Indonesian Health Justice Review
ISSN: XXXX-XXXXX (Online)
Vol. 3, No. 2, 2026, pp. 181-196
Published online since June 25, 2026

Medical Treatment Without Consent: Hospital Liability for Non-Emergency Interventions in Indonesia

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DOI: https://doi.org/10.65815/bf8z9f21

Submitted: 11-01-2026	Revised: 19-03-2026, 20-05-2026	Accepted: 15-06-2026

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Abstract

Patient autonomy constitutes a fundamental principle of modern healthcare law, requiring medical interventions to be preceded by adequate information and voluntary consent. Nevertheless, disputes may arise when healthcare providers perform medical procedures without obtaining valid consent, particularly in circumstances that do not qualify as genuine medical emergencies. This article examines hospital liability for non-emergency medical interventions conducted without informed consent in Indonesia. The study applies a normative juridical method, analyzing the legal foundations of patient autonomy, informed consent, professional medical duties, and institutional responsibility. The analysis distinguishes between emergency circumstances in which immediate intervention may be legally justified and non-emergency situations in which treatment without consent may constitute a violation of patient rights. The article argues that hospitals should not avoid institutional responsibility merely by attributing the conduct to individual physicians, particularly where inadequate consent procedures, supervision, or institutional policies contributed to the violation. A dual accountability framework is proposed, distinguishing individual professional responsibility from institutional failures in informed-consent governance. The framework emphasizes documentation, disclosure, patient capacity, alternative treatments, and institutional oversight. Strengthening these safeguards would enhance respect for patient autonomy and establish clearer legal remedies for violations occurring within Indonesian healthcare institutions.

[*Otonomi pasien merupakan prinsip fundamental hukum kesehatan modern, yang mengharuskan intervensi medis didahului oleh informasi yang memadai dan persetujuan sukarela. Meskipun demikian, perselisihan dapat timbul ketika penyedia layanan kesehatan melakukan prosedur medis tanpa memperoleh persetujuan yang sah, terutama dalam keadaan yang tidak memenuhi syarat sebagai keadaan darurat medis yang sebenarnya. Artikel ini mengkaji tanggung jawab rumah sakit atas intervensi medis non-darurat yang*

dilakukan tanpa persetujuan berdasarkan informasi di Indonesia. Studi ini menerapkan metode yuridis normatif, menganalisis dasar hukum otonomi pasien, persetujuan berdasarkan informasi, kewajiban medis profesional, dan tanggung jawab institusional. Analisis membedakan antara keadaan darurat di mana intervensi segera dapat dibenarkan secara hukum dan situasi non-darurat di mana perawatan tanpa persetujuan dapat merupakan pelanggaran hak pasien. Artikel ini berpendapat bahwa rumah sakit tidak boleh menghindari tanggung jawab institusional hanya dengan mengaitkan perilaku tersebut kepada dokter individu, terutama jika prosedur persetujuan, pengawasan, atau kebijakan institusional yang tidak memadai berkontribusi pada pelanggaran tersebut. Kerangka kerja akuntabilitas ganda diusulkan, yang membedakan tanggung jawab profesional individu dari kegagalan institusional dalam tata kelola persetujuan berdasarkan informasi. Kerangka kerja ini menekankan dokumentasi, pengungkapan, kapasitas pasien, pengobatan alternatif, dan pengawasan institusional. Penguatan perlindungan ini akan meningkatkan penghormatan terhadap otonomi pasien dan menetapkan solusi hukum yang lebih jelas untuk pelanggaran yang terjadi di dalam institusi perawatan kesehatan Indonesia.]

Keywords: Informed consent, patient autonomy, hospital liability, medical treatment, health law

Introduction

The transformation of healthcare from a paternalistic model toward an autonomy-based relationship has fundamentally altered the legal meaning of medical treatment. Medical intervention is no longer understood solely as an exercise of professional expertise but as an action requiring authorization from the person whose body and interests are directly affected. Informed consent consequently operates as both an ethical safeguard and a legal mechanism through which patients exercise control over medical decisions. Contemporary scholarship emphasizes that valid consent involves more than the patient's signature; it requires meaningful disclosure, sufficient understanding, decision-making capacity, and voluntariness (Pedersen, Hofmann, and Mangset 2007; Wolf-Braun and Wilke 2015). The significance of this distinction is particularly evident when treatment is performed without authorization. If a patient has not been given a genuine opportunity to understand and choose among medically relevant alternatives, the intervention may undermine autonomy even where the clinical outcome is satisfactory. Consent should therefore be understood as part of the substantive legal relationship between patient and healthcare provider rather than as a merely administrative procedure.

The legal problem becomes more complex when treatment is undertaken without consent on the basis that the patient required urgent intervention.

Emergency medicine presents genuine tension between autonomy and the need for immediate action. A patient may be unconscious, incapacitated, or otherwise unable to communicate a decision at the precise moment when treatment is necessary to prevent death or serious deterioration. Scholarly literature recognizes that emergency circumstances may justify limited exceptions to ordinary consent requirements, but emphasizes that such exceptions are closely connected to urgency, incapacity, and the inability to obtain authorization without jeopardizing the patient's interests (Kirby 1983; Kituuka et al. 2023). The existence of an emergency exception does not mean that healthcare professionals possess unrestricted authority to bypass consent whenever treatment appears beneficial. The legal significance of urgency must therefore be assessed objectively, with attention to whether immediate intervention was genuinely necessary and whether a reasonable opportunity existed to obtain consent.

The distinction between emergency and non-emergency treatment is particularly important in Indonesia because the legal consequences of treatment without consent may extend beyond professional ethics into civil, administrative, and potentially criminal responsibility. Indonesian scholarship has recognized informed consent as an important manifestation of patient autonomy and has identified persistent difficulties in implementing consent as a meaningful communication process rather than as an administrative formality (Susilo et al. 2012). Research concerning hospital responsibility similarly demonstrates that Indonesian healthcare institutions may bear legal responsibility for negligence occurring within institutional healthcare services (Haryanto 2019; Budiman, Rizka, and Absori 2023). The current framework is further shaped by Law Number 17 of 2023 concerning Health, which replaced several earlier health-sector statutes and reorganized the legal architecture governing health services and professional responsibility. The resulting framework requires careful interpretation because institutional responsibility cannot automatically be reduced to the personal fault of the treating physician.

This article focuses specifically on non-emergency medical interventions performed without valid patient consent. The focus is deliberate because the legal justification for emergency treatment should not obscure a distinct category of cases in which treatment could reasonably have been preceded by consent. The article asks whether a hospital may be held legally responsible when a physician performs a non-emergency intervention without valid informed consent, even when the physician acted competently and the treatment itself was medically indicated. It further examines when responsibility should be attributed individually to the physician and when it should extend institutionally to the hospital. The article argues that failure to obtain consent in non-emergency circumstances should be analyzed as an autonomous legal violation of patient autonomy and that hospital liability should arise where institutional failures contributed to the absence or invalidity of consent.

The article contributes to the literature by proposing a dual accountability framework for treatment without consent. The first dimension concerns individual professional responsibility for decisions to proceed without authorization, inadequate disclosure, failure to assess capacity, or inappropriate invocation of an emergency exception. The second concerns institutional responsibility for inadequate consent policies, ineffective supervision, deficient documentation systems, insufficient staff training, and organizational practices that normalize treatment without meaningful patient participation. This approach avoids two opposite errors. It prevents hospitals from escaping responsibility by characterizing consent failures as purely individual misconduct, while also preventing automatic institutional liability whenever a physician independently violates established procedures. The framework consequently seeks to connect patient autonomy with organizational accountability in Indonesian healthcare law.

This study employs normative juridical research using statutory, conceptual, and comparative approaches. The statutory approach examines Indonesian legal provisions governing healthcare services, patient rights, medical treatment, informed consent, professional obligations, and hospital responsibility. Particular attention is given to Law Number 17 of 2023 concerning Health, the applicable provisions of the Civil Code, and regulations concerning informed consent and medical records. The conceptual approach is used to examine the legal meaning of patient autonomy, informed consent, capacity, voluntariness, emergency treatment, professional negligence, institutional responsibility, and vicarious liability. Because Indonesian legislation does not comprehensively define every dimension of valid informed consent or establish an exhaustive test for distinguishing emergency from non-emergency interventions, comparative legal and medical-ethical scholarship is used to identify principles capable of informing the Indonesian framework.

The secondary materials consist principally of peer-reviewed journal articles concerning informed consent, patient autonomy, patient comprehension, emergency treatment, medical malpractice, hospital responsibility, and professional accountability. The literature was selected for relevance, academic reliability, and bibliographic verifiability, with the journal literature cutoff placed before 2026. International literature is used comparatively rather than as direct evidence of Indonesian practice. Indonesian journal literature is used to contextualize the domestic legal framework and institutional responsibility. The analysis is normative and prescriptive: it identifies legal relationships and principles, evaluates the adequacy of the existing framework, and formulates a proposed model for allocating responsibility. The method therefore does not seek to measure the frequency of unauthorized treatment empirically but to determine the legal consequences that should follow when a non-emergency medical intervention occurs without valid patient authorization.

Patient Autonomy and the Legal Meaning of Valid Informed Consent

Patient autonomy provides the normative foundation for informed consent because medical treatment directly affects the patient's body, health, dignity, and personal interests. Autonomy requires that competent patients be permitted to make decisions concerning medical interventions according to their own values and preferences rather than merely accepting decisions made by healthcare professionals. Pedersen, Hofmann, and Mangset explain that informed consent is closely connected to autonomy, participation, understanding, competence, and voluntariness (2007). Robertson similarly observes that contemporary informed-consent doctrine has moved away from paternalistic decision-making toward a relationship in which healthcare professionals must respect the patient's autonomous choice (2016). This development has important legal implications. The physician's professional expertise may justify recommending a particular intervention, but it does not ordinarily confer unilateral authority to impose that intervention on a competent patient. The legal relationship therefore contains two distinct dimensions: the professional duty to recommend appropriate care and the patient's right to authorize or refuse that care.

Valid informed consent cannot be reduced to a signature on a standardized form. The consent process requires disclosure of information relevant to the patient's decision, including the nature and purpose of the proposed intervention, material risks, expected benefits, reasonable alternatives, and, where appropriate, the consequences of declining treatment. Kittleson et al. emphasize that informed consent rests upon principles of autonomy, integrity, respect, and patient participation (2022). Research concerning informed-consent forms demonstrates, however, that formal documentation frequently fails to communicate all decision-relevant information. Bottrell et al. found that many hospital consent forms omitted one or more fundamental elements such as risks, benefits, and alternatives (2000). Lьhnen, Mьhlhauser, and Steckelberg similarly found substantial deficiencies in consent documents, including incomplete information concerning risks, benefits, alternatives, and the option of doing nothing (2018). These findings demonstrate why legal analysis must distinguish between documented consent and substantively informed consent.

The quality of disclosure is particularly important because patients do not necessarily understand information merely because it has been provided. Pietrzykowski and Smilowska's systematic review found that patient comprehension of important components of informed consent is frequently limited (2021). Patients may understand the general purpose of a procedure while failing to appreciate material risks, alternatives, or uncertainty concerning outcomes. Similar problems have been demonstrated in procedural settings, where patients may retain incomplete or inaccurate perceptions of benefits and alternatives despite having undergone a formal consent process (Sullivan et al. 2013). This suggests that the legal validity of consent should not depend exclusively on whether the

physician communicated information but also on whether the communication was reasonably capable of enabling patient understanding. The requirement of comprehension does not mean that physicians must guarantee perfect understanding. It does, however, require a process adapted to the patient's circumstances, language, educational background, and capacity to process information.

The communication model underlying informed consent should consequently be understood as dialogical rather than unilateral. Wolf-Braun and Wilke characterize informed consent as a process through which physicians empower patients to reach decisions reflecting their circumstances and values (2015). Gilligan et al. similarly emphasize that informed consent and shared decision-making involve communication concerning available options and the patient's goals (2023). Shared decision-making does not eliminate the physician's professional role; rather, it changes that role from unilateral decision-maker to professional adviser who provides relevant information and clinical judgment while recognizing the patient's authority to decide. This distinction is crucial in cases of alleged treatment without consent. If the healthcare professional simply assumes that a medically beneficial procedure is automatically authorized by the patient's decision to seek healthcare, the professional effectively collapses the distinction between seeking medical assistance and consenting to every intervention that the professional considers desirable.

The legal significance of informed consent is therefore independent from the technical quality of the treatment itself. A physician may perform a procedure according to the appropriate professional standard and nevertheless violate patient autonomy by performing it without valid authorization. This proposition does not mean that every deficiency in consent automatically establishes liability for all resulting injuries. Rather, it means that the legality of the intervention and the quality of the clinical performance are analytically distinct questions. The first concerns whether the patient validly authorized the intervention; the second concerns whether the intervention was performed according to professional standards. This distinction is also visible in malpractice research, where allegations concerning failure to obtain informed consent form a distinct category of claims and commonly involve failures to explain risks and alternative treatment options (Miller et al. 2017). The Indonesian legal framework should preserve this distinction rather than treating informed consent merely as evidence that the physician acted professionally.

The Emergency Exception and the Boundary of Permissible Treatment Without Consent

The emergency exception to informed consent exists because strict application of ordinary consent requirements can become incompatible with the preservation of life or prevention of serious harm. When a patient is unconscious, lacks decision-

making capacity, and requires immediate intervention, delaying treatment merely to obtain formal authorization may itself violate the healthcare professional's duty of care. Kirby's analysis of informed consent recognizes emergency circumstances as one of the principal areas in which ordinary consent requirements may be limited (1983). Contemporary literature similarly explains that emergency treatment presents special challenges because patients may lack capacity and time may be insufficient to complete ordinary disclosure and deliberation (Kituuka et al. 2023). The legal rationale, however, is not simply that treatment is beneficial. The justification depends upon a combination of urgency, necessity, incapacity or inability to obtain consent, and the patient's best interests.

The distinction between urgency and convenience is therefore essential. An intervention should not become legally exempt from consent merely because a healthcare professional considers it preferable to proceed immediately. A genuinely emergent situation normally involves a substantial risk of death, serious deterioration, or comparable harm if treatment is delayed. By contrast, a procedure that can safely be postponed for a reasonable period to allow the patient to receive information and make a decision remains subject to the ordinary consent requirement. The emergency exception should consequently be interpreted narrowly because an expansive interpretation would undermine the general principle of autonomy. If every medically advisable intervention could be characterized as urgent, consent would cease to operate as a meaningful authorization mechanism. Kituuka et al. emphasize that emergency conditions may make consent difficult but also recognize the continuing importance of autonomy, best interests, and appropriate decision-making processes (2023). The existence of difficulty therefore does not itself eliminate the legal obligation to seek consent.

Patient capacity represents another important boundary. Capacity should not be inferred merely from the fact that a patient is ill, hospitalized, anxious, elderly, or making a decision that the physician considers unwise. Lamont, Jeon, and Chiarella identify significant inconsistencies in healthcare professionals' knowledge and practice concerning capacity assessment (2013). Lamont et al. further conclude that capacity-assessment instruments should support rather than replace clinical judgment (2013). The implication for Indonesian healthcare law is that a finding of incapacity should be based upon the patient's actual ability to understand, appreciate, reason about, and communicate a treatment decision rather than upon diagnostic labels or institutional assumptions. Where capacity is absent but treatment is not immediately necessary, healthcare professionals should ordinarily seek authorization through an appropriate representative or other legally recognized mechanism rather than simply proceed without authorization.

The same principle applies when a patient initially refuses treatment. Refusal is not automatically evidence of incapacity or irrationality. Respect for autonomy requires recognition that competent patients may reject recommended treatment even where healthcare professionals believe that the refusal exposes the patient to significant risk. Emergency circumstances may alter this analysis where immediate

treatment is necessary and legally recognized exceptions apply, but non-emergency circumstances generally preserve the patient's right to refuse. The literature concerning autonomy emphasizes that informed consent includes the capacity to make voluntary choices, including choices that differ from professional recommendations (Pedersen, Hofmann, and Mangset 2007). A healthcare professional's belief that a patient is making the wrong decision therefore cannot, by itself, substitute professional preference for patient authorization.

The legal boundary should consequently be formulated around necessity rather than benefit. A medically beneficial intervention is not necessarily an intervention that may be performed without consent. The relevant question is whether immediate treatment without authorization was reasonably necessary to protect the patient's life or prevent serious and imminent harm when valid consent could not be obtained. This distinction is particularly important for hospitals because institutional protocols may unintentionally encourage healthcare professionals to treat urgency broadly. A hospital that fails to define and supervise emergency exceptions risks creating a culture in which the exception becomes routine. The institution's responsibility therefore begins before an individual physician decides to proceed. Effective governance requires clear protocols distinguishing emergency treatment from elective, routine, or deferrable intervention and requiring documentation of why consent could not reasonably be obtained.

Hospital Liability for Non-Emergency Treatment Without Consent

Hospital liability must be distinguished from the individual professional responsibility of the physician who directly performs the intervention. The physician may be responsible for failing to obtain consent, failing to disclose material information, incorrectly determining that the patient lacked capacity, or improperly invoking an emergency exception. Yet the existence of individual responsibility does not automatically eliminate institutional responsibility. Hospitals organize the environment in which medical professionals practice, establish consent procedures, employ and supervise personnel, maintain documentation systems, and determine how clinical governance operates. Indonesian scholarship concerning hospital responsibility has recognized that healthcare institutions may bear responsibility for losses resulting from negligence committed by healthcare workers in the hospital context (Haryanto 2019; Budiman, Rizka, and Absori 2023). The legal question should therefore include whether the institution itself failed to establish or enforce adequate systems for protecting patient autonomy.

This institutional dimension is especially important when unauthorized treatment results from organizational rather than purely individual failure. Suppose a physician performs a non-emergency procedure without consent because hospital policy does not require documented verification of consent, because staff members

routinely treat consent forms as administrative paperwork, or because the hospital provides inadequate training concerning capacity and emergency exceptions. In such circumstances, attributing all responsibility to the individual physician would overlook the organizational conditions that made the violation possible. Research on consent documentation demonstrates that deficiencies are often systemic rather than isolated. Studies of hospital consent forms have found recurring failures concerning risks, alternatives, patient copies, understanding, and decision-making support (Bottrell et al. 2000; Calle-Urra et al. 2015; 2013). The recurrence of these deficiencies supports the proposition that informed-consent quality should be addressed through institutional governance rather than exclusively through individual professional discipline.

Indonesian legal scholarship provides further support for examining institutional responsibility independently from individual physician fault. Haryanto identifies the legal basis for hospital responsibility in the relationship between hospitals and healthcare workers and discusses the connection between Article 1367 of the Civil Code and the former Hospital Law's institutional responsibility provisions (2019). Budiman, Rizka, and Absori similarly argue that hospitals possess legal responsibility for negligence involving healthcare personnel operating within the hospital environment (2023). Under the current Health Law framework, institutional responsibility must nevertheless be analyzed carefully rather than mechanically transferred from every physician act to the hospital. The more persuasive approach is to distinguish vicarious responsibility for personnel conduct from direct institutional responsibility for organizational failures. This distinction allows courts to identify whether liability results from the physician's conduct, the hospital's own governance failure, or both.

The distinction is particularly important in informed-consent disputes because the hospital may contribute to the violation without directly making the clinical decision. A physician may fail to disclose alternatives despite an adequate institutional protocol, suggesting individual professional responsibility. Conversely, if the hospital has no meaningful consent protocol, fails to provide appropriate consent forms, permits unauthorized personnel to obtain consent, or fails to train staff in capacity assessment, the institutional contribution becomes more substantial. The legal inquiry should therefore examine causation between the institutional failure and the absence of valid consent. This approach avoids both overextension and underenforcement of hospital liability. The hospital should not be treated as automatically liable merely because an unauthorized intervention occurred, but neither should it be allowed to avoid accountability by asserting that only the individual physician possessed the duty to obtain consent.

Documentation provides an important mechanism for determining whether institutional responsibility exists. Consent documentation should identify the procedure proposed, the information communicated, relevant risks and alternatives, the patient's decision, and the identity of the professional responsible for the discussion. Research repeatedly demonstrates that documentation quality

remains imperfect even in well-developed healthcare systems (Lьhnen, Mьhlhauser, and Steckelberg 2018; Kunneman et al. 2020). Documentation cannot substitute for actual informed consent, but it provides evidence concerning whether a consent process occurred and what information was provided. A hospital that systematically fails to document consent may therefore create both evidentiary and governance problems. Conversely, a well-designed documentation system can assist the institution in demonstrating that appropriate procedures were followed while simultaneously protecting patients from unauthorized interventions.

The hospital's liability should also be connected to its institutional duty to maintain patient-centered governance. Consent forms designed primarily to obtain signatures or protect institutional interests are insufficient if they fail to facilitate understanding. Bottrell et al. found that hospital forms frequently functioned more as authorization and liability-protection instruments than as tools supporting patient decision-making (2000). Lьhnen, Mьhlhauser, and Steckelberg reached similar conclusions concerning deficiencies in the informational quality of consent documents (2018). This evidence suggests that hospitals should be evaluated not only according to whether a signed document exists but according to whether their consent governance is reasonably capable of producing valid consent. The legal standard should consequently move from formal compliance toward functional protection of autonomy.

A Dual Accountability Framework for Indonesian Healthcare Institutions

A coherent legal response to treatment without consent requires a framework that separates individual professional responsibility from institutional responsibility while recognizing that both may arise from the same event. Individual responsibility should attach where a physician or other authorized healthcare professional independently fails to obtain consent, provides inadequate information, proceeds despite a competent refusal, incorrectly assesses capacity, or invokes emergency treatment without satisfying the necessary conditions. The professional standard should be assessed according to the circumstances existing at the time of the decision. The physician's clinical judgment remains relevant, but clinical judgment cannot eliminate the patient's legal authority over non-emergency bodily intervention. This framework recognizes that professional competence and respect for autonomy are complementary obligations rather than competing alternatives.

Institutional responsibility should arise where the hospital itself contributes to the consent failure through deficient policies, inadequate supervision, ineffective documentation, insufficient training, poor communication systems, or organizational practices that systematically weaken patient participation. This approach reflects the broader literature demonstrating that consent quality depends not only upon individual physician communication but also upon the design of institutional consent systems (Bottrell et al. 2000; Jefford and Moore 2008). Studies

evaluating consent documents across hospitals demonstrate substantial variability and recurring deficiencies, suggesting that quality improvement requires organizational intervention rather than reliance exclusively on individual professionalism (Calle-Urra et al. 2015; Henderson et al. 2020). The hospital should therefore have an affirmative governance obligation to create conditions in which valid consent can realistically be obtained.

The first operational principle of this framework is that non-emergency treatment should presumptively require prior authorization. The presumption should be displaced only where a legally recognized exception applies. This approach provides clarity to healthcare professionals and protects patients against retrospective characterization of ordinary procedures as emergencies. The hospital should require clinical documentation when consent is not obtained, including the circumstances preventing consent, the patient's capacity status, the urgency of the intervention, the potential consequences of delay, and the identity of the professional making the decision. Such documentation would create accountability without preventing genuine emergency treatment. The emergency exception would consequently function as a narrowly defined legal safeguard rather than a general institutional discretion.

The second principle concerns the quality of the consent process. Hospitals should ensure that consent procedures communicate the material information necessary for the patient to make a meaningful decision. Evidence indicates that alternative communication methods, including audiovisual tools, interactive materials, and teach-back approaches, can improve patient comprehension (Kinnersley et al. 2013; Sivanadarajah et al. 2017). However, communication technology should supplement rather than replace professional dialogue. The physician or appropriately authorized professional remains responsible for answering patient questions, addressing individualized concerns, and ensuring that the decision is voluntary. Consent documentation should therefore record not merely that information was delivered but that the patient had an opportunity to ask questions and express a decision. This would make the consent process more consistent with autonomy-centered healthcare.

The third principle concerns capacity assessment. Hospitals should establish protocols ensuring that incapacity is assessed individually rather than assumed from diagnosis, age, disability, or disagreement with medical advice. Lamont, Jeon, and Chiarella identify inconsistencies in healthcare professionals' understanding of capacity assessment, suggesting the need for clearer institutional guidance and professional education (2013). Where a patient lacks capacity, the institution should identify the appropriate surrogate or legally recognized decision-making mechanism and document why the patient could not decide independently. In a genuine emergency where no authorized representative is reasonably available, treatment may proceed within the applicable legal exception, but the justification should be documented. This model creates a traceable chain of reasoning that

allows later review without imposing unrealistic procedural requirements during critical emergencies.

The fourth principle is institutional review and accountability. Hospitals should maintain internal mechanisms for reviewing cases in which treatment was performed without ordinary consent. Such review should determine whether the intervention was genuinely emergent, whether capacity was properly assessed, whether alternatives existed, whether information was appropriately disclosed, and whether institutional procedures were followed. The objective should not be solely disciplinary. Review should identify recurring organizational failures and improve future practice. The evidence concerning deficiencies in consent documentation demonstrates the value of quality-improvement systems in identifying and correcting institutional problems (Calle-Urra et al. 2015). An effective governance model would therefore transform individual incidents into institutional learning while ensuring that serious violations remain subject to appropriate legal remedies.

The final principle concerns remedies. A patient who undergoes non-emergency treatment without valid consent should have access to an effective mechanism for challenging the intervention and seeking appropriate redress. The legal remedy should depend upon the nature of the violation and resulting harm. Where physical injury resulted from negligent treatment, ordinary malpractice and civil-liability principles may apply. Where treatment itself was unauthorized but professionally performed, the legal system should nevertheless recognize that autonomy has independent value and that the absence of consent cannot automatically be neutralized by a favorable clinical outcome. This distinction is essential because otherwise hospitals could effectively argue that unauthorized intervention is harmless whenever the treatment happens to be medically successful. Such reasoning would transform autonomy from a legal right into a conditional privilege dependent upon clinical outcome.

The dual accountability model therefore provides a more balanced basis for allocating responsibility. Individual physicians remain accountable for decisions that directly violate patient autonomy, while hospitals are accountable for organizational conditions that facilitate or tolerate such violations. The framework is not intended to create automatic institutional liability for every consent defect. Instead, it asks whether the hospital established reasonable systems, whether those systems were implemented, whether personnel were adequately trained, and whether institutional failures contributed materially to the absence of valid consent. Such an approach is consistent with Indonesian scholarship identifying the continuing need for clearer boundaries between individual and institutional responsibility in medical malpractice (Budiman, Rizka, and Absori 2023; Fakrulloh and Lubna 2023). It also responds to the broader international literature demonstrating that informed consent is fundamentally a process of patient participation rather than a document-centered administrative act.

Conclusion

Medical treatment without consent presents a distinct legal problem because the legality of a medical intervention cannot be determined solely by reference to its clinical necessity or professional quality. Informed consent embodies the patient's autonomy and establishes the legal boundary between professional recommendation and authorized bodily intervention. The literature demonstrates that valid consent requires more than a signature and depends upon meaningful disclosure, patient understanding, capacity, and voluntariness (Pedersen, Hofmann, and Mangset 2007; Pietrzykowski and Smilowska 2021). Consequently, a non-emergency intervention performed without valid authorization may constitute an independent violation of patient rights even where the physician performs the procedure competently and the treatment produces a beneficial clinical outcome.

The emergency exception should be interpreted narrowly because its justification arises from necessity rather than from the general desirability of treatment. Immediate intervention may be justified when the patient faces serious and imminent harm, lacks capacity or cannot provide authorization, and delaying treatment to obtain consent would create unacceptable risk. The exception should not, however, encompass procedures that can reasonably be postponed to permit disclosure and patient decision-making. A broad emergency exception would effectively restore paternalistic medical authority and weaken the legal significance of autonomy. Indonesian healthcare institutions should therefore establish clear criteria and documentation requirements distinguishing genuine emergencies from interventions that remain subject to ordinary consent requirements.

Hospital responsibility should be analyzed through a dual accountability model. Individual healthcare professionals may be responsible for proceeding without consent, inadequately disclosing material information, failing to assess capacity, or improperly invoking emergency authority. Hospitals may bear separate responsibility where institutional policies, supervision, training, documentation, or governance systems contributed to the violation. Indonesian legal scholarship concerning hospital responsibility supports the proposition that institutional accountability cannot always be reduced to the personal conduct of an individual healthcare worker (Haryanto 2019; Budiman, Rizka, and Absori 2023). The appropriate legal analysis should therefore identify both the individual decision and the organizational conditions under which that decision occurred.

The principal contribution of this article is the proposed dual accountability framework for informed-consent governance. The framework combines a presumption of consent for non-emergency interventions, narrow recognition of emergency exceptions, individualized capacity assessment, meaningful disclosure, robust documentation, institutional supervision, and effective remedies. It seeks to protect patient autonomy without disregarding the operational realities of healthcare delivery. The framework also recognizes that informed consent should be understood as a continuing institutional obligation rather than an isolated interaction between one physician and one patient. By strengthening institutional

governance while maintaining individual professional accountability, Indonesian health law can better reconcile patient autonomy, professional judgment, and hospital responsibility.

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Acknowledgment
None

Funding Information
None

Conflicting Interest Statement
The authors state that there is no conflict of interest in the publication of this article.

Publishing Ethical and Originality Statement
All authors declared that this work is original and has never been published in any form and in any media, nor is it under consideration for publication in any journal, and all sources cited in this work refer to the basic standards of scientific citation.

Generative AI Statement
N/A