Strengthening the Professional Disciplinary Council to Prevent the Criminalization of Physicians in Healthcare Services

Nita Asmara, Irsyam Risdawati, Marice Simarmata

Abstract

Healthcare has distinctive characteristics because physicians' actions are shaped by scientific knowledge, professional standards, patients' clinical conditions, available facilities, and medical risks. An adverse outcome following medical treatment does not necessarily establish physician fault, yet medical disputes are still frequently transferred too quickly to criminal proceedings. This study examines the legal position and the urgency of strengthening the Professional Disciplinary Council as a preliminary assessment mechanism to prevent the criminalization of physicians. This normative legal study employs statutory, conceptual, and case approaches. The findings show that the Council operates as a professional assessment gateway that distinguishes medical risk, disciplinary breach, negligence, and criminal conduct. Constitutional Court Decision Number 156/PUU-XXII/2024 confirms the constitutionality of the Council's recommendation for cases related to healthcare services. Strengthening should focus on institutional independence, balanced expertise, measurable procedures, examination deadlines, reasoned recommendations, and coordination with law enforcement. The Council must not become a shield for impunity, but an instrument that balances the legal protection of physicians and patients.

***Keywords**:* Professional Disciplinary Council, physician criminalization, healthcare services, medical disputes, health law.

Nita Asmara[1]
[1] Master of Health Law Program, Universitas Pembangunan Panca Budi, Indonesia
e-mail: nitaasmara86@gmail.com [1]

Irsyam Risdawati[2], Marice Simarmata [3]
[2,3] Master of Management, Universitas Pembangunan Panca Budi, Indonesia
e-mail irsyam.risdawati@gmail.com [2], ichesmart@yahoo.co.id [3]
3rd International Cofference on the Epicentrum of Economic Global Framework (ICEEGLOF)
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Introduction

Health is a constitutional right and a central component of human dignity. The 1945 Constitution of the Republic of Indonesia obliges the state to protect citizens' access to healthcare and to establish a legal framework that supports safe and responsible services [1]. Within that framework, physicians occupy a distinctive position. Their decisions are based on scientific knowledge, professional competence, clinical indications, available facilities, and the patient's condition at the time of treatment. The legal relationship between a physician and a patient is therefore generally an obligation to exercise appropriate professional effort, not a guarantee of recovery.

This distinction is essential because an undesirable result does not by itself prove malpractice. A patient may deteriorate because of the natural course of disease, an unavoidable complication, delayed presentation, an atypical response to treatment, limited facilities, or a recognized medical risk. Nevertheless, patients and their families understandably seek explanations when treatment fails. Poor communication, incomplete documentation, divergent expectations, or delayed disclosure can transform dissatisfaction into a dispute. The legal problem arises when the dispute is immediately framed as a criminal case before any competent assessment of professional standards, service standards, standard operating procedures, authority, competence, and causation has been conducted.

The term criminalization in this article does not mean that physicians should be immune from criminal liability. A physician who intentionally commits an offense, practices beyond lawful authority, falsifies records, or engages in culpable negligence that satisfies the elements of a criminal offense must remain accountable. Criminalization refers instead to a disproportionate use of criminal procedure based mainly on an adverse outcome, without an adequate professional inquiry into the act, the applicable standard, fault, and causal connection. Such an approach risks converting criminal law from an instrument of justice into professional and psychological pressure.

Law Number 17 of 2023 on Health established a Professional Disciplinary Council, hereafter referred to as the Council, to enforce professional discipline for medical and health personnel [2]. Government Regulation Number 28 of 2024 provides the broader implementing framework for the Health Law [3], while Minister of Health Regulation Number 3 of 2025 regulates professional discipline, complaints, examination procedures, and disciplinary decisions in greater detail [4]. Article 308 of the Health Law requires a Council recommendation before an investigation may proceed in relation to alleged unlawful conduct by medical or health personnel in the provision of healthcare. This arrangement recognizes that medical conduct cannot be evaluated adequately through an outcome based approach alone.

The constitutional status of the recommendation requirement became clearer through Constitutional Court Decision Number 156/PUU-XXII/2024, delivered on 19 January 2026. The Court rejected the petition in its entirety and held that Article 308 did not create a constitutional barrier to access to justice. It emphasized, among other safeguards, that if the Council does not issue a recommendation within fourteen working days, a recommendation permitting investigation is deemed to have been given [5]. The decision confirms that

professional assessment and law enforcement are not mutually exclusive. The recommendation is a procedural safeguard, not an absolute veto over criminal justice.

Against this background, this study addresses two questions. First, what is the legal position of the Professional Disciplinary Council within the Indonesian health law system? Second, why and how should the Council be strengthened to prevent disproportionate criminalization while preserving patients' right to justice? The article argues that the Council should be understood as an epistemic and procedural gateway. Its purpose is to supply a reliable professional classification of a medical event before the coercive power of criminal law is used, while leaving final legal responsibility to the institutions authorized by law.

Literature Review

Medical disputes occupy the intersection of ethics, professional discipline, civil liability, administrative law, and criminal law. These domains may arise from the same event, but they apply different standards and pursue different purposes. Ethics concerns the moral duties and values of the profession. Professional discipline concerns compliance with professional standards, service standards, competence, authority, and accepted procedures. Civil liability primarily concerns unlawful loss and compensation. Criminal liability concerns conduct that fulfills statutory elements and can be attributed to a blameworthy offender. A breach of ethics is not automatically a disciplinary breach, a disciplinary breach is not automatically negligence, and negligence is not automatically a criminal offense.

Medical law literature has long emphasized that the assessment of physician conduct must focus on the professional process and the circumstances existing when the decision was made, rather than on hindsight alone [6]. This process based assessment is consistent with legal protection theory, which requires state action to protect rights while providing fair procedures and preventing arbitrary exercises of public power [7]. In healthcare, the relevant rights are reciprocal. Patients are entitled to safe, competent, transparent, and accountable services, while physicians are entitled to legal protection when acting within professional standards and lawful authority.

The general principles of criminal responsibility remain relevant under Law Number 1 of 2023 on the Criminal Code [8]. A harmful consequence cannot substitute for proof of a prohibited act, fault, and causation. In medical cases, those elements must be tested against professional evidence. The decisive inquiry is not merely whether a patient suffered injury or death, but whether the physician departed from the required standard, whether that departure was blameworthy at the level required by criminal law, and whether it caused the prohibited consequence.

Indonesian scholarship has also identified the social and legal consequences of criminal proceedings in alleged malpractice cases, including professional anxiety and the growth of defensive practice [9]. International empirical research shows that liability pressure may encourage physicians to order additional tests, avoid high risk patients, or decline beneficial procedures primarily to reduce legal exposure rather than to improve expected clinical outcomes [10]. A systematic review involving studies from multiple countries reported a high prevalence of defensive medicine and linked it to prior medico legal litigation and organizational conditions [11]. These findings do not establish that professional review should displace patient remedies. They show why a fair and technically competent screening mechanism matters for both quality of care and legal justice.

The principal gap in the earlier discussion is institutional. Much of the literature predates the 2023 Health Law, the 2025 ministerial regulation, and the Constitutional Court's

2026 ruling. This article therefore places the problem within the current positive law and develops a concrete strengthening framework. The framework treats the Council neither as a professional fortress nor as a substitute court, but as a transparent expert body that must produce timely, reasoned, and reviewable professional assessments.

Research Methodology

This study uses normative legal research, understood as research directed at positive legal norms, legal principles, and doctrinal concepts [12]. It applies three approaches. The statutory approach examines the 1945 Constitution, Law Number 17 of 2023 on Health, Government Regulation Number 28 of 2024, Minister of Health Regulation Number 3 of 2025, and Law Number 1 of 2023 on the Criminal Code. The conceptual approach examines professional discipline, medical risk, negligence, criminal responsibility, proportionality, and legal protection. The case approach examines Constitutional Court Decision Number 156/PUU-XXII/2024 as the most recent authoritative interpretation of the recommendation requirement.

The legal materials consist of primary, secondary, and supporting materials. Primary materials comprise legislation and the Constitutional Court decision. Secondary materials comprise medical law books, legal research literature, and peer reviewed studies concerning criminal claims and defensive medicine. The analysis is qualitative and prescriptive. The materials are interpreted systematically by connecting the institutional provisions of Articles 304 and 308 of the Health Law with disciplinary procedures and general principles of legal responsibility. Normative legal research requires not only an inventory of rules but also an evaluation of coherence, legal purpose, and the practical implications of the applicable norms [13], [14].

Results

4.1 Legal Position of the Professional Disciplinary Council

The Council holds a strategic legal position because the state has expressly assigned it the function of determining whether medical or health personnel have committed a professional disciplinary violation. Article 304 of the Health Law places professional discipline within the national health governance system [2]. The Council's jurisdiction is specialized. It concerns the professional quality of conduct, including competence, authority, professional standards, service standards, standard operating procedures, medical records, clinical indications, and relevant patient conditions.

This specialization distinguishes the Council from an ethics body and from criminal justice institutions. The Council does not investigate crimes, prosecute defendants, or adjudicate criminal guilt. It also does not replace a civil court. Its principal contribution is an expert classification of conduct. It can identify whether the event reflects an unavoidable medical risk, a communication or administrative failure, a disciplinary departure, professional negligence, or facts that justify further legal inquiry. The classification assists investigators, prosecutors, judges, patients, and physicians in using a common evidentiary foundation.

Minister of Health Regulation Number 3 of 2025 operationalizes the disciplinary system through rules on prohibited disciplinary conduct, complaints, examinations, and decisions [4]. An effective disciplinary examination must therefore look beyond the final outcome. It should reconstruct the chronology, identify the applicable standard at the relevant time, review competence and authority, assess available facilities, examine informed consent and records, hear both parties, and determine causation. A recommendation that merely states that a physician complied or failed to comply, without explaining these elements, does not adequately perform the statutory function.

Article 308 gives the Council's professional assessment procedural significance in alleged criminal conduct connected with healthcare services [2]. The Constitutional Court has confirmed that this mechanism is constitutional and does not create an indefinite obstruction because the statute provides a fourteen working day safeguard [5]. Accordingly, the Council is best understood as a mandatory professional gateway whose operation is limited by time and subject matter. It cannot be used to protect conduct unrelated to healthcare delivery, to conceal intentional crime, or to suspend law enforcement indefinitely.

4.2 Criminalization of Physicians in Healthcare Services

Disproportionate criminalization commonly begins with outcome bias. The existence of injury or death becomes the starting point and sometimes the implicit proof of physician fault. This reasoning is legally inadequate. Medical treatment is performed under uncertainty, and the same adverse outcome may arise from very different causes. A sound assessment must distinguish at least four categories.

Tabel 1. Classficataion of Medical Events and the Appropriate Legal Response

Category	Principal Test	Professional Finding	Primary Route
Medical risk	Was the adverse outcome a recognized risk despite compliance with standards?	No disciplinary breach solely from the outcome	Explanation, disclosure, and safety review
Disciplinary breach	Was there a departure from competence, authority, or applicable professional standards?	Professional noncompliance is established	Disciplinary sanction and correction
Professional negligence	Did the physician fail to exercise the required degree of care, and did the failure cause harm?	Negligent departure and causation require proof	Civil, disciplinary, or criminal route according to legal elements
Criminal conduct	Are the statutory act, fault, unlawfulness, and causation established?	Facts justify criminal inquiry	Criminal investigation and adjudication

Source: Authors' analysis based on Law Number 17 of 2023, Minister of Health Regulation Number 3 of 2025, and Constitutional Court Decision Number 156/PUU-XXII/2024.

The table shows that classification is not intended to minimize patient harm. It determines the appropriate pathway and evidentiary threshold. A recognized medical risk may still require disclosure, explanation, and institutional learning. A disciplinary breach may justify professional sanctions and corrective measures. Civil liability may provide compensation where legal requirements are met. Criminal proceedings become appropriate when evidence supports the statutory elements of an offense, including the required form of fault and causation.

The distinction is also important for emergency and high risk care. Physicians in such settings must often decide rapidly with incomplete information and limited resources. If every unsuccessful intervention is treated as presumptive crime, physicians may avoid difficult patients, order clinically unnecessary examinations, or delay necessary interventions. Research on defensive medicine confirms that legal fear can alter clinical behavior in ways that increase cost and may impair patient centered care [10], [11]. A credible Council can reduce this distortion by ensuring that professional conduct is assessed promptly and scientifically.

Protection from criminalization must not be confused with protection from responsibility. Evidence that a physician acted outside competence, ignored a clear contraindication, failed to provide essential emergency care, falsified a record, or deliberately harmed a patient must be addressed firmly. The Council's legitimacy depends on its willingness to identify serious departures as clearly as it identifies unavoidable risks. A body perceived as automatically defending professionals would lose public trust and undermine the very protection it was designed to provide.

4.3 Urgency of Strengthening the Council

First, strengthening is necessary to correct the expertise gap between clinical decision making and ordinary legal assessment. Investigators and judges possess legal authority, but medical standards often require specialist knowledge. A valid assessment may depend on the patient's initial condition, accepted alternative treatments, time sensitivity, drug interactions, available equipment, and whether another competent physician in comparable circumstances could reasonably have made the same decision. The Council should translate these professional questions into findings that are intelligible to legal institutions.

Second, strengthening is required for legal certainty. Physicians need assurance that professional conduct consistent with applicable standards will not be treated as criminal merely because treatment was unsuccessful. Patients need equal assurance that a credible body will not dismiss complaints without a transparent investigation. Legal certainty is achieved when procedures, deadlines, evidentiary standards, decision formats, and routes for further action are known in advance and applied consistently.

Third, strengthening protects access to justice. The fourteen working day rule recognized by the Constitutional Court prevents institutional silence from blocking investigation [5]. In practice, the Council must have sufficient administrative capacity to meet that period. Digital registration, early jurisdictional screening, conflict checks, secure access to medical records, and a roster of relevant experts are essential. Delay harms both sides: patients remain without explanation, while physicians remain under unresolved legal suspicion.

Fourth, strengthening protects the healthcare system. A weak or distrusted disciplinary mechanism pushes parties toward police reports and public confrontation. A strong mechanism can provide an authoritative factual account, identify system failures, recommend professional correction, and indicate when further legal action is justified. This function supports patient safety because recurring problems can be addressed through education, supervision, credentialing, audit, and institutional reform rather than through individual blame alone.

Fifth, strengthening prevents criminal procedure from becoming bargaining pressure in compensation disputes. Criminal law should not be used merely to compel a physician or healthcare facility to pay. Conversely, disciplinary proceedings should not be used to pressure patients to abandon legitimate legal claims. Clear separation of purposes, combined with lawful coordination, is necessary to preserve the integrity of both systems.

4.4 Institutional Strengthening Framework

Institutional strengthening should begin with independence accompanied by accountability. Council members must be protected from pressure by professional organizations, healthcare facilities, government offices, law enforcement agencies, media campaigns, and interested parties. Independence, however, cannot mean secrecy. Appointment criteria, conflict of interest rules, recusals, procedural stages, and anonymized performance information should be publicly accessible.

The composition of examination panels should reflect the nature of the dispute. Professional expertise is indispensable, but it should be complemented by legal competence and a public interest perspective. The medical member should possess expertise relevant to the disputed field and should not have institutional or personal connections to the parties. Legal members should safeguard due process, evidentiary relevance, reasoned decision making, and consistency with the Council's statutory mandate.

Procedures must be simple, measurable, and fair. Complaints should undergo prompt verification to identify jurisdiction, urgency, and the documents required. Both complainant and reported professional must receive an opportunity to present a chronology, evidence, and responses. The physician must be able to explain clinical reasoning and the standards relied upon. The patient must be able to describe harm, communication, expectations, and available evidence. Confidential medical information must remain protected throughout the process.

The recommendation itself must be reasoned. At a minimum, it should state the relevant facts, the professional standard used, the conduct assessed, the evidence accepted or rejected, the analysis of causation, the disciplinary classification, and the reasons supporting further investigation or its absence. This format is crucial because law enforcement should not be expected to infer clinical meaning from a conclusory statement. A reasoned recommendation also enables public accountability without disclosing protected patient information.

Coordination with law enforcement should be institutionalized through protocols, not informal influence. Protocols may regulate secure document requests, timelines, expert clarification, and the distinction between professional findings and criminal proof. The Council must not dictate the legal conclusion, while investigators should not disregard professional findings without articulating a legally and scientifically defensible reason. This relationship preserves each institution's authority while reducing conflicting assessments.

Strengthening must also include preventive legal literacy. Many disputes are intensified by incomplete medical records, weak informed consent, inadequate risk communication, and poor continuity of care. Physicians and healthcare facilities should understand that legal protection depends not only on correct clinical action but also on the ability to demonstrate why and how the action was taken. Accurate records, meaningful consent, communication of material risks, incident reporting, and patient safety culture are therefore part of the prevention framework.

4.5 Balancing the Protection of Physicians and Patients

The Council should be positioned as an instrument of balanced protection. On one side, physicians should not be exposed to disproportionate criminal proceedings for recognized medical risks arising from conduct that complied with professional standards. On the other side, patients must not lose access to explanation, correction, compensation, or criminal justice when serious misconduct occurs. The legitimacy of the system depends on protecting both interests at the same time.

For physicians, legal protection is protection for lawful and professional practice, not protection for error or wrongdoing. For patients, a disciplinary examination can provide an accessible and technically informed account of what happened. If a breach is found, the

findings can support corrective measures and further legal action. If no breach is found, the patient should still receive an intelligible explanation of the clinical event and the basis of the decision.

The Council thus serves as a bridge between medicine and law. Medicine requires evaluation grounded in science, clinical judgment, and standards of care. Law requires proof, procedural fairness, causation, and responsibility. When the bridge is independent, timely, and transparent, it reduces both impunity and arbitrary criminalization. When it is weak, delayed, or unreasoned, mistrust increases and medical disputes remain vulnerable to emotional and outcome based judgments.

Conclusion

The Professional Disciplinary Council has a strategic position in Indonesia's health law system because it provides the specialized assessment required to determine whether medical or health personnel have violated professional discipline. Medical conduct cannot be judged from an adverse outcome alone. It must be assessed by reference to professional standards, service standards, standard operating procedures, clinical indications, competence, authority, available facilities, causation, and the patient's condition. Article 308 of the Health Law makes this assessment procedurally relevant before criminal investigation in cases connected with healthcare services, and Constitutional Court Decision Number 156/PUU-XXII/2024 confirms that the requirement is constitutional and subject to a fourteen working day safeguard.

Strengthening the Council is therefore urgent, but its purpose is not to create immunity. The Council must be capable of distinguishing medical risk, disciplinary breach, professional negligence, and criminal conduct through independent, timely, and reasoned examination. Reform should prioritize transparent appointment and conflict rules, balanced medical and legal expertise, accessible complaint procedures, secure evidence management, compliance with statutory deadlines, analytically complete recommendations, and formal coordination with law enforcement. Physicians and healthcare facilities must simultaneously improve medical records, informed consent, risk communication, and patient safety practices. A Council designed on these principles can protect physicians who act professionally, preserve patients' access to justice, and ensure that criminal law is used proportionately when the evidence genuinely supports criminal responsibility.

Conclusion

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