Legal Responsibility of Nursing Personnel in Performing Medical Procedures under Health Service Standards

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Abstract

Medical procedures performed by nursing personnel are essential to continuity of care, yet disputes may arise when professional authority and the allocation of responsibility are unclear. This study examines the limits of nurses' authority, identifies criteria for legal responsibility arising from medical procedures, and develops a governance framework consistent with health service standards. Normative legal research is conducted using statutory and conceptual approaches, focusing on Law No. 17 of 2023 on Health, Government Regulation No. 28 of 2024, and Minister of Health Regulations Nos. 13 and 3 of 2025. The findings show that mandates and delegations are subject to distinct rules: under a mandate, responsibility remains with the mandator, whereas a properly established delegation transfers responsibility to an eligible recipient under specific conditions. Transfers must be documented in writing, reflect competence, and fall within services designated by facility leadership. The article proposes a five-element assessment encompassing legal authority, competence, standards, supervision and documentation, and proof of fault and causation. An adverse clinical outcome alone does not establish negligence, and the obligations of nurses, physicians, and facilities require separate examination.

Keywords: legal responsibility; nursing personnel; medical procedures; transfer of authority; health service standards

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Introduction

Patient safety is a fundamental measure of health-care quality. In everyday practice, medical procedures are not always performed directly by physicians. In inpatient wards, emergency departments, and primary care facilities, nurses routinely implement elements of treatment plans, including medication administration, monitoring of patients' responses, and related procedures. This allocation of work supports continuity of care but raises a legal question: who is authorised to perform a given procedure, and who bears responsibility when the patient suffers harm? The World Health Organization places the prevention of avoidable harm at the centre of patient safety [1].

A legal problem arises when an intervention initially determined by a physician is carried out by a nurse without clarity about the form of transfer of authority, the recipient's competence, or the supervision provided. That uncertainty obscures the distinction between an erroneous treatment decision, an implementation error, organisational shortcomings, and an adverse outcome that can occur despite compliance with appropriate standards. Responsibility therefore cannot be inferred solely from a person's professional title. Authority, specific duties, conduct, consequences, and causation must be considered.

Indonesia's legal framework has substantially changed. Law No. 17 of 2023 on Health regulates professional practice and the transfer of authority under Article 290 [2]. Government Regulation No. 28 of 2024 places competence, clinical privileges, credentialing, and transferred authority within the governance of professional practice. In particular, Article 745 distinguishes mandate from delegation by reference to where responsibility rests [3]. Minister of Health Regulation No. 13 of 2025 subsequently requires a written transfer and establishes detailed conditions governing mandates and delegations [4].

Professional discipline is a distinct route of scrutiny. Minister of Health Regulation No. 3 of 2025 governs discipline for failures to comply with professional standards, service standards, and standard operating procedures [5]. This matters because a professional disciplinary violation is not automatically proof of civil liability or a criminal offence. The issue becomes more difficult where facilities permit undocumented verbal orders, fail to update clinical privileges, or assign nurses tasks beyond their competence.

Existing scholarship addresses aspects of the physician-to-nurse transfer of clinical responsibilities. Sylvana, Firmansyah, and Haryanto examine the formal basis and legal effects of the transfer [6]. Fiah, Lewar, and Ritti investigate nurses' knowledge of legal responsibility for actions undertaken under physician authorisation in a primary care setting [7]. Indriono and Widayanti consider the transfer from a health-law perspective, while Widyaningsih and colleagues study nurses' legal responsibility for delegated medical procedures in hospitals [8], [9]. These studies illuminate the authority issue, but a combined analysis is still needed of the specific delegation requirements introduced by the 2025 ministerial regulation and of responsibility across nurses, physicians, and health facilities.

This article addresses three questions: (1) what legal limits govern nursing personnel who perform medical procedures under current law; (2) how legal responsibility should be assessed when health service standards are not met; and (3) which governance model can clarify responsibility while safeguarding patients. It seeks to develop a sequence of normative tests, with particular attention to the law in force as of October 2026.

Literature Review

2.1 Professional authority, competence, and service standards

Authority is not identical to practical skill. A person may be technically capable of performing a procedure without holding the legal entitlement or clinical assignment to do so. Articles 742 and 743 of Government Regulation No. 28 of 2024 identify competence and credentialing as bases for assigning clinical privileges to relevant health personnel [3]. In

administrative law, authority is a condition for the validity of an act; in health law, competence and standards provide measures of safe performance. Both must be present.

2.2 Mandate, delegation, and the allocation of responsibility

Article 290 of Law No. 17 of 2023 distinguishes a mandate, under which legal responsibility and accountability remain with the mandator, from delegation, under which those consequences pass to the recipient of the delegation [2]. Article 745 of Government Regulation No. 28 of 2024 reinforces this distinction [3]. Articles 182–184 of Minister of Health Regulation No. 13 of 2025 specify written authorisation, competence, supervision, and circumstances in which the delegator is unavailable [4]. The classification of a transfer is thus legally significant rather than merely administrative terminology.

2.3 Patient safety and the limits of attribution

An error in carrying out a procedure must be distinguished from an adverse event that cannot reasonably be prevented. Regarding medication safety, WHO identifies medicine-related harm as a substantial component of preventable harm and calls for interventions involving personnel, processes, and systems [10]. An international scoping review of nurse delegation also highlights the importance of clear models, instructions, and organisational support. That review, however, concerns nurses delegating work to support workers; its findings cannot automatically be treated as a statement of Indonesian law governing physician-to-nurse transfers [11].

2.4 Distinct tracks of legal responsibility

Professional discipline examines compliance with professional obligations and standards. Civil liability requires examination of the relevant legal relationship, harm, fault, and causation. Criminal liability demands proof of every element of an applicable offence and individual culpability through a lawful process. Ministerial Decision No. HK.01.07/Menkes/775/2025 provides descriptions of disciplinary violations, while Minister of Health Regulation No. 24 of 2022 establishes the legal framework for medical records and clinical documentation [12], [13]. Evidence may overlap across the three tracks, but none replaces the requirements of another.

Research Methodology

This research applies a normative legal method using statutory and conceptual approaches, supplemented by a limited comparison of scholarly positions. Primary legal materials comprise Law No. 17 of 2023, Government Regulation No. 28 of 2024, Minister of Health Regulations Nos. 13 and 3 of 2025, Ministerial Decision No. HK.01.07/Menkes/775/2025, and Minister of Health Regulation No. 24 of 2022. Secondary materials include Indonesian legal scholarship, WHO publications, and an international scoping review addressing safety and delegation [1]–[15].

The analysis identifies connections between legal authority, procedural standards, documentary evidence, and legal consequences. Three hypothetical situations are distinguished: a procedure within a nurse's original professional authority, an act performed under a mandate, and an act performed under delegation. Five elements are tested in each situation: the legal basis of assignment, competence, applicable standards, supervision and documentation, and the connection between culpable conduct and harm. The resulting framework is the authors' normative construction rather than a field-tested instrument.

No interviews, hospital audits, or analysis of specific court judgments were undertaken. Illustrative scenarios in the discussion should therefore not be read as reports of actual incidents. This paper does not estimate the prevalence of nursing error or the effectiveness of a particular governance model because primary evidence and quantitative comparison data were not collected.

Results and Discussion

4.1 Professional authority following health-law reform

Law No. 17 of 2023 places nursing practice within a consolidated legal framework. Nursing authority can no longer be grounded exclusively in Law No. 38 of 2014 on Nursing, which was repealed by Law No. 17 of 2023 [2], [16]. Likewise, Minister of Health Regulation No. 26 of 2019 was repealed by Regulation No. 13 of 2025 [4], [17]. Scholarship that presents these older instruments as currently operative without acknowledging their repeal risks reaching an inaccurate conclusion.

The post-2025 framework requires three situations to be distinguished. The first involves original professional authority consistent with a nurse's competence and clinical privileges. The second involves a written mandate, permitting tasks within the recipient's competence under supervision while excluding transfer of clinical decision-making. The third involves written delegation meeting specific statutory conditions, including the delegator's unavailability and the recipient's competence and clinical privileges [3], [4].

Article 182(5) of Minister of Health Regulation No. 13 of 2025 expressly requires written transfer. Article 183 keeps responsibility with the mandator and requires reporting by the recipient. Article 184, in contrast, transfers responsibility to a duly qualified delegate and includes conditions concerning the delegator's absence, such as leave or official assignment [4]. An ordinary spontaneous instruction from a physician should therefore not automatically be labelled delegation. Moreover, the facility head must determine which services are eligible for transferred authority.

4.2 Service standards as criteria for assessing conduct

Professional standards and standard operating procedures are not merely internal documents detached from the law. They help assess whether decisions and interventions met a reasonable level of care. Nonetheless, a procedural irregularity does not automatically establish patient harm, and the occurrence of a complication does not automatically establish a breach. Assessment must take account of the clinical information and resources reasonably available to practitioners at the time, rather than relying only on the eventual outcome [5], [10].

Table 1. Mandate and delegation under the current regulatory framework

Element	Mandate	Delegation
Main provisions	Art. 745, Gov. Reg. 28/2024; Arts. 182–183, MoH Reg. 13/2025	Art. 745, Gov. Reg. 28/2024; Arts. 182 and 184, MoH Reg. 13/2025
Form	Written transfer required	Written transfer required
Competence	Within the recipient's competence	Trained recipient with appropriate competence and clinical privileges
Supervision	Subject to the mandator's supervision	Subject to the transfer conditions and reporting duties
Clinical decisions	Decision-making is not transferred	Within the scope of authority validly delegated
Responsibility	Remains with the mandator	Passes to the delegate
Specific conditions	No requirement that the mandator be absent	The delegator must be unavailable as specified in Art. 184

Source: authors' normative analysis based on [2]–[5].

Consider a hypothetical nurse who administers a medicine recorded in the treatment plan but whose dose differs from the prescription without adequate verification. The legal inquiry cannot stop at the fact that a physician signed an order. It should identify the person who decided the treatment, the person who prepared and administered the medicine, whether patient identification and dose checking occurred, and when a change in the patient's condition was recognised. If a nurse accurately follows an order but the underlying clinical

decision is mistaken, the allocation of responsibility may differ. This scenario illustrates legal analysis; it is not a finding of fault in an actual case.

Health facilities must also be included in the inquiry. Articles 743 and 745 of Government Regulation No. 28 of 2024 assign facility leadership important functions concerning clinical privileges and determining services that can be transferred [3]. Failures to provide appropriate assignment, supervision, or reporting arrangements must be examined independently. Transfer of responsibility for a delegated clinical task does not automatically extinguish every institutional obligation to maintain a safe system of care.

4.3 Mandate and delegation: evidentiary implications

The central distinction between mandate and delegation is who may make decisions and who must supervise performance. Under a mandate, decision-making is not transferred and the mandator retains responsibility; the nurse still has a professional duty to perform competently and report results. Under delegation, responsibility associated with the properly delegated authority passes to an eligible and competent delegate. Such a transfer cannot legitimise an assignment to an untrained person or a service not approved for delegation under the regulatory framework [4].

For legal clarity, a sound transfer document should identify the delegator and recipient, the precise procedure, limits of clinical decision-making, reasons and duration for the transfer, escalation and reporting mechanisms, and evidence of competence. These features form the governance proposal advanced by this article; they are not all verbatim requirements of a single statutory provision. The mandatory core, namely facility determination, competence, and written authorisation, derives from Articles 182–184 of Minister of Health Regulation No. 13 of 2025 [4].

4.4 Categories of responsibility and causal assessment

Professional discipline concerns compliance with professional standards, service standards, and operating procedures. Minister of Health Regulation No. 3 of 2025 establishes the professional disciplinary process and complaints mechanism, while Ministerial Decision No. HK.01.07/Menkes/775/2025 specifies forms of disciplinary violation [5], [12]. A disciplinary assessment may inform understanding of professional performance but is not a substitute for proof of civil or criminal liability.

Table 2. The authors' proposed legal assessment matrix

Stage	Key question	Relevant evidence
1. Authority	What is the legal basis of the act?	Registration/licence, clinical privileges, written transfer
2. Competence	Was the practitioner trained and competent?	Credentialing, training, clinical assignments
3. Standards	Were relevant safety procedures observed?	Operating procedures, professional standards, care notes
4. Supervision	Who instructed, monitored, and received reports?	Written orders, medical records, escalation notes
5. Causation	Were fault, damage, and causal connection established?	Clinical records, expert evidence, case evidence

Source: authors' normative analysis based on [2]–[5].

In civil disputes, the patient's loss and the causal link must be connected to the conduct or duty of each defendant. The physician who grants a mandate, the nurse who carries out an intervention, and the facility may occupy different legal positions depending on the assignment and established facts. Criminal liability requires even more exacting safeguards: an undesirable clinical outcome is insufficient without proof of the elements of an offence, relevant fault, and causation. Accordingly, allocation of professional responsibility in delegation instruments must be considered alongside, not in place of, the independent requirements of the relevant branch of law.

This approach rejects two simplifications. It is incorrect to assume that nurses are invariably fully responsible simply because they physically carry out a procedure. It is equally incorrect to assume that physicians are invariably responsible for every consequence of a nurse's act. Either assumption may overlook the legal basis of the assignment, the standard of care, and independent error at the stages of preparation, performance, supervision, or follow-up. Prior work on haemodialysis procedures and nursing clinical privileges similarly identifies the importance of clearly delimited and documented authority [14], [15].

4.5 Clinical records as the link between actions and responsibility

Clinical documentation connects orders, interventions, patient responses, and follow-up care. Minister of Health Regulation No. 24 of 2022 requires health facilities to maintain electronic medical records and addresses clinical information about services provided [13]. For evidentiary purposes, traceable entries assist in distinguishing the person who ordered a procedure, the person who carried it out, and the person who reviewed the result. Missing documentation does not necessarily prove that negligence caused injury, but it complicates the reconstruction of events and may reveal deficiencies in institutional governance.

Operationally, records of transferred authority should be linked to clinical privileges, physician instructions, nursing intervention notes, and adverse-event reporting. The authors propose a traceable audit trail showing time, staff identity, and changes to instructions so that later causal analysis need not depend principally on retrospective recollection. This proposal accords with WHO's emphasis on preventing avoidable harm through systemic improvement [1], [10].

4.6 A five-element framework for assessing responsibility

The paper's principal normative finding is a five-element assessment framework. The first element is proof of legal authority, whether original professional authority, mandate, or delegation. The second is competence and appropriate clinical privileges. The third is compliance with professional, service, and operating standards. The fourth is supervision, reporting, and documented care. The fifth is proof of fault, damage, and causation where required by the applicable legal route. These elements form an order of inquiry, not a newly invented set of legal ingredients for a criminal offence.

Table 3. Preliminary mapping of legal responsibility

Track	Primary issue	Limit of inference
Professional discipline	Compliance with standards and authority	Disciplinary breach does not automatically establish crime
Civil	Duty, fault, damage, and causation	Depends on legal relationship and admissible evidence
Criminal	Offence elements, culpability, and causation	A poor clinical outcome is insufficient for conviction
Institutional	Credentialing, permitted tasks, resources, governance	Not automatically extinguished by delegation

Source: authors' normative analysis based on [2]–[5].

The value of this model is its ability to separate an assignment error from an execution error. A nurse who refuses a task beyond their competence should not be evaluated in the same way as a nurse who receives a lawful assignment but disregards safety procedures. A physician issuing incomplete orders should be assessed in relation to clinical decisions and supervision, while facility management should be examined with regard to assignment policies, credentialing, resource availability, and reporting. These are analytical recommendations and have not yet been validated by empirical study.

4.7 Policy implications and limitations

For policymakers and facility leaders, better governance is not a matter of adding paperwork alone. The types of eligible procedures must match service needs, competence must actually be verified, and written authorisations must be usable at the point of care. In

emergencies or other specified conditions, the analysis must recognise special provisions permitting care outside ordinary authority, including urgent life-saving care, as governed by Government Regulation No. 28 of 2024 and Minister of Health Regulation No. 13 of 2025 [3], [4]. Those exceptions must not be used to justify routine and undocumented transfers.

Further research should examine actual clinical assignment records and disputes resolved through appropriate legal procedures. Without field evidence, this article cannot estimate the frequency of undocumented transfers or demonstrate that one assignment arrangement is safer than another. Its contribution is a systematic legal framework for examining those questions following the 2025 regulatory changes.

Conclusion

First, nursing personnel's legal authority to undertake medical procedures cannot be inferred solely from practical ability or verbal instructions. Applicable law requires a valid source of authority, competence, clinical privileges, and observance of standards. Law No. 17 of 2023, Government Regulation No. 28 of 2024, and Minister of Health Regulation No. 13 of 2025 distinguish mandates from delegations, with different conditions and allocations of responsibility [2]–[4].

Second, responsibility must be assessed in the relevant legal track. Professional discipline concerns compliance with professional standards; civil liability involves duty, damage, fault, and causation; criminal liability requires proof of a specific offence and culpability. An unfavourable clinical outcome is not in itself proof of negligence. Mandators, delegates, procedural performers, and health facilities should each be evaluated according to their actual acts and obligations.

Third, this article proposes a five-element assessment model covering authority, competence, applicable standards, supervision and documentation, and proof of legal consequences. Facilities should define delegable services, update clinical privileges, implement operational written authorisations, and establish traceable reporting processes. Empirical studies and analyses of actual judgments are needed to examine the model's practical utility.

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