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Research Article

A Legal Analysis of Medical Malpractice in the Indonesian Legal System

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Abstract

This study examines the legal phenomenon of medical malpractice in the Indonesian legal system. The background is based on the need for legal certainty, patient protection, and certainty of responsibility of medical personnel and health care facilities in the event of alleged negligence. The study aims to (1) map the regulation of medical malpractice in Indonesian laws and regulations and (2) analyze the legal provisions that can be applied when malpractice occurs. The method used is normative legal research with a statutory approach , a conceptual approach, and case studies. Primary legal materials include the Law on Medical Practice, the Hospital Law, the Health Law , and implementing regulations related to informed consent and the obligation to make medical records; secondary legal materials are obtained from literature and relevant research results. The results of the study indicate that legal responsibility for alleged medical malpractice is spread across three regimes: (a) civil—through therapeutic relationships and unlawful acts, including hospital responsibility for negligence of health workers; (b) criminal—based on the element of negligence (culpa) that results in consequences for the patient in accordance with statutory provisions ; and (c) administrative/disciplinary including compliance with professional standards and standard operating procedures, the obligation to have a STR/SIP, the creation of medical records, and the application of professional disciplinary mechanisms. The role of informed consent and the completeness of medical records occupy a central position in proving

Introduction

In practice, doctors and dentists play a central role as the frontline providers of care. Medical practice is regulated to ensure patient protection while maintaining quality of care. Law Number 29 of 2004 concerning Medical Practice mandates that all medical procedures be based on service standards, performed by authorized and registered personnel, accompanied by informed consent, and documented in medical records. Consent, granted after adequate explanation to the patient, is an ethical and legal prerequisite for any procedure, while medical records serve as legal evidence and a patient safety instrument.

On the other hand, hospitals, as healthcare facilities, are obligated to implement safe clinical and managerial governance. Positive law places hospitals under legal responsibility for losses arising from the negligence of

their healthcare personnel. Consequently, quality management and patient safety, including incident reporting, learning from incidents, and continuous improvement, are inseparable from the institution's legal obligations.

Despite the development of technical regulations (for example, regarding consent for procedures and medical records, as well as patient safety programs in hospitals), Indonesia does not yet have a specific law that comprehensively defines "malpractice" along with its limitations and evidentiary criteria. As a result, the handling of alleged malpractice cases is spread across several regimes: (i) civil—through breach of contract or unlawful acts; (ii) criminal—through negligence resulting in serious injury or death; (iii) administrative—through licensing/professional development and sanctions; and (iv) a professional disciplinary mechanism through the Indonesian Medical Discipline Honorary Council (MKDKI). This fragmentation often gives rise to the public perception that every poor clinical outcome is synonymous with malpractice, even though legally it requires proof of negligence, loss, and a sufficient causal relationship.

Hypothesis Development

(1) Informed consent requires adequate explanation of the diagnosis, treatment plan and risks, alternatives, and prognosis; and in emergency situations, life-saving/disability-causing measures may be taken without formal consent.
(2) Complete, timely, and traceable medical records (including electronic ones) serve as evidence of clinical processes and clinical communication. Compliance with these two instruments is crucial for assessing standards of care and quality of care.

The four regimes—civil, criminal, administrative, and disciplinary—can operate in parallel with different emphasis. For example, in cases of alleged surgical negligence, hospitals can be held liable based on vicarious liability; medical personnel are assessed based on disciplinary and professional standards; while criminal proceedings are only appropriate if clear elements of a crime (culpa) are met. Documentation coherence (medical records), procedural compliance (informed consent), and patient safety governance serve as bridges connecting these four regimes.

Several challenges that are apparent in the field include: (i) the absence of a single definition of "malpractice" in statutory regulations, so that handling remains cross-regime; (ii) a high burden of proof on causality and professional standards; (iii) the quality of clinical documentation that is not yet uniform, especially in the transition to electronic medical records; and (iv) public understanding that often equates all undesirable clinical outcomes with malpractice. On the other hand, strengthening patient safety through national standards and the obligation of hospitals to implement patient safety programs are crucial prevention instruments.

Enforcement Route Map

(1) Discipline Channel: complaints to MKDKI for assessment of disciplinary violations and professional sanctions;
(2) Administrative Channel: guidance/supervision by professional and health regulators regarding STR/SIP and facility compliance;
(3) Civil Channel: claims for damages based on breach of contract or unlawful acts;
(4) Criminal Channel: reporting to law enforcement if the elements of a crime are met. The synergy of channels and the selection of the appropriate path depend on the facts, clinical evidence, and recovery goals.

Method

1) Statute approach by examining the 1945 Constitution, Law 29/2004 concerning Medical Practice, Law 44/2009 concerning Hospitals, Law 17/2023 concerning Health, the Criminal Code, the Civil Code, and implementing regulations (e.g. related Ministerial Regulations).

2) Case approach by tracing relevant court decisions and/or ethical/disciplinary body decisions (e.g. MKDKI) to understand the application of norms.
3) Conceptual approach through exploring the doctrines regarding "malpractice", negligence (culpa), professional standards, informed consent, and legal responsibility (civil-criminal-administrative-disciplinary).
4) (If necessary) A limited comparative approach is used to enrich the argument by comparing concepts/standards from other relevant literature or jurisdictions. The scope of the material is limited to the legal regulations and accountability related to alleged medical malpractice in the Indonesian legal system. The main unit of analysis is norms (statutory regulations and legal principles), supported by court decisions, as well as recognized professional guidelines/standards. The temporal limitation is directed at the current legal regime, with special attention to updates through Law 17/2023. The collection was carried out through literature studies and systematic searches of official databases (JDIH, judicial websites, ministry/institutional pages) and scientific databases. The keywords used include: “malpractice/medical malpractice”, “medical negligence”, “informed consent”, “medical professional standards”, “hospital responsibility”, “Law 29/2004”, “Law 17/2023”, “Law 44/2009”, “Criminal Code Articles 359–361”, “Civil Code Articles 1365/1366”. The search results are inventoried in a concise table (title, number/year, source, main content) to facilitate systematization.

Results and Discussion

Result

a) Criminal Code (general regime). Negligence resulting in death (Article 359) or serious injury (Article 360) can be prosecuted; if committed while carrying out a position/work, the criminal threat can be aggravated (Article 361). However, the application of these articles to medical practice must take into account professional standards, the medical risks that can occur even if SOPs are followed, and the principle of reasonable care (lex artis).
b) 2023 Health Law (special regime). The latest Health Law emphasizes the obligation to provide assistance in emergencies and prohibits the refusal of services that result in death or disability. Criminal acts involving negligence by medical personnel/health workers resulting in death (or injury) are regulated as special offenses in the health sector, with separate criminal penalties. This special regulation serves as a current reference beyond the Criminal Code and should be read in conjunction with Government Regulation 28/2024, which serves as implementing regulations regarding practice standards, legal protection, and guidance.
c) Corporate liability. Under certain circumstances, healthcare facilities as legal entities may be held criminally liable (for example, when systemic policies/management lead to safety standard violations).

Consumer Protection in Healthcare Services As recipients of services, patients are also protected by the Consumer Protection regime: the right to correct information, the right to security/safety, and the right to compensation/redress if they suffer losses due to the services provided. This provision strengthens the basis for claims for compensation and places a certain burden of proof on service providers, as long as it is in accordance with the special nature of healthcare services (which are profession-based and risky). Key Documents for Proving Medical Disputes

a) Complete, chronological, and signed medical records (including electronic) must be complete.
b) Informed consent forms that comply with procedures, especially for high-risk procedures.
c) Evidence of implementation of professional standards/SOPs, including patient safety checklists, action notes, evidence of internal audits, and incident reporting (if any).
d) Evidence that emergency obligations have been met (triage, stabilization, timely referral).
e) Internal policies and HR training that demonstrate managerial due care (coaching, supervision, competence).

Key Principles for Assessing “Malpractice”

a. Lex artis: are the actions in accordance with professional standards, SOPs, and current guidelines?
b. Duty of care: is the duty of care met, including risk communication and informed consent?

c. Causation: was the patient harm a direct/foreseeable result of the standard violation (not an unavoidable medical risk)?
d. Documentation: are medical records/IC/administrative evidence adequate?
e. System vs individual fault: whether the failure occurred due to the system (managerial) or the individual is relevant to distinguishing sanctions and responsible parties.

Discussion

(1) Professional discipline (MKDKI) assesses disciplinary violations; (2) Administrative oversees licensing, standards, medical records, patient safety; (3) Civil law provides a compensation mechanism based on breach of contract/PMH (including vicarious liability); (4) Criminal law punishes negligence that has serious consequences or special offenses in the health sector; (5) Hospitals bear legal responsibility for the negligence of health workers under them; (6) The Consumer Protection Regime strengthens patients' rights to information, security, and compensation.

Conclusion

1. Medical malpractice regulations in Indonesia have not been codified in a specific law that comprehensively defines "malpractice." Its handling is spread across several legal regimes: professional disciplinary, administrative, civil, and criminal. This situation implies the need for cross-regime mapping in each case to determine the most appropriate resolution.
2. Within the professional disciplinary regime, the Indonesian Medical Disciplinary Honorary Council (MKDKI) serves as an ethical and scientific forum for assessing disciplinary violations by physicians and dentists. This process is separate from but can run parallel to civil and criminal proceedings. This channel is crucial for assessing compliance with professional standards and clinical competence.
3. In an administrative regime, formal and material compliance with medical practice forms the basis of accountability: mandatory registration and practice permits; implementation of service standards and standard operating procedures; informed consent; and complete medical records (including electronic medical records/EME). Administrative violations can result in sanctions in the form of guidance/enforcement and serve as key evidence when disputes enter civil/criminal courts.
4. In the civil law regime, liability can be sought through breach of contract (breach of the therapeutic contract) and/or tort (PMH) due to negligence. The elements tested include duty, breach of standard (lex artis), actual loss, and causal relationship. Hospital liability can arise from both vicarious liability (the actions of healthcare workers) and corporate liability (failure of the managerial system).
5. In the criminal regime, the crime of negligence (culpa) resulting in serious injury or death remains the general reference; in addition, there are specific crimes in the health sector that emphasize the obligation to provide emergency assistance and criminal sanctions for negligence by medical/healthcare personnel. Criminal penalties must be applied carefully to ensure that differences in clinical judgment that are within the standard are not immediately criminalized.
6. Two documentation instruments—informed consent and medical records—are central to assessing due care, risk communication, and standards compliance. EMR strengthens audit trails, data integrity, and traceability of clinical processes, contributing to legal certainty and patient safety.
7. Patient safety programs in healthcare facilities are a pillar of dispute prevention: incident reporting, root cause analysis, and continuous improvement minimize the opportunity for standards violations to occur while strengthening the evidentiary position when disputes arise.
8. Overall, the existing legal framework provides a relatively comprehensive set of accountability tools in each regime. The main challenges lie in (i) the burden of proof for causality and professional standards; (ii) the quality of clinical documentation; (iii) variations in public understanding of adverse clinical outcomes versus malpractice; and (iv) inter-agency coordination when parallel resolution pathways are pursued.
9. The practical implications of this research are the need to harmonize and strengthen the implementation of: (a) the development of national operational guidelines for lex artis and standards of evidence for health cases; (b) optimization of RME, patient safety, and continuing education and certification; (c)

strengthening risk management and professional insurance; and (d) the use of medical mediation/ADR before litigation to accelerate recovery and reduce the burden on the judiciary.

10. Going forward, further studies are recommended to examine the latest jurisprudence and implementation of Law 17/2023 and its implementing regulations in the context of medical disputes, including the impact of RME integration on evidence, in order to produce sharper and more applicable policy recommendations for medical personnel, hospitals, regulators, and patients.

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