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

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Abstract

The ability to seek a second medical opinion is an important mechanism for patients to participate meaningfully in decisions concerning diagnosis and treatment. Despite its relevance to patient autonomy, the practical exercise of this right may be constrained by institutional practices, physician attitudes, costs, and difficulties accessing medical records. This article examines the legal status of the patient's right to obtain a second medical opinion in Indonesia and evaluates the responsibilities of hospitals in facilitating its exercise. Using normative legal research, the study analyzes patient autonomy, informed consent, professional duties, medical records, and healthcare institutional obligations. The analysis reveals that the right to a second opinion should be understood not merely as an administrative option but as an integral component of meaningful patient autonomy. Hospitals should therefore facilitate access to relevant medical information and should not impose unnecessary barriers that discourage patients from seeking alternative professional assessments. The article proposes a patient-centered framework requiring accessible medical records, transparent referral procedures, non-retaliation guarantees, and clear information regarding potential costs and treatment alternatives. Recognizing and operationalizing the right to a second opinion can reduce information asymmetry between healthcare professionals and patients while strengthening informed decision-making, accountability, and fairness in Indonesian healthcare.

[*Kemampuan untuk meminta pendapat medis kedua merupakan mekanisme penting bagi pasien untuk berpartisipasi secara bermakna dalam pengambilan keputusan terkait diagnosis dan pengobatan. Meskipun relevan dengan otonomi pasien, pelaksanaan praktis hak ini dapat dibatasi oleh praktik institusional, sikap dokter, biaya, dan kesulitan mengakses rekam medis. Artikel ini mengkaji status hukum hak pasien untuk mendapatkan pendapat medis kedua di Indonesia dan mengevaluasi tanggung jawab rumah sakit dalam memfasilitasi pelaksanaannya. Dengan menggunakan penelitian*

hukum normatif, studi ini menganalisis otonomi pasien, persetujuan berdasarkan informasi, kewajiban profesional, rekam medis, dan kewajiban institusional layanan kesehatan. Analisis menunjukkan bahwa hak untuk mendapatkan pendapat kedua harus dipahami bukan hanya sebagai pilihan administratif tetapi sebagai komponen integral dari otonomi pasien yang bermakna. Oleh karena itu, rumah sakit harus memfasilitasi akses ke informasi medis yang relevan dan tidak boleh memaksakan hambatan yang tidak perlu yang menghalangi pasien untuk mencari penilaian profesional alternatif. Artikel ini mengusulkan kerangka kerja yang berpusat pada pasien yang membutuhkan rekam medis yang mudah diakses, prosedur rujukan yang transparan, jaminan tidak akan ada pembalasan, dan informasi yang jelas mengenai potensi biaya dan alternatif pengobatan. Pengakuan dan penerapan hak untuk mendapatkan pendapat kedua dapat mengurangi asimetri informasi antara tenaga kesehatan dan pasien sekaligus memperkuat pengambilan keputusan yang berdasarkan informasi, akuntabilitas, dan keadilan dalam sistem kesehatan Indonesia.]

Keywords: Second medical opinion, patient autonomy, informed consent, hospital obligations, health justice

Introduction

Modern healthcare increasingly recognizes that patients are not passive recipients of professional expertise but participants who possess legitimate authority over decisions affecting their bodies and lives. This transformation from paternalistic medicine toward autonomy-centered healthcare has changed the legal significance of information, communication, and patient choice. Shared decision-making requires clinicians to provide relevant evidence while supporting patients in considering alternatives according to their individual preferences and circumstances (Elwyn et al. 2012). In this context, a second medical opinion is particularly significant because it allows patients to test, clarify, or reconsider a diagnosis or proposed treatment through an additional professional assessment. The legal importance of such an opportunity is therefore broader than obtaining another medical recommendation. It creates a mechanism through which patients can exercise meaningful control over decisions that might otherwise remain dominated by professional expertise. The second opinion consequently occupies an important position at the intersection of informed consent, patient autonomy, professional accountability, and patient-centered healthcare.

The practical value of a second opinion is supported by empirical literature. A systematic review by Payne et al. found that second opinions generally confirm the initial diagnosis or treatment but may also generate substantial changes in diagnosis, treatment, or prognosis, with reported changes varying considerably across studies (2014). A later systematic review similarly identified discrepancies

between first and second opinions and found that patients commonly seek additional opinions to obtain information, reassurance, or greater confidence in treatment decisions (Sewell et al. 2021). These findings are important for legal analysis because the value of a second opinion does not depend upon the second physician proving the first physician wrong. Confirmation itself can strengthen patient confidence and facilitate informed decision-making. Conversely, disagreement may reveal diagnostic uncertainty, alternative treatment possibilities, or previously undisclosed information. The second opinion therefore functions as an additional informational safeguard rather than as an institutional mechanism designed to determine which physician is "correct."

The problem arises when the formal existence of a patient right does not correspond to its practical accessibility. Patients may hesitate to seek another opinion because they fear offending their physician, damaging the therapeutic relationship, experiencing delay in treatment, or incurring additional expenses. Physicians may also perceive requests for second opinions as challenges to professional authority. Research concerning physician-patient interactions indicates that second-opinion encounters can generate tensions involving professional control, loyalty, trust, and patient autonomy (Tattersall et al. 2012). Research involving breast cancer patients further indicates that patients are not necessarily informed equally about the possibility of seeking another opinion; information concerning second opinions may be associated with age and educational status (GroЯ et al. 2017). These findings transform the legal question from whether patients may seek second opinions into a more demanding question: what positive and negative obligations must hospitals and healthcare professionals undertake to make the right realistically exercisable?

In Indonesia, this question has particular importance because patient rights are increasingly articulated within a broader health-law framework centered on patient protection and participation. Indonesian legal scholarship has examined informed consent as a mechanism for protecting the doctor-patient relationship and patient rights (Mayasari 2017; Rohman and Syafruddin 2019). Research concerning teleradiology has also identified second opinion as relevant to diagnostic accuracy and patient rights, particularly where interpretation of medical images may differ among specialists (Mardi Putra, Dewi, and Wibowo 2018). More recent Indonesian scholarship explicitly characterizes second opinion as a patient right under the contemporary health-law framework (Ali and Siregar 2025). The legal development is therefore moving toward recognition rather than denial of the patient's ability to obtain another professional assessment. The remaining challenge concerns operationalization: whether hospitals must merely tolerate a request for a second opinion or must actively facilitate the patient's ability to exercise that right.

This article argues that the right to a second medical opinion should be reconstructed as an instrumental component of patient autonomy rather than treated as an independent administrative entitlement. Its function is to reduce informational asymmetry, strengthen informed consent, facilitate shared decision-

making, and provide patients with an opportunity to challenge or confirm professional recommendations. The article further argues that the hospital's obligation is not unlimited. Hospitals cannot reasonably be required to guarantee that every requested opinion will be immediately available regardless of clinical circumstances or resource limitations. They should, however, establish procedures that prevent unnecessary barriers, provide access to relevant medical information, disclose costs, facilitate independent assessment where appropriate, and protect patients from adverse treatment because they exercised their rights. The article consequently develops a four-dimensional governance model based on accessibility, informational equality, procedural independence, and non-retaliation.

This article employs normative juridical research using statutory, conceptual, and comparative approaches. The statutory approach examines Indonesian legal provisions concerning patient rights, healthcare services, informed consent, medical records, professional obligations, and hospital responsibilities, with particular attention to Law Number 17 of 2023 concerning Health and regulations governing medical records and patient information. The conceptual approach examines patient autonomy, informed consent, shared decision-making, information asymmetry, professional independence, and health justice. The comparative approach draws on peer-reviewed international literature concerning second medical opinions and patient access to health information to identify principles that may inform the Indonesian legal framework. The analysis is normative rather than empirical: it evaluates whether the existing framework adequately protects the patient's ability to obtain a second opinion and formulates institutional obligations that could make the right substantively effective.

The secondary literature consists principally of peer-reviewed journal articles published before 2026. The literature includes systematic reviews, empirical studies, legal and ethical analyses, and Indonesian health-law scholarship. International evidence is used to establish the conceptual and practical dimensions of second opinions rather than to assert that foreign legal rules automatically apply in Indonesia. Indonesian sources are used to identify domestic legal developments and institutional concerns. The analysis proceeds from the premise that a legal right should be accompanied by corresponding obligations; otherwise, formal recognition may have little practical significance. The article therefore evaluates both negative obligations, such as the duty not to obstruct or retaliate against patients seeking another opinion, and positive obligations, such as facilitating access to records, referral mechanisms, and relevant information.

Second Medical Opinion as an Expression of Patient Autonomy

A second medical opinion should first be understood within the broader legal transformation of the doctor-patient relationship. Traditional medical paternalism assumes that the physician possesses superior knowledge and therefore should

determine the appropriate course of treatment, while the patient primarily receives professional direction. Contemporary autonomy-based models reject this assumption as a sufficient foundation for legitimate medical decision-making. The physician remains professionally responsible for diagnosis and treatment recommendations, but the competent patient retains authority to decide whether and how to proceed. Shared decision-making operationalizes this principle by requiring clinicians to identify available choices, explain relevant options, and support patients in developing informed preferences (Elwyn et al. 2012). A second opinion strengthens this process because it allows the patient to obtain an additional professional assessment before making a decision with potentially significant consequences. It therefore represents an extension of autonomy beyond the immediate consultation and gives practical substance to the patient's ability to deliberate rather than merely accept a recommendation.

The legal significance of the second opinion becomes clearer when it is connected to information asymmetry. Medical decision-making is characterized by a structural imbalance because physicians generally possess specialized knowledge that patients cannot independently reproduce. Rochaix conceptualizes the physician-patient relationship through information asymmetry and argues that the possibility of seeking a second opinion can operate as an ex ante monitoring mechanism, encouraging physicians to act more consistently with patient interests (1989). This insight is particularly relevant to healthcare law because autonomy cannot be meaningful where one party controls almost all decision-relevant information. A patient technically free to choose may nevertheless be practically dependent upon a single professional interpretation. The second opinion reduces that dependency by introducing another source of expertise. It does not eliminate information asymmetry, but it can moderate it. The right therefore serves both an individual autonomy function and a structural accountability function by creating a mechanism through which professional recommendations can be independently evaluated.

The value of a second opinion should not be measured solely by whether the second physician changes the diagnosis or treatment. Payne et al.'s systematic review demonstrates that second opinions often confirm the initial assessment, yet a meaningful proportion result in changes to diagnosis, treatment, or prognosis (2014). Similarly, Ruetters et al. found substantial variation in the extent to which second opinions alter cancer diagnoses and treatment recommendations, while patient satisfaction was generally high (2016). This means that a legal system should avoid framing the second opinion as an accusation that the first physician is incompetent. Such a characterization may discourage both patients and physicians from participating. The second opinion should instead be regarded as a deliberative safeguard operating under conditions of medical uncertainty. Confirmation may provide reassurance, while disagreement may create an opportunity to reconsider the available alternatives. Both outcomes contribute to autonomous decision-

making because the patient receives additional information before determining the course of treatment.

The autonomy rationale also explains why the right should generally belong to the patient rather than being dependent upon physician approval. Beglinger and Rokkas describe the ethical and legal debate concerning whether second opinions should be understood as a right or merely as a concession and conclude that contemporary practice increasingly recognizes them as patient rights (2007). Isaacs similarly emphasizes the principle that patients should be able to request another physician's opinion because professional fallibility is an unavoidable feature of medicine (2023). If the treating physician were given unilateral authority to decide whether a patient may seek another opinion, the right would become structurally dependent upon the very professional relationship that generates the request. Such a model would be inconsistent with autonomy. The physician may explain potential disadvantages, including treatment delays or costs, but should not transform professional disagreement into a legal barrier against independent assessment.

The second opinion is also closely connected to informed consent because a patient's consent is meaningful only when the patient possesses sufficient information to make a decision. Indonesian research concerning informed consent has demonstrated that incomplete disclosure of medical information can undermine autonomous decision-making (Dewi, Sastrowijoto, and Padmawati 2021). The possibility of seeking another opinion can compensate, at least partially, for the limitations of a single consultation. It may allow patients to clarify information, compare treatment alternatives, and ask questions that were not adequately addressed during the first consultation. Nevertheless, a second opinion should not be used to excuse deficiencies in the original informed-consent process. The first physician remains responsible for providing adequate information and respecting patient autonomy. The second opinion should therefore be conceptualized as an additional safeguard that strengthens informed choice rather than as a mechanism through which hospitals can transfer their primary responsibility for patient communication to another physician.

The Legal Status of the Right to Second Opinion in Indonesia

The Indonesian legal framework provides a strong normative basis for recognizing patient participation in healthcare decisions. The current Health Law, Law Number 17 of 2023 concerning Health, should be treated as the principal statutory framework in contemporary analysis. Indonesian scholarship has specifically identified the right to seek a second opinion as part of patient protection and autonomy under the new health-law regime (Ali and Siregar 2025). Earlier legislation and regulatory instruments also established important foundations through provisions concerning patient rights, medical information, informed consent, and access to healthcare services. The legal development indicates a movement away from a purely physician-centered model toward recognition of

patients as legal subjects capable of exercising choices concerning their treatment. The second opinion should therefore be interpreted consistently with the broader principle that patients possess rights concerning information and participation in medical decision-making. The central legal issue is not whether the concept exists, but how broadly its practical consequences should be understood within hospital governance.

The right to seek a second opinion should be distinguished from the right to demand a particular treatment. This distinction is essential because patient autonomy does not transform a patient's preference into an unconditional entitlement to any medical intervention. A second opinion provides an additional professional assessment; it does not require the second physician to endorse the patient's preferred treatment. Cave's analysis of patient and professional autonomy in shared decision-making demonstrates that patient choice operates within a framework in which professionals retain legitimate authority over clinically appropriate treatment options (2020). The patient's right therefore concerns access to an independent opportunity for assessment and deliberation rather than control over the professional conclusion. This distinction protects both sides of the relationship: patients receive meaningful participation, while physicians retain professional independence. The legal system should consequently prevent hospitals from obstructing access while avoiding an interpretation that requires physicians to provide treatment they reasonably consider medically inappropriate.

The legal recognition of second opinion also creates an important question concerning the hospital's role. If the right exists only as an abstract patient entitlement, without procedures for obtaining medical records, referrals, diagnostic images, pathology results, laboratory data, and other relevant information, its practical value may be limited. The teleradiology literature in Indonesia demonstrates the importance of second opinions in circumstances where diagnostic interpretation may vary among specialists and identifies patient information and access as significant legal considerations (Mardi Putra, Dewi, and Wibowo 2018). This is especially relevant in complex hospital settings because the first institution frequently controls the clinical information necessary for an effective second opinion. A patient may technically be free to consult another physician but unable to do so meaningfully if the original hospital delays or restricts access to relevant records. The right should therefore include a corresponding institutional duty to facilitate reasonable information transfer.

The legal relationship can consequently be conceptualized as a combination of negative and positive obligations. The negative obligation requires hospitals and healthcare professionals not to prohibit, discourage, penalize, or otherwise retaliate against a patient who seeks another opinion. The positive obligation requires institutions to establish reasonable procedures through which patients can obtain relevant records and referrals. This distinction is important because non-interference alone may be insufficient. A hospital could formally state that patients are free to seek second opinions while maintaining procedures that make obtaining

records excessively difficult or expensive. Such a system would satisfy formal freedom but undermine substantive autonomy. The concept of effective rights requires attention to the institutional conditions necessary for exercising the right. Contemporary scholarship concerning patient access to medical records similarly emphasizes that access promotes autonomy and enables patients to participate more actively in their healthcare decisions (D'Costa, Kuhn, and Fritz 2020).

The relationship between second opinion and medical records also has implications for data protection and confidentiality. Facilitating access does not mean that hospitals should disclose information indiscriminately. The institution must verify the patient's identity and authorization and should transmit information through appropriate channels. The patient's right to obtain a second opinion should therefore be reconciled with legitimate confidentiality interests involving third parties. The appropriate legal approach is not to treat confidentiality as a reason to prevent patient access but to design controlled disclosure procedures that allow the patient's own medical information to be transferred securely. Research on patient access to medical records indicates that access can improve communication, patient control, and engagement without necessarily producing the harms feared by healthcare professionals (Neves et al. 2020; Tapuria et al. 2021). The legal principle should consequently favor secure accessibility rather than institutional control over information.

Institutional Barriers, Information Inequality, and Health Justice

The practical exercise of the second-opinion right is affected by socioeconomic and informational inequalities. A patient with financial resources, high health literacy, geographical mobility, and access to specialist networks is better positioned to obtain an independent assessment than a patient who lacks these resources. A systematic review by Sewell et al. found that patients seeking second opinions were more likely in several studies to have higher income, higher education, or residence in central urban areas (2021). Benbassat argues that access to second opinions may itself become a neglected source of healthcare inequality because patients with greater resources are more capable of obtaining independent professional assessments (2019). These findings have direct relevance to the Indonesian context, where differences in geographic access, specialist distribution, socioeconomic status, and health literacy may affect the practical availability of second opinions. A formally equal right may therefore generate substantively unequal outcomes unless hospitals and health systems address barriers to exercising it.

Information asymmetry is reinforced when patients do not know that they can request a second opinion. Research among breast cancer patients demonstrates that patients who were informed about the possibility of obtaining another opinion were more likely to seek one, while information about the option was not necessarily distributed equally across age and education groups (GroЯ et al. 2017). This finding

has significant implications for hospital obligations. If information about the right is provided only to patients whom physicians consider sufficiently educated or sophisticated to request it, the institution may unintentionally reproduce inequality. The right should therefore be communicated as part of standardized patient information rather than being selectively disclosed. This does not mean that every patient must be encouraged to obtain another opinion. It means that every patient should know that the option exists and understand the general process, costs, potential benefits, and possible consequences. Transparency is therefore a prerequisite for genuine choice.

Health literacy presents a related difficulty. Patients may technically possess access to medical information while lacking the capacity to interpret specialized terminology, statistical probabilities, or competing treatment recommendations. Pietrzykowski and Smilowska demonstrate that patient comprehension of informed-consent information is frequently incomplete (2021). A second opinion can potentially improve understanding, but it can also increase confusion where two professionals provide divergent recommendations without explaining the reasons for disagreement. Kassouf et al. found that patients receiving discordant second opinions may nevertheless maintain their initial preferences, demonstrating that disagreement alone does not automatically produce better decisions (2022). The legal objective should therefore not be to maximize the number of opinions obtained but to facilitate meaningful deliberation. Hospitals should encourage physicians to explain why opinions differ and should provide patients with opportunities to ask questions, compare alternatives, and understand the clinical basis for competing recommendations.

The potential for physician resistance represents another institutional barrier. Second opinions may be perceived as evidence that the patient distrusts the original physician or as a threat to professional authority. Tattersall et al. found that second-opinion encounters can involve tensions between loyalty and autonomy and that physicians may perceive such requests as threatening to the professional relationship (2012). Yet treating the request as disloyal misunderstands the legal function of the right. A patient may seek confirmation without distrusting the first physician, particularly where the diagnosis is serious, treatment is invasive, or uncertainty is significant. Indeed, systematic reviews show that reassurance and confirmation are among the principal motivations for obtaining another opinion (Payne et al. 2014; Hillen et al. 2017). Hospitals should therefore cultivate an institutional culture in which seeking another opinion is normalized as part of responsible decision-making rather than interpreted as professional disloyalty.

The cost of obtaining another opinion raises a further health-justice concern. Where the second opinion requires consultation fees, travel expenses, repeated diagnostic tests, or administrative charges, the right may become substantially more accessible to affluent patients. A legal framework committed to substantive equality should distinguish between legitimate costs and unnecessary financial barriers. Hospitals should transparently disclose whether a second opinion involves

additional professional fees, repeat diagnostic examinations, transportation requirements, or other expenses. Patients should not be surprised by costs after initiating the process. In publicly financed or insurance-based systems, policymakers may also consider coverage mechanisms for clinically significant cases, particularly where treatment is high-risk, irreversible, or contested. The principle of health justice does not necessarily require every second opinion to be free, but it requires that financial arrangements not operate as opaque or arbitrary obstacles to the exercise of patient autonomy.

Access to medical records is perhaps the most concrete institutional prerequisite. A second physician cannot provide a meaningful independent assessment without relevant clinical information. Systematic reviews indicate that patient access to medical records can improve patient control, communication, engagement, and understanding, although implementation challenges remain (D'Costa, Kuhn, and Fritz 2020; Tapuria et al. 2021). Digital health systems can strengthen this process by allowing patients to obtain records and diagnostic materials electronically. Nevertheless, electronic accessibility must be accompanied by appropriate security, authentication, and data governance. The hospital's responsibility is therefore two-dimensional: it must prevent unauthorized disclosure while avoiding unnecessary restriction of access by the patient. An institutional culture in which the hospital treats medical records as its exclusive informational property is inconsistent with an autonomy-centered model. The relevant principle should be stewardship of patient information rather than institutional ownership that defeats patient participation.

Reconstructing Hospital Obligations Through a Patient-Centered Second-Opinion Framework

A patient-centered second-opinion framework should begin with automatic informational transparency. Hospitals should provide patients with accessible information that they may seek another professional assessment and should explain how to initiate the process. This information should be provided without requiring the patient first to demonstrate dissatisfaction with the treating physician. Such a requirement would incorrectly characterize the second opinion as a complaint mechanism rather than as an ordinary component of autonomous decision-making. The literature demonstrates that patients seek second opinions for multiple reasons, including confirmation, uncertainty, dissatisfaction with communication, persistent symptoms, and the desire for more information (Payne et al. 2014; Sewell et al. 2021). Hospitals should therefore treat the request as legitimate regardless of whether the patient expresses distrust. Informational transparency should include the procedure for requesting records, possible waiting periods, professional qualifications of the second-opinion provider, applicable costs, and the implications of obtaining a divergent recommendation.

The second component is information portability. Hospitals should establish standardized procedures enabling patients to obtain or authorize transfer of relevant clinical information to another qualified healthcare professional. The information should include, where clinically relevant, medical histories, diagnostic reports, laboratory findings, imaging, pathology results, medication histories, treatment plans, and other material necessary for an independent assessment. This principle is supported by evidence that patient access to records can increase engagement and strengthen communication (Alomar et al. 2024). Although the technical implementation will vary between institutions, the legal principle should remain constant: a hospital should not make the patient's ability to obtain an independent opinion dependent upon unnecessary administrative discretion. Access should be timely, secure, and sufficiently complete to allow the second physician to evaluate the case rather than merely reproduce the limitations of the first consultation.

The third component is procedural independence. The second opinion should possess sufficient independence from the initial decision-maker to provide meaningful additional scrutiny. This does not necessarily require an external institution in every case. In some circumstances, another specialist within the same hospital may provide an appropriate second opinion, while in others the patient's interests may require an external professional or institution. The crucial issue is whether the second assessment is genuinely independent in professional judgment. Tattersall has emphasized that the independence of a second opinion can be complicated, particularly in specialized areas where professional networks and institutional relationships overlap (2011). Hospitals should therefore disclose whether the second physician is employed by or otherwise institutionally connected to the original treating team. Transparency concerning institutional relationships allows patients to evaluate the significance of the additional opinion without requiring an unrealistic assumption that geographical separation automatically guarantees independence.

The fourth component is non-retaliation. A patient should not receive inferior treatment, experience discriminatory communication, lose access to necessary services, or face other adverse consequences merely because the patient requests another opinion. This obligation follows logically from autonomy. If exercising the right produces an institutional penalty, patients may rationally avoid using it even though the law formally recognizes it. The same principle applies to physician communication. A treating physician should not characterize a second-opinion request as misconduct or disloyalty. Instead, professional communication should normalize the possibility that patients may reasonably seek additional information. Isaacs argues that acceptance of second opinions reflects recognition of professional fallibility and respect for patient rights (2023). The hospital's organizational culture should therefore ensure that patients can disagree without jeopardizing the therapeutic relationship.

The fifth component is clinical continuity and proportionality. A second opinion should not unnecessarily interrupt urgent care or expose patients to avoidable clinical risk. The right should consequently be exercised differently according to clinical circumstances. In an elective intervention, there may ordinarily be sufficient time to obtain another opinion before treatment. In an urgent but non-emergency situation, hospitals may need to facilitate rapid consultation. In a genuine emergency, the priority may be immediate treatment because delay could threaten life or cause serious deterioration. The existence of a right to a second opinion does not therefore imply an absolute right to delay medically necessary emergency intervention. Rather, the right should be balanced against the patient's immediate clinical interests. This approach is consistent with the broader principle that autonomy operates within the realities of healthcare while remaining the default principle whenever meaningful deliberation is possible.

The sixth component is support for divergent opinions. A second opinion is most valuable when disagreement is treated as an opportunity for informed deliberation rather than as a dispute between institutions. Where the first and second physicians disagree, the patient should receive an understandable explanation of the grounds for disagreement, including differences in diagnostic interpretation, evidence, risk assessment, treatment objectives, or professional judgment. Research indicates that second opinions may produce significant changes in diagnosis and treatment, but evidence regarding which opinion is ultimately superior is often limited (Ruetters et al. 2016; Payne et al. 2014). The law should therefore avoid assuming that the second opinion automatically prevails. The patient's autonomy requires the patient to be able to consider both assessments and choose among legally and clinically available alternatives. The role of the hospital is to facilitate informed choice rather than to determine which professional opinion the patient must follow.

The final component is institutional accountability and review. Hospitals should monitor requests for second opinions, identify recurring barriers, evaluate waiting times, review complaints concerning denial or delay, and assess whether patients from disadvantaged groups are disproportionately unable to exercise the right. This moves the issue from individual patient advocacy into healthcare governance. Evidence concerning inequalities in second-opinion access demonstrates that socioeconomic and demographic characteristics can influence who actually uses the option (Sewell et al. 2021; Benbassat 2019). Institutional monitoring could therefore become an instrument for health equity. A hospital that formally recognizes the right but repeatedly imposes barriers on patients with limited resources should not be considered fully compliant with patient-centered governance. The appropriate standard is not merely whether a policy exists, but whether the policy produces reasonably equal practical opportunities to obtain independent medical information.

The reconstructed framework thus changes the legal conception of the second opinion from a passive permission into a procedurally supported patient right. The hospital does not become responsible for guaranteeing a particular medical conclusion, nor must it automatically pay for every external consultation. Its obligation is to create fair conditions under which patients can exercise informed choice. This includes information about the right, reasonable access to medical records, transparent procedures, appropriate referral mechanisms, professional independence, cost transparency, continuity of care, and protection against retaliation. Such obligations are consistent with the broader movement toward patient-centered decision-making and with evidence that access to health information can improve patient engagement and control (D'Costa, Kuhn, and Fritz 2020; Neves et al. 2020).

Conclusion

The right to a second medical opinion should be understood as an integral component of patient autonomy rather than as an optional administrative facility. The medical profession inevitably operates within conditions of information asymmetry, clinical uncertainty, and professional fallibility. A second opinion provides patients with an additional opportunity to evaluate diagnosis, prognosis, and treatment recommendations before making decisions affecting their health and bodily integrity. The literature demonstrates that second opinions may confirm existing recommendations or produce significant changes, while patients commonly perceive them as valuable sources of reassurance and information (Payne et al. 2014; Sewell et al. 2021). The legal significance of the right therefore lies not in guaranteeing disagreement but in ensuring that patients possess a meaningful opportunity to deliberate.

The Indonesian legal framework should consequently interpret patient rights, informed consent, and hospital obligations in a manner that gives practical effect to the second-opinion right. Recognition of the right without access to medical records, transparent procedures, or protection against institutional resistance would produce only formal autonomy. The more appropriate approach is to impose both negative and positive obligations upon hospitals. Hospitals should not obstruct or retaliate against patients seeking another opinion and should affirmatively facilitate reasonable access to the information and procedures required to obtain one. This approach is supported by Indonesian scholarship concerning patient autonomy, informed consent, medical information, and second opinions (Mayasari 2017; Rohman and Syafruddin 2019; Dewi, Sastrowijoto, and Padmawati 2021; Ali and Siregar 2025).

The proposed patient-centered framework rests upon accessibility, information portability, professional independence, non-retaliation, clinical proportionality, support for divergent opinions, and institutional accountability. Its broader significance extends beyond individual patient choice. Because access to

second opinions is influenced by education, income, geography, health literacy, and institutional culture, the issue is also one of health justice. A legal system that formally grants equal rights but allows only well-resourced patients to exercise them risks reproducing structural inequality. Indonesian hospitals should therefore treat the second opinion as part of good clinical governance and patient-centered care. Reconstructing the right in this manner would reduce information asymmetry, strengthen informed consent, improve accountability, and more effectively align Indonesian healthcare law with the contemporary principle that patients are not merely recipients of medical decisions but autonomous participants in determining their own healthcare.

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