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Revisiting The Legal Implications of Medical Malpractice : A Case Study in Indonesia

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Abstract: Medical malpractice presents complex legal and ethical challenges in Indonesia and worldwide. This expanded analysis delves into Indonesia's current malpractice framework – examining how criminal, civil, and professional regulations intersect – and provides a richer discussion of its shortcomings and recent reforms. Comparative case studies from the United States, United Kingdom, Australia, Japan, and Sweden offer international perspectives, highlighting a spectrum from faultbased tort litigation to nofault compensation systems. We incorporate relevant data, including claim frequencies and compensation costs, and present tables to contextualize Indonesia's experience against global trends. Based on these analyses, the discussion proposes specific, actionable reforms for Indonesia, emphasizing improved patient compensation mechanisms, strengthened professional oversight, and legal adjustments to balance deterrence and fairness. The recommendations aim to foster a more coherent, efficient, and just system for addressing medical errors. By integrating comparative insights and evidence, this article provides an academic yet practical roadmap for legal and healthcare stakeholders in Indonesia to reform medical malpractice policy.

Keyword: Medical Malpractice, Legal Reform, Patient Compensation.

INTRODUCTION

Medical malpractice – defined broadly as professional negligence by act or omission by a health care provider that causes harm to a patient – is a critical issue at the intersection of healthcare and law. Worldwide, malpractice liability systems strive to compensate injured patients and deter negligence by providers, but they often struggle to achieve these goals efficiently. Traditional tortbased litigation has been widely criticized as inefficient, costly, and unfair to both patients and physicians. High litigation expenses, protracted legal processes, and inconsistent outcomes can leave patients uncompensated and doctors practicing defensive medicine. For example, in the United States the fear of lawsuits has contributed to "high cost and defensive health service delivery", as physicians order extra tests or procedures primarily to avoid liability. On the other hand, alternative approaches such

as nofault compensation have emerged in some countries to address these concerns, trading some degree of legal deterrence for efficiency in compensating patients.

In Indonesia, the issue of medical malpractice has gained prominence due to several highprofile cases and growing public awareness of patients' rights. The legal landscape in Indonesia is unique, as it blends elements of civil, criminal, and administrative law in addressing malpractice. Patients and their families have at times resorted to the criminal justice system to seek redress, leading to doctors being prosecuted under general criminal provisions for negligence. At the same time, civil lawsuits for compensation are possible under Indonesia's civil code and contract law (the concept of "therapeutic contract" or Perjanjian Terapeutik frames the doctorpatient relationship as an agreement of besteffort). Additionally, professional bodies like the Indonesian Medical Disciplinary Board (MKDKI) handle ethical breaches and have authority to impose disciplinary sanctions on practitioners. This multifaceted system has, however, been criticized for lacking coherence and clarity, often leaving both patients and doctors unsure of their rights and obligations.

The need to revisit the legal implications of medical malpractice in Indonesia is underscored by recent developments. New legislation – notably Law No. 17 of 2023 on Health – has been enacted to improve the resolution of medical disputes through mediation and to incorporate a more restorative justice approach. This law aims to prevent cases from immediately escalating to court by mandating that professional honor councils review allegations of malpractice before criminal charges can proceed, ensuring that expert medical assessment informs legal action. Such reforms signal a recognition that the prior system was inadequate in protecting patients' rights while also being fair to medical professionals.

This article provides a comprehensive analysis of Indonesia's medical malpractice framework and its implications, and expands the perspective by comparing it with international practices. We will first outline the legal framework for medical malpractice in Indonesia, including relevant laws, procedures, and a case study illustrating current challenges. We then present comparative case studies from the United States, United Kingdom, Australia, Japan, and Sweden – countries that offer a crosssection of malpractice system models from adversarial tort litigation to nofault compensation schemes. Data and tables are included to highlight key differences, such as the frequency of claims and the scale of compensation in each jurisdiction. In the discussion, we synthesize these insights to identify strengths and weaknesses in Indonesia's approach, and how international experiences can inform improvements. Finally, the recommendations section proposes specific reforms – legal, institutional, and practical – to enhance patient protection and healthcare quality in Indonesia, while ensuring fairness and accountability for medical professionals. The goal is a more integrated and effective malpractice resolution system that learns from global best practices yet is tailored to Indonesia's social and legal context.

Medical Malpractice in Indonesia: Legal Framework and Challenges

Legal Definition and Scope: Indonesian law does not provide a singular, explicit definition of "medical malpractice." Instead, malpractice is understood through various legal provisions covering civil negligence, criminal negligence, and professional misconduct. An early reference point is Law No. 6 of 1963 on Healthcare Workers, which generally describes malpractice as a breach of professional obligations – essentially failing to do something that should have been done, resulting in harm. However, this law is broadly framed and offers only a rudimentary overview. In practice, more specific statutes and regulations govern the consequences of malpractice. Key among these are Law No. 36 of 2009 on Health and Law No. 29 of 2004 on Medical Practice, as well as the Indonesian Medical Association's Kodeki (Code of Ethics). These laws collectively establish duties for healthcare providers (such as obtaining informed consent, maintaining medical records, and holding proper licenses) and attach sanctions for various failures. For example, Law 36/2009 contains provisions where

certain severe failures (unrelated to routine negligence but still illustrative of legal expectations) – like refusing to provide emergency aid, or conducting unauthorized medical procedures – can carry criminal penalties including imprisonment and fines. Law 29/2004 provides administrative and criminal penalties for practicing without a license or serious violations of professional standards. Yet, none of these explicitly delineate the standard of care or negligence threshold for typical malpractice scenarios (e.g. a surgical error or diagnostic mistake). Consequently, courts and prosecutors have often resorted to general provisions of the Indonesian Penal Code (KUHP) to handle cases of alleged medical negligence causing harm.

Criminal Liability and the Use of Penal Code Articles: A distinctive aspect of Indonesian malpractice handling is the potential criminalization of medical errors. Under the Penal Code, Article 359 KUHP stipulates that anyone whose negligence causes the death of another can be subjected to criminal punishment. This article, a relic of general criminal law, has been applied to doctors in instances of patient death allegedly due to negligence. For instance, in a notable Supreme Court case (Verdict No. 365K/Pid/2012), a physician was prosecuted and initially acquitted at trial, but upon appeal the Supreme Court found the doctor guilty under Article 359 for a patient's death. This set a controversial precedent. Legal scholars argue that applying Article 359 – a generic negligence law – to medical contexts is often inappropriate, because medical adverse outcomes are complex events not always fitting the simplistic "causeeffect" negligence model used in ordinary accidents. In the 2012 case, the Supreme Court's conviction was criticized as irrelevant and lacking causation, since the link between the doctor's alleged administrative lapse and the patient's death was not clearly established. Critics note that criminalizing medical errors in this way can "violate human rights and deny proper legal basis" in malpractice cases, essentially punishing doctors under an illfitting statute. Despite these concerns, the threat of criminal charges has loomed over Indonesian healthcare: when a poor outcome occurs, families sometimes file police reports, and investigations under Article 359 (or Article 360 for negligence causing injury) may follow. This creates an atmosphere of fear among medical practitioners and arguably encourages defensive practices, similar to the feardriven defensive medicine seen in the U.S. but with the added specter of criminal liability.

Civil Liability and Patient Compensation: On the civil side, patients in Indonesia can seek compensation through lawsuits based on tort (under Article 1365 of the Civil Code on unlawful acts) or breach of contract (the therapeutic agreement between patient and provider). However, civil malpractice litigation has been relatively infrequent and faces substantial hurdles. Patients often lack access to expert evidence to establish a doctor's deviation from the standard of care, and procedural delays can be significant. Moreover, because many patients are not fully aware of their legal rights or find litigation costly and slow, the civil justice route is seldom the first choice. In many cases, disputes are settled internally by hospitals or mediated informally, sometimes with modest ex gratia compensation to the patient's family. Data on civil malpractice suits are not centrally collected, but available indicators suggest the number of successful malpractice claims in court is very low relative to Indonesia's population. For example, over a nineyear span (2006–2015), the Indonesian Medical Council – which also receives complaints – recorded only 317 alleged malpractice cases submitted for review. This figure (roughly 35 cases per year on average) reflects cases reported through official channels and is strikingly low for a country of over 250 million people, indicating that most incidents either go unreported or are handled outside formal legal processes. Indeed, many patient grievances arise from miscommunication or unmet expectations rather than clearcut professional negligence. These often do not escalate to lawsuits when clarified through dialogue.

Role of Professional Councils and Disciplinary Actions: In Indonesia, professional selfregulation plays an important role in malpractice issues. The Medical Ethics Honor

Council (MKEK) addresses ethical violations, and the Medical Discipline Honor Council (MKDKI) examines cases of alleged professional misconduct or malpractice. These bodies can investigate complaints and impose sanctions like reprimands, license suspensions, or revocations for malpractice or ethical breaches. However, their authority is administrative; they do not directly provide patient compensation. The MKDKI's findings can influence legal proceedings – for instance, a clear determination of malpractice by MKDKI might support a patient's civil case or prompt hospital accountability. Historically, there was a disconnect: a doctor could be acquitted in court but still face MKDKI discipline, or vice versa. To better integrate these processes, Law No. 17/2023 introduced a significant reform: healthcare workers accused of negligence must first be evaluated by the appropriate honor council before any criminal process. Under this new system, if the council (MKDKI for doctors) finds that negligence occurred and harmed the patient, it will recommend the case be forwarded for prosecution. This effectively means that professional peer review is now a gatekeeper for criminal malpractice charges, ensuring that medical experts assess whether an adverse outcome was due to a true breach of the standard of care or just an unfortunate complication. The aim is to prevent unjust criminalization of doctors for bad outcomes that were not due to negligence, while still allowing serious malpractice to be punished. It is a step toward aligning Indonesia's approach with practices in countries where independent medical review or medical malpractice tribunals play a role in adjudicating such disputes.

Mediation and "Penal Mediation" Efforts: Another notable feature in Indonesia has been the exploration of mediation as a tool to resolve malpractice disputes, even in the context of criminal cases. Penal mediation (mediasi penal) refers to the process of resolving a criminal matter by mutual agreement of the parties (withdrawing charges in exchange for compensation or remedial actions). In the malpractice context, this approach has gained traction as a culturally palatable means to achieve reconciliation and compensation without a lengthy court battle. Research indicates that criminal mediation has been used as an effective alternative to settle malpractice cases "fairly and quickly" for both sides. Through this process, the patient (or family) and the healthcare provider come to a negotiated settlement – often involving a monetary payment or an apology – and the criminal complaint is dropped. While this can provide speedy relief and reduce antagonism, it raises concerns about consistency and justice. It is crucial that such settlements fully respect the rights of the victim and are not coercive. Scholars argue that Indonesia should strengthen human rights protections in penal mediation, for example by ensuring that victims are truly heard and that any agreement is equitable. The involvement of impartial mediators and competent legal counsel for both parties is recommended to make sure that victims do not feel pressured to accept insufficient remedies and that doctors are treated fairly. Interestingly, the concept of penal mediation for malpractice is not common in many other countries – the United States, for instance, lacks any federal statute on criminal mediation in malpractice cases. Thus, Indonesia's inclination toward outofcourt settlement reflects both local legal culture and necessity, given the drawbacks of formal litigation. Under the new Law 17/2023, mediation is formally emphasized as the primary step in medical dispute resolution. Hospitals and providers are encouraged to use mediation to address complaints at an early stage, aligning with the law's restorative justice spirit. This move is expected to reduce the adversarial nature of disputes and provide remedies more amicably, though its success will depend on implementation details and the goodwill of all parties.

Current Challenges: Despite these evolving mechanisms, significant challenges remain in Indonesia's malpractice system. One challenge is the lack of a dedicated medical malpractice statute or court, which means cases are handled in general courts that may not have specialized knowledge. Judges must rely on expert witnesses (often from the forensic medical association or hospital peers), which can lead to inconsistent outcomes. Another challenge is underreporting and data scarcity – without mandatory reporting of adverse events

or centralized claims data, it is difficult to gauge the true scale of malpractice in Indonesia or to identify systemic problems that need addressing. The low number of officially recorded cases (e.g., 317 over nine years to MKDKI) likely underestimates the incidence of malpractice or patient harm. Cultural factors also play a role: patients may be reluctant to accuse doctors, and there is still a somewhat paternalistic doctorpatient dynamic (as was historically the case in Japan) where raising a legal dispute is seen as taboo. Additionally, when compensation is obtained through mediation or outofcourt settlements, it often remains confidential and potentially inadequate, as there are no standard compensation guidelines. Victims of malpractice can thus end up with very disparate outcomes – some may get a settlement, others nothing at all if they do not pursue a case.

Another pressing issue is the absence of malpractice insurance coverage for many doctors and hospitals. While major hospitals may insure against liability, many individual practitioners do not carry personal malpractice insurance, partly because it has not been legally required nor widely practiced in Indonesia. This means if a court does award significant damages to a patient, the ability of the patient to actually recover that compensation from an individual doctor can be limited (unless the doctor is wealthy or the hospital is vicariously liable). This stands in contrast to countries like the U.S., where malpractice insurance is standard, or the U.K., where the state (NHS) effectively covers claims. The financial risk of malpractice litigation in Indonesia thus weighs heavily on providers and, conversely, the financial recovery for patients is uncertain.

In summary, Indonesia's legal framework for medical malpractice is in a state of transition. The system has historically oscillated between underenforcement (few civil claims) and overenforcement (harsh criminal charges). Recent reforms such as Law 17/2023 aim to strike a better balance by using mediation and expert review to filter cases. The following section will broaden the perspective by examining how other countries handle similar issues. These comparative insights will help illuminate how Indonesia might further refine its approach to achieve a more just and effective malpractice resolution system.

International Perspectives: Comparative Case Studies

Medical malpractice is a global concern, yet countries address it through vastly different legal and administrative frameworks. This comparative analysis explores the systems in the United States, United Kingdom, Australia, Japan, and Sweden, highlighting how each model reflects national values, institutional capacities, and policy priorities. These systems offer lessons for Indonesia as it considers reforms to its predominantly punitive approach.

1. United States: Tort Litigation and HighStakes Jury Trials

   The U.S. system is highly adversarial and rooted in statelevel tort law, requiring the injured party to prove provider negligence in civil court—often with a jury trial.

   a) High Frequency of Claims: Roughly 7.4% of U.S. physicians face malpractice claims annually. Lifetime risk is as high as 99% for highrisk specialties like surgery.
   b) Expensive and Litigious: The system costs around \$55.6 billion annually, including payouts, legal fees, and defensive medicine (unnecessary procedures done to prevent lawsuits).
   c) High Payouts and Juries: Average paid claims approach \$485,000, with some jury verdicts reaching tens of millions (later reduced). Most claims settle; few go to trial.
   d) InsuranceDriven: Physicians carry costly malpractice insurance, especially in highrisk regions and specialties.
   e) Reforms Exist but Limited Impact: Some states have implemented damage caps, statutes of limitations, and pretrial expert certification, but the fundamental tort structure remains.

The U.S. model provides deterrence and legal empowerment for patients, yet is widely criticized for inefficiency, inequality, and exorbitant costs. Many injured patients never sue, while many lawsuits lack proven negligence.

2. United Kingdom: NHSFunded Claims and Administrative Resolution

In contrast, England (as part of the UK) handles malpractice through a centralized public model under the National Health Service (NHS). Claims are processed administratively by NHS Resolution rather than through personal lawsuits against individual doctors.

a) Managed by NHS Resolution: Claims are investigated and negotiated by a state body representing NHS hospitals and providers.
b) No Juries, JudgeBased Decisions: Civil cases are adjudicated by judges using legal precedent, leading to faster, less adversarial, and more predictable outcomes.
c) Rising Costs, Moderate Payouts: Around 13,784 claims were filed in 2023/24, costing £2.8 billion, with 19% spent on legal fees. Damages are compensatory only—no punitive damages.
d) "Loser Pays" Rule: Losing parties must cover the winner's legal fees, discouraging frivolous claims. This contrasts sharply with the U.S., where each side usually pays its own fees.
e) Caps and Early Settlement: Recent laws cap pain and suffering compensation to \~£30,000 in noncatastrophic cases. The system emphasizes candor and apologies to resolve issues early.

Though the UK model is more efficient and less confrontational, it faces sustainability challenges. Future liabilities for the NHS now exceed £58 billion, sparking policy discussions about how to enhance safety and manage rising compensation costs.

3. Australia: Tort Reform and Structured Compensation

Australia operates under a common law tort system, but a medical indemnity crisis in the early 2000s prompted major reforms to stabilize insurance markets and control costs. Today, the country sees around 2,000 private sector malpractice claims annually—far fewer than in the U.S.—partly due to a "loser pays" rule and emphasis on pre-trial mediation.

Key reforms include caps on non-economic damages (e.g., AU\$600,000 in NSW), injury severity thresholds, structured settlements, and clearer negligence standards under Civil Liability Acts. The federal government also supports high-cost claims through subsidy schemes like ROCS.

Although not a full no-fault system, Australia introduced targeted no-fault compensation for birth injuries and promotes alternative dispute resolution and apology laws. These changes created a more predictable, stable system that balances patient rights with insurer viability.r

However, experts argue that further reforms are needed to better serve victims and reduce dependency on litigation. While the current system improves efficiency and reduces speculative lawsuits, it may still fall short in delivering timely and holistic support for all injured patients.

4. Japan: Hybrid Approach and Low Litigation Rates

Japan's medical malpractice system reflects a culture of restraint, limited legal infrastructure, and a cautious shift toward greater transparency and patient rights. Historically, litigation rates have been remarkably low—fewer than 1,000 cases annually in a country of 125 million. In 2020, only 674 cases were closed, largely due to cultural deference to doctors, a shortage of medical malpractice lawyers, and a legal process seen as slow and burdensome.

To address these limitations, Japan introduced several reforms. Medical Alternative Dispute Resolution (ADR) centers were established in 2007 to mediate cases outside

court. In 2009, a no-fault compensation scheme for cerebral palsy cases was launched, leading to a sharp decline in OB/GYN lawsuits. Courts began to more strictly enforce informed consent, and in rare, high-profile cases, criminal charges were filed against doctors. Additionally, the 2015 Medical Accident Investigation System now mandates objective, third-party reviews of serious medical incidents.

Japan's system shows that malpractice can be addressed with minimal litigation by combining cultural values with administrative innovation. However, underreporting remains an issue, and reforms continue to seek a better balance between protecting providers and ensuring justice for harmed patients.

5. Sweden: Comprehensive NoFault Patient Compensation

Sweden offers a leading example of a no-fault medical malpractice system, where patients are compensated for avoidable injuries without needing to prove provider negligence. Under the Patient Insurance Act of 1997, all healthcare providers must carry patient injury insurance, with most claims handled by Löf, a publicly owned insurer.

The process is non-adversarial: expert reviewers assess whether the injury could have been avoided under optimal care, without assigning personal blame or legal fault to doctors. As a result, approximately 9,000–10,000 claims are filed annually—among the highest per capita globally—with about 45–50% resulting in compensation

Payouts are moderate and standardized, covering medical costs, lost income, and pain and suffering. Legal costs are minimal, and most patients navigate the process without needing a lawyer. Although some critics argue that a no-fault approach weakens individual accountability, Sweden addresses this through robust peer review systems, institutional quality improvement, and system-level safety incentives.

Ultimately, Sweden's model prioritizes swift, equitable, and affordable compensation. It reduces the burden of litigation and fosters a healthcare environment focused on learning and patient support, even if it limits the potential for large individual settlements.

RESULTS AND DISCUSSION

The comparative review above reveals wide variation in how societies handle medical malpractice, each with its own benefits and drawbacks. Indonesia's approach to date – a mix of criminal law application, sporadic civil litigation, and professional discipline – appears fragmented and often ineffective in serving the dual goals of malpractice policy: compensating injured patients and promoting safer medical practice. By reflecting on the international models, we can identify specific areas where Indonesia's system could be reformed and improved. Several key themes emerge from this analysis:

1. Compensation Mechanisms and Patient Rights: A fundamental observation is that Indonesia lacks a reliable compensation mechanism for malpractice victims. In the U.S. and UK, despite their flaws, a patient who is truly harmed by negligence has a path to obtain monetary redress – via courts or via a statebacked claims process – and providers (or their insurers) have the financial capacity to pay. In Sweden, even patients harmed by nonnegligent adverse events have access to compensation through nofault insurance. In Indonesia, however, if a patient is injured by a medical error, their prospects for compensation are uncertain. Unless the case becomes highprofile (prompting the hospital or doctor to pay a settlement to avoid criminal charges or media scandal), the patient might receive nothing at all. The data showing only \~35 reports per year to the Medical Council belies a likely larger number of injurious incidents that go uncompensated. This is a major justice gap. International experience suggests the need for a more structured patient compensation system. For example, Indonesia could consider establishing a mandatory medical malpractice insurance scheme or a patient compensation fund. Such a fund – potentially modeled after Sweden's or a modest version thereof – would allow patients to file claims and receive compensation for avoidable medical injuries without

proving criminal negligence. This would alleviate the current overreliance on criminal law as a proxy for patient justice. It would also align with the restorative approach in Law 17/2023, giving victims a straightforward route to relief. Admittedly, a national nofault scheme might be financially and administratively ambitious for Indonesia in the short term, but even a pilot program focusing on specific highimpact injuries (for instance, birth injuries or surgical accidents) could demonstrate the benefits, much as Japan's obstetric nofault program did by sharply reducing litigation and quickly aiding affected families.

2. Deterrence and Accountability: Shifting away from criminalization raises concerns about maintaining accountability. One reason families go to the police after a malpractice incident in Indonesia is the perception that otherwise the provider "gets off scotfree." The comparative analysis shows different ways to ensure accountability: In the U.S., deterrence is primarily via fear of liability and large payouts, though this also leads to defensive practices. In the UK and Australia, accountability is achieved through robust civil claims and also professional regulation – a doctor who is repeatedly negligent can be disciplined or even lose their license, and hospitals face budgetary pressure to avoid lapses due to the litigation cost. Sweden's nofault model relies on systemic accountability: transparency of errors, peer review, and the idea that healthcare institutions will improve to reduce claim rates even if individual doctors aren't sued. For Indonesia, a calibrated approach could involve strengthening the role and transparency of the MKDKI (Medical Disciplinary Board) and MKEK (Ethics Council). These bodies should be empowered and resourced to investigate incidents thoroughly and impose sanctions on providers who commit gross or repeated malpractice. The new requirement of council review before prosecution is a positive step; it should ensure that only truly blameworthy cases enter the criminal realm, while most issues can be handled via professional or civil channels. To bolster public trust, the outcomes of disciplinary actions (e.g., number of doctors sanctioned, types of violations) should be published in an anonymized annual report. This mirrors practices in places like the UK, where the General Medical Council publicizes when doctors are struck off or suspended for incompetence, signaling that the profession does hold its members accountable outside of lawsuits.
3. Reducing Adversarial Conflict – the Role of Mediation and ADR: A striking commonality in progressive systems is the use of mediation and alternative dispute resolution to resolve cases without courtroom battles. Indonesia's Law 17/2023 explicitly promotes mediation, which is in line with global trends. The U.K. settles \~75% of claims without trial; Australia encourages prelitigation mediation; Japan's ADR centers divert cases from court; New Zealand (not covered above but notable) has virtually no litigation because all goes to a nofault scheme and complaints are handled by an Ombudsman. Mediation in Indonesia should be institutionalized and made trustworthy. Currently, "penal mediation" occurs in an ad hoc way, sometimes at the police station or prosecutor's office, which can be informal and inconsistent. It would be better to create a formal Medical Mediation Board or utilize courtannexed mediation with trained mediators who specialize in medical disputes. Such a body could operate under the Ministry of Health or Supreme Court and offer services in major cities. For mediation to succeed, both patients and doctors must perceive it as fair. Ensuring the mediator's neutrality, protecting the patient's rights (e.g., allowing lawyer support), and having hospital representatives with authority to offer compensation are all important. A mediated resolution can include not only compensation but also a clear explanation of what went wrong and an apology – which often is what patients seek to achieve closure. Other countries' experiences show that apologies, when given sincerely and early, can significantly reduce the desire for litigation (hence "apology laws" in some U.S. states to

allow saying sorry without admitting liability). Indonesia might consider a similar provision that an apology or expression of regret by a healthcare provider is not admissible as evidence of guilt, to encourage open communication postincident.

4. Legal Reform – Clarifying Malpractice in Statute: Indonesia may benefit from enacting a dedicated Medical Malpractice Act or revising existing health laws to more clearly define malpractice and appropriate responses. The absence of a clear legal definition (as noted, malpractice is not explicitly defined in statutes) has led to confusion and overreach, such as misusing Article 359 KUHP. Legislation could define the standard of care expected, delineate which lapses constitute civil negligence versus those that rise to criminal negligence, and establish the jurisdiction of civil courts versus disciplinary bodies. For example, criminal liability might be explicitly limited to cases of recklessness or gross negligence (akin to conscious disregard of substantial risk), distinguishing them from ordinary negligence which should be dealt with civilly. This is a concept in line with many legal systems that reserve criminal punishment for only the most egregious medical misconduct (like a surgeon operating while intoxicated, or intentional harm). By drawing this line, doctors would be less fearful of criminal charges for judgment errors or system failings. It would also implement what scholars advocate – stopping the "generalization of negligence principle" to every medical mishap. Additionally, a Medical Malpractice Act could formalize the role of expert testimony in court and possibly create medical review panels (a pretrial expert review process as used in some U.S. states or France) to advise courts, thereby improving decision quality in the often technical malpractice cases.
5. Learning from NoFault Elements: The Swedish nofault system demonstrates an efficient way to achieve broad compensation and maintain goodwill. While Indonesia might not be ready to adopt a full nofault model, it could incorporate nofault elements gradually. One suggestion is to implement a nofault compensation pilot for certain injuries: for example, a fund for children who suffer severe injury or death due to childbirth or pediatric care. This would mirror Japan's targeted approach and could be funded via a small levy on obstetric services or through a governmentbacked insurance scheme. Not only would this directly help some of the most devastating cases (which often capture public attention), but it would also alleviate pressure on the criminal system – families of injured newborns might opt for guaranteed compensation rather than lodging a police complaint out of desperation. Over time, if such pilots prove successful and financially manageable, the scheme could expand to other areas (e.g., vaccine injuries, which many countries handle via nofault programs, or other highrisk surgeries).
6. Data Collection and Transparency: Another lesson from abroad is the value of data in driving policy. The UK publishes detailed annual reports on claims, which has helped identify problematic areas (like the disproportionately high obstetric claims leading to targeted safety interventions). Sweden's system captures data on thousands of injuries which are analyzed for patient safety improvements (e.g., identifying common causative factors in orthopedic claims versus medication errors). Indonesia should improve its reporting mechanisms: require hospitals to report adverse events and claims to a central authority (with patient confidentiality protections), and empower that authority (perhaps a patient safety committee under the Ministry of Health) to analyze and publish trends. Such transparency can show whether reforms are working – for instance, has Law 17/2023's mediation mandate reduced criminal filings? Has the number of compensated patients increased? Without data, policymaking is blind.
7. Patient Safety and Prevention: Ultimately, the best way to reduce the malpractice problem is to reduce malpractice occurrences. The Guardian report on the NHS highlighted that despite spending billions on claims, "far too many patients still suffer clinical negligence". This shifted the conversation to prevention. In Indonesia, a focus on patient safety standards, training, and hospital accreditation will be crucial. Many errors result

from system issues (communication failures, inadequate staffing, lack of protocols) rather than individual recklessness. Introducing safety checklists (e.g., the WHO Surgical Safety Checklist), encouraging a culture where healthcare workers can report nearmisses without fear, and ongoing education on risk management can reduce adverse events. If fewer incidents occur, there will naturally be fewer legal disputes. This is a longterm endeavor and extends beyond legal reform into healthcare management, but it should be mentioned in any comprehensive malpractice policy approach.

8. Finally, it's important to note that no system is perfect. Each country balances a set of factors: cost, deterrence, fairness, accessibility of compensation, and societal values about justice. As one analysis aptly stated, "There is no perfect medical malpractice system… countries should tailor their system to their conditions and needs." Indonesia's solution must fit its context – including resource constraints, public expectations, and legal culture. The comparative insights serve not to prescribe a onesizefitsall model, but to enrich the menu of options Indonesian policymakers and stakeholders can consider.

Recommendations

Building on the above discussion, this section outlines specific and actionable reforms to improve Indonesia's medical malpractice framework. These recommendations aim to create a coherent, fair, and effective system that better protects patients and supports healthcare providers in delivering safe care. Each recommendation is informed by both the Indonesian context and lessons drawn from international practices:

1. Enact a Comprehensive Medical Liability Law: Draft and pass legislation that clearly defines medical malpractice, the standard of care, and distinguishes between civil negligence and criminal gross negligence. This law should consolidate relevant provisions (now scattered in health and medical practice laws) into a single, clear framework. Criminal prosecution should be reserved for only the most egregious cases (e.g., willful misconduct or extreme recklessness), with all other cases directed to civil or administrative handling. This will remove ambiguity and prevent misuse of general criminal laws. The law should also formalize the requirement of expert medical review panels before a case proceeds to court, ensuring that judges have unbiased professional input on whether malpractice likely occurred.
2. Establish a NoFault Compensation Scheme (Pilot Program): Create a pilot nofault medical injury compensation fund for a highneed area such as obstetric injuries or vaccinerelated injuries. This fund, possibly supported by government and small levies on healthcare services, would offer prompt compensation to patients/families for defined severe injuries without litigation. Criteria of compensability (e.g., injury occurred in course of medical management and is severe) can be defined, following the Swedish model. Even a limited scheme will demonstrate the feasibility of "social insurance of goodwill" where patients are cared for without proving fault. In parallel, analyze the costs and benefits to inform potential expansion to a broader nofault system in the future.
3. Mandatory Malpractice Insurance and a Guarantee Fund: Require all hospitals (and perhaps all practicing physicians) to carry medical malpractice insurance. The government can facilitate this by partnering with insurance providers to create affordable group plans or a national insurance pool for healthcare providers. Additionally, set up a State Guarantee Fund for instances where an uninsured or underinsured provider is found liable, so that patients are not left uncompensated due to inability of the provider to pay. This mirrors practices in many countries where either private insurance or statebacked funds ensure that awards can be collected. Over time, universal provider insurance will normalize the concept of compensation and spread the risk, rather than the current scenario where compensation is ad hoc.

4. Strengthen the Medical Disciplinary Board (MKDKI): Provide more resources and authority to the MKDKI to investigate alleged malpractice swiftly and transparently. The Board should include not only senior physicians but also representatives of patients' rights or legal experts to provide a balanced perspective. Publish annual statistics on the number of complaints received, outcomes (e.g., number of doctors warned, licenses suspended, etc.), and general findings. When the MKDKI finds a serious violation, that information (respecting confidentiality where appropriate) should be shared with civil courts or prosecutors as needed. Essentially, the MKDKI should become a trusted mechanism for holding professionals accountable outside the criminal courts, giving the public confidence that poor practitioners are not beyond reproach. A robust MKDKI can act similarly to the UK's General Medical Council or Australia's Medical Boards, enforcing standards through professional sanctions.
5. Implement and Regulate Mediation Services: Following Law 17/2023's mandate, establish a formal Medical Dispute Mediation Center in each province (or empower existing court mediation centers) to specifically handle medical cases. Set clear guidelines: mediation should be offered as a first resort in all malpractice claims (civil or criminal). Ensure mediators are trained in health law and ethics. To protect patients, any settlement agreement should acknowledge the patient's rights and should ideally be reviewed by a neutral party or judge to prevent coercion. Encourage hospitals to adopt internal mediation as well – e.g., a hospitalbased complaint resolution office that can resolve issues before they escalate. International experience indicates that when patients receive an explanation, apology, and fair offer early, many are satisfied without pursuing legal action. Indonesia should capitalize on its cultural inclination towards consensus by providing a reliable structure for it.
6. Introduce "Apology Law" Protection: Amend the law to state that expressions of apology or sympathy by healthcare providers are inadmissible as evidence of liability. This kind of rule (present in numerous U.S. states and recommended in other jurisdictions) allows doctors to communicate openly with patients after an adverse event – to apologize and express concern – without fear that their words will be used against them in court. By reducing the legal risk of apology, providers are more likely to engage compassionately with patients postincident, which can mitigate anger and reduce the impulse to punish via criminal charges or lawsuits.
7. Damage Caps and Predictable Awards in Civil Cases: As part of tort reform, consider imposing reasonable caps on noneconomic damages in civil malpractice cases, similar to reforms in Australia and some U.S. states. For instance, painandsuffering damages could be capped at a certain rupiah amount (indexed for inflation) for typical malpractice cases. This does not limit compensation for actual economic losses (medical bills, lost earnings), but it curtails unpredictable, subjective awards. Caps would assuage healthcare providers' fears of ruinous payouts and might make liability insurers more willing to insure at affordable rates. Coupled with this, developing guideline compensation tables for various injuries (like loss of an organ, permanent disability levels, etc.) as used in Europe can make settlement negotiations more straightforward and equitable.
8. Enhance Patient Safety Programs: While not a direct legal reform, this recommendation underpins the malpractice issue: the Ministry of Health and hospital associations should aggressively push patient safety initiatives. Set up a National Patient Safety Council that analyzes malpractice claims and "near miss" reports to recommend safety improvements. Encourage all hospitals to implement standard safety protocols (e.g., surgical checklists, infection control bundles) and to obtain accreditation that evaluates quality of care. The government might incentivize safety compliance by linking it to malpractice insurance premiums (hospitals with strong safety records or accreditation could get lower premiums, analogous to "experience rating"). Ultimately, safer care reduces errors, which

reduces claims and the resort to legal action. The UK's Commons committee explicitly tied the huge NHS liability to failures in patient safety and urged systemic action – a pertinent lesson that investing in safety yields dividends in reduced legal costs and better outcomes.

9. Public Education and Communication: Many disputes in Indonesia stem from miscommunication and unrealistic expectations. A softer but important measure is to educate both the public and healthcare workers. The public should be informed about what constitutes malpractice versus an inherent risk or complication, and about the avenues for redress when something goes wrong. This can be done via patient rights brochures in hospitals and community outreach. Concurrently, train healthcare providers in communication skills – obtaining proper informed consent, explaining possible outcomes, and being transparent when complications occur. If patients feel respected and informed, they are less likely to resort to adversarial channels in the event of an adverse outcome. Additionally, educating doctors about the new processes (like mediation and the role of MKDKI in reviews) is crucial so they understand that these mechanisms exist to protect both patients and practitioners through fair resolution, not solely as punitive measures.

Implementing these recommendations requires coordination among various stakeholders – the legislature, judiciary, medical professional bodies, insurance industry, and patient advocacy groups. There may be resistance from some quarters (for instance, doctors may initially fear a compensation fund will encourage claims, or insurers might worry about mandates), but the overall aim is to strike a better balance between patients' rights and physicians' interests. International models show that fairness and efficiency can go hand in hand: a system that promptly compensates patients and holds providers accountable in a just way can actually reduce the impulse for vengeance or criminalization. It can also enhance the medical profession's reputation by showing commitment to selfimprovement and patient welfare.

By adopting these reforms, Indonesia can move toward a malpractice system that is integrated and trustworthy. Patients who suffer avoidable harm will have a clear, accessible path to compensation and resolution. Doctors and hospitals, in turn, will benefit from clearer rules, reduced fear of arbitrary punishment, and hopefully, insurance mechanisms that protect them from personal ruin while still incentivizing adherence to standards. Over time, the hope is for a culture shift: away from seeing medical accidents through a lens of crime and punishment, and toward viewing them as critical incidents to respond to with compassion, learning, and appropriate restitution.

CONCLUSION

Medical malpractice is a complex challenge at the nexus of healthcare delivery and legal accountability. Indonesia's current framework, historically characterized by legal ambiguity and reactive measures, has left many stakeholders unsatisfied – patients often struggle to obtain redress, while doctors feel vulnerable to criminal prosecution even in borderline cases. In this expanded analysis, we revisited the legal implications of malpractice in Indonesia, uncovering the need for deeper structural reforms. By comparing Indonesia's experience with international case studies – from the litigious environment of the United States to the collaborative nofault model of Sweden – we have gleaned valuable insights into how different systems strive to balance compensation, deterrence, cost, and fairness.

Several overarching conclusions emerge. First, Indonesia must develop a more consistent and compassionate method of compensating patients injured by medical care. The absence of such a mechanism undercuts public trust in the health system and drives aggrieved parties toward punitive actions. Second, the role of criminal law in medical negligence should be minimal, reserved only for truly reckless behavior, as criminalizing human error in

healthcare is neither a sustainable nor just approach to improving patient safety. Third, the healthcare and legal systems in Indonesia should embrace greater transparency, data, and expertise – whether through expert panels, improved reporting of incidents, or specialized mediation services – to ensure that decisions in malpractice disputes are wellinformed and credible.

The recommendations outlined provide a roadmap for action: legal reform to clarify obligations and consequences; institutionbuilding such as insurance systems and mediation centers; and cultural shifts to encourage openness and learning from mistakes. These changes are ambitious but not unprecedented – each finds a parallel in the experience of other nations that have faced similar issues. Importantly, any reform must be tailored to Indonesia's context, phased appropriately, and supported by training and education to all involved parties.

If implemented, the reforms could yield tangible improvements: more patients receiving timely compensation (reducing the need for protracted battles), medical professionals feeling more secure and focusing on safe practice rather than defensive practice, and a reduction in adversarial conflict that currently pits doctors against patients. Over time, Indonesia can move toward a modern malpractice resolution system that aligns with global best practices while reflecting local values of justice and harmony.

In closing, revisiting the legal implications of medical malpractice in Indonesia is not just an academic exercise – it is a necessary step towards a healthier society. Every patient harmed by a preventable medical error is a tragedy, and while no system can undo that harm, a good system can ensure the patient is cared for and the error leads to improvement, not just blame. Every doctor who strives to heal should do so supported by a just system that differentiates human fallibility from egregious misconduct. Striking this balance is challenging, but the comparative perspectives and data indicate it is achievable. By learning from both domestic experiences and international examples, Indonesia can enact reforms that make its malpractice framework more coherent, integrated, and humane, ultimately strengthening the trust between its people and those entrusted with their care.

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