

*Conceptual Article***Reconceptualizing Legal Arrangement on the Doctor-Patient Relationship in Indonesia**Hargianti Dini Iswandari^{1*}, Sanjana Hoque²¹Department of Medical Informatics, Universitas Widya Husada Semarang²School of Law, Chittagong Independent University

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ABSTRACT

The doctor-patient relationship in Indonesia has changed. In the past, patients were inferior to doctors, but over time the relationship has put the two in a more balanced position. This article aims to examine the legal substance in regulating doctor-patient relationships in Indonesia. The arguments presented in this study demonstrated the increase in the number of civil lawsuits or complaints/criminal lawsuits has a substantial impact on legal resolution shifting. Although the law placed the legal relationship among two parties as mere contract-civil relationship, the criminalization is increasingly favored in recent years. As a recommendation, future law-making process needs to comprehensively consider medical science as the basis to lay the legal foundation in regulating doctor-patient relationships.

Keywords: Medical Service; Health Law; Patient-Doctor Relationship; Malpractice.

A. INTRODUCTION

New discoveries in medicine can cause various problems that were not predicted beforehand. In the realities found in Indonesia, for example, problems in the field of law arise related to new medical technologies, new surgical procedures, organ transplants, artificial organ operations, gene therapy, IVF, uterine leases, human genome projects and so on (Southon, & Braithwaite, 1998; Rendtorff, 2002). The existence of these institutions is considered positive if their activities are solely for the benefit of the community (Brown, 1981). On the one hand, it helps to monitor the quality of health services so that it is a warning for doctors to prioritize the precautionary principle that is beneficial in the long term, on the other hand, it

helps the community through the educational function that doctors cannot afford.

The institution that cares about health can function as a mediator for the parties to the conflict by preventing as many cases of health conflict as possible from being brought to the jurisdiction. Through mediation, it is hoped that a win-win solution will be obtained. Besides being related to the field of law, these developments in turn also affect other fields such as ethics.

The concept of law in development stated that law in a developing community should have several roles (Kusumaatmaja, 1986). The first is as a tool to maintain order which means that the law "plays a role in preserving and maintaining what has been achieved. The second is as a tool to bring about social changes" which means that

the law has a role "to help the process of change in society. Following Kusumaatmaja (1986), it can be said that law is instrumental in that it can consciously be used to achieve certain goals. In every area of life, there are legal regulations that regulate the norms/guidelines for human behavior so that it can be said that the law penetrates almost all aspects of human life (Rahardjo, 1980).

As civilization advances, there have been changes in the pattern of relationships between patients and doctors. In the past, with a paternalistic pattern in which doctors always knew best, patients "accepted" whatever happened so that doctors were never blamed. Nowadays, after the patient receives the necessary information, the doctor must face the patient's autonomy rights to decide for himself what to do with him, even the patient has the right to refuse the doctor's treatment. In certain cases, the provision of information from doctors to patients cannot always occur because of the patient's inability to capture and understand information. The inability of doctors to provide information is caused by the lack of communication and the provision of information being too detailed considered wasting time (Amirthalingam, 2017; Wei, Xu, & Wu, 2020). It will also cause patient concern, so that the patient may actually feel discouraged from undergoing treatment (Raduma-Tomàs et.al., 2011; Bending, 2015). In its development, if the patient is dissatisfied with the doctor's service or thinks the doctor has done something negligent, the patient has the courage to make demands.

Nowadays, there are more and more expressions of dissatisfaction with health services, especially at the referral level, namely hospitals. In various mass media, for example, there are often reports of moral and material losses suffered by patients as a result of negligence by doctors or other health workers. Most of the dissatisfaction that is followed up in the form of demands is directed at the behavior of doctors and hospitals that puts something in but at the same time puts something out which is a right and should be accepted by health service users (Hsieh, & Kagle, 1991; Hutchinson, & Gilvarry, 1998; Nimmon, & Stenfors-Hayes, 2016; Richter, & Kazley, 2020).

The report on tonsillectomy carried out at Tegal hospital, from the ENT section of Dr. Sardjito Hospital Yogyakarta, showed that most operations from 184 operations conducted in 1994, 115 operations in 1995, 104 operations in 1996, 107 operations in 1997 and 102 operations in 1998 were performed at the age of 5-15 years (medical record records at the ENT section of RSUP Dr. Sardjito Yogyakarta 1998). Based on these data, Primara (1999) said that the indication of tonsillar surgery is difficult to account for scientifically because the number of tonsil surgeries by ENT doctors has started to be more due to: (1) excessive assessment of subjective complaints (from sufferers and parents); (2) The parents request that their child be operated on; (3) The policy of the examiner (the treating ENT doctor).

Dwiprahasto's (2004) research on general practitioners and specialists in Yogyakarta showed 82% of antibiotics for upper respiratory tract infections (ARI) were not correct. Utarini (2000) showed that 50% of prophylactic antibiotics for Caesarean section was not precise in terms of time or dose. In another study, Utarini (2000) found that 80% of appendectomy was performed without anatomical pathology examination. Riwanto's (1992) research shows that there are medical considerations, the reasons for determining surgery. In managing patients with acute lower right abdominal pain, a bargain occurs between suppressing the incidence of negative appendectomy on the one hand and reducing the risk of perforation on the other. They wait until the clinical diagnosis of acute appendicitis is confirmed, where the negative appendicitis rate will decrease but the perforated appendicitis rate with complications that can be very serious will increase, and vice versa. On that basis, a negative appendectomy rate of 15-25% is still acceptable. Riwanto's (1992) research showed that the correct appendectomy rate (clinics according to pathological examination) of 332 cases with a diagnosis of acute appendicitis was 79%, meaning that the appendectomy was negative 21% (Riwanto, 1992).

There are increasing demands against doctors, most of which are in the form of suspected medical negligence or medical malpractice (Vincent, Phillips, & Young, 1994). Historically, from 1998-2004, the Indonesian

Health Consumers Empowerment Foundation (YPKKI) received and handled 306 malpractice complaints and only 2 of them went to court. The rest was resolved by means of mediation to find a peaceful way. The reality shows that in Indonesia the increasing demand can be read as an expression of public criticism of the services they receive. The existence of demands is of course based on a motive, even various motives can play behind a demand, whether with the motive of questioning the quality of service, the competence and ability of health care providers or based on financial motives (Yong, 2003). It is suspected that in Indonesia, this seems to have increased since the enactment of Law No. 8 of 1999 on Consumer Protection.

Several previous studies have analyzed the relationship between doctors and patients in a legal context. Zara J Bending in an article entitled 'Reconceptualizing the Doctor-Patient Relationship: Recognizing the Role of Trust in Contemporary Health Care' analyzes the doctor-patient relationship in a contractual framework (Bending, 2015). Laura Nimmon & Terese Stenfors-Hayes in an article entitled "The "Handling" of power in the physician-patient encounter: perceptions from experienced physicians," points out the need for a patient-centered therapeutic relationship pattern, and emphasizes the need for ethical patient-centered therapeutic communication to stay away from conflicts and lawsuits that may arise in medical therapy (Nimmon & Stenfors-Hayes, 2016). In an

article entitled "Lies in the doctor-patient relationship". Palmieri, & Stern stated that concern about patient complaints and litigation encourages doctors to be less open, although evidence shows that disclosure can reduce the detrimental effects of litigation (Palmieri, & Stern, 2009). Furthermore, the legal relationship between doctor and patient has also theoretically been reviewed by previous research (Lussier, & Richard, 2005; He & Qian, 2016; Blum, 2003) which highlighted legal complaints and actions in the dynamics of the recent rapid development of technology and the internet. More specifically in Indonesian context, Mannas discussed doctor and patient legal relations and doctor responsibilities in implementing national health services (Mannas, 2018). Wiriadinata (2014) analyzes malpractice and its legal consequences in the relationship between doctors and patients, while Supriyatin (2018) has analyzed the legal relationship between patients and medical personnels in health services.

B. DISCUSSION

In general, people in Indonesia still respect doctors as people who are educated in the medical field and still respect doctors as a profession that can help solve health problems. The patient feels satisfied when the doctor is 'saé', smart and cheap. The 'Saé' by patient measure is: always there when the patient needs it; serving the patient personally; be willing to hear complaints, and be willing to provide as much

information as possible. Smart according to patient's perspective is: patients recover quickly because of the right medicine and do not need to come back for treatment, and cheap in the sense that the costs that must be paid are affordable by the purchasing power of the community (Roux-Kemp, 2011).

For example, when dealing with cancer sufferers, doctors must train themselves to master certain skills to convey bad news to patients with information that fosters enthusiasm for life, because for sufferers who are then accompanied by depression, a bad mental situation (mental breakdown) will decrease endurance and will affect the healing process of the disease. On the other hand, if the body resistance increases, treatment efforts receive a better response so that the chance of recovery also increases (Lepore, & Revenson, 2014). Various motives become the basis for interacting and behaving in social life (Lyman, 1995). Is a professional governed by special ethical norms or standards, which allow or require acting (lie) that is not allowed by general norms that apply to everyone? (Werth Jr, Hastings, & Riding-Malon, 2010; Byrd, & Winkelstein, 2014; Freedman, 1978). Nasronudin (2005) showed that a diagnosis statement is a stressor for individuals that can trigger stress and has the potential to affect the apoptosis mechanism and the course of the disease, conveying honestly a diagnosis of HIV/AIDS infection to individuals requires wise steps. Nursalam (2005) stated that psychosocial-spiritual

stress is very influential for HIV patients. If the stress reaches the exhausted stage, it can lead to the failure of immune function. Modulation of the immune response will decrease significantly and accelerate the onset of AIDS to cause death.

The illustrations are an example of dilemma situations faced by everyday doctors. In dealing with various patients with demands that the doctor must do the best for the patient, doctors often base their actions on the following perceptions: If the patient is educated enough, he/she will ask as much as he needs to, so that when detailed information is given, the patient will understand the state of the disease. Or vice versa, if the patient does not ask questions, the doctor will not provide detailed information that may not be understood. Based on these perceptions, the doctor's attitude is sometimes dishonest in communicating, giving sufficient comments according to his capacity or even being silent so that the patient feels as if he is being treated as an object.

In the interaction between doctors and patients, a contractual relationship in civil law perspective is created between doctors as health service providers and patients as service recipients. The process begins with (1) the patient's arrival to the doctor voluntarily; (2) the delivery of complete and adequate information between the patient and the doctor based on The Right to Information and followed by (3) approval or rejection of medical action because each individual has the right to determine his own fate.

This process is an elaboration of the informed consent doctrine which embodies the concept of human rights. Informed consent can be: (1) real consent, (2) expressed orally or in writing, (3) presumed consent, (4) implied consent, (5) tacit consent, (6) substitute consent, (7) proxy consent. In a well-informed condition, the patient has the ability to make decisions for himself. Both of these rights are stated in The Universal Declaration of Human Rights. The series of processes above are called the legal model of the medical decision-making process (Braddock et.al., 1997; Wainwright et.al, 2010).

To date, informed consent has not been properly implemented and is understood to be only a formality. The impact of this understanding is that a patient is asked to sign the Medical Action Approval form while the doctor has decided to operate. After receiving the information and "assuming the patient has understood its meaning", the patient is asked to sign the approval form as stipulated in the Minister of Health Regulation No. 58/Men.Kes/Per/IX/1989, which took effect on September 4, 1989.

Judging from the law of law, the approval form signed by the patient is proof that the doctor has carried out the obligation to convey information to the patient, so that it can be used as an anticipation for handling the problem because the doctor has the authority to interpret legal material from a medical point of view, but the process is being undertaken to get approval by ignoring The patient's right to medical

information is not in accordance with the essence of the doctrine of informed consent. For this reason, the medical community needs to be constantly reminded of the patient's right which must be respected as a subject capable and entitled to determine their own destiny.

The use of approval form in accordance with the meaning of the doctrine of informed consent should be carried out in every doctor's service, both in private practice, at health centers, health clinics and in hospitals. In fact, approval form is rarely used in private practice, because medical actions in the practice room are generally simple medical actions that technically do not require complicated equipment or facilities. If it does require more severe medical action, usually the patient will be referred to the hospital for further treatment. This illustration proves that approval is still understood as a form and has not been interpreted as a series of doctrinal descriptions.

The implementation of informed consent is an obligation as a compulsion for doctors to provide complete and correct information. The risk of prosecution in the hospital is greater than that of a private doctor, so the hospital should prepare the right mechanism to protect all parties (Nasirin, & Lionardo, 2021).

One of the obligations of doctors in carrying out medical services is to make notes/recordings of the patient's condition into the medical record which is also often referred to as a status card. According to the doctor's perception, the essence

of medical record has a high value, because the medical record is complete, contains information on the history of the disease and the actions that the doctor has taken in an effort to cure the patient, is also a doctor's tool to follow the course of the disease by preventing patients from becoming the object of repeated interviews and examinations, and is one of the benchmarks for the quality of the doctor's services provided.

The medical record value changes when it is linked to the Decree of the Director General of Medical Services, which regulates medical records. In the regulation of the Director General Decree, it is stated that a medical record is a secret document belonging to a medical service facility, but the contents of the medical record belong to the patient. The Director General Decree was confirmed by Government Regulation No. 10 of 1966 (PP No. 10/1966) concerning Mandatory Keeping of Medical Secrets. The definition of medical record according to the Director General Decree has implications for the emergence of differences in understanding and meaning of medical records and the occurrence of variations in the handling of these documents.

The existence of legal rules that give the meaning of a medical record as a document belonging to a service institution, which is then linked to the absolute duty of keeping secrets, creating new perceptions. For the doctor and/or hospital's perception, the hospital has full rights over these documents as if the medical record could be used to help hospitals and doctors if one

day, they have a legal problem. Meanwhile in public perception, the hospital deliberately keeps the medical record because something is kept secret, for example, the medical record which was originally incomplete, can be manipulated if one day a problem arises.

Research conducted by Meliala and Sunartini (2004) at the Neurology Section of the Dr. Sardjito Hospital Yogyakarta showed that the RM of epilepsy patients treated during 1990 was only 70% completely filled, in September 1999 in the Children's Section of the same hospital, 92.81% RM in August had not been completed.

The results of Hatta's (2010) research at Harapan Kita Hospital Jakarta showed that, there were many irregularities in the synchronization of the data listed in the medical record, 63.8% of medical records were incomplete, and there were various kinds of other incompleteness in each part of the medical record. The incompleteness of filling in the medical record is in the form of: date of entry and exit, history taking, introduction to medical records, diagnosis of patient entry and exit, laboratory tests, indications for surgery, preoperative records, records of anesthesia, analysis resume, fluid control, administration of blood transfusions, control, weight, records of disease progression, records of drug administration, informed consent, signatures of doctors or supervisors, and others (Hatta, 2010).

The data revealed from the results of the studies above show that there are many problems in health services that must be addressed by the

health sector itself without the intervention of other parties who may not understand the problems of the health profession.

Research shows that hospital doctors (who perform surgery) do not always report their actions to the hospital director, for some reasons such as that there are no regulations that require reporting, directors are considered too busy to receive every report from their colleagues, and indirectly, the director can read what the doctor has written and has done, even though it is against the principle of keeping secrets.

From a regulatory standpoint, a doctor who does not report his actions to the director cannot be blamed, but organizationally, if at one time a complaint occurs that develops into a claim, other than the doctor concerned must be responsible for his action (liability), the hospital is a deep *rechtspersoon*. It is represented by the director, inseparable from the responsibility of the corporation (Mannas, 2018). This obligation is based on the doctrine of vicarious liability and article 1367 of the Civil Code which reads: 'a person is not only responsible for losses caused by his own actions, but also for losses caused by the actions of his dependents or items under his control'.

The behavior of doctors who do not want to report their actions to the director is based on the concept of clinical autonomy which is more oriented to clinical practice, where a doctor feels that he has full authority in treating his/her patients based on individual opinions and

experiences and uses medical management methods he adheres to. The concept of clinical autonomy tends to override clinical leadership, as evidenced by the opinion of doctors who think that clinical leadership related to managerial issues should be separated from clinical matters and not the responsibility of the doctor in charge of the clinic (Armstrong, 2002).

The rapid advancement of medical science and technology requires doctors to work in teams when performing surgery. Collective work in a team is a manifestation of the interdependence of doctors with their peers, as well as proof that no doctor is capable of mastering disease progression and management. Corporate accountability also implies that health care is no longer the responsibility of individual doctors but collective professional responsibilities.

The legal system and the doctor culture as a distinctive community are two systems that do not always coincide. This incompatibility is due to the fact that they both have different logics and points of view, both of which are even products of social construction from different worlds. The basic concept of 'social construction' proposed by Peter Berger is the concept of the Three Moment Theory (Berger, & Luckmann, 1966). This theory views society as a human product and humans as a product of society. This is a dual reality where humans as subjects carry out a dialectic between the self and the socio-cultural world, in a process that takes place in three simultaneous moments, namely externalization, objectivation, and

internalization so that social reality is constructed as a result of individual intersubjective interactions in society. Berger was much influenced by the thoughts of Edmund Husserl, a phenomenologist, who stated that the "world of life" is understood as a social reality by a group of people. Berger's concept is a correction and at the same time complements Marx's idea that seeing matter creates mind, whereas according to Berger & Luckmann (1966), mind creates matter. Also, a correction to the Parsonian opinion with structural functionalism which is more concerned with the moment of objectivation, and the Weberian opinion which is more concerned with the moment of internalization. This discrepancy has become a separate problem in connection with the development of medical science and technology which is so advanced and has undergone significant changes. As a result, the medical field has become not a mere medical problem, but is linked to other fields and disciplines.

So far, doctor community does not consider medical profession as a producer of health services, this has since the enactment of Law No. 8 of 1999 concerning Consumer Protection (UUPK) placed doctors as service providers as in general economic actors.

In the medical world, even though the obligations and rights of health workers have been regulated in the Kodeki and Law No. 36 of 2009 concerning Health (Health Law), but in its implementation there are still obstacles due to the

absence of adequate regulations. The obligation of health workers is to comply with professional standards and respect the rights of patients in accordance with Article 53 paragraph (2) of the Health Law. Legal protection for health workers is still difficult to obtain because judges cannot prove their truth/error.

The use of the terms consumers and producers is actually inappropriate in health services and will lead to thinking towards a contractual relationship pattern according to the understanding of economic actors in general. The idea of a contract, which is a modern thought for regulating relations in modern society, has distanced itself from the original purpose of the profession.

Even though the term contractual is used, the relationship between patient and doctor is more human rights oriented. This orientation is a dimension that is maintained in health services to the community. Patients have the freedom to determine services, whereas doctors have freedom of profession. The nature of the relationship is a therapeutic transaction in which the commodity exchanged is medical services. Because it is oriented towards human rights, doctors are obliged to do their utmost to cure patients (*inspiringverbintenis*) without promising a result (*resultaatsverbintenis*).

Rahardjo (2005) said that law science is always undergoing formation and has a shifting field of knowledge that is almost endless. This shows that the science of law should not be a

static and sterile science. Rahardjo's (2005) thought is a scientific evolution, this is in line with Berman's (1983) thought which states that law has an internal logic, meaning that change is not only an adaptation from the old to the new, but also part of the pattern of change. With shifting times and needs, the concept of law has changed (Berman, 1983).

Medicine belongs to the exact sciences, but the fact that patients who receive "correct therapy, will definitely recover" or who receive "wrong therapy, are sure to die" is not the realm of medicine and is beyond the ability of a doctor. The fact proves that, medical science has not been able to identify all the variables that affect health efforts, nor has it succeeded in measuring the magnitude of each variable and its resultant. As a result, medical science is always full of uncertainties because the success of treatment is strongly influenced by various possibilities (Indrayan, 2021).

Medical science is influenced by probability, but that does not mean that doctors can act according to their own standards because there are professional standards that must be used as a reference. In article 2 KODEKI, it is stated that: "*a doctor must always perform his profession according to the highest standards,*"

What is meant by the highest measurement in KODEKI is in accordance with the latest standards of medical science, general ethics, medical ethics, law and religion. Unfortunately, the existing professional standards are not yet

considered a strong measure. Although health services contain many economic calculations, not all of them can be transformed according to the standards of economics (Eysenbach, 2001). For example, a minimum standard of health services demands maximum service to provide optimal results (Burau, & Blank, 2007). In this situation, the efficiency principle cannot be used in terms of economics, which means using minimal inputs to produce maximum output. Efficient, Effective and Economical in health services are translated as: 'doing things right', 'doing the right things' and 'doing things cheap'.

Every problem that arises in health services is qualified as a legal dispute in the field of health law (*lex specialist*) unless the medical audit states there are offenses against medical treatment. In this situation, criminal and civil lawsuits can be filed against health workers, such as general law cases (*lex generalis*).

In the case of Martha at St Carolus Hospital, hospitals are forced to "lay off" a doctor, and doctors "will only speak" before a court hearing. The hospital policy gave rise to an impression of being closed and defensive when in fact the hospital was prioritizing article 13 KODEKI to keep patient secrets. However, the high cost of litigation incurred by patients in seeking justice has prevented several cases from reaching the courts and as a result the clarity of the origin of the dispute is not resolved. On the one hand, doctors do not get the opportunity to defend themselves by revealing what really

happened, on the other hand, health consumers do not get justice because what is being demanded stops in the middle of the road. At different times, similar conditions also occurred in developed countries though, a wider explanation (Brain, 1991; Berlant, 1976).

The cutting-edge equipment industry also creates problems for the medical world. Since the patient is hospitalized, it is the doctor's duty to treat and treat the patient (Rosenberg, 1987). Under normal circumstances, death is an easily discernible biological process (e.g., not breathing). In comatose patients, the use of sophisticated equipment such as a pacemaker (pace maker), breathing assistance (respirator), provision of nutrition through the use of intravenous fluids (hydration), does not provide a place for death (Rothstein, 1992). If all the tools are removed, death is no longer a biological process but due to medical action.

Medical logic says that without these tools, the patient has no hope of life anymore, even though there is something beyond the assessment and ability of the doctor. It is proven that this happened to a woman from New Jersey (USA), after the breathing apparatus was stopped, she was still in a coma for 10 years before finally dying. The family has the right to bring the patient home to die biologically, but proposing euthanasia in any form will not be granted in Indonesia. Because apart from breaking the law, the doctor's ethical decision does not justify this action (Sofyan, 2017).

Negligence occurs when someone does something that should not be done, or does not do something that should be done, by another person with the same qualifications in the same conditions and situations. The general characteristics of malpractice from the negligence aspect according to the specific health law literature contain the '4 D negligence' benchmark below (Sakidjo, & Poernomo, 1990), including Duty (the obligation to take or not take certain actions against certain patients in certain situations and conditions), Dereliction (deviation from said obligation), Damage (everything that is felt as a loss as a result of the services provided), and Direct causal relationship (real cause and effect relationship between liability deviations committed with losses suffered by patients).

In some cases that fail to ensnare doctors, it does not mean that doctors are never wrong but because of the weakness of the current legal system. Several studies or issues below are used as material for reflection for the medical community to conduct introspection in order to restore the dignity of the medical profession.

In general, doctors interpret the law as a rule made by a regulatory agency. Even though the preparation of regulations has gone through the correct procedure, the final determination is greatly influenced by the interests of individuals in the regulatory agency. Individuals in regulatory agencies do not always understand the factual conditions under which the regulations will be enforced, so that regulatory agencies also

experience difficulties in implementing and monitoring them. The problems that arise are expected to be resolved with legal assistance which is considered to have dimensions of justice, certainty and benefit, but the resolution is often not beneficial to those who expect justice and instead creates new problems.

The medical profession needs legal protection because its work contains many risks. However, doctors must also understand that patients need the same protection. Protection does not mean giving immunity to someone who is guilty because every legal subject has the same rights before the law. Legal protection is given to doctors only if they are already working on the right track even though the current law does not always guarantee this (Kusumaatmaja, 1986). The increasing demand for health services, and the weak ability of parties outside of medical care to seek results that benefit all parties, it is better to start increasing the empowerment of the activities of non-governmental organizations engaged in health services such as medical watch, the Indonesian Health Consumer Protection Foundation (YPKKI) or the Legal Aid Institute (LBH) Kesehatan. The existence of these institutions is considered positive if their activities are solely for the benefit of the community. On the one hand, they help to monitor the quality of health services so that it is a warning for doctors to prioritize the precautionary principle that is beneficial in the long term. On the

other hand, they help the community through educational function that doctors cannot afford.

The institution that cares about health can function as a mediator for the parties to the conflict by preventing as many cases of health conflict as possible from being brought to the jurisdiction. Through mediation, it is hoped that a win-win solution will be obtained.

Every health professional must base the implementation of their professional duties as health care providers on the 4 principles of medical ethics known as the Georgetown Mantra (Little, 2000), including beneficence (the act of doing good for each patient), non-maleficence (the avoidance of doing harm), respect for the individual autonomy of each patient as a decision maker, justice (the principle of equal treatment for each person, regardless of their personal or cultural attributes).

In addition to basing every action on medical ethics above, before deciding to perform surgery, an expert doctor must pay attention to 7 patient rights, namely (McCullough, Jones, & Brody, 1998), not to be killed intentionally or negligently by the surgeon, not to be harmed by intent or negligence of the surgeon, not to be deceived by surgeon, adequately informed about risk and benefit of surgery, to be treated by knowledgeable, competent practitioners, to have his or her health and wellbeing more highly valued than the surgeon's own economic interest, and to decide whether to accept treatment under the conditions described.

According to McLaren (1991), patients have the right to know all information about their disease that the doctor has known and have the right to determine the best for themselves, and the doctor is fully aware of this, but if it becomes the doctor's responsibility to increase public understanding of the meaning of information, of course doctors are faced with limited time and limited communication skills of doctors. Various obstacles faced by professionals even though they understand very well that this is part of their responsibility (Dahnke, 2014).

According to the doctor's perception, the various forms of friendliness and explanation that the patient expects can only be fulfilled in the best possible situation. When many patients are waiting at the practice, or when the doctor makes a visit to the treatment room, the doctor only provides an explanation as necessary, with consideration, among the waiting patients there may be something more severe than the patient. The above conditions seem to confirm Moore (1970) opinion that professionals often ignore the possibility of learning from their clients. Doctors also recognize that the information in communication and interaction sometimes helps reduce patient illness. Many sufferers of chronic illness or serious illness are accompanied by undetected emotional/psychological problems, or conversely, patients with mental/psychological disorders will develop undiagnosed physical illness.

Patients assess that the doctor's attention is more focused on (1) symptoms of the disease, (2) the course of the disease, (3) differential diagnoses, (4) types of therapy given, (5) complications that occur, or (6) prognosis, which are steps -the doctor's approach in trying to cure a patient, while on the other hand, the patient actually wants more than that (Brennan, 1991; Brennan et al., 2004). Patients do not want themselves to only be the object of a doctor; they demand doctor empathy in dealing with their problems.

Society realizes that every individual has limitations so that doctors must be able to take into account their personal abilities. If they are unable to do good constantly, doctors can actually limit the number of patients. It is very unfortunate when a doctor works beyond his limits, even if for humanitarian reasons (IDI, 1994). Apart from emergency cases, people understand that doctors need time off for themselves. In fact, after practicing for a long period of time, many doctors begin to get caught up in their routine and begin to forget the main purpose of their medical practice, which according to Turner, & Hodge (1970) is what is called the conceptual trap of a profession that has yet to find a solution so it needs to be anticipated by every doctor.

In the context of health, the public expectation for doctors apart from being health care providers is to provide education, learning and information about the meaning of health, the importance of healthy living and how to obtain

healthy conditions, through communication and interaction at any time (Woolley, Kane, Hughes, & Wright, 1978; Ha, & Longnecker, 2010). The role and function of doctors as consultants are indeed needed in public health development. However, the public has not yet realized that information is ideally given in a dialogical manner between two interacting parties where each party has rights and obligations (Gonçalves, 2020). The doctor has the right to know the patient's problem and the patient is obliged to disclose the problem completely. On the other hand, the doctor is obliged to inform everything that belongs to the patient, such as: the results of the examination suggest the best course of action, convey possible complications resulting from the action to be taken and the consequences of risks (including costs) that must be borne and leave the decision completely to the patient.

On the other hand, doctors understand the patient's expectations and place the patient as the party who needs help as well as making sacrifices (time, morally and financially). Doctors have obstacles in fulfilling the patient's expectations optimally, both internal constraints and their external environment (Mira, Guilabert, Pérez-Jover, & Lorenzo, 2014). Moore (1970) opinion which states that a professional obligation is to study becomes an ethos in the world of medicine and tends to determine the color of a doctor practice. Competition between professionals and a shift in diseases that are increasingly varied, are the reasons for continuing to specialization

education. In the doctor's perception, to be able to provide the best service for patients, doctors must always add/deepen knowledge (medicine) as a basic need that must be met. The doctor will use all his abilities to meet his basic needs, where the ultimate goal is to provide the best for patient satisfaction. Nevertheless, there is always the possibility of forgetting another component that is actually important for patients, namely respecting the patient's rights (Fallberg, 2000).

The professionalism of Indonesian doctors is not yet optimal, shown by several behaviors such as: doctors selling drugs in their practice rooms (dispensing); the writing of a doctor's prescription is influenced by the will of the drug or medical equipment distributor; doctors write half prescriptions based on the patient's request/purchasing power; doctor service rates (medical services) and hospital service rates vary and others. If doctors and hospitals have acted professionally, there are ways that can be done so that neither parties become a victim, for example as follows: If a patient is unable but requires inpatient treatment at the hospital, the doctor is obliged to examine the patient as a professional, and has the right not to ask for compensation for humanitarian considerations. The right of doctors to give humanitarian considerations is not in accordance with the contract theory according to Veatch (1981). Veatch (1981) does not agree that health services use the term "contractual". Then the doctor refers the patient to class III hospital where all treatment

costs are borne by the government. This is what the government is striving for in order to improve welfare, especially for the poor. This effort also did not run smoothly because the community was still demanding for other assistance, such as transportation costs (ambulance), casket costs (if they died), which are actually the responsibility of the patient himself.

C. CONCLUSION

Various conditions must be considered carefully before doctors decide to perform surgery, because in time the chosen action will bring the doctor into legal trouble. People in Indonesia still respect doctors as people who are educated in the medical field and still respect doctors as a profession that can help solve health problems. The patient expects the doctor who serves him to be 'saé', smart and cheap. On the other hand, doctors understand the patient expectations and place the patient as the party who needs help as well as making sacrifices (time, morally and financially), but doctors have obstacles in fulfilling the patient's expectations optimally, both constraints from themselves (internal) and their environment (external).

In the interaction between doctors and patients, a contractual relationship is created between doctors as health service providers and patients as service recipients. The process begins with (1) the patient's arrival to the doctor voluntarily, (2) the delivery of complete information between the patient and the doctor

(adequate information) based on The Right to Information and continues with (3) approval or rejection of medical action because each individual has the right to determine his fate alone. Until now, the informed consent has not been implemented properly and is understood as only a formality.

The use of the terms consumers and producers is actually inappropriate in health services and will lead to thinking towards a contractual relationship pattern according to the understanding of economic actors in general. The idea of a contract, which is a modern thought for regulating relations in modern society, has distanced itself from the original purpose of the profession. In the doctor-patient relationship, there is the possibility of medical error. The medical error can be caused by (1) a doctor's error, if it occurs due to inaccuracy or due to limited knowledge, or (2) it is not a doctor's fault, if the action was carried out for other considerations. Indonesian law in this case has not been fully able to accommodate the interests of doctors and patients in solving these problems.

REFERENCES

JOURNALS

- Amirthalingam, K. (2017). Medical dispute resolution, patient safety and the doctor-patient relationship. *Singapore medical journal*, Vol.58, (No.12), pp.681-684. <https://doi.org/10.11622/smedj.2017073>.
- Armstrong, D. (2002). Clinical autonomy, individual and collective: the problem of changing doctors' behaviour. *Social science & medicine*, Vol.55, (No.10), pp.1771-1777. [https://doi.org/10.1016/S0277-9536\(01\)00309-4](https://doi.org/10.1016/S0277-9536(01)00309-4).
- Bending, Zara J. (2015). Reconceptualising the doctor-patient relationship: Recognising the role of trust in contemporary health care. *Journal of bioethical inquiry*, Vol.12, (No.2), pp.189-202. <https://doi.org/10.1007/s11673-014-9570-z>.
- Berlant, Jeffrey L. (1976). Profession and Monopoly: A Study of Medicine in the United States and Great Britain. *Health Care Management Review*, Vol.1, (No.1), pp.107. https://journals.lww.com/hcmrjournal/Citation/1976/00110/Profession_and_Monopoly__A_Study_of_Medicine_in.15.aspx.
- Blum, John. D. (2003). Internet medicine and the evolving legal status of the physician - patient relationship. *The Journal of Legal Medicine*, Vol.24, (No.4), pp.413-455. <https://doi.org/10.1080/714044486>.
- Braddock, Clarence H., Fihn, Stephan D., Levinson, Wendy., Jonsen, Albert R., & Pearlman, Robert A. (1997). How doctors and patients discuss routine clinical decisions: informed decision making in the outpatient setting. *Journal of general internal medicine*, Vol.12,(No.6),pp.339-

- 345.<https://doi.org/10.1046/j.1525-1497.1997.00057.x>.
- Brain, D. (1991). Practical knowledge and occupational control: The professionalization of architecture in the United States. *Sociological Forum*, Vol.6, (No.2), pp.239-268. <https://doi.org/10.1007/BF01114392>.
- Brennan, Troyen A., Leape, Lucian L., Laird, Nan M., Hebert, Liesi., Localio, A. Russell., Lawthers, Ann G., Newhouse, Joseph P., Weiler, Paul C., & Hiatt, Howard H. (2004). Incidence of adverse events and negligence in hospitalized patients: results of the Harvard Medical Practice Study I. *BMJ Quality & Safety*, Vol.13, (No.2),pp.145-151. <http://dx.doi.org/10.1136/qshc.2002.003822>
- Brown, P. (1981). The mental patients' rights movement and mental health institutional change. *International Journal of Health Services*, Vol.11,(No.4),pp.523-540. <https://doi.org/10.2190%2FCU8G-D0RJ-YY54-UC3F>.
- Burau, Viola., & Blank, Robert H. (2007). Comparing health policy: An assessment of typologies of health systems. *Journal of Comparative Policy Analysis*, Vol.8, (No.1), pp.63-76. <https://doi.org/10.1080/13876980500513558>.
- Byrd, Gary D., & Winkelstein, Peter. (2014). A comparative analysis of moral principles and behavioral norms in eight ethical codes relevant to health sciences librarianship, medical informatics, and the health professions. *Journal of the Medical Library Association: JMLA*, Vol.102,(No.4),pp.247-256. <https://dx.doi.org/10.3163%2F1536-5050.102.4.006>.
- Dahnke, Michael D. (2014). Utilizing codes of ethics in health professions education. *Advances in Health Sciences Education*, Vol.19,(No.4),pp.611-623. <https://doi.org/10.1007/s10459-013-9484-2>.
- Dwiprahasto, I. (2004). Medical Error di rumah sakit dan upaya untuk meminimalkan risiko. *Jurnal Manajemen Pelayanan Kesehatan*, Vol.7,(No.1),pp.13-17. <https://jurnal.ugm.ac.id/jmpk/article/view/2884>.
- Eysenbach, G. (2001). What is e-health?. *Journal of medical Internet research*, Vol.3, (No.2), p.20. <https://doi.org/10.2196/jmir.3.2.e20>.
- Fallberg, Lars H. (2000). Patients' rights in Europe: Where do we stand and where do we go. *European Journal of Health Law*, Vol.7,(No.1),pp.1-3. <https://doi.org/10.1163/15718090020523007>.
- Freedman, B. (1978). A meta-ethics for professional morality. *Ethics*, Vol.89, (No.1),pp.1-19. <https://www.journals.uchicago.edu/doi/10.1086/292100>.
- Gonçalves, G. (2020). Are hospitals our friends? An exploratory study on the role of Facebook in hospital organizations' dialogic communication. *Health Marketing*

- Quarterly*, Vol.37,(No.3),pp.265-279.
<https://doi.org/10.1080/07359683.2020.1805898>.
- Ha, Jennifer Fong., & Longnecker, Nancy. (2010). Doctor-patient communication: a review. *Ochsner Journal*, Vol.10, (No.1), pp.38-43. <http://www.ochsnerjournal.org/content/10/1/38.full>
- He, Alex Jingwei., & Qian, Jiwei. (2016). Explaining medical disputes in Chinese public hospitals: the doctor–patient relationship and its implications for health policy reforms. *Health Economics, Policy and Law*, Vol.11, (No.4), pp.359-378. <https://doi.org/10.1017/S1744133116000128>.
- Hsieh, Mei-O., & Kagle, Jill Doner. (1991). Understanding patient satisfaction and dissatisfaction with health care. *Health & Social Work*, Vol.16, (No.4), pp.281-290. <https://doi.org/10.1093/hsw/16.4.281>.
- Hutchinson, Gerard., & Gilvarry, Catherine. (1998). Ethnicity and dissatisfaction with mental health services. *The British Journal of Psychiatry*, Vol.172,(No.1),pp.95-96. <https://doi.org/10.1192/bjp.172.1.95c>.
- Indrayan, A. (2021). Medical biostatistics as a science of managing medical uncertainties. *Indian Journal of Community Medicine: Official Publication of Indian Association of Preventive & Social Medicine*, Vol.46, (No.2),pp.182. https://doi.org/10.4103/ijcm.ijcm_763_20.
- Lussier, Marie-Thérèse., & Richard, Claude. (2005). Doctor-patient communication: complaints and legal actions. *Canadian Family Physician Medecin de Famille Canadien*, Vol.51,pp.37-39. <https://europepmc.org/article/med/15732220>.
- Lyman, Stanford M. (1995). Without morals or mores: Deviance in postmodern social theory. *International Journal of Politics, Culture, and Society*, Vol.9,(No.2),pp.197-236. <https://doi.org/10.1007/BF02904334>.
- Mannas, Yussy A. (2018). Hubungan Hukum Dokter Dan Pasien Serta Tanggung Jawab Dokter Dalam Penyelenggaraan Pelayanan Kesehatan. *Jurnal Cita Hukum*, Vol.6, (No.1),pp.163-182. <https://doi.org/10.15408/jch.v6i1.8274>.
- McLaren, Paul. (1991). The right to know. *BMJ: British Medical Journal*, Vol.303, (No.6808), pp.937-938. <https://doi.org/10.1136/bmj.303.6808.937>.
- Meliala, Andreasta., & Sunartini. (2004). Telaah Rekam Medis Pendidikan Dokter Spesialis Sebelum Dan Sesudah Pelatihan Di IRNA II RSUP Dr. Sardjito Yogyakarta. *Jurnal Manajemen Pelayanan Kesehatan*, Vol.7, (No.03),pp.163-171. <https://journal.ugm.ac.id/jmpk/article/view/2907>.
- Mira, José Joaquín., Guilabert, Mercedes, Pérez-Jover, Virtudes., & Lorenza, Susana. (2014). Barriers for an effective communication around clinical decision making: an analysis of the gaps between

- doctors' and patients' point of view. *Health Expectations*, Vol.17, (No.6), pp.826-839. <https://doi.org/10.1111/j.1369-7625.2012.00809.x>.
- Nasirin, Chairun., & Lionardo, Andries. (2021). Decentralization, public services and neglected children in Mataram City, West Nusa Tenggara. *Research Horizon*, Vol.1, (No.2), pp.55-61. <https://doi.org/10.54518/rh.1.2.2021.55-61>.
- Nimmon, Laura., & Stenfors-Hayes, Terese. (2016). The "Handling" of power in the physician-patient encounter: perceptions from experienced physicians. *BMC medical education*, Vol.16,(No.1), pp.1-9. <https://doi.org/10.1186/s12909-016-0634-0>.
- Palmieri, John. J., & Stern, Theodore. A. (2009). Lies in the doctor-patient relationship. *Primary care companion to the Journal of clinical psychiatry*, Vol.11, (No.4), pp.163-168. <https://dx.doi.org/10.4088%2FPC.09r00780>.
- Raduma-Tomàs, Michelle A., Flin, Rhona., Yule, Steven., & Williams, David. (2011). Doctors' handovers in hospitals: a literature review. *BMJ quality & safety*, Vol.20, (No.2), pp.128-133. <http://dx.doi.org/10.1136/bmjqs.2009.034389>.
- Rahardjo, S. (2005). Hukum Progresif: Hukum yang Membebaskan. *Jurnal Hukum Progresif*, Vol.1,(No.1), pp.1-24. <https://doi.org/10.14710/hp.1.1.1-24>
- Rendtorff, Jacob D. (2002). Basic ethical principles in European bioethics and biolaw: autonomy, dignity, integrity and vulnerability—towards a foundation of bioethics and biolaw. *Medicine, health care and philosophy*, Vol.5, (No.3), pp.235-244. <https://doi.org/10.1023/A:1021132602330>.
- Richter, Jason P., & Kazley, Abby S. (2020). Social media: How hospital facebook activity may influence patient satisfaction. *Health marketing quarterly*, Vol.37, (No.1), pp.1-9. <https://doi.org/10.1080/07359683.2020.1713573>.
- Sofyan, A. (2017). Euthanasia: concept and rule of law in Indonesia. *Journal of Law, Policy and Globalization*, Vol.58, pp.27-32. <https://www.iiste.org/Journals/index.php/JLPG/article/view/35570>
- Southon, Gray., & Braithwaite, Jeffrey. (1998). The end of professionalism?. *Social Science & Medicine*, Vol.46, (No.1), pp.23-28. [https://doi.org/10.1016/S0277-9536\(97\)00131-7](https://doi.org/10.1016/S0277-9536(97)00131-7).
- Supriyatin, U. (2018). Hubungan Hukum Antara Pasien Dengan Tenaga Medis (Dokter) Dalam Pelayanan Kesehatan. *Jurnal Ilmiah Galuh Justisi*, Vol.6,(No.2), pp.184-194. <http://dx.doi.org/10.25157/jigj.v6i2.1713>.
- Vincent, Charles., Phillips, Angela., & Young, Magi. (1994). Why do people sue doctors? A study of patients and relatives taking legal action. *The Lancet*, Vol.343,

- (No.8913), pp.1609-1613. [https://doi.org/10.1016/S0140-6736\(94\)93062-7](https://doi.org/10.1016/S0140-6736(94)93062-7).
- Wainwright, Susan Flannery., Shepard, Katherine F., Harman, Laurinda B., & Stephens, James. (2010). Novice and experienced physical therapist clinicians: a comparison of how reflection is used to inform the clinical decision-making process. *Physical Therapy*, Vol.90,(No.1),pp.75-88. <https://doi.org/10.2522/ptj.20090077>.
- Wei, Dong., Xu, Anqi., & Wu, Xue. (2020). The mediating effect of trust on the relationship between doctor–patient communication and patients' risk perception during treatment. *PsyCh Journal*, Vol.9, (No.3), pp.383-391. <https://doi.org/10.1002/pchj.327>
- Werth Jr, James L., Hastings, Sarah L., & Riding-Malon, Ruth. (2010). Ethical challenges of practicing in rural areas. *Journal of Clinical Psychology*, Vol.66,(No.5),pp.537-548. <https://doi.org/10.1002/jclp.20681>
- Wiradinata, W. (2014). Dokter, Pasien dan Malpraktik. *Mimbar Hukum*, Vol.26, (No.1), pp.43-54. <https://doi.org/10.22146/jmh.16053>.
- Woolley, F. Ross., Kane, Robert L., Hughes, Charles C., & Wright, Diana D. (1978). The effects of doctor-patient communication on satisfaction and outcome of care. *Social Science & Medicine. Part A: Medical Psychology & Medical Sociology*, Vol.12, pp.123-128. [https://doi.org/10.1016/0271-7123\(78\)90039-1](https://doi.org/10.1016/0271-7123(78)90039-1).
- BOOKS**
- Berger, Peter Ludwig., & Luckmann, Thomas. (1966). *The social construction of reality: A treatise in the sociology of knowledge*. New York: Doubleday & Company, Inc.
- Berman, Harold J. (1983). *The formation of the western legal tradition*. Boston: Harvard University Press.
- Brennan, Troyen A. (1991). *Just Doctoring: Medical Ethics in the Liberal State*. Berkeley, CA: University of California Press.
- Hatta, Gemala R. (2010). *Pedoman Manajemen Informasi Kesehatan di Sarana Pelayanan Kesehatan*. Jakarta: Penerbit Universitas Indonesia.
- Ikatan Dokter Indonesia (IDI). (1994). *Panduan Aspek Hukum Praktik Swasta Dokter*. Jakarta: Percetakan IDI.
- Kusumaatmaja, M. (1986). *Fungsi dan Perkembangan Hukum Dalam Pembangunan Nasional*. Bandung: Lembaga Penelitian Hukum Dan Kriminologi Fakultas Hukum Universitas Padjadjaran.
- Lepore, Stephen J., & Revenson, Tracey A. (2014). Resilience and posttraumatic growth: Recovery, resistance, and reconfiguration. In Lawrence G. Calhoun and Richard G. Tedeschi (Eds.), *Handbook*

- of *posttraumatic growth* (pp. 24-46). New York: Routledge.
- Little, John M. (2000). *Ethics of Resource Allocation*. In Brendan Dooley, Michael Fearnside and Michael Gorton (Eds.), *Surgery, Ethics and the Law*. Carlton South, Vic.: Blackwell Science Asia.
- McCullough, Laurence B., Jones, James Wilson., & Brody, Baruch A. (Eds.). (1998). *Surgical ethics*. Oxford: Oxford University Press.
- Moore, Wilbert E. (1970). *The professions: Roles and rules*. New York: Russell Sage Foundation.
- Rahardjo, S. (1980). *Hukum dan Masyarakat*. Bandung: Angkasa.
- Rosenberg, Charles E. (1987). *The care of strangers: The rise of America's hospital system*. New York: Basic Books.
- Rothstein, William G. (1992). *American physicians in the nineteenth century: From sects to science*. Baltimore: JHU Press.
- Roux-Kemp, Andra le. (2011). *Law, Power and the Doctor-Patient Relationship*. Riga: VDM Verlag Dr. Müller.
- Sakidjo, Aruan., & Poemomo, Bambang. (1990). *Hukum Pidana Dasar Aturan Umum Hukum Pidana Kodifikasi*. Jakarta: Ghalia Indonesia.
- Turner, Chris., & Hodge, M. N. (1970). *Occupations and Professions*. In J. A. Jackson (Ed.), *Professions and Professionalization* (pp. 19–50). Cambridge: Cambridge University Press.
- Veatch, Robert. M. (1981). *A theory of medical ethics*. New York: Basic Books.

DISSERTATIONS

- Nasronudin. (2005). *Efek Pernyataan Diagnosis Terinfeksi HIV/AIDS Terhadap Mekanisme Apoptosis Limfosit T-CD4 pada Penderita HIV/AIDS*. (Doctoral Dissertation). Surabaya: Airlangga University.
- Nursalam. (2005). *Efek Model Pendekatan Asuhan Keperawatan (PAKAR) Terhadap Perbaikan Respons Kognisi dan Biologis Pada Pasien Terinfeksi HIV*. (Doctoral Dissertation). Surabaya: Airlangga University.
- Primara, I W. (1999). *Hubungan antara tanda klinis dengan hasil pemeriksaan histopatologis pada tonsilitis kronis yang telah dilakukan tonsilektomi*. (Doctoral dissertation). Yogyakarta: Universitas Gadjah Mada.
- Riwanto, I. (1992). *Acute appendicitis: intracecal pressure and other causal factors: a clinical epidemiological study* (Doctoral dissertation, Academic Proefschrift. Febodruk Enschede. Amsterdam).

CONFERENCE

- Yong, T. S. (2003). *Medical Conflict. Paper presented at the Medico Legal Annual Seminar, Singapore, 27-28 October*.

REPORT

Utarini, A. (2000). Medical error in health care organizations and quality system in higher education institutions of health personnels. *Research Report*, Fakultas Kedokteran UGM, Yogyakarta.