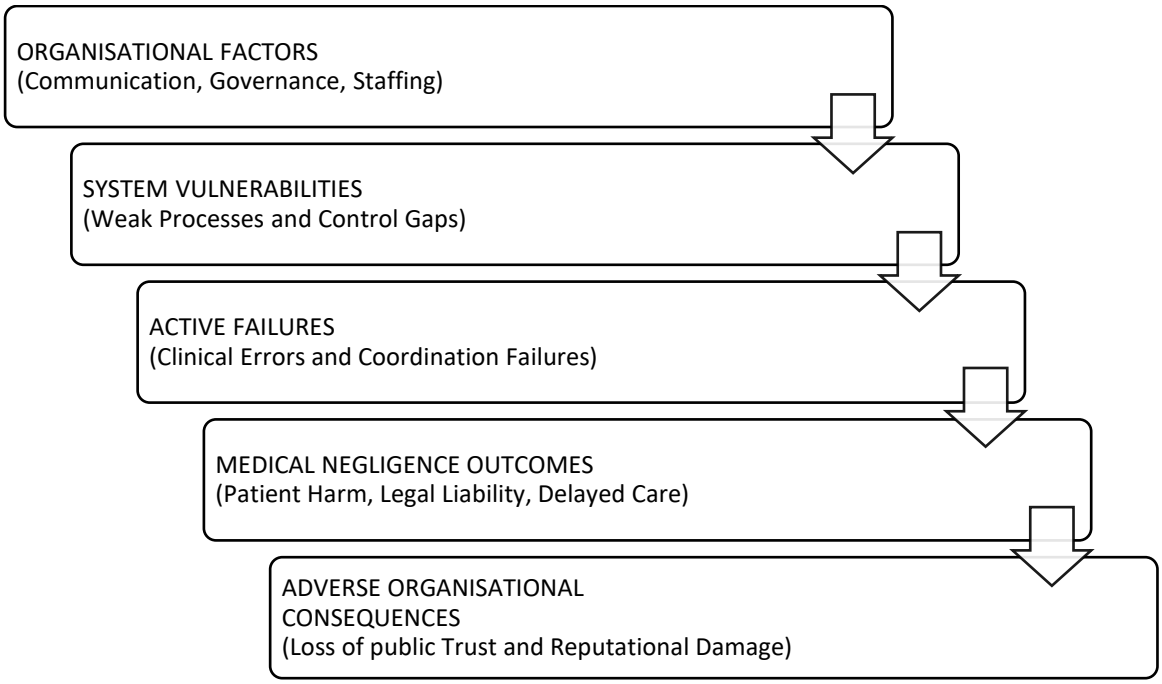


Figure 3: Organisational Risk Model of Medical Negligence in Malaysian Hospitals Adapted from Reason's Swiss Cheese Model (Reason, 2021) and Systems Theory.

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This model demonstrates how systemic factors including communication failures, documentation gaps, weak governance structures, and resource constraints interact to create conditions that increase the likelihood of medical negligence, consistent with systems theory and the Swiss Cheese Model.

4.6 Summary of Findings

In general, the results indicate that not only personal negligence but also an organisational and systemic nature of medical negligence in Malaysian hospitals. The four themes, communication breakdown, documentation failure, weak governance, and system-level risks, are underpinned by the interaction of these failures at various levels of the healthcare system to cause adverse outcomes.

These findings strongly suggest systems-based strategies to patient safety and the importance of healthcare organisations to work on underlying structural weaknesses.

5. Discussion

5.1 Correlating Results and Trends in the World.

The results of this research support the fact that there is an increasing global consensus that medical negligence is, in fact, more of a systemic issue than merely a consequence of a single clinical malpractice. This is in line with the general trends in the healthcare research, whereby increased focus is put on organisational aspects, patient safety regimes, and governance frameworks (Dahlawi et al., 2021).

The identified themes, namely, communication breakdown, documentation failure, weak governance, and risk factors at the system level, reflect the patterns found in international studies. Healthcare systems around the globe are starting to realise that the adverse events are the result of the complex interplay between the organisational environment and the adverse event (Slawomirski & Klazinga, 2022). The current research builds on this insight by offering practical evidence in the Malaysian context, which shows that there are similar systemic vulnerabilities in the developing health care systems.

Significantly, although global studies like bibliometric analyses offer opportunities to obtain broad knowledge about the research trends, they are often lacking in contextual depth (Dahlawi et al., 2021). This research is useful in that it presents evidence based on cases to show how the systemic failures can be manifested in real life clinical and legal situations. The Malaysian context presents some of the unique challenges such as resource constraints,

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changing governance structures, and the degree of institutional maturity, which affect the way negligence happens and how it is addressed.

5.2 The theoretical implications: A Systems-Based conceptualization of negligence.

The results indicate strongly the use of the systems theory in the explanation of the medical negligence. Healthcare organisations are complex adaptive systems, the results of which are determined by interactions between various components, including human actors, processes, technologies, and institutional structures (Jin et al., 2022). In these types of systems, failures are also not usually linear or can be caused by one factor.

The Swiss Cheese Model is a handy model which can be used to explain the results of this research. All the identified themes can be viewed as a defence level in the healthcare system. All the intended processes are aimed at preventing any mistakes and maintaining the safety of patients. But once there are weaknesses in these layers, they allow an opportunity to introduce errors into the system, which ultimately leads to adverse consequences (Reason, 2021).

In this light, medical negligence is not to be considered a single event but as the climax of a series of latent conditions and active failures. In this instance, a misdiagnosis can seem to be an individual mistake, yet it is often affected by the inadequate communication, incomplete patient records, as well as by insufficient clinical support systems. It is through studying of such underlying conditions that healthcare organisations can take a step towards more effective prevention strategies.

Moreover, the results can be added to the existing literature that questions the blame-based strategies to medical error. The traditional paradigms focusing on personal responsibility might lack the systemic approach to healthcare delivery, as well as the solution to the root causes. Conversely, systems-based approach promotes organisations to analyse their structures, processes and cultures to identify and reduce risks.

Implications on organisations and governance in Malaysia.

The research indicates that there are major governance issues in Malaysian healthcare organisations. The mechanisms of weak oversight, vague accountability mechanisms, and lack of adequate enforcement of clinical standards contribute to an environment in which negligence can occur. Such results are like those reported by studies that show that

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governance is a critical factor influencing the performance and patient safety outcomes of organisations (Slawomirski & Klazinga, 2022).

The growing appreciation of institutional liability by Malaysian courts can be regarded as a move towards governance-based accountability. Healthcare organisations are no longer perceived as passive but are active in their role to provide safe and effective care. This is significant to the management of the hospital as the organisations need to incorporate more formidable systems of governance and risk management.

Moreover, the results indicate that organisational culture is an important factor that causes behaviour in a healthcare environment. An organisational culture that does not promote reporting of mistakes or focus more on blame than learning can be a barrier to enhancing patient safety. On the other hand, organisations that promote openness, accountability, and constant improvement are in a better position to detect and deal with systemic vulnerabilities.

The Malaysian setting is no exception, as it faces peculiar challenges, such as the imbalance between the public and the private healthcare providers, the lack of resources, and the difference in the level of institutional capacity. The challenges outlined above would need a concerted effort at the organisational and policy levels with the primary focus on enhancing the governance structure and promoting the culture of safety.

This finding extends existing literature by demonstrating that organisational failures are not merely contributing factors but central determinants of medical negligence in the Malaysian healthcare context. It also challenges traditional legal-centric interpretations by highlighting the operational and structural dimensions of risk within healthcare institutions.

6. Managerial Implications

The results of the current research have several significant implications on the healthcare management and policy. These implications emphasise the need for proactive, system-oriented strategies to reduce medical negligence and enhance patient safety.

6.1 Enhancing Risk Management Systems.

Healthcare organisations ought to embrace holistic risk management models that will help in the early detection and prevention of the possible hazards. ERM systems can be especially helpful in uniting the risk evaluation at various organisational tiers. These systems enable the

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detection of clinical and non-clinical risks to implement preventive actions before adverse events take place (Mohd Zulkefli et al., 2021).

Moreover, data-driven practices, such as incident reporting systems, and performance monitoring tools can be used to increase organisational awareness of risks and can aid in making evidence-based decisions.

6.2 Enhancing Governance and Accountability

Well established governance systems are the key to accountability and high standards of care. The healthcare organisations should put in place clear lines of responsibility that are backed by effective oversight mechanisms including clinical governance committees and audit systems.

It is also important that leadership is very critical in the development of the organisational behaviour. The hospital management needs to make patient safety a central organisational objective and make sure that policies and practices are in line with this objective. This involves compliance with clinical guidelines, and ethical standards.

6.3 Improving Communication Systems

Since communication plays a pivotal role in avoiding medical errors, healthcare organisations ought to adopt well-structured communication practices. The information transfer can be enhanced using such tools as the standardised handover procedures and interdisciplinary communication frameworks.

The development of training programs should also facilitate the development of communication skills among healthcare professionals, especially in high-risk settings. The organisational policies that promote open dialogue and cooperation should support these initiatives.

6.4 Strengthening Documentation Practices

Both legal protection and clinical care require accurate and comprehensive documentation. To make sure that the information about patients is easily available and confirmable, healthcare organisations are encouraged to invest in good documentation systems such as electronic medical records.

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Documentation practices can also be standardised to further promote consistency and minimise errors. It is advisable to conduct regular audits to gauge the level of compliance and where there is need to improve on.

6.5 Promoting Organisational Learning and Safety Culture

One of the main elements of patient safety is the creation of the learning-based organisational culture. Healthcare organizations need to promote reporting of errors and near miss without fear of reprimand. This necessitates a change in the blame-based strategies to systems-based accountability.

Staff competence, awareness of patient safety issues, can also be improved by means of continuous training and professional development programs. With an inculcation of learning and improvement, organisations can be better placed to meet the challenges and minimise the risk of negligence.

6.6 Limitations of the Study

There are a few limitations in this study. Firstly, the research is limited to several medico-legal court decisions in Malaysia, which may not be a true reflection of medical negligence cases that exist in healthcare institutions in Malaysia. First, the qualitative thematic approach does not involve direct observation or interview with healthcare professionals and patients but is interpretive analysis of judicial documents. Third, the findings are specific to the Malaysian healthcare setting and could not be generalised to other contexts of healthcare systems or other jurisdictions. The study also concentrates mainly on the factors related to organisations and governance and does not explore in depth the technical clinical aspects of medical negligence. Despite these shortcomings, the study has yielded valuable contextual information on medical negligence in Malaysian hospitals from a systemic and an organisational perspective.

6.7 Future Research Directions

Further studies following this work could investigate more medico-legal cases from public and private healthcare centres in Malaysia. It may also be helpful to compare the systems of healthcare in other ASEAN countries to gain a wider understanding of the factors related to organisation and governance that may lead to medical negligence. Furthermore, future research can use quantitative or mixed methods to confirm the themes of the organisations in this research. In-depth studies of patient safety culture, healthcare governance structures,

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incident reporting procedures, and accountability systems within healthcare organisations could help inform the creation of more robust strategies to minimize medical negligence and enhance healthcare quality.

7. Conclusion

The medical negligence in Malaysian hospital could be best viewed as a systemic organisational problem and not an isolated outcome of a particular clinical error made by an individual medical practitioner. This study has shown that communication, documentation, governance, and system-level conditions failures, in combination, have led to negative patient outcomes.

Through qualitative thematic approach, the research offers detailed information on the interaction of these factors in real medico-legal cases. The results justify the use of the systems theory and support the applicability of the Swiss Cheese Model in the explanation of the occurrence of medical negligence.

Notably, the study will add to the literature in that it will fill the gap between the healthcare management and the legal analysis. It expands global trends in research by offering contextualised evidence in Malaysia on patient safety and highlights the importance of system-based interventions on patient safety in developing healthcare systems.

Practically, the study highlights the need to strengthen risk management frameworks, improve the governance structures, improve communication and documentation practices, as well as develop a culture of organisational learning. Such actions are needed to minimize medical negligence and enhance the quality of healthcare.

Further studies are needed to quantitatively validate these results and contemplate comparative research in different healthcare systems in the area. Such a study would be a further contribution to the knowledge of the impact of organisational and systemic factors on medical negligence and patient safety.

References

[1] Abd Samah, S. Z., & Say, K. (2022). Challenges and proposals to the Malaysian healthcare system. Journal of Health Management, 24(3), 215–228.

[2] Abosheisha, M., & Omar, I. (2025). Dimensions of medical errors: The three victims and defensive medicine. Journal of Patient Safety and Risk Management, 37(1). https://doi.org/10.1177/09246479251372341

[3] Braun, V. and Clarke, V. (2021) Thematic Analysis a Practical Guide. Sage.

[4] Chen, G. R., Luo, X., Huang, R. R., Xiong, H. Y., Ding, X. M., & Pan, S. H. (2026). The Relationship Between Barriers to Medical Error Disclosure and Patient Safety Culture: A Cross-Sectional Study. *Journal of nursing management*, *2026*(1), e9980576. https://doi.org/10.1155/jonm/9980576

[5] Crocker H, Cromwell DA, Modha S*, et al* (2026), Patient-reported harm from NHS treatment or care, or the lack of access to care: A cross-sectional survey of general population prevalence, impact and responses *BMJ Quality & Safety* 2026;**35:**30-42.

[6] Dahlawi, S., Menezes, R. G., Khan, M. A., Waris, A., Saifullah, & Naseer, M. M. (2021). Medical negligence in healthcare organizations and its impact on patient safety and public health: A bibliometric study. F1000Research, 10, 174. https://doi.org/10.12688/f1000research.37448.1

[7] Hatta, M., Sumiadi, S., & Zulfan, Z. (2024). Settlement of medical negligence cases in Malaysia. In Proceedings of Malikussaleh International Conference on Law, Legal Studies and Social Science (Vol. 4, pp. 112–120).

[8] Jang, S. J., Lee, H., & Son, Y. J. (2021). Perceptions of Patient Safety Culture and Medication Error Reporting among Early- and Mid-Career Female Nurses in South Korea. International journal of environmental research and public health, 18(9), 4853. https://doi.org/10.3390/ijerph18094853

[9] Jin, X., Smith, R., & Lee, K. (2022). System-level failures in healthcare: A systems theory perspective. Journal of Healthcare Management, 67(2), 89–102.

[10] Kakemam, E., Albelbeisi, A. H., Rouzbahani, M., Gharakhani, M., Zahedi, H., & Taheri, R. (2024). Nurses' perceptions of patient safety competency: A cross-sectional study of relationships with occurrence and reporting of adverse events. *PloS one*, *19*(1), e0297185. https://doi.org/10.1371/journal.pone.0297185

[11] Mensah, E. K. G., & Adzah, I. D. (2026, March 17). *Medical negligence and patient safety: A medical-legal and human rights analysis of healthcare systems in Ghana and the United States*. SSRN. https://doi.org/10.2139/ssrn.6488418

ISSN: 2519-9439

[12] Mohd Zulkefli, N. A., Yusof, M. M., & Ahmad, R. (2021). Barriers to incident reporting in Malaysian hospitals: A qualitative study. BMJ Open, 11(3), e045678. https://doi.org/10.1136/bmjopen-2020-045678

[13] Reason, J. (2021). Human error: Models and management in healthcare systems. BMJ, 320(7237), 768–770. https://doi.org/10.1136/bmj.320.7237.768

[14] Rodziewicz, T. L., Houseman, B., Vaqar, S., & Hipskind, J. E. (2024). Medical Error Reduction and Prevention. In StatPearls. StatPearls Publishing.

[15] Schulz, J. S. (2025). Resolution After Medical Injuries: Case Studies of Communication-and-Resolution-Programs Demonstrate Their Promise as an Alternative to Clinical Negligence. Laws, 14(4), 55. https://doi.org/10.3390/laws14040055

[16] Slawomirski, L., & Klazinga, N. (2022). The economics of patient safety: Strengthening a value-based approach to reducing patient harm at national level. Organisation for Economic Co-operation and Development. https://doi.org/10.1787/761f2da8-en

[17] Webb, C., Dabkowski, E., Missen, K., & Missen, A. (2025). Contributing Factors to Medication Administration Errors Among Novice Registered Nurses: An Integrative Review. *Journal of clinical nursing*, *34*(11), 4499–4519. https://doi.org/10.1111/jocn.17721

[18] World Health Organization. (2023). Patient safety. https://www.who.int/news-room/fact-sheets/detail/patient-safety

[19] Zainal, H., Razali, H. Y., Khan, J., & Islam, M. N. (2020). Medical negligence in Malaysian practice: Legal and ethical perspectives. International Journal of Ethics, Trauma & Victimology, 6(2), 22–25.