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TORT LITIGATION VERSUS MEDIATION IN MEDICO-LEGAL DISPUTES: EVALUATING THE LIMITS OF MEDIATION AND PROPOSALS FOR REFORM

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ABSTRACT

Mediation has increasingly been promoted as an alternative to litigation in resolving medico-legal disputes. A substantial body of literature critiques the adversarial nature of tort litigation, particularly the evidentiary burdens imposed on patients, the emotional toll of courtroom proceedings, and systemic delays that undermine access to justice. In contrast, mediation is praised for its efficiency, confidentiality, and potential to facilitate amicable settlements in a less confrontational setting. However, despite growing advocacy for mediation, there remains a notable gap in academic discourse concerning its structural limitations especially in the context of medical negligence. This paper addresses that gap by critically examining the current use of mediation in Malaysia and Indonesia, two jurisdictions with distinct legal traditions but similar institutional challenges. Using a doctrinal legal research methodology combined with comparative analysis, this study systematically reviews statutory frameworks, case law, and institutional practices to evaluate the practical effectiveness of mediation in resolving medical negligence disputes. Scholarly literatures are also analysed to uncover recurring procedural and structural shortcomings. The paper argues that while mediation holds considerable promise, it often provides only the illusion of resolution due to the non-binding and unenforceable nature of its outcomes. In cases where patient harm is severe and power imbalances are pronounced, such weaknesses may leave injured parties without meaningful remedy. As a key contribution, the paper proposes several targeted reforms: (1) the introduction of mandatory mediation for appropriate medical cases; (2) the establishment of specialised medico-legal mediation panels; and (3) the granting of legal enforceability to mediated settlements through court registration. These reforms are essential to strengthen public trust in mediation and to ensure it delivers real, enforceable justice in the sensitive context of medical

harm. Furthermore, it resonates with the Shariah mandate to remove harm (raf' al-ḍarar) and with fiqh guidance endorsing ṣulḥ (amicable settlement).

Keywords: *Medico-Legal, Sulh, Mediation, Malaysia, Indonesia.*

1. INTRODUCTION

In recent decades, the resolution of medical negligence disputes has emerged as a significant concern within health law and policy, particularly in jurisdictions where access to litigation is burdened by procedural complexity, evidentiary hurdles, and prohibitive costs. Medical negligence which is commonly defined as the failure of a healthcare professional to meet the expected standard of care resulting in harm presents unique legal and ethical challenges. Traditional tort litigation, although doctrinally robust, often imposes emotional, financial, and procedural burdens on patients, making justice elusive for those harmed by substandard care (Khan et al. 2022; Azmi et al. 2021).

Therefore, numerous scholars have championed mediation over tort litigation for its potential to foster confidential, timely, cost-effective, and amicable settlements, particularly in complex and sensitive contexts such as medical disputes (Perangin-Angin et al., 2025; Khan et al., 2022; Mokhtar, 2024; Azmi et al., 2021; Nemie, 2017). However, critical scrutiny of mediation's practical limitations especially in medical negligence cases remains relatively underdeveloped. Accordingly, this paper seeks to critically evaluate the feasibility and limitations of mediation and to propose targeted reforms, particularly in relation to the non-binding nature of mediated settlements, the absence of specialised medico-legal expertise among mediators, and the lack of enforcement mechanisms to ensure compliance

To this end, this paper seeks to fill that gap by critically examining the mediation landscape in Malaysia and Indonesia; two Southeast Asian jurisdictions with differing legal systems, Malaysia's rooted in common law and Indonesia's grounded in civil law—both of which face systemic challenges in resolving medical negligence disputes. Although their institutional structures differ, both countries grapple with similar issues: high evidentiary thresholds, limited access to expert testimony, and procedural fragmentation in existing dispute resolution mechanisms. Drawing on comparative legal analysis, the paper argues that while mediation holds theoretical promise, in practice, it may offer only the illusion of resolution when not supported by strong institutional safeguards and legal enforceability.

In light of the significant challenges posed by tort litigation in resolving medical disputes, and in response to growing scholarly advocacy for mediation as a viable alternative (Mokhtar, 2024; Azmi et al., 2021; Shipley, 2018; Nemie, 2017), this paper critically assesses the feasibility and limitations of mediation in Malaysia and Indonesia and explores practical reforms to enhance its effectiveness. The first section examines the structural and procedural barriers that undermine the effectiveness of tort litigation in medical negligence claims, particularly the burden of proving breach and causation. The second section explores the evolution and institutionalisation of mediation in both jurisdictions, highlighting its advantages while interrogating its shortcomings. The final section presents reform proposals, including: (1) the introduction of mandatory mediation for suitable medical cases; (2) the establishment of a specialised medico-legal panel of mediators; and (3) the strengthening of the binding force of mediated settlements. Ultimately, this paper argues for a paradigm shift—from viewing mediation as merely appropriate to recognising the need for a robust, enforceable, and patient-centred dispute resolution framework in cases of healthcare-related harm.

2. LITERATURE REVIEW

2.1 *Understanding Medico-Legal Concepts: Medical Negligence and Malpractice*

The term medico-legal refers to issues that lie at the intersection of medical practice and legal accountability. It encompasses legal matters that arise from the actions or omissions of healthcare professionals during patient care. Medico-legal concerns typically surface when there is a question of whether a healthcare provider has breached their duty of care, resulting in harm to a patient (Donoghue v Stevenson 1932; Hidayani et al., 2023). One of the most significant aspects of medico-legal cases is medical negligence or malpractice; a situation where a doctor or medical institution fails to meet the accepted standard of care, leading to injury, worsening of a condition, or even death. When such negligence is alleged, the case may develop into a medical malpractice lawsuit, where the affected patient seeks legal redress, often in the form of compensation.

Sourcing back to the invention of the term “malpractice”, this term is derived from the Latin words "mall," meaning bad, and "practice," meaning action or conduct. Thus, malpractice literally translates to "bad practice." (Sinamo & Sibarani, 2020). Terminologically, malpractice is an act of professional staff that is contrary to SOP, codes of ethics, and applicable laws, whether intentional or due to negligence resulting in loss or death to other people (Zahir, 2024). In medical law, malpractice is thus understood as "bad doctor practice,"

emphasising the misconduct or failure in medical treatment that deviates from established professional standards (Sinamo & Sibarani, 2020).

In Indonesia, the definitions of medical malpractice (*malpraktik medik*) and medical negligence (*kelalaian medik*) have been adopted in both societal and academic settings (Susila, 2021). However, there is a distinction between these terms. Medical malpractice is understood to encompass a broader scope than medical negligence (Zahir, 2024; Achadiat, 2007). In addition to including the meaning of negligence, the term malpractice includes actions that are done intentionally (*dolus; opzettelijk*) and violate the law (Mulyadi et al., 2020). In simple words, medical malpractice includes both intentional acts of wrongdoing by a medical professional and unintentional acts that result in harm to a patient, whereas medical negligence is limited to unintentional conduct.

Thus, medico-legal matters are closely tied to medical negligence and malpractice claims, as they involve evaluating clinical decisions and professional conduct under legal scrutiny. These cases require the integration of legal principles (such as duty of care, breach, causation, and damage) with medical expertise to determine whether a violation of the standard of care has occurred.

2.2 *Approaches to Medical Negligence in Malaysia and Indonesia: A Critical Evaluation of Tort Litigation and The Case for Reform*

2.2.1 *The Malaysian Approach*

Malaysia's approach to resolving medical negligence claims is deeply rooted in its common law heritage, inherited from its colonial ties to Britain (Hidayani et al., 2023; Zainal et al., 2020). Within this legal framework, claims are typically pursued through tort litigation which requires plaintiffs to prove three core elements: that a duty of care existed, that the duty was breached, and that the breach directly caused harm (Mokhtar, 2024; Khan et al., 2022; Zainal et al., 2020). Although this doctrinal structure has long been the foundation for medical negligence cases, in practice, it presents a range of substantive and procedural hurdles for injured patients (Mokhtar, 2024; Kassim & Najid, 2013).
Historically, the standard of care in Malaysia was assessed using the Bolam test, derived from the English case *Bolam v Friern Hospital Management Committee* [1957] 1 WLR 582. According to this test, a doctor would not be deemed negligent if their actions were supported by a responsible body of medical opinion. While this professional deference offered predictability for clinicians, it frequently sidelined the patient's perspective and undervalued their right to informed decision-making.

A significant development occurred in *Foo Fio Na v Dr Soo Fook Mun & Anor* [2007] 1 MLJ 593, where the Federal Court departed from the Bolam test and adopted the reasoning of the Australian High Court in *Rogers v Whitaker* [1992] HCA 58. The court emphasised that it is ultimately the role of the judiciary and not the medical profession alone to determine legal standards, especially in cases involving informed consent. This shift signalled a growing judicial commitment to patient autonomy and transparency in clinical practice (Zainal et al., 2020; Amirthalingam, 2017).

Despite this progressive shift, many patients continue to face formidable barriers when bringing medical negligence claims. The burden of proof particularly in establishing causation remains high (Hidayani et al., 2023; Mokhtar, 2024). The "but for" test from *Barnett v Chelsea and Kensington Hospital Management Committee* [1969] 1 QB 428 requires plaintiffs to show that their injury would not have occurred but for the healthcare provider's negligence. Yet medical outcomes are often shaped by complex, multifactorial conditions that make isolating a single cause inherently difficult. Compounding this, Malaysia does not recognise the "loss of chance" doctrine as seen in *Gregg v Scott* [2005] UKHL 2, which limits recovery options for patients whose future health prospects were diminished by negligence.

Beyond legal doctrines, practical barriers weigh heavily on patients. Expert medical testimony is crucial to support negligence claims, but plaintiffs often struggle to find specialists willing to testify against their peers. This so-called "conspiracy of silence" creates a culture of silence and discourages accountability (Hatta 2018; Amirthalingam 2017; Kassim & Najid 2013). Financial costs and emotional strain from protracted litigation add further disincentives. In addition, the adversarial nature of courtroom proceedings can erode trust in the healthcare system and discourage patients from seeking justice.

While the Bolitho refinement which is established in *Bolitho v City and Hackney Health Authority* [1998] AC 232 allows courts to assess whether medical opinions are logically defensible, its application in Malaysia has been inconsistent. In *Zulhasnimar Hasan Basri & Anor v Dr. Kuppu Velumani P & Ors* [2017] MLJU 2059, the court ultimately defaulted to deference despite logical contradictions, highlighting the judiciary's reluctance to move away from traditional professional dominance.

Collectively, these doctrinal and systemic challenges reflect a legal environment that can be overwhelmingly difficult for injured patients to navigate. Upholding professional standards is, of course, important. However, a system that disproportionately favours clinician's risks denying justice to

those most in need of redress. As Hatta (2018) warns, if evidentiary standards and litigation pathways are not meaningfully reformed, the legal system may continue to exclude the very individuals it purports to protect.

In response, there has been growing academic and policy interest in alternative dispute resolution particularly mediation as a more accessible and empathetic approach to resolving medical disputes. Mediation provides a confidential, less adversarial setting where both parties can discuss issues openly and work toward mutually agreeable outcomes (Amirthalingam, 2017). This paper therefore raises an important question: To what extent can mediation within the ADR framework address the challenges faced by patients in pursuing redress for medical negligence? The following sections critically examine this question by evaluating the current use and limitations of mediation in Malaysia and Indonesia and offering proposals for meaningful reform.

2.2.2 *The Indonesian Approach: Legal Structures and Practical Challenges*

Indonesia's approach to resolving medical disputes is embedded within its civil law tradition, heavily influenced by Dutch legal principles (Ichsan et al., 2022). Unlike Malaysia's common law system, which benefits from the development of binding precedent, Indonesia lacks the doctrine of *stare decisis*. Consequently, judicial decisions are not binding on future cases, leading to inconsistencies and uncertainty in the resolution of medical negligence claims. This absence of jurisprudential cohesion poses challenges for both patients and legal practitioners seeking predictability and guidance.

The Indonesian legal framework for medical disputes is dispersed across multiple laws including the *Medical Practice Act*, *Health Law*, *Civil Code*, and *Penal Code*—each with different standards and procedures. This fragmentation leads to procedural confusion, forcing plaintiffs to navigate complex and overlapping routes (disciplinary, civil, and criminal), which can delay justice and increase costs. The foundational statute is the *Medical Practice Act 2004* (Law No. 29 of 2004), which affirms patients' rights to safe and standardised healthcare services. Under this law, patients may report violations of medical standards to competent authorities (Nasrul et al., 2024). Victims of medical malpractice are entitled to pursue civil claims for compensation, including damages for physical, psychological, or financial harm. In cases involving death or serious injury, the statute permits the filing of criminal complaints against the responsible healthcare professional or institution.

Complementing this is the *Health Law 2009* (Law No. 36 of 2009), which reinforces the right to healthcare and establishes mechanisms for redress. Article 55 of this statute specifically states that negligence by healthcare

workers that causes harm gives rise to a right to compensation. Furthermore, Article 29 emphasises that medical disputes should, where possible, be resolved through non-litigation means, including mediation, prior to being brought before a court. This reflects a broader institutional push for alternative dispute resolution mechanisms.

The application of criminal law in cases of medical malpractice is reserved for more serious instances involving *culpa lata*, or gross negligence. This threshold requires evidence of extreme carelessness and is limited to the primary perpetrator and their assistants. This restricts the scope of criminal liability and places a high evidentiary burden on the complainant.

Civil liability, on the other hand, is governed by the Indonesian Civil Code (*Kitab Undang-Undang Hukum Perdata*). Article 1239 addresses breach of contract, applicable where the doctor–patient relationship is based on an outcome-oriented agreement. Meanwhile, Articles 1365 and 1371 provide the legal basis for tort claims involving unlawful acts and negligence. Civil claims require clear evidence of causation and breach, which is difficult for lay patients without legal aid or expert witnesses. This mirrors challenges faced in Malaysia's tort litigation system but is exacerbated by Indonesia's lack of binding precedent and underdeveloped case law.

Procedurally, Supreme Court Regulation No. 1 of 2016 mandates mediation as a compulsory preliminary step in all civil disputes, including medical cases. This aligns with the non-litigation preference expressed in the *Health Law*. Institutions such as the Consumer Dispute Settlement Agency (BPSK) further support this objective by facilitating mediation, arbitration, negotiation, or conciliation sessions, often before formal court action begins.

However, despite this multi-tiered framework, significant limitations persist. The dispersal of authority across civil, criminal, and disciplinary domains often results in procedural confusion. Patients may be unsure of which path to pursue, and each avenue imposes different thresholds and institutional requirements. The Indonesian Medical Discipline Honorary Council (*Majelis Kehormatan Disiplin Kedokteran Indonesia*, MKDKI) plays a central role in handling disciplinary matters, yet it lacks the authority to award compensation (Ichsan et al., 2022). This creates a gap between accountability and remedy, where patients may receive ethical vindication without financial redress.

Compared to Malaysia's common law model, which benefits from established case law and clearer procedural rules, Indonesia's framework appears more fragmented and less accessible. However, both systems face similar practical challenges, such as high evidentiary burdens and limited access to expert

witnesses.

In a nutshell, Indonesia's approach to medical disputes reveals a legal architecture that is both comprehensive and complex. While its statutes demonstrate a strong institutional commitment to patient protection, their implementation is hampered by fragmentation, procedural opacity, and limited enforceability. Future reforms should focus on harmonising statutory provisions and enhancing the authority of mediation outcomes to ensure that medical dispute resolution is not only procedurally sound but also substantively just.

Table 1. Comparative Analysis on the Approaches to Medical Disputes in Indonesia and Malaysia

Aspect	Indonesia	Malaysia
Legal System	Civil law (non-binding precedent)	Common law (precedent-based)
Primary Legal Basis	Article 1365 Civil Code; Medical Practice Act 2004; Health Act 2009	Tort law under Civil Law Act; post-*Foo Fio Na* informed consent framework
Dispute Channels	Hospital complaints, MKDKI, MKEK, civil/criminal courts	Civil litigation, court-annexed mediation,
Mediation	Mandatory pre-trial mediation (Reg. No. 1/2016)	Encouraged but not mandatory (Mediation Act 2012, Practice Direction 2022)
Expert Testimony Challenges	Lack of independent experts; limited transparency	Conspiracy of silence; dependence on partisan experts
Legal Predictability	Low – precedent not binding	Moderate to high – precedent guides judicial reasoning
Enforcement and Remedies	Ethical sanctions, discipline, or civil compensation	Monetary damages, and court-enforced orders

3. METHODOLOGY

This study adopts a qualitative and comparative legal research methodology to examine the use and limitations of mediation in resolving medico-legal disputes in Malaysia and Indonesia (Taylor et al., 2016). The

doctrinal approach forms the foundation of the analysis, involving an in-depth review of primary legal sources, with particular emphasis on statutory provisions relevant to Malaysia and Indonesia. Judicial decisions, legal commentaries, and institutional policy documents are also analysed to interpret how these frameworks operate in practice (Saldana, 2011). Scholarly articles are additionally reviewed to critically evaluate the challenges in tort litigation and to assess the feasibility and limitations of mediation in resolving medical disputes (Barbour et al, 2018). The comparative component of the methodology enables a systematic evaluation of the similarities and divergences between Malaysia's common law-based mediation practices and Indonesia's civil law model. Neely and Ponshunmugam (2019) noted that this approach is particularly useful in highlighting how legal culture, procedural mandates, and institutional design affect the implementation and effectiveness of mediation in medical disputes.

4. RESULTS & DISCUSSION

4.1 *Mediation as an Appropriate Dispute Resolution Mechanism for Medico-Legal Cases: Navigating Its Limitations and Pathways for Reform*

4.1.1 *The Significance of Mediation in Addressing Medical Disputes*

In recent years, the term appropriate dispute resolution has gained traction in legal discourse as a more purposive alternative to the traditional notion of alternative dispute resolution (ADR). This conceptual shift was notably articulated by Chief Justice Sundaresh Menon in his keynote address at the Global Pound Conference 2016, Singapore, where he argued that mediation and other non-litigation processes should not merely be seen as alternatives to litigation, but rather as forms of appropriate dispute resolution. Within this framework, mediation is no longer regarded as a secondary or optional path but as a potentially optimal mechanism, depending on the nature and context of the dispute. This reframing is particularly salient in the field of medico-legal disputes, where the formalities and adversarial nature of tort litigation may fail to meet the therapeutic or relational needs of patients and healthcare providers (Amirthalingam, 2017).

Mediation as one of the core components of Alternative Dispute Resolution (ADR) encompasses various non-judicial mechanisms aimed at resolving disputes outside the formal court system. The word "mediation" is derived from the Latin term "mediare," which means "to be in the middle". This

etymology reflects the role of the mediator as a neutral third party who facilitates communication and resolution between disputing parties to help them reach a mutually acceptable resolution or win-win situation (Perangin-Angin et al., 2025; Amirthalingam., 2017). Unlike adjudication or arbitration, the mediator does not impose a decision but supports voluntary agreement. In the context of medico-legal disputes, mediation is especially attractive due to its non-confrontational nature, emphasis on confidentiality, and ability to address not just legal liability but also relational and emotional concerns.

One of the key advantages of mediation in resolving medical disputes lies in its capacity to foster an amicable and non-adversarial environment. Unlike traditional litigation, which is inherently adversarial and often intensifies tensions between patients and healthcare providers, mediation encourages open dialogue and mutual understanding (Zainal et al., 2020; Amirthalingam, 2017). This feature is particularly important in medical negligence cases, where emotions frequently run high and the preservation of the doctor–patient relationship may be desirable (Shipley, 2018). Through mediation, parties are more likely to engage constructively and collaboratively, thereby facilitating the expression of concerns, the acknowledgment of harm, and, in some cases, the restoration of trust. The emphasis on cooperation rather than confrontation enables the disputants to jointly craft solutions that are not only legally acceptable but also emotionally and morally satisfying.

In addition to its relational benefits, mediation is widely recognized for its procedural flexibility and expedited timelines. The process can be arranged at the convenience of the parties and does not require strict adherence to court calendars or procedural formalities. This makes mediation particularly appropriate for medical disputes, which often involve complex clinical evidence and emotionally vulnerable parties who may benefit from a more responsive and adaptable forum. The mediator's role in guiding parties toward a shared resolution often accelerates the negotiation process, thereby reducing delays that are typically encountered in the litigation system. As a result, mediation offers a more efficient pathway to resolution, which can be especially meaningful for patients who seek timely redress and closure.

Another significant advantage of mediation is its cost-effectiveness when compared to litigation (Shipley, 2018). Legal proceedings in court are often expensive, requiring payment for legal representation, expert witnesses, and protracted administrative processes. For many patients, who may already be financially strained due to medical expenses or disability, these costs present a

substantial barrier to justice (Kassim & Najid, 2013). Mediation, on the other hand, generally involves lower expenses, as it reduces the need for extensive legal procedures and typically resolves disputes within a shorter timeframe. This not only eases the financial burden on patients and their families but also presents cost savings for hospitals and medical indemnity insurers, making it a more economically viable dispute resolution mechanism.

Mediation also contributes to judicial efficiency by helping reduce the backlog of cases within the court system. In jurisdictions such as Malaysia and Indonesia, where delays in court proceedings are a well-documented concern, early settlement of disputes through mediation relieves pressure on judicial resources. By diverting cases that can be amicably resolved outside of the courtroom, mediation allows judges to concentrate on matters that require formal adjudication. This redirection supports the overall administration of justice by streamlining caseloads and promoting the timely delivery of legal outcomes for all litigants.

Furthermore, mediation allows the discussion to move beyond the narrow confines of legal liability. Many patients are not solely motivated by financial compensation but seek acknowledgment, clarity on what went wrong, and assurance that similar errors will not recur. Mediation creates a space where these broader objectives can be addressed, as healthcare providers are often more willing to speak candidly and empathetically in a private, non-adversarial setting than they would be during a formal court trial. By fostering communication and mutual understanding, mediation enables outcomes that better align with the emotional and moral dimensions of patient harm.

4.1.2 *Evaluating the Challenges and Limitations of Mediation in Medico-Legal Disputes*

In the context of medical negligence claims, mediation holds promise as an appropriate dispute resolution mechanism due to its potential to reduce adversarial conflict, promote healing dialogue, and deliver timely settlements. However, for mediation to truly function as "appropriate," it must go beyond surface-level resolution and address substantive issues of fairness, power imbalance, and enforceability (Amirthalingam, 2017)

Despite the conceptual appeal of mediation, its actual application in medico-legal contexts raises critical concerns, foremost among them being procedural fairness and power asymmetry. Medical negligence claims often pit individual

patients, who may lack legal literacy or institutional support, against powerful healthcare providers, insurance-backed hospitals, or government entities. In such scenarios, mediation may not provide a level playing field. Without procedural safeguards such as legal representation or mediator neutrality, patients may be pressured into accepting settlements that inadequately reflect their suffering or fail to hold providers accountable (Amirthalingam, 2017)

Moreover, the very flexibility that makes mediation attractive can also undermine its effectiveness. Since mediation can be conducted at any time and place convenient for the parties, the absence of one party can easily derail the session. In cases where parties are unwilling to compromise or agree on proposed terms, the process may collapse entirely, resulting in wasted time and costs without a resolution. This adds to the uncertainty and discourages participation, especially for parties already vulnerable due to health, emotional stress, or financial hardship.

Another concern involves the transparency of the mediation process. Unlike litigation or arbitration, which include strict procedural rules and evidentiary disclosure, mediation allows parties to withhold important information. A lack of transparency may skew the process, particularly if one party uses strategic non-disclosure to gain advantage. This can result in settlements that do not accurately reflect the merits of the case, leaving patients feeling disempowered and dissatisfied. (Amirthalingam, 2017).

The informal, private, and confidential nature of mediation, while often seen as beneficial, also limits its predictability and transparency. Outcomes from one case cannot be cited in another, and there is no consistent jurisprudence to guide future mediations. This makes it difficult for parties to anticipate possible outcomes or understand what constitutes a fair and reasonable settlement. Such unpredictability may reduce confidence in the process, especially for those seeking a sense of justice beyond monetary compensation.

Mediator competence also plays a crucial role. While mediators do not issue binding decisions, their ability to manage the session, encourage dialogue, and facilitate agreement significantly affects the process. A mediator who lacks experience in medico-legal disputes or demonstrates bias can render the session ineffective or even harmful. This is particularly relevant in sensitive medical cases, where technical understanding and emotional intelligence are both essential (Shipley, 2018; Nemie, 2017; Amirthalingam, 2017).

An additional limitation lies in the non-binding nature of mediation outcomes. Unlike court judgments or arbitral awards, a mediated settlement does not automatically carry legal enforceability unless formally registered or

incorporated into a consent order. This creates fundamental uncertainty for parties, particularly the complainant, who may have invested time, effort, and emotional energy into the process. If one party later refuses to honour the agreement, the other may be forced to initiate fresh legal proceedings to seek enforcement, thereby defeating the very objective of using mediation as a faster and less burdensome alternative to litigation. In medico-legal disputes where the stakes often involve serious harm or loss, this lack of enforceability undermines the credibility and reliability of mediation as a mechanism for delivering just and lasting outcomes.

Ultimately, while mediation offers clear advantages such as cost savings, speed, and therapeutic engagement, it also presents substantial limitations that must be critically addressed. Without enforceable outcomes, transparent procedures, and safeguards against imbalance, mediation risks becoming a tool of expedience rather than justice. A reformed framework is therefore necessary to enhance its credibility, ensure equity between parties, and uphold the promise of genuine resolution in medical negligence cases.

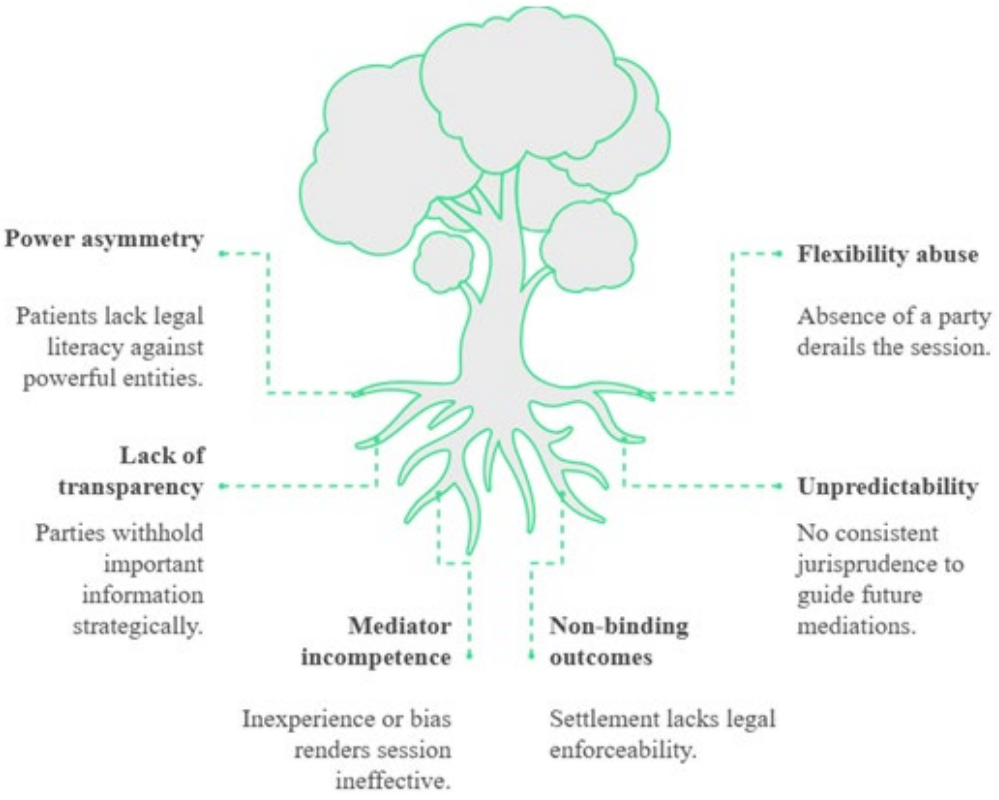

Figure 1. Limitations of mediation in resolving medical disputes

4.1.3 *Limitations of Mediation and Reform Proposals: Strengthening the Effectiveness of Mediation in Medico-Legal Disputes*

To overcome the limitations identified in the previous section and to ensure that mediation functions as an effective and fair mechanism for resolving medical disputes, a series of targeted reforms must be introduced. These proposals aim to address each limitation systematically while promoting procedural fairness and access to justice.

a. Towards a Structured and Mandatory Mediation Framework in Malaysia

In Indonesia, mediation is mandatory for all civil disputes, including medical cases, pursuant to Supreme Court Regulation No. 1 of 2016. This regulation obliges parties to attempt mediation before proceeding to trial, making it a compulsory preliminary step. The Indonesian Health Law 2009 (Article 29) further encourages the non-litigation resolution of healthcare disputes, reinforcing a normative expectation for mediation in medical negligence cases. This dual mandate reflects the Indonesian judiciary's strong institutional commitment to reducing litigation backlog and enhancing access to justice through Alternative Dispute Resolution (ADR). Mediation is operationalised through the Indonesian Mediation Centre (Pusat Mediasi Nasional) and court-affiliated mediation panels, which provide structured and accessible forums for early dispute settlement.

In contrast, Malaysia maintains a voluntary model. Mediation is promoted but not obligatory, including medical negligence claims. Under Practice Direction Regarding Mediation No. 2 Year 2022, judges may refer civil cases to court-annexed mediation, while Order 34 of the Rules of Court 2012 allows courts to suggest mediation during pre-trial case management (Order 34 Rules of Court 2012 Malaysia). However, these instruments fall short of mandating mediation, and there is no statutory requirement specific to medical disputes (Malaysian Legal Aid Department; Zainal et al., 2020; Nemie, 2017). Consequently, mediation uptake remains inconsistent and largely dependent on judicial discretion or the willingness of the parties. Beyond court-annexed mediation, Malaysia also offers ADR through several private institutions, such as the Malaysian International Mediation Centre (MIMC), the Asian International Arbitration Centre (AIAC), the Securities Industry Dispute Resolution Centre (SIDREC), and the Borneo International Centre for Arbitration and Mediation (BICAM). However, the lack of a coherent national policy or legal obligation has contributed to fragmentation in practice and limited the development of mediation as a mainstream mechanism for resolving healthcare disputes.

To address the existing gaps, Malaysia should consider introducing a statutory requirement for mediation in specified categories of medical negligence cases. A legal mandate, akin to Indonesia's model, would not only reduce court congestion but also encourage earlier, more collaborative resolutions between patients and healthcare providers. Such a framework should be supported by amendments to the Rules of Court and relevant healthcare legislation, clearly outlining the conditions under which mediation is compulsory. By mandating mediation in suitable cases and embedding it within a centralised institutional framework, Malaysia can enhance legal certainty, promote procedural efficiency, and provide a more therapeutic form of justice for both patients and medical professionals.

On another note, a compelling precedent for structured mediation can be found in Malaysia's Syariah court system, which has implemented Sulh (Shariah mediation) with considerable success. Since the introduction of the Selangor Syariah Court Civil Procedure (Sulh) Rules 2001 and further codification in state enactments such as Sections 87–93 of the Selangor Syariah Civil Procedure Enactment 1991 (amended 2003), Sulh has become a widely accepted mechanism for resolving matrimonial and family disputes. Notably, settlements achieved through Sulh are routinely endorsed as binding court orders—a feature that has enhanced compliance and reduced case backlogs (Ahmad, 2010). Building on this procedural success, this paper suggests that a Shariah-inspired model of structured, court-recognised mediation could be piloted in civil medical dispute cases, especially where cultural and legal legitimacy are crucial. The structured nature of Sulh which includes trained officers, clear procedures, and enforceable outcomes provides a strong blueprint for designing more effective medico-legal mediation frameworks (Hak 2010).

b. Enhancing Mediator Competency and Specialisation in Medico-Legal Disputes

The qualification and institutional recognition of mediators in Malaysia and Indonesia reflect differing regulatory philosophies, but both systems reveal gaps when it comes to ensuring competency in complex medico-legal disputes. In Malaysia, the route to becoming a mediator depends largely on the forum in which mediation takes place. Within administrative bodies such as the Estate Distribution Division (EDD) and Amanah Raya Berhad (ARB), there is no strict requirement for formal qualifications or mediation training. By contrast, court-annexed mediations are typically conducted by judicial officers consisting of judges, judicial commissioners, or court registrar whose legal training offers procedural integrity but not necessarily mediation expertise (Practice Direction Regarding Mediation No. 2 Year 2022). For private mediation institutions like

the Malaysian Mediation Centre (MMC), candidates must complete a 40-hour training programmed, pass a practical assessment, and observe the MMC's Code of Ethics and Professional Conduct (Nasrul et al., 2024). Indonesia adopts a more standardised and regulated approach. Mediators must undergo 60 hours of training that includes academic theory and practical simulation, pass a qualifying exam, and be registered with either the Supreme Court or the Indonesian Mediation Centre. Fluency in local language and adherence to a national code of ethics are also mandated (Nasrul et al., 2024).

However, across both jurisdictions, a critical shortcoming remains: the lack of a requirement for mediators to possess specialised medico-legal knowledge. Medical negligence disputes involve not just legal questions, but also clinical standards, healthcare ethics, and emotional trauma (Shipley, 2018). These elements necessitate nuanced understanding that extends beyond generic mediation skills. To ensure equitable outcomes, mediators in such cases must be trained not only in conflict resolution but also in medical law, patient safety norms, and professional healthcare standards (Zainal et al., 2020; Nemie, 2017). Without this dual expertise, mediators risk facilitating settlements that are procedurally smooth but substantively unjust—particularly where power asymmetries exist between institutional healthcare providers and individual patients (Hatta, 2018; Amirthalingam, 2017).

To address these competency gaps, both Malaysia and Indonesia must move towards professionalising mediation in healthcare by establishing specialised accreditation for mediators in medical disputes. This reform should introduce mandatory medico-legal training as part of the mediator certification process for those intending to handle healthcare-related cases. An independent accreditation authority—potentially housed under national medical councils or judicial training institutes should oversee ongoing certification, quality assurance, and ethical compliance. This body could also maintain a national panel of approved medico-legal mediators with expertise in both law and medicine. By embedding specialised knowledge into the qualification structure, such a reform would ensure that mediators are better equipped to understand the nuances of clinical evidence, patient harm, and legal liability. This would, in turn, improve the quality, credibility, and fairness of medical mediation outcomes, ultimately enhancing public trust in ADR processes within the healthcare context.

c. From Dialogue to Directive: Strengthening the Binding Force of Mediation in Medico-Legal Disputes

A central limitation in the current use of mediation for resolving medical disputes in both Malaysia and Indonesia lies in the non-binding nature of

mediation outcomes. In Malaysia, settlements reached through mediation are not automatically enforceable unless formalised as consent judgments or contractual agreements. Even then, if one party defaults, the other must initiate legal proceedings to enforce the terms—thereby undermining the very efficiency mediation is meant to offer. Moreover, there is no specific legislation that guarantees enforceability in medical negligence disputes, which can deter patients from viewing mediation as a reliable route to justice. Similarly, in Indonesia, although mediation is compulsory in all civil matters under Supreme Court Regulation No. 1 of 2016 and encouraged by Article 29 of the Health Law 2009, the outcome is only enforceable if officially recorded by the court. In both systems, this creates a structural vulnerability: where parties fail to comply, mediated agreements may become mere moral understandings without legal consequence.

Unlike arbitration, where the arbitrator renders a binding award, a mediator's role is facilitative rather than adjudicative; they assist parties in reaching consensus but do not impose decisions. Consequently, the success of mediation depends entirely on party cooperation and mutual agreement, which can be problematic in medical disputes involving severe power asymmetries—such as individual patients negotiating against state-linked hospitals.

To strengthen public confidence in mediation and encourage its use in medico-legal contexts, reform is essential. Malaysia should introduce legislative provisions allowing mediated settlements—particularly in medical cases—to be automatically registered as enforceable court orders, provided they meet standards of voluntariness, fairness, and clarity. This would reduce the need for post-mediation litigation, enhance finality, and ensure that mediation functions as a truly effective alternative to adjudication. Judicial oversight mechanisms could further ensure that vulnerable parties are protected, transforming mediation into not just an efficient, but a trustworthy and enforceable path to redress in healthcare disputes.

5. CONCLUSION

This paper critically examined the suitability and effectiveness of mediation as an alternative dispute resolution (ADR) mechanism for resolving medical negligence disputes in Malaysia and Indonesia. Beginning with an exploration of the challenges inherent in tort-based litigation—such as evidentiary burdens, systemic delays, and emotional tolls, the discussion identified mediation as a potentially more efficient, confidential, and therapeutic pathway. However, the paper also highlighted that the promise of mediation remains unrealised unless key structural and legal reforms are adopted.

In examining the institutional frameworks of both jurisdictions, it became evident that Indonesia adopts a more integrated approach by mandating mediation in all civil disputes through Supreme Court Regulation No. 1 of 2016. This is further reinforced by provisions in the Health Law 2009. Malaysia, by contrast, offers mediation through court-annexed and private institutional mechanisms, but lacks a mandatory framework, particularly for medico-legal cases. The fragmented and voluntary nature of Malaysia's model often leaves the process underutilised and inconsistently applied.

Another critical gap lies in the competence and specialisation of mediators. In both countries, general mediation training is required, but neither system ensures the availability of mediators with specialised medico-legal knowledge. This is particularly problematic for complex clinical disputes that demand an understanding of both legal standards and medical practice. The paper proposed that both jurisdictions should adopt continuous accreditation models and establish specialist panels with dual expertise.

One of the most significant limitations discussed was the non-binding nature of mediation outcomes. Unlike arbitration, where decisions are enforceable awards, mediation relies entirely on party consensus. In Malaysia, while mediated settlements can be formalised as consent judgments, this is not automatic. Indonesia also faces similar challenges in ensuring the enforceability of mediated outcomes. To address this, the paper advocated for legislative amendments to grant legal enforceability to mediated agreements, provided they meet criteria of procedural fairness and mutual consent.

In synthesising the comparative analysis, while both Malaysia and Indonesia are advancing the use of mediation in medical disputes, significant legal and institutional reforms are needed. Malaysia should consider introducing mandatory mediation in suitable medical cases, establish a specialised mediation panel under the Ministry of Health, and expand access through legal aid. Indonesia, while stronger on institutional mandates, must similarly enhance mediator specialisation and streamline multi-tiered procedures to improve access and clarity for patients.

Ultimately, for mediation to serve as a meaningful alternative to litigation in medical negligence disputes, both jurisdictions must move beyond treating it as a procedural formality. Instead, mediation should be embedded in a robust legal framework that ensures accessibility, enforceability, and subject-matter competence. By doing so, the process can fulfill its true potential—not merely as a tool for dispute avoidance, but as a mechanism for delivering real justice, restoring trust, and promoting healing in the often emotionally charged landscape of healthcare.

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