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Beyond "malpractice" reconstructing medical negligence in Indonesia through the lens of patient safety, defensive medicine, and health system error

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ABSTRACT

Introduction: Medical negligence in Indonesia is often compressed into the single public label of "malpractice," although contemporary legal and patient-safety scholarship distinguishes unavoidable medical risk, human error, professional negligence, reckless conduct, and organizational failure. This review aims to reconstruct medical negligence in Indonesia through the integrated lenses of patient safety, defensive medicine, and health system error.

Methods: This narrative legal-policy review synthesized peer-reviewed scientific journal articles published between 2022 and 2026, with legal analysis limited to Indonesian statutes and regulations. Sources were selected when they addressed medical negligence, hospital liability, professional accountability, patient safety culture, incident reporting, defensive medicine, or hospital risk management.

Results: Indonesian medical negligence should not be assessed only as individual fault, but as a layered phenomenon involving clinical judgment, team communication, institutional governance, safety culture, reporting systems, and regulatory design. Law No. 17 of 2023 on Health strengthens the legal basis for patient rights, professional accountability, hospital responsibility, and dispute processing, while Minister of Health Regulation No. 11 of 2017 provides a patient-safety framework for incident prevention and learning. However, fear of litigation and criminalization may encourage defensive medicine, while blame-oriented cultures suppress incident reporting and weaken organizational learning.

Conclusion: Reconstructing medical negligence beyond "malpractice" requires a shift from retrospective blame toward proportionate accountability, just culture, system learning, and legally coherent risk management. Indonesian health law should be implemented in a way that distinguishes medical risk from negligent conduct, protects patients' rights, supports fair professional evaluation, and makes hospitals accountable for preventable system failures.

Keywords: defensive medicine, health system error, medical malpractice, medical negligence, patient safety.
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INTRODUCTION

The term "malpractice" has become a powerful shorthand in Indonesian public discourse, but it is analytically too blunt to explain the complexity of adverse outcomes in health care.[1] Contemporary literature emphasizes that poor medical outcomes may arise from unavoidable medical risk, ordinary human error, diagnostic uncertainty, deviation from professional standards, or institutional failure.[2] This conceptual compression is legally and clinically dangerous because it may transform every adverse outcome into a presumed violation before the causal chain is properly examined. Legal studies in Indonesia increasingly argue that medical risk, medical error, and malpractice must be differentiated because each category has different implications for proof, liability, compensation, and professional discipline.[3]

The enactment of Law No. 17 of 2023 on Health reshaped Indonesia's health-law landscape by integrating provisions on patient rights, medical and health personnel, hospitals, professional discipline, and legal accountability.[4] In this framework, patient rights must be protected. Still, legal protection for health personnel must also be preserved when care has been delivered according to professional standards, service standards, standard operating procedures, and patient needs.[5] Hospital liability has also become more prominent after Law No. 17 of 2023 because hospitals are not merely physical places where doctors act, but corporate health-service institutions with duties of governance, supervision, facilities, risk management, and patient safety.[6,7] Indonesian scholarship has therefore begun to move from a doctor-centered malpractice model toward a broader institutional model that evaluates whether the hospital system created, tolerated, or failed to correct unsafe conditions.[4]

Patient safety offers a crucial lens for this reconstruction because preventable harm often emerges from interacting system weaknesses rather than from a single careless act.[8] Studies on Indonesian hospital safety culture show persistent weaknesses in staffing, open communication, non-punitive response to error, and incident reporting,

all of which may convert small clinical vulnerabilities into serious patient harm.[9] Defensive medicine adds another layer to the problem because clinicians who fear litigation, complaints, reputational damage, or criminal sanctions may alter clinical decisions in ways that are not primarily patient-centered.[10] International evidence shows that defensive medicine is common among physicians and may include unnecessary tests, excessive referrals, over-documentation, avoidance of high-risk patients, or reluctance to perform indicated procedures.[11]

In Indonesia, the challenge is therefore not only to punish wrongful conduct, but to design a fair legal and institutional ecology that encourages truth-telling, early disclosure, learning, and prevention.[12,13] A negligence framework that ignores patient safety may over-punish individuals while leaving unsafe systems untouched, whereas a framework that ignores accountability may deny justice to injured patients.[14] The central argument is that Indonesian medical negligence should be understood as a layered legal-safety phenomenon requiring proportionate accountability at the individual, team, institutional, and regulatory levels.[7]

Existing Indonesian studies on medical negligence have largely examined "malpractice" through separate legal, ethical, or professional accountability perspectives. At the same time, patient-safety literature has more often focused on incident reporting, safety culture, and hospital risk management without fully connecting these issues to negligence doctrine. As a result, there remains a conceptual gap in explaining how adverse medical outcomes should be differentiated among unavoidable medical risk, human error, professional negligence, institutional negligence, and broader health system error within Indonesia's legal framework. Limited scholarship has also integrated defensive medicine into this discussion, despite its relevance to legal uncertainty, fear of litigation, and clinical decision-making. Therefore, this review addresses this gap by reconstructing medical negligence in Indonesia through an integrated framework that combines patient rights, professional accountability, hospital responsibility, defensive medicine, and patient-safety system learning.

METHODS

Search Strategy

This review synthesized scientific journal articles published from 2022 to 2026 in the fields of health law, medical negligence, hospital liability, defensive medicine, patient safety culture, incident reporting, and hospital risk management. Searches were conceptually organized using combinations of the terms "medical malpractice," "medical negligence," "patient safety," "hospital liability," "defensive medicine," "health system error," "incident reporting," "risk management," and "Indonesia." The legal analysis was limited to Indonesian legal instruments, especially the 1945 Constitution of the Republic of Indonesia, Law No. 17 of 2023 on Health, the Indonesian Civil Code as applied in Indonesian legal scholarship, and Minister of Health Regulation No. 11 of 2017 on Patient Safety. Indonesian legal instruments were used as normative objects of analysis, while the reference list was restricted to peer-reviewed journal literature published between 2022 and 2026

Inclusion and Exclusion Criteria

Articles were included when they discussed medical negligence, malpractice, professional accountability, patient rights, hospital legal responsibility, patient safety culture, incident reporting, just culture, defensive medicine, or hospital risk management. Articles were excluded when they were published before 2022, were not scientific journal publications, focused on non-Indonesian legal systems without relevance to patient safety or defensive medicine, or addressed clinical outcomes without legal or safety-system implications. This review did not use foreign statutes, foreign regulations, or non-Indonesian legal doctrine as normative legal sources. Comparative scientific literature was used only to clarify patient-safety and defensive-medicine concepts, not to import foreign legal standards into the Indonesian legal framework.

Data Extraction

Data were extracted into four analytic categories: legal classification of medical negligence, institutional hospital liability, patient-safety culture and incident reporting, and defensive medicine. The synthesis then compared Indonesian legal scholarship with patient-safety evidence to identify where conventional malpractice thinking fails to capture system-based causes of patient harm. A thematic synthesis approach was used to construct a layered model of negligence involving individual clinical conduct, team processes, organizational governance, and regulatory conditions. This approach is appropriate because medical negligence is not merely a legal event, but also a safety-system event embedded in clinical workflows, hospital management, and professional culture.

RESULTS AND DISCUSSION

Reframing "Malpractice" as a Layered Legal-Safety Problem

The conventional malpractice narrative often begins after an injury has occurred and asks whether a doctor made a mistake.[1] This framing is incomplete because medical harm may result from a spectrum that includes unavoidable medical risk, diagnostic uncertainty, ordinary error, negligent deviation from standards, reckless conduct, and institutional failure.[2] Indonesian legal literature emphasizes that medical risk, medical error, and malpractice should not be treated as identical categories. Medical risk refers to harm that may occur despite appropriate care, whereas malpractice requires a legally relevant breach of duty, causal connection, and damage.[3]

This distinction is essential because health care is intrinsically uncertain, especially in emergency care, complex procedures, high-risk surgery, intensive care, and resource-constrained settings.[1] When every adverse outcome is socially treated as malpractice, the law may become a foghorn of blame rather than a compass for justice.[10] A reconstructed model should therefore ask not only "Who erred?" but also "Why did the system permit this harm to occur?" Hospital liability studies in Indonesia show that institutional responsibility may arise when hospitals fail to provide adequate facilities, supervision, safe procedures, competent staffing, or risk-control mechanisms.[6,7]

Law No. 17 of 2023 strengthens this broader view because hospitals

are positioned not merely as passive containers of professional acts, but as accountable health-service institutions.[4] Recent scholarship argues that hospital accountability after the 2023 Health Law must include corporate governance, patient safety, risk management, and compliance with service standards.[7] Medical negligence should therefore be reconstructed as a layered phenomenon.[6] At the first layer lies the clinician's professional conduct; at the second lies team communication and workflow; at the third lies hospital governance; and at the fourth lies broader system design, including regulation, financing, workforce distribution, and reporting culture.[14]

Indonesian Legal Architecture for Negligence, Patient Rights, and Hospital Accountability

The Indonesian legal foundation for this reconstruction begins with the constitutional right to health and is operationalized through Law No. 17 of 2023 on Health.[4] Contemporary Indonesian legal scholarship interprets the 2023 Health Law as an effort to harmonize previously fragmented health regulations while strengthening legal certainty for patients, medical personnel, health workers, and health institutions.[5] Patient rights under the Indonesian health-law framework include the right to information, appropriate health services, professional standards, quality care, consent or refusal of interventions, and access to medical records.[3] These rights are central to medical negligence analysis because a violation may occur not only through technical error, but also through poor communication, inadequate consent, unsafe service organization, or failure to disclose relevant information.[5]

Professional accountability is also reorganized through mechanisms that require disciplinary evaluation before certain legal processes related to health services proceed.[4] This mechanism is important because negligence disputes often involve technical clinical judgments that courts and investigators may not be able to evaluate fairly without professional expertise.[5] However, professional protection cannot become institutional immunity. Hospital liability scholarship after Law No. 17 of 2023 argues that hospitals must remain accountable for unsafe systems, defective procedures, inadequate supervision, and failures of organizational risk management.[6,7]

The Indonesian Civil Code remains relevant in civil liability analysis, particularly when patient injury is framed through unlawful acts, employer responsibility, or institutional responsibility.[2] Legal studies on hospital liability argue that patient claims should examine not only individual negligence, but also whether the hospital fulfilled its duty to organize safe, lawful, and quality health services.[6] Minister of Health Regulation No. 11 of 2017 on Patient Safety strengthens this system perspective by requiring patient-safety programs, incident reporting, learning, and prevention of repeated events.[14] Although it is not a malpractice statute, it provides a safety architecture that can help distinguish preventable system failure from unavoidable clinical risk.[13] The Indonesian legal instruments and their relevance to reconstructing medical negligence are shown in **Table 1.**

Table 1. Indonesian legal instruments and their relevance to reconstructing medical negligence

Indonesian legal instrument	Main relevance	Implication for medical negligence reconstruction
1945 Constitution of the Republic of Indonesia	Constitutional foundation of the right to health	Medical negligence analysis must begin from the state's duty to ensure safe, accessible, and quality health services.[4,5]
Law No. 17 of 2023 on Health	Governs patient rights, health personnel, hospitals, professional discipline, health information, and legal accountability	Negligence should be assessed through patient rights, professional standards, hospital duties, and health-system governance.[6,7]
Indonesian Civil Code	Basis for civil liability, unlawful acts, and responsibility for losses	Patient injury claims may involve individual fault, employer responsibility, or institutional liability.[2,6]
Minister of Health Regulation No. 11 of 2017 on Patient Safety	Establishes patient-safety duties, incident reporting, and prevention-oriented learning	Adverse events should trigger safety investigation, root-cause analysis, and corrective action before simplistic blame.[13,14]
Hospital accreditation and internal SOP obligations under Indonesian health governance	Require hospitals to maintain service standards, documentation, supervision, and risk controls	Failure to implement safe SOPs, staffing, reporting, and monitoring may support institutional negligence.[4,7]

Patient Safety as the Missing Bridge Between Law and Clinical Reality

Patient safety reframes medical negligence as a preventable harm problem rather than merely a blame problem.[9] This perspective is essential because many adverse events arise from communication breakdowns, poor handover, fatigue, staff shortage, weak supervision, equipment problems, documentation gaps, or organizational silence.[8] Indonesian studies indicate that patient safety culture remains uneven across hospitals. A hospital-based study using the AHRQ framework found a positive safety culture score of 72.12%, but also identified staffing as a weak dimension and incident reporting, open communication, feedback, and non-punitive response as areas requiring improvement.[9]

Another Indonesian hospital study using HSOPSC 2.0 found an overall positive safety culture of 62%, with strong teamwork and organizational learning but very low scores for staffing and work tempo, incident reporting, and response to errors.[13] These findings suggest that hospitals may endorse patient safety

rhetorically while still struggling with the practical conditions required for safe care.[9] A validated Indonesian version of HSOPSC 2.0 helps make this problem measurable. The availability of a culturally adapted instrument supports hospitals in diagnosing safety-culture weaknesses rather than waiting for litigation to reveal hidden hazards.[8]

Incident reporting is particularly important because unreported events become buried fossils in the hospital sediment.[15] Indonesian evidence shows that reporting barriers include fear of sanctions, blaming culture, limited procedural awareness, high workload, poor feedback, and weak use of root-cause analysis.[16] Studies on medication error reporting and event-reporting culture confirm that blame perceptions can influence nurses' willingness to report incidents.[17,18] This is legally important because a hospital that suppresses reporting may appear safer on paper while becoming more dangerous in practice.[14]

Web-based incident reporting systems can improve data capture, but technology alone is insufficient. A study in Hospital X Tangerang documented 774 patient-safety incident reports from March 2023 to December 2024, yet also found that dashboards and root-cause analysis were underused and that staff training, procedure awareness, and system usability required strengthening.[15] Thus, patient safety should be treated as an evidentiary infrastructure for negligence prevention. When hospitals build reporting, analysis, feedback, and corrective-action systems, negligence assessment becomes more precise because investigators can distinguish isolated error from recurring system failure.[14]

Defensive Medicine and the Legal Psychology of Clinical Decision-Making

Defensive medicine occurs when clinicians alter practice primarily to reduce legal risk rather than to maximize patient benefit. A systematic review and meta-analysis reported a pooled prevalence of defensive medicine of 75.8%, with determinants operating at individual, relational, organizational, and environmental levels.[11] Defensive practice may be "positive," such as ordering excessive tests, documentation, referrals, or admissions, or "negative," such as avoiding high-risk procedures or patients. Both forms may harm patients because positive defensive medicine increases cost and iatrogenic exposure, while negative defensive medicine may restrict access to needed care.[10]

In Indonesia, defensive medicine may be intensified when adverse outcomes are rapidly labeled as malpractice before technical review, patient-safety analysis, or disciplinary evaluation has occurred.[4] This does not mean clinicians should be shielded from accountability; it means accountability must be accurate, proportionate, and evidence-based.[10] A legal environment that treats every adverse event as a potential criminal event risks producing fear-driven practice. International patient-safety literature warns that fear of punishment can weaken reporting, transparency, and learning, which are precisely the conditions needed to prevent future harm.[12]

Defensive medicine also distorts informed consent.[10] Clinicians may overload patients with risk information to protect themselves legally, rather than communicate in a balanced way that genuinely supports patient understanding and shared decision-making.[11] The Indonesian solution should not be to reduce patient rights, but to clarify the pathway from complaint to investigation, discipline, civil accountability, and criminal accountability.[4] Law No. 17 of 2023 and the patient-safety regulation can be implemented together. Thus, professional evaluation, safety investigation, and patient remedy operate as coordinated doors, not as a maze with hidden teeth.[14]

Health System Error and the Institutional Ecology of Negligence

Health system error refers to preventable harm produced by the design, governance, or functioning of the health system rather than by the isolated incompetence of one individual.[6] In hospital negligence cases, this may include unsafe staffing, unclear SOPs, inadequate supervision, lack of equipment, poor infection control, ineffective reporting, incomplete documentation, or failure to respond to known hazards.[7] Indonesian studies on hospital risk management show that risk governance is increasingly recognized as part of hospital performance and safety. A SEM-PLS study on Indonesian hospital risk management highlights the importance of leadership, risk culture, communication, and organizational commitment in strengthening hospital risk management.[19]

The legal implications are significant.[6] If a hospital repeatedly records similar incidents but fails to act, the problem is no longer a single error; it becomes organizational negligence because the institution has tolerated a known risk.[14] This reconstruction aligns with corporate legal analyses of hospitals after Law No. 17 of 2023.[4] Hospitals must establish supervision, standards, risk management, patient safety systems, and accountability mechanisms because the hospital corporation benefits from organized health-service delivery and must also bear responsibility for organized health-service failure.[7]

The same principle applies to SOPs. Recent Indonesian legal scholarship argues that Law No. 17 of 2023 requires hospitals to adjust SOPs and risk management systems toward accountability, transparency, and patient safety.[7] Therefore, health system error should not excuse negligence; instead, it should relocate accountability to the correct level.[14] A nurse who fails to report because the hospital punishes reporters, a doctor who works beyond safe workload limits, or a patient harmed by unavailable equipment may all reveal institutional failures that individual blame alone cannot fix.[16] Reconstruction of medical negligence beyond the "malpractice" label is shown in **Table 2.**

Just Culture as a Legal-Safety Strategy

A just culture distinguishes human error, at-risk behavior, and reckless conduct so that organizations can respond fairly.[14] Patient-safety literature emphasizes that a just culture encourages reporting without fear while still preserving accountability for reckless or intentionally unsafe behavior.[12] This distinction is directly relevant to Indonesian medical negligence because a blame culture may hide incidents until they become lawsuits. Studies on Indonesian

Table 2. Reconstruction of medical negligence beyond the "malpractice" label

Category	Core meaning	Typical evidence	Appropriate response under the Indonesian health-law and safety framework
Unavoidable medical risk	Harm occurs despite appropriate care and known inherent risk	Adequate consent, appropriate indication, standard-compliant care, no preventable deviation	Disclosure, clinical explanation, documentation, quality review, no punitive labeling.[1,3]
Human error	Unintentional mistake by a competent professional	Slip, lapse, documentation error, communication failure, without reckless disregard	Patient-safety reporting, root-cause analysis, feedback, training, system redesign.[12,14]
At-risk behavior	Drift from safe practice due to normalization, workload, pressure, or weak supervision	Repeated shortcuts, ignored the checklist, informal workarounds	Coaching, supervision, workflow correction, leadership intervention, and monitoring.[14,19]
Professional negligence	Failure to meet professional standards causes patient harm	Breach of standards, causation, damage, and inadequate clinical justification	Disciplinary evaluation, civil accountability where proven, and corrective professional action.[2,5]
Reckless or gross negligence	Conscious disregard of substantial patient risk	Serious deviation, ignored obvious danger, severe injury, or death	Disciplinary, civil, and potentially criminal processing according to Indonesian law.[3,4]
Institutional negligence	The hospital system fails to provide safe governance, staffing, facilities, SOPs, reporting, or supervision	Unsafe staffing, absent equipment, weak incident response, repeated uncorrected events	Hospital liability, governance reform, risk-management enforcement, and patient remedy.[6,7]
Regulatory or health-system error	Harm enabled by broader policy, financing, workforce, or access failures	Structural shortage, fragmented standards, unclear referral or reporting mechanisms	Policy correction, regulatory supervision, system-level quality improvement.[4,19]

hospitals show that fear of sanctions and blame culture remain important barriers to incident reporting.[16,18]

A just-culture model does not mean "no blame." Instead, it means that blame is reserved for conduct that deserves blame, while system weaknesses are corrected through learning, redesign, and leadership accountability.[12] For Indonesia, just culture can be operationalized through the Minister of Health Regulation No. 11 of 2017, hospital risk management, accreditation standards, internal patient-safety committees, and Law No. 17 of 2023 accountability mechanisms.[4] This allows hospitals to investigate harm in a way that protects patients, treats professionals fairly, and produces institutional prevention rather than ritual paperwork.[14]

Toward an Indonesian Reconstruction Model of Medical Negligence

An Indonesian reconstruction model should begin with classification. Every adverse event should first be classified as medical risk, human error, at-risk behavior, professional negligence, reckless conduct, institutional negligence, or regulatory/system failure.[1,6] The second step should be a safety investigation. Hospitals should use incident reporting, root-cause analysis, morbidity and mortality review, audit, and corrective-action monitoring to determine whether the event was isolated or systemically predictable.[14,15] The third step should be a professional and legal evaluation. Professional discipline should evaluate whether clinical conduct complied with standards, while civil or criminal processes should focus on legally proven breach, causation, damage, and degree of fault.[2,5] The fourth step should be patient, remedy, and communication. Patients deserve honest explanations, access to records, complaint pathways, mediation where appropriate, and compensation when liability is established.[3,4] The fifth step should be institutional prevention. Hospitals must convert each substantiated incident into revised SOPs, staffing review, equipment correction, supervision improvement, training, and reporting feedback.[7,19]

This model preserves accountability while preventing the malpractice label from becoming a diagnostic shortcut. It also prevents patient safety from becoming a shield for negligent institutions because system error, when preventable and unmanaged, is itself a form of accountability failure.[6,14]

CONCLUSION

Medical negligence in Indonesia should be understood beyond the label of "malpractice" by distinguishing medical risk, human error, professional negligence, institutional negligence, and health system error. Law No. 17 of 2023 and Minister of Health Regulation No. 11 of 2017 provide a foundation for patient rights, professional accountability, hospital responsibility, and patient-safety learning. Therefore, negligence analysis should combine legal precision with patient-safety principles, ensuring fair accountability for health professionals and hospitals while promoting incident reporting, system improvement, and protection of patient rights.

DISCLOSURES

AUTHORS CONTRIBUTION

[Initials] conceptualized the study, designed the review framework, conducted literature synthesis, and wrote the original draft. [Initials] contributed to legal analysis, interpretation of Indonesian regulatory instruments, and manuscript revision. All authors have read and approved the final version of the manuscript.

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CONFLICT OF INTEREST

The authors declare no conflict of interest related to this study.

ETHICAL CONSIDERATION

Not applicable.

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