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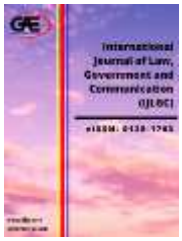

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BETWEEN STETHOSCOPE AND STATUTE: WHO COUNTS AS MEDICO-LEGAL EXPERT IN MALAYSIA?

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Abstract:

Doctors in Malaysia regularly provide expert opinions to courts, regulators, and healthcare institutions, yet there is no structured mechanism for recognising or validating medico-legal expertise. Because medical law is not recognised as a clinical specialty under the Medical Act 1971 [*Act 50*], medico-legal competence develops outside the statutory specialist framework. This creates a recognition gap in which legitimacy, scope, and accountability remain unclear. This paper argues that treating medico-legal practice as a missing specialty misdiagnoses the problem. Specialist recognition is designed to validate clinical competence in therapeutic decision-making. Medico-legal work, by contrast, concerns accountability, regulatory interpretation, and institutional decision-making. The difficulty lies not in the absence of title, but in the absence of a governance framework for non-clinical subject-matter expertise. Through comparative analysis and doctrinal examination, the paper identifies structural constraints in current practice, including reliance on ad hoc reputation and case-specific judicial gatekeeping. It distinguishes between clinicians who undertake occasional expert work and practitioners whose roles are predominantly governance-oriented, noting that neither pathway is supported by a standardised validation model. To address this gap, the paper proposes a Subject-Matter Expert (SME) framework based on function rather than status. The framework introduces structured validation, time-limited recognition, defined scope, and independence safeguards. It recommends administrative hosting within the Academy of Medicine of Malaysia to ensure professional oversight without incorporating medico-legal expertise into the National Specialist Register. By prioritising competence and accountability over title creation, the framework offers a governance-based solution that preserves judicial discretion and respects the statutory separation between the medical and legal professions.

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Introduction

Doctors in Malaysia are routinely asked to give expert opinions to courts, advise regulatory authorities, interpret statutory requirements, and participate in disciplinary or enforcement proceedings. Yet there is no structured mechanism within the professional regulatory system to recognise or validate medico-legal expertise. Because medical law is not recognised as a clinical specialty under the Medical Act 1971 [*Act 50*], doctors who develop substantial medico-legal competence do so outside any formal recognition architecture (Medical Act 1971 [*Act 50*]; MMC, 2019a). This creates uncertainty about legitimacy, scope of authority, and accountability. Medico-legal competence exists in practice but lacks institutional form. This absence has practical consequences. Courts rely on medical experts to assist in determining standards of care and causation (Montgomery v Lanarkshire Health Board, 2015; Daubert v Merrell Dow Pharmaceuticals, Inc., 1993). Regulators depend on medical input when exercising discretionary powers that may affect licensing, discipline, or institutional approval (Private Healthcare Facilities and Services Act 1998 [*Act 586*]; Cane, 2011). Healthcare institutions require legally informed clinical judgment when designing governance frameworks and managing risk (Hood, Rothstein & Baldwin, 2001; Power, 2007). Despite this reliance, there is no coherent framework for identifying who qualifies as a medico-legal expert, what competencies are required, or how such competence should be validated. Some may assume that the solution lies in recognising medical law as a new medical specialty. This paper argues that such an approach misdiagnoses the problem. Specialist recognition under Malaysian law is designed to validate structured postgraduate clinical training directed toward therapeutic decision-making (Medical Act 1971 [*Act 50*]; MMC, 2019b). Medico-legal work, by contrast, concerns interpretive reasoning, evidentiary standards, regulatory accountability, and institutional governance (Faigman et al., 2014; Cane, 2011). The issue is not the absence of a specialty, but the absence of a governance framework for recognising non-clinical subject-matter expertise. Drawing on professional boundary theory (Abbott, 1988), administrative law principles (Cane, 2011), and comparative regulatory practice (Herring, 2020; Mason & McCall Smith, 2019), this paper reconceptualises medico-legal expertise as a form of subject-matter competence grounded in governance rather than clinical service delivery. It distinguishes between different modes of medico-legal engagement among doctors and identifies the risks that arise when competence is recognised informally rather than through structured validation. The central question is therefore not whether medical law should become a specialty, but how medico-legal expertise can be recognised, bounded, and made institutionally defensible without distorting existing statutory structures.

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Research Questions

1. How is medico-legal expertise defined and validated in places where medical law is not acknowledged as an official medical speciality?
2. What unique professional trajectories and methods of involvement have arisen among physicians engaged in medico-legal work, and in what ways do these trajectories vary in terms of role orientation, emphasis on competence, and susceptibility to governance and accountability risks?
3. Why does portraying medico-legal knowledge as a non-existent or deficient medical speciality misrepresent the fundamental governance and regulatory issues?
4. What governance, procedural, and regulatory issues emerge from the lack of established role distinction, competency validation, and independence safeguards in medico-legal practice?
5. How can a framework for subject-matter experts be constructed to acknowledge, govern, and incorporate medico-legal expertise without establishing a new medical speciality or infringing upon existing legal professional territories?

Research Objectives

1. To investigate the recognition, application, and limitations of medico-legal skills in nations lacking formal acknowledgement of medical law as a distinct medical speciality.
2. To examine the strengths, limitations, and risk profiles related to various professional pathways and styles of participation through which physicians conduct medico-legal work.
3. To rigorously assess the appropriateness and constraints of specialty-specific recognition models in the context of medico-legal expertise.
4. To identify governance vulnerabilities stemming from title inflation, role ambiguity, informal expert selection methods, and inadequate safeguards against bias in medico-legal decision-making.
5. To establish a framework for subject-matter experts that facilitates legitimate acknowledgement, responsible supervision, and cohesive institutional incorporation of medico-legal expertise within current legal and professional parameters.

Methodology

This paper adopts a conceptual and doctrinal approach to examine the governance of medico-legal expertise. It does not seek to quantify the prevalence of medico-legal practice or to conduct an empirical survey of practitioners. Instead, it addresses a structural recognition problem: the absence of a formal mechanism for identifying and validating medico-legal competence in jurisdictions where medical law is not recognized as a clinical specialty. The analysis proceeds in three stages. First, it undertakes a doctrinal examination of statutory frameworks, professional regulation, and judicial approaches to expert evidence in order to clarify how medico-legal authority is currently recognized and constrained. Second, it draws on comparative practice to identify recurring structural features across legal systems, particularly the reliance on evidentiary standards, ethical regulation, and institutional appointment rather than specialty recognition. Third, it develops a normative governance framework designed to address the identified recognition gap. Malaysia is used as an illustrative case study. The analysis draws on the Medical Act 1971 [*Act 50*], related

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amendments, regulatory instruments issued by the Malaysian Medical Council, relevant legislation, and judicial authorities. The purpose is not to provide an exhaustive doctrinal survey, but to assess how existing legal architecture shapes the recognition of medico-legal expertise and to evaluate the feasibility of reform within that structure. The proposed Subject-Matter Expert (SME) framework is presented as a governance design response grounded in comparative insight and statutory coherence. The study is therefore normative rather than empirical. It aims to inform professional regulation, institutional practice, and future research on the structured recognition of medico-legal expertise.

Scope and Limitations

This discussion is intentionally limited to medical practitioners, notwithstanding that medico-legal roles are increasingly undertaken by other healthcare professionals such as nurses, pharmacists, allied health practitioners, and healthcare administrators. This limitation reflects the paper's specific focus on the regulatory, professional, and career structures governing doctors, where questions of specialty recognition, professional identity, and medico-legal authority are most pronounced. While the conceptual framework developed may have relevance beyond the medical profession, extending the analysis to other healthcare disciplines would raise distinct regulatory, professional, and educational considerations that fall outside the scope of this paper and warrant separate, discipline-specific examination.

Foundations of Medical Law

Medical law is not a single, self-contained doctrinal field. It operates across multiple areas of law that together regulate healthcare practice. These include civil liability, criminal accountability, professional discipline, and administrative oversight (Herring, 2020; Mason & McCall Smith, 2019). Understanding this structure is essential before examining medico-legal expertise. At its most visible level, medical law engages civil liability. Courts determine whether standards of care were met, whether valid consent was obtained, and whether harm was caused (Montgomery v Lanarkshire Health Board, 2015). This compensatory function is only one dimension of the field. Medical law also includes criminal and quasi-criminal processes, such as statutory offences and professional misconduct proceedings. In these contexts, the focus shifts from private redress to public accountability (Mason & McCall Smith, 2019). Equally significant is the administrative law dimension. Licensing authorities and professional councils exercise statutory powers affecting registration, certification, suspension, and discipline. In Malaysia, these powers operate under statutes such as the Private Healthcare Facilities and Services Act 1998 [*Act 586*] and are guided by professional instruments issued by the Malaysian Medical Council (MMC, 2019a, 2019b, 2020). Courts have consistently emphasised that such decisions must comply with procedural fairness and proportionality (Pengarah Tanah dan Galian v Sri Lempah Enterprise, 1979; Sivarasa Rasiah v Badan Peguam Malaysia, 2010). These domains intersect within broader institutional governance. Healthcare organisations engage in statutory interpretation, regulatory drafting, and risk management as part of routine operations (Hood et al., 2001; Power, 2007). Seen in this way, medical law functions as a regulatory ecosystem rather than a discrete specialty. This ecosystem perspective provides the necessary foundation for analysing medico-legal expertise.

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Medical Speciality According to Malaysian Medical Law

In Malaysia, recognition as a medical specialist is a matter of statute rather than professional self-description. The Medical Act 1971 [*Act 50*] establishes the framework governing medical registration, discipline, and specialist recognition. The Malaysian Medical Council (MMC) is vested with authority to regulate standards of practice and the use of professional titles. Sections 14A to 14C of the Medical Act 1971 [*Act 50*], introduced by the Medical (Amendment) Act 2012 and brought into force on 1 July 2017, created the National Specialist Register (NSR). Registration on the NSR is a legal prerequisite for practising or holding oneself out as a specialist. Specialist status is therefore conferred only upon satisfaction of statutory criteria and formal entry into the Register.

Under Section 14B of the Medical Act 1971 [*Act 50*], eligibility requires full registration as a medical practitioner, completion of recognised specialist training, possession of an accredited qualification, and satisfaction of the MMC as to fitness and good character. The statutory model emphasises structured postgraduate training, supervised practice, and formal assessment within defined clinical disciplines. Specialisation, as conceived by the Act, is anchored in therapeutic decision-making and patient care. This framework carries regulatory consequences. The use of specialist titles is tightly controlled, and misrepresentation may attract disciplinary action under the MMC's Code of Professional Conduct. The underlying objective is public protection through clarity and accuracy in professional representation.

Importantly, the Act confines specialist recognition to the clinical domain. It does not extend to non-clinical forms of expertise, including regulatory interpretation, governance work, policy advisory roles, or medico-legal practice. Subsequent amendments, including the Medical (Amendment) Act 2024 [*Act A1729*], have refined the registration regime but have not altered this clinical orientation. The statutory structure therefore achieves two things. It protects the integrity of clinical specialist titles. At the same time, it leaves other legally consequential forms of medical expertise outside the recognition architecture. Medico-legal competence, however significant in practice, has no equivalent structured pathway.

This absence has educational implications. In Malaysia, specialist recognition is supported by structured postgraduate training pathways that are formally accredited and assessed under the Medical Act 1971. No equivalent statutory or regulatory pathway exists for medico-legal competence. While medical curricula commonly introduce legal and ethical principles within broader modules on professionalism, substantial variability exists in how these components are structured and assessed (Goldie, 2000; Lehmann et al., 2004). Professionalism teaching frequently integrates legal issues into general training frameworks rather than organising them as distinct postgraduate competencies subject to formalised assessment (Cruess et al., 2008). As a result, medico-legal competence is not typically validated through a standardised certification pathway. Without defined benchmarks or validated pathways, recognition of medico-legal competence remains informal and context-dependent. Determining when a practitioner has attained sufficient expertise therefore depends less on standardised criteria and more on institutional judgment.

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What is Medico-Legal Expertise? A Conceptual Definition

Medico-legal expertise is best understood as a function rather than a title. It refers to medical practitioners who apply clinical knowledge within legal, regulatory, and institutional decision-making contexts. Their task is to translate clinical facts into forms that courts, regulators, and healthcare institutions can use. This translation occurs within defined constraints, including relevance, scope, independence, and procedural fairness (Faigman et al., 2014). This functional orientation distinguishes medico-legal expertise from clinical practice as recognised under the Medical Act 1971 [*Act 50*]. Clinical expertise is directed toward diagnosis, treatment, and therapeutic decision-making within the doctor–patient relationship. Medico-legal expertise, by contrast, is directed toward accountability and institutional decision-making. It requires familiarity with evidentiary standards, administrative processes, and regulatory frameworks. The medico-legal expert does not determine liability or exercise statutory power. Rather, they assist decision-makers by providing independent and reasoned medical input within defined professional limits (Cane, 2011).

For analytical clarity, this paper distinguishes between two common modes of medico-legal engagement. The first involves practitioners whose roles are predominantly medico-legal or regulatory, with sustained involvement in advisory or governance contexts. The second involves practitioners who undertake medico-legal work alongside ongoing clinical practice within recognised specialties. These categories are descriptive rather than hierarchical. They illustrate differences in professional orientation and exposure to risk. Practitioners whose work is primarily medico-legal may develop substantial competence in regulatory interpretation and institutional processes but may face questions about clinical currency. Practitioners who remain clinically active may derive legitimacy from current practice yet may be expected to perform medico-legal functions without structured preparation in legal reasoning or governance principles. Legal and regulatory systems rely on both forms of engagement, often without clearly differentiating their scope. Recognising this distinction helps clarify how legitimacy is constructed and where governance vulnerabilities may arise. It provides the conceptual foundation for the comparative analysis that follows.

Comparative Assessment of Medico-Legal Expertise: Global Frameworks and Applications

Across jurisdictions, medico-legal expertise is rarely formalized through specialty recognition. Instead, legitimacy tends to emerge through a combination of evidentiary standards, ethical regulation, institutional appointment, and professional performance. The underlying logic is consistent. Medicine regulates clinical competence. Law regulates expert authority. Medico-legal legitimacy arises at their intersection and is defined by function rather than title. In common law systems, courts act as central gatekeepers. In the United States, the Daubert framework requires expert testimony to be both relevant and reliable, with judges assessing methodology and "fit" to the issues in dispute (Daubert v. Merrell Dow Pharmaceuticals, Inc., 1993). Medical credentials alone are insufficient. Expertise must be demonstrated in relation to the specific question before the court. Professional ethical standards reinforce this model by requiring experts to testify within their competence and to avoid advocacy (American College of Physicians, 2011).

Singapore adopts a similar approach. Expertise is defined through the law of evidence and assessed within the forum of the proceedings. Ethical rules tightly regulate professional self-representation, limiting misleading claims of expertise while preserving access to qualified

testimony (Singapore Medical Council, 2016). The system does not certify "medical law specialists." Instead, legitimacy is managed through conduct standards and evidentiary scrutiny. In many civil-law jurisdictions in Europe, medico-legal expertise is institutionalized through court-appointed experts. Expert status is procedural and linked to appointment rather than to a transferable professional credential (European Parliament, 2015). Experts function as auxiliaries to the court. They provide technical assessments, while legal interpretation remains with judges. This model reduces adversarial competition but may raise concerns about independence, particularly where appointments are repeatedly drawn from a limited pool (Cane, 2011).

Taking together, these systems reveal a common pattern. Mature jurisdictions avoid recognizing medical law as a formal specialty. Instead, they rely on procedural, ethical, and evidentiary constraints to manage legitimacy. The central governance question is therefore not whether to create a new title, but how to define scope, validate competence, and safeguard independence. Across legal systems, recognition of medico-legal expertise remains deliberately constrained. One constraint is the absence of formal specialist recognition. Although courts and regulators depend heavily on medical input, most jurisdictions avoid recognizing medical law as a medical specialty in order to preserve boundaries between the medical and legal professions (Herring, 2020; Mason & McCall Smith, 2019). This protects professional separation but leaves medico-legal expertise under-defined outside litigation.

A second constraint arises from judicial control over expert evidence. Courts determine who qualifies as an expert and whether testimony is admissible. Recognition is therefore case-specific rather than continuous. The focus is whether the evidence assists in resolving the dispute, not whether the practitioner possesses broader regulatory or governance experience (Daubert v. Merrell Dow Pharmaceuticals, Inc., 1993; Faigman et al., 2014). Expertise that is highly relevant in non-litigation contexts may therefore remain institutionally invisible. A third constraint concerns professional regulation of public representation. Ethical codes in jurisdictions such as Australia and Singapore restrict misleading claims of expertise (Medical Board of Australia, 2020; Singapore Medical Council, 2016). These safeguards protect the public, but they also limit how medico-legal competence can be communicated in the absence of recognized descriptors.

Finally, systems frequently rely on practitioners with differing professional orientations, some primarily clinical, others predominantly advisory without clearly articulating when each form of experience is most appropriate. In civil-law systems, reliance on a limited pool of court-appointed experts may further intensify concerns about independence (European Parliament, 2015). These recurring features demonstrate that the difficulty in recognizing medico-legal expertise is structural rather than jurisdiction-specific. They underscore the need for frameworks that clarify competence and responsibility while respecting professional boundaries and preserving judicial discretion.

Challenges in Recognising Medico-Legal Subject-Matter Expertise in Malaysia

Although medico-legal work plays a significant role in Malaysia's healthcare system, there is no structured mechanism for recognizing doctors as subject-matter experts in medico-legal matters. The difficulty does not lie in the absence of such work. Doctors routinely contribute to court proceedings, disciplinary processes, licensing decisions, and regulatory interpretation.

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The difficulty lies in the absence of governance mechanisms that make this expertise visible, assessable, and institutionally defensible.

Absence of Recognition Outside Clinical Specialization

Malaysia's professional recognition framework is centered on clinical specialization. Under the Medical Act 1971 [*Act 50*], advanced professional status is tied to structured postgraduate training and entry into the National Specialist Register. This architecture is designed to validate clinical competence. Medico-legal work does not fit within this structure. It is not a clinical discipline and does not involve therapeutic decision-making. Doctors who develop medico-legal competence therefore do so outside any recognized pathway. Their expertise may be substantial, but it has no formal institutional category. This creates what may be described as a recognition vacuum: competence exists, but there is no mechanism to validate or signal it.

Regulatory Sensitivity to Titles and Representation

Professional regulation further complicates recognition. The Malaysian Medical Council's Code of Professional Conduct and related guidance require doctors to avoid misleading representations of expertise. Advertising guidelines issued by the Ministry of Health similarly prohibit claims that may create unjustified expectations. These rules serve important consumer-protection functions. However, in the absence of recognized descriptors, doctors engaged in medico-legal work have limited means of signaling subject-matter competence. Any attempt to describe oneself as an "expert" risks scrutiny if not grounded in formally recognized credentials. The result is a paradox: medico-legal expertise is relied upon, but difficult to declare.

Reliance on Informal and Ad Hoc Recognition

In practice, medico-legal expertise is often recognized informally. Appointments may depend on reputation, institutional familiarity, or prior experience. While this may function adequately in individual cases, it lacks transparency and consistent criteria. Administrative law principles require public decision-making to be reasoned and defensible. When medico-legal opinions influence regulatory or enforcement outcomes, institutions must be able to justify why particular individuals were treated as experts. Informal recognition makes this difficult. It exposes decisions to challenge and undermines procedural clarity.

Misalignment Between Legal Exposure and Professional Preparation

Healthcare regulation in Malaysia operates within dense statutory frameworks. Laws such as the Private Healthcare Facilities and Services Act 1998 [*Act 586*] confer discretionary powers that are subject to judicial review. Courts have repeatedly emphasized that such powers must comply with procedural fairness and proportionality. Despite this legal exposure, medical training does not systematically prepare doctors for medico-legal reasoning as a recognized competency. Legal principles are often introduced within ethics or professionalism modules, but not developed into structured, assessed capabilities. As a result, medico-legal expertise develops unevenly. Recognition depends more on circumstance than on demonstrable standards.

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Fragmented Governance Instruments

Finally, medico-legal work is assessed against multiple overlapping instruments: statutes, professional codes, disciplinary procedures, and policy guidelines. While this layered approach allows flexibility, it does not aggregate medico-legal competence into a coherent framework. There is no integrated system for defining domains of expertise, setting benchmarks, or validating competence across contexts. This fragmentation makes it difficult to identify, compare, or deploy medico-legal subject-matter experts systematically.

These challenges are not incidental. They arise from a structural mismatch between Malaysia's specialty-centred recognition system and the functional nature of medico-legal work. So long as professional recognition remains tied exclusively to clinical specialization, medico-legal competence will remain informal and procedurally vulnerable. What is required is not the creation of a new specialty, but a governance framework that validates subject-matter expertise without distorting statutory boundaries. The following section proposes such a framework.

Establishing a Subject-Matter Authority Framework for Medico-Legal Expertise

The preceding analysis demonstrates that Malaysia's difficulty is not the absence of medico-legal work, but the absence of a structured mechanism for recognising and validating it. Comparative systems avoid treating medical law as a clinical specialty. Instead, they manage legitimacy through procedural, ethical, and evidentiary controls (Herring, 2020; Mason & McCall Smith, 2019). The diagnostic error, therefore, lies in assuming that specialist status would resolve recognition concerns. The problem is not insufficient title. It is insufficient governance. Malaysia's task is not to create a new specialty. It is to design a framework that makes medico-legal competence visible, assessable, and accountable without disturbing the statutory architecture of clinical specialisation. The proposal advanced here is a Subject-Matter Expert (SME) framework grounded in function rather than status.

Definition and Scope

Under this framework, a medico-legal SME is a medical practitioner who has demonstrated competence in defined medico-legal domains, such as expert evidence, administrative decision-making, regulatory interpretation, or healthcare governance. Recognition does not confer statutory authority or create a protected title. It operates as an administrative signal of competence aligned to specific tasks (Faigman et al., 2014). The purpose of recognition is limited. It clarifies scope. It signals capability. It does not elevate status or displace judicial discretion.

Validation, Re-validation, and Institutional Hosting

Recognition must replace informal and reputation-based selection with structured validation. This requires three elements: defined learning pathways, applied assessment, and periodic review. In Malaysia, the framework could be administratively hosted by the Academy of Medicine of Malaysia (AMM), potentially through a dedicated Chapter or Faculty developed in collaboration with the Medico-Legal Society of Malaysia (MLSM). Hosting within the AMM ensures institutional continuity and professional credibility while avoiding incorporation into the National Specialist Register. Validation should remain multidisciplinary. Input from legal academics, judges, regulators, and experienced practitioners would ensure that

assessment reflects both medical and legal competence. Recognition should be time-limited and subject to re-validation. This prevents stagnation and reinforces accountability.

Interaction with Judicial Gatekeeping

The SME framework does not bind courts. Under the Evidence Act 1950, judges retain authority to determine admissibility and weight of expert testimony. SME recognition creates no presumption of competence in litigation. Instead, it functions as an administrative aid. It assists institutions in identifying qualified practitioners for advisory or governance roles. It may serve as a capability signal in appointment processes. Judicial discretion remains intact.

Respecting the Legal Profession Boundary

The framework does not create a pathway to legal practice. It respects statutory separation between professions, including restrictions under the Legal Profession Act 1976 [*Act 166*]. Medico-legal SMEs do not interpret law authoritatively or provide legal representation. Their role remains explanatory and assistive. This preserves professional boundaries while enabling informed decision-making.

Functional Differentiation of Medico-Legal Expertise

The framework recognises that medico-legal engagement takes different forms. Practitioners whose roles are primarily governance-oriented may contribute to regulatory interpretation and institutional risk analysis. Clinically active practitioners may contribute to standards-of-care assessment and feasibility analysis. Recognition attaches to function rather than seniority. It clarifies which domain of expertise is validated. This prevents conflation of clinical reputation with medico-legal competence and enables more precise deployment of expertise.

Ethical Independence and Bias Control

Medico-legal work carries risks of partiality and "hired gun" dynamics. The framework should include a formal duty of independence. The SME's primary obligation is to the decision-maker, not to the instructing party. Operational safeguards may include written independence declarations, conflict disclosure, defined scope statements, transparent reasoning, and documentation of assumptions. These measures align with common law expectations of expert independence (National Justice Compania Naviera SA v Prudential Assurance Co Ltd (The Ikarian Reefer), 1993) and with judicial scrutiny of reliability (Daubert v. Merrell Dow Pharmaceuticals, Inc., 1993).

Transparency and Anti-Capture Safeguards

To prevent elite gatekeeping, eligibility criteria should be publicly available, and competency based. Access should be open to qualified practitioners. Recognition should be time-limited, with maintenance-of-recognition requirements. Appointment processes and scope determinations should be reviewable. These measures transform recognition from informal reputation into structured governance.

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The SME framework responds directly to the identified governance gap. It does not create a new specialty. It does not inflate titles. It does not encroach upon judicial or legal authority. Instead, it provides structured validation of competence within defined functional boundaries. By anchoring recognition in demonstrable capability, embedding independence safeguards, and preserving professional separation, the framework makes medico-legal expertise institutionally defensible without distorting Malaysia's statutory architecture.

Conclusion

The central problem addressed in this paper is the absence of a structured mechanism for recognising medico-legal expertise in Malaysia. Doctors perform legally consequential functions across courts, regulatory bodies, and healthcare institutions. Yet there is no formal pathway for validating or signalling competence in this domain. This gap produces uncertainty about legitimacy, scope, and accountability. The analysis has shown that this difficulty is structural rather than jurisdiction specific. Across legal systems, medical law is not treated as a clinical specialty. Instead, legitimacy is managed through evidentiary standards, ethical constraints, and institutional appointment. While this preserves professional boundaries and judicial independence, it leaves medico-legal competence under-defined outside litigation. The core insight of this paper is that the recognition problem is not one of missing specialist status. It is one of governance design. Medico-legal expertise is best understood as subject-matter competence exercised within legal and institutional constraints. When governance systems fail to define scope, validate competence, and manage risks such as bias, ambiguity emerges. The proposed Subject-Matter Expert (SME) framework responds directly to this governance gap. It introduces structured validation, time-limited recognition, defined scope of practice, and formal independence obligations. It preserves judicial discretion. It respects the statutory separation between the medical and legal professions. Most importantly, it makes medico-legal competence visible and reviewable without creating a new specialty or distorting the National Specialist Register (NSR) currently present. Effective regulation of medico-legal expertise does not depend on title creation. It depends on institutional mechanisms that clarify function, enforce accountability, and safeguard independence. By shifting the focus from status to competence, the framework offers a legally coherent and administratively defensible path forward within Malaysia's existing statutory architecture.

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