

Legal Liability for Medical Risk in Hospital Healthcare Services Based on Therapeutic Transactions

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Abstract

Informed consent to a medical procedure is the foundation of the legal relationship and contractual obligation between a patient and a physician or other healthcare professional within a therapeutic transaction. As medical science and technology advance, health law evolves with them, and one significant development is the enactment of Law No. 17 of 2023 concerning Health (the Health Law), which addresses the formulation of informed consent. In practice, however, informed consent is frequently structured through standard clauses prepared to simplify the formation of the therapeutic agreement. This study addresses two problems: first, how legal liability for medical risk in hospital-based therapeutic transactions is regulated; and second, how such liability is borne in practice. It is a normative legal study that employs a statutory approach and a conceptual approach, and it analyses legal materials using descriptive, systematic, evaluative and argumentative techniques. The findings show that liability is regulated principally in Articles 56 to 58 of the Health Law, which require physicians to comply with the Indonesian Code of Medical Ethics, professional standards and Standard Operating Procedures (SOPs), and to hold the administrative documents needed to practise, namely a Registration Certificate (STR) and a Practice License (SIP). Hospital liability depends heavily on the legal relationship between medical personnel and the hospital. Where the relationship is one of employment, the hospital is liable for the unlawful acts of its employees under Article 1367 paragraph (3) of the Indonesian Civil Code. Where it is contractual, for example where physicians lease hospital facilities, the hospital is generally not liable for the acts or negligence of the medical personnel that harm patients or their families.

Keywords: legal liability; medical risk; therapeutic transaction; informed consent; hospital.

INTRODUCTION

The 1945 Constitution of the Republic of Indonesia guarantees that everyone has the right to a good and healthy environment and to obtain healthcare services (Article 28H paragraph (1)). Health development is meant to raise the capacity of every person to live healthily, and the state carries out this mandate through health legislation. Health is treated as a human right that must be realised through quality and affordable health efforts for all citizens.

Hospitals are at the centre of this system. A hospital is an institution that provides comprehensive individual health services, including inpatient, outpatient and emergency care. Its role has broadened from curative care alone to promotive, preventive, curative and rehabilitative efforts. Because hospitals are capital-, technology- and labour-intensive, they are no longer managed purely as social units but as socio-economic units. A hospital is also a legal entity and a complex business in which many professions work side by side, so the legal problems it faces are varied and distinctive.

One reason is the nature of the service: the relationship between a physician and a patient is generally an *inspanningsverbintenis* (an obligation of best effort) rather than a *resultaatsverbintenis* (an obligation to achieve a result) (Komalawati, 2002; Nasution, 2005).

Medical doctors are one category of health personnel that a hospital depends on. Doctors may stand in different legal positions relative to a hospital. A permanent or "organic" doctor is in principle a subordinate of the hospital (an employee), a pattern common in government hospitals whose doctors are paid a fixed salary. By contrast, a visiting or partner doctor is not tied to the hospital but is allowed to use its facilities for a certain period. A hospital may engage non-permanent staff and consultants according to its needs and capacity, and a doctor may practise at up to three places under the Regulation of the Minister of Health No. 2052/Menkes/Per/X/2011. The literature therefore recommends a written agreement that spells out the legal liability toward patients if a claim arises (Haryanto, 2019).

Informed consent, the consent to a medical action, is the basis of the legal relationship between patient and doctor in a therapeutic transaction (Mayasari, 2017; Busro, 2018). Law No. 17 of 2023 concerning Health (the Health Law) regulates the giving of consent for health service actions, but it does not define consent to a medical action. That definition must be sought in the Regulation of the Minister of Health No. 290/Menkes/Per/III/2008, which describes informed consent as consent given by the patient or closest family after receiving a complete explanation of the medical or dental action to be performed (Kusnadi, 2023). In practice, informed consent is often set out in standard clauses, prepared to make it easier for doctors and patients to form the therapeutic agreement (Sahril, 2020; Baroto, 2023). Article 293 paragraph (4) of the Health Law recognises two forms of express consent, oral and written, yet it does not explain oral consent. Implementing rules on the agreement between doctor and patient are also lacking.

Several questions follow. Where a partner doctor performs surgery with the help of a hospital's own nurses, and the nurse is at fault, who is liable? The doctrine of the "captain of the ship" would place responsibility on the surgeon, while Article 46 of Law No. 44 of 2009 concerning Hospitals holds the hospital legally liable for all losses caused by the negligence of health personnel working in it. This gap between the norms and their practice (*das sollen* and *das sein*) motivates the present study, which addresses two research questions:

1. How is legal liability for medical risk in hospital healthcare services based on therapeutic transactions regulated?
2. How is legal liability for medical risk in hospital healthcare services based on therapeutic transactions borne in practice?

Theoretically, the study is intended to advance health law scholarship and to clarify the

concepts used to regulate liability for medical risk. Practically, it offers guidance for hospital policy and decision-making on therapeutic transactions under Indonesian regulation.

LITERATURE REVIEW

Medical risk

Every medical action carries potential side effects and risks. Medical risk refers to the possible consequences that arise during therapy or treatment, and the patient becomes aware of it through the informed consent given by the doctor before the procedure. Consequently, a medical risk cannot generally be treated as negligence, because the patient has understood and agreed to the action. A doctor cannot in principle be held liable for a medical risk as long as the action followed standard procedures and applicable treatment rules. Unlike medical negligence, a medical risk arises despite compliance with SOPs, care in performance, the absence of negligence, and preventive effort. Medical risk is commonly understood to include (Desyari et al., 2023):

- risks inherent in the medical procedure;
- risks arising from allergic reactions;
- complications that had already developed in the patient's body;
- medical accidents or unexpected incidents (mishap, accident, misadventure, mischance);
- non-negligent errors of clinical judgment;
- the principle of *volenti non fit injuria*, under which a person who voluntarily accepts a risk cannot claim for the resulting loss; and
- contributory negligence, where the patient contributes to the occurrence of the risk.

In legal terms, medical risk is the patient's burden of bearing losses in a therapeutic transaction that are caused by factors outside the doctor's fault. Its elements are an obligation to bear, a loss (material or non-material), suffered by the patient, resulting from a medical action, and occurring outside the doctor's fault (Tsanie & Kusumaningrum, 2023). A professional must act with care, thoroughness and sound judgment; according to Stolker, the expected standard is that of a reasonably competent practitioner (*redelijk bekwaam geneester*). Applying this standard also protects the doctor from claims when a patient suffers loss from an unforeseeable risk.

Clear and complete communication in language the patient understands is essential to avoid misunderstanding of medical risk. The agreement in a therapeutic transaction is formed in two stages: first, the agreement to enter into the therapeutic transaction, where the doctor offers care and the patient accepts on the basis of trust in the doctor's competence; and second, consent to the medical action (informed consent). The information to be given covers the diagnosis, the proposed action, alternative

procedures, benefits, the way the procedure is carried out, the risk of not acting, the medical risks of the action, confirmation of the patient's understanding, voluntariness, and the prognosis (Tsanie & Kusumaningrum, 2023).

Healthcare services and their legal basis

Healthcare service is a right of every person guaranteed by the Constitution and covers any effort, carried out alone or jointly within an organisation, to maintain and improve health, prevent and cure disease, and restore the health of individuals, families, groups or communities (Komalawati, 2002). Article 52 of the Health Law distinguishes individual health services, delivered in hospitals, maternity clinics and independent practices, from public health services, delivered by community-oriented bodies such as community health centres. Comprehensive services consist of promotive, preventive, curative and rehabilitative activities. Article 54 paragraph (1) requires that health services be delivered responsibly, safely, with quality, equitably and without discrimination, and Article 53 requires that saving the patient's life take priority over other interests. Article 29 paragraph (1) letter (b) of the Hospital Law adds that hospitals must provide safe, quality, non-discriminatory and effective services that put the patient's interest first (Triwibowo, 2014).

Several parties are involved in healthcare services: doctors, nurses, midwives and pharmacists. Each is defined and regulated by its own instruments, including Law No. 29 of 2004 on Medical Practice, the Regulations of the Minister of Health on nurses and midwives, and Government Regulation No. 51 of 2009 on Pharmaceutical Practice. The legal relationship between patients and providers has two dimensions: a medical relationship governed by medical norms, and a legal relationship governed by written and unwritten legal norms (Koeswadji, 1998). At the hospital, this relationship rests on the therapeutic transaction, and the validity of the agreement is tested against Article 1320 of the Civil Code (agreement, capacity, a certain object, and a lawful cause). Two types of agreement are distinguished: a care agreement, under which the hospital provides rooms and nursing staff, and a medical service agreement, under which the hospital's medical personnel undertake to make maximum efforts to cure the patient (Astuti, 2009).

Therapeutic transactions

A therapeutic transaction is an agreement between doctor and patient that gives rise to rights and obligations for both. It differs from ordinary agreements in its object and character. Its object is the health service performed by the doctor, and its character is *inspanningsverbintenis*, that is, the doctor's effort to cure the patient, not the guarantee of a cure. Doctor and patient stand in an equal position, and the law therefore gives both legal accountability under the transaction (Komalawati, 2009). The purposes of a therapeutic transaction follow those of medicine itself: to cure and prevent

disease, to relieve suffering, and to accompany the patient.

The transaction is governed by Book III of the Civil Code. Article 1319 provides that all agreements, whether named or unnamed, are subject to the general rules; Article 1338 gives a valid agreement the force of law between the parties and requires performance in good faith; and Article 1339 extends its binding force to what custom, fairness or law requires by the nature of the agreement. The four conditions of Article 1320 apply as follows in the medical setting (Komalawati, 2002; Miru & Pati, 2011):

1. Agreement. Informed consent is the legal construction of the meeting of wills between doctor and patient after each has been informed. It is defined as "consent after information".
2. Capacity. Adults under guardianship need the consent of the guardian, and minors need the consent of a parent or guardian.
3. A certain object. The healing effort must be capable of being explained and must follow medical service standards. If the doctor cannot state or explain the intended action, this condition is not met.
4. A lawful cause. The content of the agreement must not contradict law, morality or public order. Under Article 3 of the Regulation of the Minister of Health No. 290/2008, every high-risk medical action requires written consent signed by the person entitled to give it.

Theoretical framework

Four theories support the analysis. The first is the theory of the state based on law (*rechtsstaat*), which follows from Article 1 paragraph (3) of the 1945 Constitution. In a state based on law, government action must rest on legislation, power must be divided, basic rights must be protected, and judicial oversight must be available (Busro & Busro, 1993; Azhary, 2003). Its Anglo-Saxon counterpart, the rule of law, stresses the supremacy of law, equality before the law and human rights. The second is the theory of legislation, which examines how legal norms are formed and requires that a statute have philosophical, juridical and sociological foundations (Soeprapto, 2007; Sulaiman, 2017).

The third is the theory of legal liability. Following Kelsen (2006), a person is legally liable for a given act when he or she may be subject to a sanction for a contrary act. Kelsen distinguishes individual liability, collective liability, liability based on fault and absolute liability. In the law of tort, Muhammad (2010) separates liability for intentional torts, liability for negligence and strict liability. The fourth is the theory of legal protection, which sees protection as the whole of the legal means, preventive and repressive, written and unwritten, through which the law delivers justice, order, certainty and benefit (Rahardjo, 2003, 2004). The first two theories help answer the first research question on regulation, and the last two help answer the second question on liability.

METHODS

This is a normative legal study. Following Marzuki (2005), legal research is a process of finding legal rules, legal principles and legal doctrines in order to answer the legal issue at hand, and normative research takes as its core the legislation that governs the problem (Nasution, 2008). The research begins with the health law and the regulations that implement it.

Two approaches are used. The statutory approach examines the legislation that applies to the issue, above all Law No. 17 of 2023 on Health, together with the Civil Code, the Penal Code and the relevant ministerial regulations. The conceptual approach clarifies the concepts that arise in the analysis, notably medical risk, therapeutic transaction, informed consent and legal liability. The legal materials are of three kinds:

- Primary legal materials, which are binding: the 1945 Constitution; Law No. 29 of 2004 on Medical Practice; Law No. 44 of 2009 on Hospitals; Law No. 17 of 2023 on Health; and the Regulation of the Minister of Health No. 2052/Menkes/Per/X/2011 on Practice Licences and the Implementation of Medical Practice.
- Secondary legal materials, which explain the primary materials: textbooks, literature and scholarly writing, including journal articles.
- Tertiary legal materials, which guide the reading of primary and secondary materials: articles, legal dictionaries and internet sources.

The materials were gathered through documentary study, meaning recording, identifying and inventorying the relevant primary and secondary materials by note-taking or citation. They were then analysed descriptively, systematically, evaluatively and argumentatively. The materials are set out in an orderly, sequential and logical way so that interpretation is easier and the results can be understood.

RESULTS AND DISCUSSION

Regulation of liability for medical risk in therapeutic transactions

The urgency of informed consent

Informed consent plays a vital role in determining the quality of the legal relationship between doctor and patient. If it is prepared with fault or negligence, legal liability arises for the party responsible, whether doctor or patient. A medical action concerns the life and body of the patient. If it has a fatal outcome, physical disability, mental disability or loss of life may follow, and the law must therefore set out clearly how consent is given and who bears the consequences (Ramadhan & Mutiari, 2020). The Regulation of the Minister of Health No. 290 of 2008 defines informed consent as consent given by the patient or family on the basis of an explanation of the medical action. This means the patient has a right to information, and the doctor's communication must be effective, that is, in simple and understandable language, and comprehensive. Article 7 of the regulation sets out what the

explanation must include: the diagnosis and procedure, the purpose of the action, alternative actions and their risks, risks and possible complications, the prognosis, and the estimated cost.

This regime reflects a move away from a paternalistic relationship toward a partnership between doctor and patient. Knowledge gaps have narrowed as access to information has grown (Kusuma, 2015). The rules on informed consent are found in several instruments:

- Article 4 paragraph (1) letter j of the Health Law, which gives everyone the right to obtain information about their own health data, including the actions and treatment received or to be received;
- Article 293 paragraphs (1) and (2) of the Health Law, under which every individual health service action requires consent, given after the patient has received an adequate explanation;
- Article 276 of the Health Law, on patients' rights to information, to an adequate explanation, to a second opinion, and to accept or refuse a medical action, except where the action is needed to prevent a threat to public health;
- the Regulation of the Minister of Health No. 290/Menkes/Per/III/2008 on Consent to Medical Action;
- Article 17 of the Regulation of the Minister of Health No. 1419/Menkes/Per/X/2005 on the Practice of Doctors and Dentists;
- Article 20 of the Indonesian Hospital Code of Ethics (KODERSI) of 2022; and
- the Manual on Consent to Medical Action of the Indonesian Medical Council (2006), which describes consent as a unilateral statement by the patient, revocable at any time, and as a process of effective communication rather than the mere signing of a form.

Informed consent thus serves two functions: it fulfils patients' rights and it protects the doctor legally. It also gives the patient a basis for legal action if the doctor fails to carry out what was stated in the consent document (Busro, 2018). The Health Law contains no explicit provision on oral consent, and this is a gap that hospitals cannot ignore. Hospitals must apply informed consent in every medical action, and failure to obtain proper consent can cause legal problems. In emergencies the hospital must be able to show that the action was taken to save a life in circumstances that allow an exception to patient consent (Baroto, 2023).

The form of the therapeutic agreement

A therapeutic transaction is an agreement to provide therapy across promotive, preventive, curative and rehabilitative care. It is a civil-law relationship governed by the Civil Code, and its content is an obligation of effort, not of result, so that it gives rise to civil liability for all parties. A doctor bears civil liability for loss caused by an unlawful act (Article 1365 of the Civil Code),

by negligence or lack of care (Article 1366), and, as a superior, for subordinates (Article 1367) (Asvatham & Purwani, 2020). Liability of the doctor in a therapeutic agreement is also regulated in Articles 56 to 58 of the Health Law. In substance, these provisions require doctors to follow and comply with the Indonesian Code of Medical Ethics, professional standards and SOPs, together with administrative law requirements such as a valid STR and SIP.

The therapeutic agreement is characterised as an agreement for services under Article 1601 of Book III of the Civil Code, for which the special provisions are those of the Health Law as *lex specialis*. Because its essence is to give help, it can also be viewed as the management of another's affairs (*zaakwaarneming*, Article 1354), which makes it a special agreement of its own kind (*contractus sui generis*). Its special features are its object (medical service or healing effort), its special nature, its regulation by the Health Law, and its function as a form of legal protection for both doctor and patient (Sriatmi, n.d.). The legal relationship between doctor and patient arises in two ways: by agreement (*ius contractus*) and by law (*ius delicto*) (Mannas, 2018).

The agreement may take two forms. An express agreement is one in which the scope of the service is offered clearly, in writing or orally. An example is a patient who, after examination, and with the doctor, agrees on a specific medical action and expresses consent through informed consent. An implied agreement is inferred from the conduct of the parties. An example is an unconscious accident victim brought to a hospital emergency room and treated without waiting for consent; coming to a clinic or hospital already indicates an implied agreement (Putri, 2020). The parties are further bound by four basic rules: trust, care, use of the latest knowledge and standards, and openness, including the patient's right to a second opinion.

The therapeutic agreement in the Health Law

The Health Law does not regulate the therapeutic agreement specifically, but it does so implicitly through its provisions on rights and obligations (Articles 4 to 13) and on health personnel (Articles 21 to 29). The technical rules are found in implementing instruments such as Law No. 29 of 2004 on Medical Practice and Law No. 36 of 2014 on Health Personnel. Articles 57 and 58 of the latter set out the rights and obligations of health personnel, and Article 68 concerns consent to action, subject to the exception in Article 69 paragraph (2) that public health services that are government programmes do not require consent. The Health Law also uses the terms "fault or negligence" in Articles 54 and 55, rather than the term malpractice. Whether there has been fault or negligence is decided by a disciplinary mechanism (the Health Personnel Disciplinary Council), and compensation for loss follows the general law.

From these provisions, four elements can be drawn out. The first is the subjects, namely

the patient and the doctor or dentist. The second is the object, which is the maximum effort to cure or treat. The third is the rights and obligations, namely the doctor's duty to make serious efforts to cure and the patient's duty to pay the agreed costs. The fourth is good faith and a lawful cause. The relationship must also carry the marks of agreement and of trust (a fiduciary relationship). Under Articles 50 and 53 of the Health Law, a doctor performs activities within his or her competence, complies with professional standards, and respects patients' rights to information and to give consent.

Legal relationships in a therapeutic transaction at the hospital

Doctor and patient

The legal relationship between doctor and patient embodies two human rights protected by law and international convention: the right to self-determination and the right to information (Ricky, 2020). Thiroux distinguishes three views of the relationship: paternalism, where the doctor decides as a parent would; individualism, where the patient has absolute rights over his or her body; and the reciprocal and collegial view, where the patient and family are at the core and doctors and health workers cooperate to give the best care (Mannas, 2018). Two patterns therefore exist: a vertical, paternalistic pattern and a horizontal, contractual one. Indonesian regulation increasingly favours the horizontal pattern.

As an agreement, the therapeutic transaction must meet the four conditions of Article 1320. The first two are subjective, and if either is missing the agreement can be annulled by a judge at the request of the party concerned. The last two are objective, and if either is missing the agreement is void by law. Because the transaction is an *inspanningsverbintenis*, a departure from standard medical procedure amounts to default or breach of promise under Article 1239 of the Civil Code. Articles 2 and 3 of the Regulation of the Minister of Health No. 290/2008 require consent for all medical actions, in writing or orally, after the necessary explanation; in an emergency, action to save the patient's life may proceed without prior consent.

Medical personnel and the hospital

There are broadly two legal relationships between medical personnel and a hospital (Haryanto, 2019). In the first, an employment relationship, the doctor is an employee of the hospital (an "in" doctor), subject to labour law, the Civil Code and the reciprocal rights and duties of employer and employee. In the second, a relationship based on agreement, the doctor is not an employee but is bound to the hospital by an agreement that allows the use of hospital facilities, for example outpatient or inpatient facilities, while treating patients. The rules on this relationship are found in the Civil Code.

Which relationship exists is decisive for determining the hospital's liability for malpractice by a doctor. Where the relationship is one of employment, the hospital answers for the acts of those working under its orders (Article 1367 paragraph (3) of the Civil Code), and in practice liability is often joint and several between the hospital and the doctor or other medical personnel whose act caused the loss. Where the relationship rests on agreement, liability lies with the doctor or medical personnel concerned, and the hospital is released, because the hospital and the doctor are separate legal entities. The Indonesian Hospital Code of Ethics (KODERSI) also shows that a hospital owes duties to its staff regarding welfare, safety and continuing training, and that professional freedom does not remove the employer's civil liability where an employment relationship exists (Haryanto, 2019).

Liability for medical risk in hospital healthcare services

The doctor's liability for the patient's loss

Under Article 1338 of the Civil Code, a valid agreement has the force of law for those who made it, so the therapeutic transaction produces rights, obligations and accountability for each party. The doctor's basic legal duty is not to commit errors in medical treatment, which is carried out solely for the patient's health. Article 39 of Law No. 29 of 2004 states that medical practice is carried out on the basis of an agreement between doctor and patient. Because the obligation is one of best effort, a doctor cannot be blamed if the result is not what the patient and family had hoped, provided there was no negligence. This is tied to the maxim *volenti non fit injuria*: a person who has agreed to bear a risk cannot claim when the risk occurs. A doctor also has a right to legal protection so long as he or she acts in accordance with the professional standard, the standard of professional service and SOPs (Article 57 letter a of Law No. 36 of 2014). Cases such as *Whitehouse v Jordan* (1980) illustrate error of judgment as a type of medical risk (Tsanie & Kusumaningrum, 2023).

Civil law recognises several bases for liability. Contractual liability arises from default; liability in tort rests on unlawful acts; strict liability arises without fault; and vicarious liability arises from the fault of a subordinate (Panjaitan, 1997). Komalawati (2002) divides a doctor's legal liability into liability for fault and liability without fault. A patient who suffers loss from a doctor's fault may claim compensation either for default or for an unlawful act. The two differ in important ways. For an unlawful act, the patient must prove that the loss was caused by an act contrary to the doctor's professional duty, the patient's rights, morality or social propriety. Default requires evidence of loss arising from the failure to meet the professional standard promised in the agreement. Liability for default is narrower, since it recognises only material loss, whereas an

unlawful act may also give rise to compensation for immaterial loss (Syamsu & Sulistyawati, 2011). Because it is hard to fix exactly when a doctor is in default of an obligation of effort, most malpractice claims in Indonesia are founded on unlawful acts (Article 1365) rather than default.

The elements of an unlawful act in this setting are an act (whether positive or negative, and classically nonfeasance, misfeasance or malfeasance), fault (intention or negligence), loss (material or immaterial, which must be itemised, as Supreme Court decisions require) and a causal link between the act and the loss. Where careless conduct causes serious injury, permanent disability or death, criminal liability may arise under Articles 90, 359, 360 and 361 of the Penal Code. Criminal prosecution is thus limited to cases in which the patient suffers permanent disability or death from gross negligence (*culpa lata*). Beyond civil and criminal routes there is the disciplinary route: under Article 66 of the Medical Practice Law, anyone who knows of or is harmed by a doctor's action may complain in writing to the Indonesian Medical Discipline Honour Council (MKDKI), which can impose a written warning, revocation of the STR or SIP, or an obligation to undergo further education. A complaint does not remove the right to file a civil or criminal claim.

The hospital's liability for malpractice by medical personnel

Article 1 point 10 of the Health Law defines a hospital as a health facility that provides comprehensive individual health services through promotive, preventive, curative, rehabilitative and/or palliative care, with inpatient, outpatient and emergency services. Malpractice means treatment that is wrong, or harm that arises not from deliberate act but from negligence that a doctor should not have committed, resulting in disability or death. Hanafiah (2009) explains that, however malpractice is defined, it involves at least one of these elements: the doctor lacks the medical knowledge and skill generally accepted in the profession; services are below standard; there is gross negligence or lack of care, whether by failing to do what should be done or doing what should not be done; or the medical action is contrary to law.

From the civil-law perspective, malpractice can be grouped into default (Article 1239 of the Civil Code), an unlawful act (Article 1365), negligence causing loss (Article 1366), and failure to supervise as a person responsible for others (Article 1367 paragraph (3)). Under Article 1367, an employer, and those who appoint others to represent their affairs, are liable for loss caused by servants or subordinates while doing the work for which they are employed. This is the doctrine of vicarious liability, under which a corporation such as a hospital can be held liable for the fault of those working for it (Panjaitan, 1997). Haryanto (2019) proposes three parameters for judging how far a hospital is liable for the negligence of medical personnel:

1. The pattern of the therapeutic relationship. Where the hospital is the party that owes the performance to the patient and the doctor is only an employee carrying out the hospital's obligations, the hospital is the principal and the doctor is the agent. This typically applies to government hospitals with salaried doctors.

2. The pattern of the work relationship of medical personnel. Doctors may be employees, partners (attending physicians) or independent contractors, and each pattern determines whether and how far the hospital is liable.

3. The hospital as a corporation. As a legal entity, the hospital can be sued for malpractice by personnel under the doctrine of vicarious liability.

The table below summarises how the legal relationship allocates liability, which is the central finding of the second research question.

Relationship pattern	Status of the doctor	Basis of hospital liability	Who bears liability
Employment ("in" doctor)	Employee; hospital as principal, doctor as agent	Vicarious liability, Article 1367(3) of the Civil Code; unlawful act of subordinates	Hospital, often jointly and severally with the doctor
Agreement (visiting or partner doctor)	Not an employee; uses hospital facilities under an agreement	No basis for vicarious liability; hospital and doctor are separate legal entities	Doctor or medical personnel concerned; hospital generally released

Table 1. Allocation of hospital liability by legal relationship with medical personnel

The allocation in Table 1 has practical consequences. First, patients cannot assume that the hospital they were treated in will answer for every loss. Whether they can proceed against the hospital depends on how the doctor is tied to it. Second, hospitals with partner doctors should make the allocation of liability explicit in the written agreement, as the literature recommends, since a hospital that admits partner doctors while remaining silent invites disputes. Third, the position of hospital-employed staff who assist a partner doctor, such as the operating nurse in the earlier example, remains contested between the "captain of the ship" doctrine and hospital liability under Article 46 of the Hospital Law, and it deserves clearer regulation.

Lastly, the discussion shows why informed consent matters beyond its formal role. The therapeutic transaction is an obligation of effort, so failure of treatment does not by itself prove malpractice or a breach of SOPs. Properly done, informed consent helps patients and families understand that medical services are an effort (*ikhtiar*) that may fail, and it also documents what was agreed, which can serve as evidence in a dispute (Article 308 of the Health Law). Where consent is done badly, for instance through rigid standard clauses that the patient did not understand, its protective function for both sides is weakened

CONCLUSION

This study concludes, first, that legal liability for medical risk in hospital healthcare services based on therapeutic transactions is regulated in Law No. 17 of 2023 on Health, especially Article 56 paragraphs (1) to (3), Article 57 paragraphs (1) and (2), and Article 58 paragraphs (1) to (3). In substance, these articles require a doctor to comply with the Indonesian Code of Medical Ethics, professional standards and SOPs, and with administrative requirements such as holding a valid STR and SIP. These provisions sit alongside the general law of obligations in the Civil Code, which governs the therapeutic transaction as an obligation of effort.

Second, liability for medical risk in such transactions depends heavily on the legal relationship between medical personnel and the hospital. If the relationship is one of employment, the hospital is liable for the unlawful acts of employees or subordinates under Article 1367 paragraph (3) of the Civil Code. If it is based on an agreement, for example where doctors and other medical personnel lease hospital facilities, the hospital is not liable for acts or negligence that cause loss to patients or their families, and liability rests on the medical personnel.

Three recommendations follow. First, the public should understand that medical action is not an exact science whose outcome can be fixed in advance. Informed consent helps patients and families see that health services are an effort that can fail without malpractice or breach of SOPs, and informed consent should therefore follow a standard procedure that protects patients and is applied in line with the regulations. Second, to mitigate risk from the acts of personnel working under them, hospitals should make the legal relationship with each medical professional clear and certain, and should be professionally managed, with competent staff who act carefully. Third, policymakers should provide training and technical support for the tools used in this practice and introduce systems gradually, since doctors are not technical experts and are reluctant to use complex systems without support. Future research could test these findings empirically, for example by examining court decisions on hospital liability for partner doctors, and could study how the standard clauses used in hospitals affect the validity of consent.

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