The Standing of Anatomical Pathology Examination Results in Proving Medical Disputes in Indonesia

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Abstract

When a patient is harmed after a tissue diagnosis, the anatomical pathology (PA) report and the specimens behind it become evidence of what was found and when. This paper examines the standing of PA examination results in proving medical disputes in Indonesia under Law No. 17 of 2023 on Health and the new Criminal Procedure Code (Law No. 20 of 2025). It uses normative legal research with statutory, conceptual and case approaches, supported by secondary data from the Ministry of Health, universities and press reports. None of the provisions read names a PA report. The authors place it as a document, expert testimony and physical evidence under Article 235(1) of the new Code, and as written evidence in civil cases. Article 308 of the Health Law makes a recommendation of the professional discipline council a step before investigation and before a civil claim, and the recommendation is deemed given if the council is silent for 14 working days, but the articles read do not say how the council weighs pathology material. The supply of pathologists limits whether such evidence exists: the shortfall is 1,407 of 2,259 specialists (62.28%), and only 52 of 514 districts and cities (10.12%) have both equipment and staff. The paper recommends report and custody standards, a national retention rule for blocks and slides, a referral route for second readings, and published dispute data.

Keywords*: anatomical pathology; medical dispute; evidence; Law No. 17 of 2023; criminal procedure*

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Introduction

Anatomical pathology is the examination of tissue and cells by a specialist physician (Sp.PA). For conditions such as cancer it supplies the reference diagnosis that guides whether treatment is limited surgery or a wider removal [1]. When a patient later dies or is harmed, the report and the specimens behind it are the record against which a wrong, late or missed diagnosis can be judged. They are therefore likely to matter when a medical dispute is argued before a disciplinary council, a civil court or a criminal court.

Disputes of this kind are not rare. At a working meeting with Commission IX of the House of Representatives on 2 July 2025, the Minister of Health reported 51 complaints about alleged malpractice and patient-safety incidents for 2023–2025, 21 received directly and 30 found through media monitoring. Twenty-four involved the death of the patient, 13 of them in 2025 [2], [3]. A representative of the Indonesian Medical Association (IDI) warned that Law No. 17 of 2023 on Health (the Health Law) lets a patient pursue ethics, discipline and legal channels at the same time [2], [4].

The rules that govern proof in these disputes changed within three years. The Health Law revoked eleven earlier laws, among them the Medical Practice Law (Law No. 29 of 2004) and the former Health Law (Law No. 36 of 2009) [5]. On 29 February 2024 the Constitutional Court rejected the formal challenge to it, finding that it was drafted by the omnibus method and that real efforts had been made to involve the public [6]. The new Criminal Procedure Code (Law No. 20 of 2025, the new KUHAP) took effect together with the new Criminal Code on 2 January 2026 [7], [8] and lists eight types of evidence in Article 235(1) [9].

A recent prosecution shows what is at stake. A paediatrician in Pangkalpinang, Bangka Belitung, was named a suspect under Article 440 of the Health Law after an examination by the professional discipline council (*Majelis Disiplin Profesi*, MDP) [10]. The prosecutor demanded 4 years 6 months [11], and the District Court acquitted her on 20 July 2026, holding that the charge was not proven lawfully and convincingly [12]. The court is reported to have found no breach of procedure or hospital rules [13]. None of the reports read for this paper says what evidence the court weighed, and none mentions pathology.

Indonesian work on medical evidence centres on the medical record [14]. In the sources reviewed, the authors found no study that asks where the PA examination result stands among the types of evidence, which leaves the question open for lawyers, judges and pathologists. This paper asks three questions. First, in which evidentiary categories can PA material be placed under the rules now in force? Second, how do the gatekeeping steps of the Health Law shape its use? Third, what do the supply of pathologists and the capacity of laboratories imply for whether such evidence exists and can be re-examined?

Literature Review

2.1 How a PA report is produced

A PA report is the end of a chain: the specimen is collected, labelled, received by the laboratory, processed, read by a pathologist and reported. The tissue that remains is kept as paraffin blocks and stained glass slides, which are the physical record of the examination. A pathologist speaking at the annual scientific meeting of the pathologists' association (IAPI) described three groups of error: before analysis (mislabelled samples and specimens that do not meet intake requirements, with data entry as a high-risk point), during analysis (processing and interpretation), and after analysis (transferring results to answer sheets, typing mistakes and inconsistent terminology) [1]. The same report adds that under the national health insurance package, pathology may go unpaid when it costs more than the package allows, that hospital deaths often have no clinical autopsy, and that local governments often do not treat pathology laboratories as a priority [1].

2.2 Proof in criminal and civil proceedings

In criminal cases the new KUHAP lists witness testimony, expert testimony, documents (*surat*), the defendant's statement, physical evidence (*barang bukti*), electronic evidence, the judge's observation, and anything else usable for proof at trial if lawfully obtained (Article 235(1)). Generally known facts need not be proven, and evidence must be provably authentic and lawfully obtained (Article 235(2)–(3)) [9]. The presiding judge may call an expert, and if the defendant or the advocate raises a reasoned objection, re-examination is ordered, by the original institution with different personnel or by another institution with authority (Article 230) [9]. A conviction requires that the offence be proven "lawfully and convincingly" (Article 244(1)), and commentators note that the judge's conviction remains part of that standard [15].

In civil cases the five types of evidence are writing, witnesses, presumptions, admission and oath [16], and the judge may seek an expert opinion when it is useful, under Article 154 of the *Herziene Inlandsch Reglement* (HIR) [17]. A study of medical records concludes that they are written evidence that can be strong in civil cases, but that the Criminal Procedure Code does not regulate their strength, so expert testimony is needed to reinforce them [14]. The Health Law requires medical records (Article 296) and provides that they belong to the health facility, with a right of access for the patient and a duty to keep them secure (Article 297) [18].

2.3 Legal politics, delegated rule-making and overlapping oversight

Four studies by Tanjung and co-authors give the paper its analytical lens. In a critique of the omnibus method, Tanjung and Arminsyah argue that an opaque process and little public participation weaken the legitimacy of omnibus laws, and that broad government authority to change regulations is a risk [19]. In a study of judicial supervision, Tanjung examines the Judicial Commission's supervision of judges and notes that other institutions also hold oversight authority [20]. In studies of cybercrime (with Adriani) and of the narcotics trade, he analyses penal and non-penal measures, and the narcotics study proposes an integrated approach of prevention, repression, therapy and rehabilitation [21], [22]. The paper applies these ideas to medical disputes by asking whether the Health Law leaves too much to the executive, whether the oversight bodies overlap, and whether penal and non-penal measures are combined.

Research Methodology

This is normative legal research with statutory, conceptual and case approaches. The primary legal materials are the Health Law (Law No. 17 of 2023) and the new KUHAP (Law No. 20 of 2025), and the civil procedure rules as described in legal commentary. The secondary materials are journal articles and commentary, including the studies by Tanjung and co-authors cited above. Secondary empirical data come from the Ministry of Health's National Cancer Plan 2024–2034, a 2019 report on anatomical pathology republished by the Faculty of Medicine of Universitas Indonesia, a 2024 news release of Universitas Gadjah Mada, and the Minister's 2025 statement to Parliament as reported in the press. The cases are two publicly reported criminal prosecutions of doctors: the Manado case (2011–2014), used as an analogy for contested causation evidence, and the Pangkalpinang case (2026), the application of Article 440 that the authors found.

The analysis is descriptive and qualitative with three simple measures, all calculated by the authors. A share is the part divided by the total. The case load per pathologist is the number of new cancer cases divided by the number of available Sp.PA. The demand ratio is the prison term demanded divided by the statutory maximum.

The study has limits. The authors could not access the Supreme Court decision directory and found no judgment in which a PA report was decisive; this reflects the search, not proof that none exists. Articles of the Health Law and the new KUHAP were read on Pasal.id, whose text of the Health Law contains character errors, and only the articles cited here were read, so statements that the law is silent on a point refer to those articles. The new KUHAP's rule on the number of pieces of evidence needed for conviction was not located; the commentary read does

not quote it [15]. The 2019 workforce figure is dated, the year of the 2024 supply figure of 852 is not stated in the plan, and the complaint data are a ministerial statement reported by two news sites. News reports of the two cases do not describe the evidence, and the placement of PA material in evidentiary categories is the authors' reading.

Results and Discussion

4.1 Where the PA report fits in the rules of evidence

None of the provisions read for this study names a PA report, so the report has to be placed by analogy in categories written for other things. Table 1 shows the placements that the authors consider open.

Table 1. Placement of PA material in the rules of evidence

PA material	Evidence category and provision	Condition or limit
Signed PA report	Criminal: *surat*, Art. 235(1)(c), new KUHAP. Civil: written evidence [16]	Authenticity must be provable and the document lawfully obtained (Art. 235(3)). As part of a medical record it is strong written evidence, but the strength is not regulated and expert support is needed [14]
Pathologist testifying on the report	Criminal: *keterangan ahli*, Art. 235(1)(b). Civil: expert opinion sought by the judge, Art. 154 HIR [17]	A reasoned objection leads to re-examination (Art. 230(2)). If the expert refuses the oath without valid reason, the testimony only strengthens the judge's conviction (Art. 211)
Paraffin blocks and stained slides	Criminal: *barang bukti*, Art. 235(1)(e)	Authenticity and lawful acquisition (Art. 235(3)); a documented custody path is implied; no national retention rule was found
Second reading of the same slides	Criminal: re-examination, Art. 230(2)–(3)	By the original institution with different personnel, or by another institution with authority; availability depends on pathologist supply (Table 3)
Laboratory information-system records and scans	Criminal: electronic evidence, Art. 235(1)(f)	Same authenticity condition; the authors' reading, not tested in any judgment found
Findings of a clinical autopsy	Criminal: *surat* or *keterangan ahli*, depending on form	Hospital deaths often have no clinical autopsy [1], so this material may not exist

Note: the placement of PA material in categories is the authors' reading; no provision read names a PA report. Source: [1], [9], [14], [16], [17].

Three points follow. First, the same material can enter in more than one category: the signed report as a document, the pathologist as an expert, and the blocks and slides as physical evidence. The categories are not interchangeable. A document proves what it says, an expert can be questioned, and a slide can be read again. Second, Article 235(3) requires evidence to be provably authentic and lawfully obtained. For a specimen this implies a documented path from collection to court, which is an inference by the authors because the article does not mention custody. The mislabelling and intake errors described above are exactly the points at which authenticity can be challenged [1]. Third, Article 230(2)–(3) gives the defence a route to a second reading, by different personnel of the same institution or by another institution. That route helps only if the slides still exist, and the authors found no national rule on how long blocks and slides must be kept, so the right to re-examination may depend on local practice.

In civil cases the report is written evidence, and the pathologist can be heard as an expert if the judge seeks an opinion under Article 154 HIR [16], [17]. Because a medical record is strong but not self-sufficient written evidence [14], the same logic applies to a PA report that forms part of the record: the reading needs an expert to explain it. This is the authors' extension of findings that concern medical records in general.

4.2 Gatekeeping: the council, dispute resolution and the offence

The Health Law places steps between a dispute and a court. The Minister forms the professional discipline council (the *majelis*, Article 304), which receives complaints (Article 305) and can impose sanctions from a written warning to a recommendation to revoke the practice permit (Article 306) [18]. Its decisions can be reviewed by the Minister on three grounds: new evidence, an error in applying a violation or discipline, or a conflict of interest (Article 307). Before an investigation, investigators must ask the council for a recommendation on whether practice met professional, service and operating-procedure standards. The council has 14 working days, after which it is deemed to have recommended an investigation (Article 308(3), (5), (7)–(8)). For civil claims the health worker asks for a similar recommendation (Article 308(2), (4), (6)) [18]. A dispute arising from an alleged error that harms a patient must first go through alternative dispute resolution outside court (Article 310) [18], [23]. The offence is Article 440: negligence causing serious injury carries up to three years' imprisonment or a fine, and negligence causing death up to five years or a fine [18]. Table 2 sets the pathways beside the points at which PA material can enter.

Table 2. Dispute pathways under the Health Law and the entry points for PA material

Pathway	Basis	Where PA material can enter	What the law leaves open
Discipline	Arts. 304–306: council formed by the Minister; sanctions from written warning to recommending revocation of the practice permit [18]	Council examination of compliance with standards	What the council may request; hearing rules are not in the articles read
Recommendation before investigation	Art. 308(3), (5), (7)–(8): after the investigator's written request; 14 working days; deemed to recommend investigation if silent	Practice is tested against professional, service and operating-procedure standards; PA material is the factual basis for judging a diagnosis (inference)	Whether specimens are examined; how a deemed recommendation is reached with no examination
Recommendation before civil claim	Art. 308(2), (4), (6): requested by the health worker after a patient's claim	Same test of standards	Status in civil proceedings is unregulated [24]
Review of a council decision	Art. 307: review by the Minister for new evidence, error or conflict of interest	A second reading by another pathologist as new evidence (inference)	Review of a *recommendation*: petition declared inadmissible [25]
Resolution outside court	Art. 310: alternative dispute resolution first [23]	A shared reading of the report may narrow disagreement (inference)	Who convenes it; what disclosure is required
Criminal offence	Art. 440: negligence causing serious injury (up to 3 years) or death (up to 5 years)	Document, expert and physical evidence (Table 1)	Proof must be "lawful and convincing" (Art. 244(1), new KUHAP)

Note: entries marked inference are the authors' reading of the text. Source: [9], [18], [23]–[25].

Article 308 is where a PA report can matter most and is least regulated. The recommendation tests practice against standards, and a diagnosis cannot be tested without the report and the slides behind it. Yet the articles read do not say what the council may request, whether it must examine specimens, or how it weighs pathology material. Andrianto argues that in criminal matters the council in effect takes over an investigative function, because its recommendation decides whether an investigation may proceed [26], and that the legal status of a council recommendation in civil proceedings is not yet regulated [24]. The deemed recommendation in Article 308(8) adds to the concern: silence for 14 working days opens the way to investigation without any examination of the specimen.

The Constitutional Court did not resolve the question of review. The Pangkalpinang paediatrician asked it to read Article 307 so that recommendations, and not only decisions,

could be reviewed, and the Court declared the petition inadmissible on 30 October 2025 [10], [25]. Whether a pathology second opinion could count as new evidence under Article 307(a) is untested; this is the authors' inference.

These features can be read through Tanjung's work. The Health Law was made by the omnibus method, which the Court accepted as formally valid [6]. Tanjung and Arminsyah warn that omnibus lawmaking carries legitimacy risks when the process is opaque and government authority is broad [19]. In the Health Law the Minister forms the council and hears the review of its decisions (Articles 304 and 307), so the executive holds both roles [18], and the articles read say little about procedure and the weight of evidence. Tanjung's study of judicial supervision observes that supervision of judges is shared among institutions [20]. Medical disputes have the same overlap, since ethics, discipline and legal channels may run at once [2]. Where several bodies can examine one report, the rules on what they may ask of the laboratory and how they share findings are what keep their outcomes consistent.

Article 310 and Article 440 pull in opposite directions in the sense that Tanjung uses: the first is a non-penal route that asks the parties to settle, and the second is a penal sanction. His studies of cybercrime and narcotics argue that penal and non-penal measures should be combined in an integrated approach [21], [22]. For PA evidence, the non-penal measures that make sense are those that precede any dispute: report standards, specimen custody and retention, and referral for second reading. The criminal provision can work only as well as these allow.

4.3 Supply and quality: can the evidence exist?

The National Cancer Plan 2024–2034 lists a requirement of 2,259 Sp.PA and a supply of 852, a shortfall of 1,407 (62.28%) [27]. In its mapping of 514 districts and cities, only 52 (10.12%) have both the equipment (an immunohistochemistry set) and the personnel (a Sp.PA and a laboratory technologist) for PA services in cancer care. A further 185 (35.99%) have personnel but no equipment, and 277 (53.89%) have neither [27]. Figure 1 shows both findings. The 2022 incidence of 408,661 new cancer cases [27] gives about 480 new cases for each available Sp.PA. Not every case produces a specimen, so this illustrates scale and is not a workload.

Table 3. Anatomical pathology capacity indicators

Indicator	Value	Source
Sp.PA required for cancer care	2,259	[27]
Sp.PA available (supply)	852 (37.72%)	[27]
Shortfall	1,407 (62.28%)	[27]
Districts and cities with equipment and personnel (n = 514)	52 (10.12%)	[27]
Districts and cities with personnel but no equipment	185 (35.99%)	[27]
Districts and cities with neither	277 (53.89%)	[27]
New cancer cases in 2022	408,661	[27]
New cases per available Sp.PA (illustrative)	about 480	Calculated
Anatomical pathologists, 2019	about 610	[1]
Government hospitals, 2019	about 2,800	[1]
Pathologists per government hospital, 2019	0.22	Calculated
East Kalimantan, 2019	9 pathologists, 7 hospitals	[1]
Specialist doctors, Dec. 2023	47,454	[28]
Specialists per 1,000 population	0.17	[28]
Estimated need (280 million people)	about 78,000	[28]

Note: percentages and ratios calculated by the authors. The year of the supply figure of 852 is not stated in the plan, and the 2019 figures are dated. Incidence is not the number of tissue specimens.

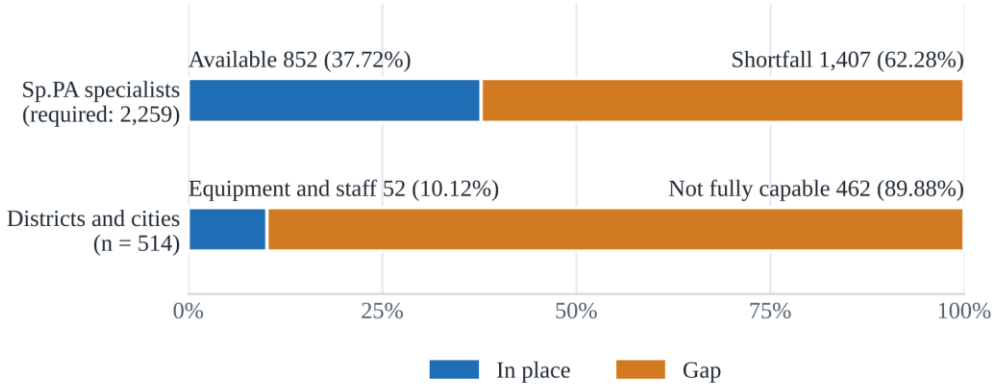


Figure 1. Anatomical pathologists (Sp.PA) required and available, and districts and cities with equipment and personnel for PA services in cancer care. Source: [27]; percentages calculated by the authors.

Older and broader data point the same way. In 2019 about 610 anatomical pathologists served the country against about 2,800 government hospitals, which is 0.22 per hospital. East Kalimantan had nine pathologists in seven hospitals, and patients were sent to Jakarta, Surabaya or Makassar [1]. Across all specialties, 47,454 specialist doctors in December 2023 gave 0.17 per 1,000 people against an estimated need of about 78,000, a gap of 30,546 (39.16%) [28].

For proof, the shortage has three consequences, each an inference by the authors. First, a report may not exist where no pathologist or equipment is present, and a claimant cannot rely on evidence that was never produced. Second, a second reading by "another institution" (Article 230(3)) requires a reachable laboratory, and in the 277 districts with neither staff nor equipment the nearest one may be far away. Third, a small pool raises the risk that the treating pathologist, or a close colleague, is the only expert available, which weakens the independence on which a second reading depends.

4.4 Disputes and decisions

Table 4 reproduces the Minister's breakdown of the 51 complaints. Deaths account for 24 of them (47.06%), and 13 of those deaths were in 2025 (54.17%) [3]. The figures do not say in how many complaints a PA examination or an autopsy was done, so the share of disputes in which PA evidence is relevant cannot be derived from them.

Table 4. Complaints on alleged malpractice reported by the Minister of Health, 2023–2025

Type of impact	Complaints	Share (%)
Death of the patient	24	47.06
Infection or complications	10	19.61
Procedure or administrative error	8	15.69
Disability or serious injury	7	13.73
Dispute over medical information	2	3.92
Total	51	100.00

Note: of the 51 complaints, 21 (41.18%) were received directly and 30 (58.82%) came from media monitoring; 13 of the 24 deaths (54.17%) were in 2025. Shares calculated by the authors and rounded, so the rows sum to 100.01. Source: [2], [3].

The Manado case shows how the same documents can be read differently at successive levels. Three obstetricians were charged after a patient died following an emergency caesarean section in 2010; the cause of death was air embolism in the right ventricle. The District Court acquitted them in 2011, relying on witness and expert testimony and on a ruling of the regional ethics council of the medical association, which found no breach of operating procedure. The Supreme Court in cassation (No. 365 K/Pid/2012) sentenced each to 10 months, relying on the medical record, read by an expert, and a hospital certificate [29]. On judicial review the

Supreme Court acquitted them on 7 February 2014 by a non-unanimous panel, finding that procedure had not been breached [30], [31]. This was a forensic and not a PA case, and the reasoning on review is only partly reported, so it serves here as an analogy for contested causation evidence.

The Pangkalpinang case applies Article 440(2), negligence causing death. The prosecutor demanded 4 years 6 months, which is 90% of the five-year maximum [11], [18], and the court acquitted, reportedly finding that the doctor did not breach procedure or hospital rules [12], [13]. The reports do not mention pathology, autopsy or the council's recommendation in discussing the verdict, so the authors cannot say what role, if any, a PA report played. Two cases are not a pattern, but in both the acquittal rested on a finding of compliance with procedure, the same question that Article 308 asks the council to test before an investigation. If compliance decides outcomes, the quality of the evidence of what was done and diagnosed, including PA material, is what the test rests on; this is an inference by the authors.

4.5 Recommendations

Five measures follow from the analysis. First, a minimum standard for the PA report: a unique specimen identifier, the time of receipt, the name of the reading pathologist and a record of any second opinion, so that the report can meet the authenticity test of Article 235(3). Second, a national rule on retention and release of blocks and slides, so that re-examination under Article 230(3) remains possible; the period should be set by the Ministry of Health after consulting pathologists. Third, a referral protocol for second readings, with a list of laboratories able to act as "another institution with authority". Fourth, rules on what material the council examines before it recommends, and on the status of its recommendation in civil proceedings. Fifth, publication of dispute data that records whether a PA examination or a clinical autopsy was done, so that the role of PA evidence can be measured.

Conclusion

First, no provision read for this study names the PA examination result. It can be placed as a document, as expert testimony and as physical evidence under Article 235(1) of the new KUHAP, and as written evidence with expert support in civil cases. Each placement carries conditions, namely provable authenticity, lawful acquisition and the possibility of re-examination by another institution, and the first two imply a documented chain of custody for specimens.

Second, the Health Law places a council recommendation before investigation and before a civil claim, deems it given after 14 working days of silence, and requires dispute resolution outside court first, but the articles read do not state how pathology material is examined or weighed. Supply limits are severe: the shortfall of Sp.PA is 62.28%, and only 10.12% of districts and cities have both the equipment and the staff. Such evidence may not exist, and a second reading may be out of reach.

Third, the authors recommend report and custody standards, a retention rule for blocks and slides, a referral protocol, clearer rules for the council and published dispute data. Further research should read the full Health Law and its implementing regulations, obtain judgments from the Supreme Court decision directory in which a PA report was weighed, and interview pathologists and council members about how specimens are requested and examined.

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