Medical Dispute Resolution from a Health Law Perspective in Indonesia

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Abstract

The transition to the digital era has increased public awareness of patient rights, ultimately contributing to the increased potential for medical disputes in clinical healthcare practices. Medical disputes generally arise from medical errors, negligence, malpractice, or communication failures between healthcare professionals and patients. The underlying causes of these errors are multifactorial, including human factors, system weaknesses, and equipment failures, all of which can threaten patient safety and undermine public trust in the medical profession. Diagnostic errors and failures in clinical reasoning are key factors contributing to the rise in medical disputes, often related to the limited knowledge and cognitive abilities of healthcare professionals. In Indonesia, medical dispute resolution can be pursued through litigation and non-litigation mechanisms, each encompassing legal, ethical, and professional dimensions. This study analyzes the main factors causing medical disputes, examines the influence of diagnostic errors and clinical reasoning, and examines available resolution mechanisms. Furthermore, this study also formulates a comprehensive prevention strategy to minimize medical errors, improve the quality of healthcare, and reduce the risk of future disputes.

Keywords: Medical Disputes, Misdiagnosis, Clinical Reasoning, Litigation, Non-Litigation, Patient Safety, Quality of Health Care.

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Introduction

In the digital era, the public is increasingly aware of patients' rights in healthcare, increasing the potential for medical disputes. One key concern is that medical errors, including incorrect or delayed diagnoses and failures in clinical reasoning, significantly contribute to these disputes. For example, a meta-analysis showed that among inpatients, at least 0.7% of all admissions involve detrimental diagnostic errors (Gunderson et al., 2020). In emergency services, estimates suggest that approximately 5.7% of visits may result in diagnostic errors, with serious consequences including permanent disability and death (AHRQ, 2022). Analysis of the causes of medical errors indicates that individual factors, weaknesses in the care system, and communication failures between healthcare professionals and patients significantly contribute to the occurrence of medical errors (Lee et al., 2022). The impact of these medical errors not only threatens patient safety but also damages the doctor-patient relationship and causes significant economic losses. For example, in the United States, preventable medical errors are estimated to contribute to more than 250,000 deaths annually, with estimated national costs exceeding one trillion dollars per year (Lee et al., 2022).

In Indonesia, the mechanism for resolving medical disputes has developed through legal channels. litigation and non-litigation, such as mediation and arbitration, are justified by the latest regulations (Kurniawati & Yusuf Daeng, 2023). The new Health Law (Law No. 17 of 2023) strengthens alternative mechanisms for resolving medical disputes as a preliminary step before litigation (Widjaja & Harry, 2025). Medical dispute resolution in Indonesia can be pursued through several institutions, including: the Civil Law Courts, the Criminal Law Courts, the Medical Ethics Honorary Council (MKEK), the Medical Ethics Advisory and Development Committee (P3EK), and the Indonesian Medical Discipline Honorary Council (MKDKI). Each institution has its own function and authority in resolving disputes, whether related to legal, ethical, or disciplinary aspects of the medical profession (Kurniawati & Yusuf Daeng, 2023). The primary research question is identifying the main factors causing medical disputes in clinical care, including the role of misdiagnosis and failures in clinical reasoning, and how available resolution mechanisms can be optimized. Several similar studies have been conducted in the past five years. Triana and Sulistyorini (2021) reviewed the effectiveness of mediation as an alternative for resolving medical disputes and found that non-litigation channels offer advantages in terms of cost efficiency, confidentiality, and speed of resolution. Susila et al. (2021) examined amicable settlements for malpractice disputes in Indonesia, highlighting the importance of a peaceful approach in resolving doctor-patient disputes. Other studies have shown that failures in initial assessment, test interpretation, and weaknesses in reasoning or communication are key factors in misdiagnosis (AHRQ, 2022). A UK study found that in general practice, misdiagnosis occurred in 4.3% of general consultations, 37% of which resulted in moderate to severe harm (Sohi et al., 2021).

From this series of studies, it is clear that although there have been many studies on diagnostic errors, clinical reasoning, and dispute resolution mechanisms, there is still a gap: not many studies have integrated all three aspects simultaneously in the context of clinical health services in Indonesia. This means that previous studies tend to discuss only one aspect for example, diagnosis or dispute resolution without considering the relationship between medical processes, dispute resolution systems, and prevention strategies holistically. Based on this, this study aims to: (1) explain the meaning, forms, and causes of medical disputes in health care practice; (2) analyze the contribution of diagnostic errors and failures in clinical reasoning to the emergence of medical disputes; (3) identifying available medical dispute resolution pathways, both through litigation and non-litigation; (4) explaining the roles and authorities of institutions that handle medical disputes from a legal, ethical, and disciplinary perspective; and (5) formulating medical error prevention strategies to reduce the potential for disputes. It is hoped that this research can provide practical and academic contributions to the development of health policies, strengthen patient safety systems, and encourage continuous improvement in the quality of health services.

Research Methodology

The methodology for writing this article applies the approachliterature review by reviewing various relevant literature sources, including legal studies, health fields, and laws and regulations related to medical disputes in the last five years. This article is compiled to describe the concept, characteristics, and factors causing medical disputes in the provision of health services; examine the role of diagnostic errors and failures in clinical reasoning as triggers for disputes; map dispute resolution mechanisms that can be pursued through litigation and non-litigation alternatives; examine the functions and authorities of institutions authorized to handle medical disputes from the perspective of law, ethics, and professional discipline; and formulate preventive measures to reduce the risk of medical errors. The writing process is carried out through a process of searching, selecting, and analyzing scientific journals, reference books, legal provisions, and relevant articles, which are then presented descriptively and analytically to illustrate the trends of problems, implemented solutions, and gaps that are still found in health care practices in Indonesia. This approach is expected to be able to produce theoretical and applied contributions to the development of health policies, strengthening patient safety systems, and improving the quality of health care on an ongoing basis.

Results

1. Medical Disputes

The term medical dispute is composed of two main concepts: dispute and medical. In English terminology, there are two words often used to describe disputes:conflictAnddispute, which although both indicate a conflict of interest, have different meanings.Conflict generally describes a condition of conflict or disagreement, whereasdispute refers to a dispute that has developed into a formal dispute. In the Indonesian context,conflicttranslated as conflict, whiledisputeIt is more accurately defined as a dispute. A dispute arises when a conflict is not resolved, resulting in one party feeling a loss and demanding accountability from the other party, perceived as the cause. Therefore, a dispute can be understood as the next stage of a protracted, unresolved conflict. Disputes between healthcare professionals, such as doctors or dentists, and patients or their families regarding medical services are referred to as medical disputes (Kurniawati & Yusuf Daeng, 2023).

2. Causes of Medical Disputes

In general, the causes of medical disputes can be classified into four main groups, namely:

a. Medical errors or negligence

Medical errors include actions taken outside professional standards, such as misdiagnosis, incorrect medication administration, inappropriate surgical procedures, and delayed treatment. Negligence often occurs due to a lack of care, fatigue, or excessive workload, resulting in decreased quality of care. Gunderson et al. 2020

b. Malpractice

This is a more serious form of misconduct, where the medical treatment not only deviates from the standard but also causes real harm to the patient, such as permanent disability or even death. Malpractice is a major trigger for lawsuits because it directly relates to the ethical and legal responsibilities of medical personnel. Gunderson, et al. 2020

c. Adverse events

These are incidents that occur during medical care that are not caused by direct error but still have an adverse impact on the patient. Examples include undetected allergic drug reactions, nosocomial infections, or post-procedural complications. While not always preventable, a lack of communication or adequate documentation often worsens the patient's perception of these incidents. Gunderson et al. 2020

d. Communication failure

Poor communication between healthcare providers and patients is a frequently

overlooked cause of disputes. When information about diagnoses, risks of procedures, or treatment options is not clearly communicated, patients tend to feel excluded from medical decision-making. This can lead to disappointment and negative perceptions of the care received, even if the procedure was technically performed according to procedure. Gunderson et al. 2020

3. Factors Influencing the Occurrence of Medical Disputes

Medical disputes are complex and multidimensional issues, arising from the interaction of various factors, including the medical side, the healthcare system, patient characteristics, and social and economic expectations. Increasing public awareness of patient rights and advances in information technology have increased demands for quality healthcare services. Consequently, the gap between patient expectations and medical reality often triggers disputes. One major contributing factor is the lack of effective communication between patients and healthcare professionals. Patients often have unrealistic expectations for treatment outcomes due to a lack of understanding of the limits of medical capabilities, while healthcare professionals sometimes lack empathy or are unprepared to handle complex cases, leading to tension and dissatisfaction. (Qi et al., 2025) Furthermore, the type and department of healthcare also influence the frequency of medical disputes.

Departments such as Orthopedics, General Surgery, Obstetrics and Gynecology, and Intensive Care Medicine are at higher risk due to the complexity of their handling of cases, invasive procedures, and the potential for significant complications. Research even shows that Orthopedics ranks first in the number of disputes. However, the risk of disputes can also arise in medical technology departments such as radiology and laboratories due to misinterpretation of test results or delayed reporting. The length of a patient's hospital stay also plays a role. The longer a patient is treated, the greater the likelihood of dissatisfaction with the service, especially if it is accompanied by high costs and treatment outcomes that do not meet expectations. This imbalance between costs and outcomes often creates a perception that healthcare services are "transactional," so patients feel entitled to demand compensation if dissatisfied. Furthermore, the method of patient discharge from the hospital also determines the risk of disputes; patients who die during treatment are more likely to face disputes than those referred or discharged at their own request, as death often triggers suspicion and mistrust from families. (Li et al., 2024) The level of competence and experience of medical personnel are also important factors. Junior doctors or those with limited experience are more frequently involved in disputes due to deficiencies in clinical practice, inadequate training, and difficulties in handling difficult cases. Approximately one-third of medical disputes are caused by the limited professional capabilities of medical personnel. From the patient perspective, socioeconomic factors such as occupation and payment method also influence. Patients who pay out-of-pocket without insurance or come from lower economic groups, such as farmers or the unemployed, tend to be more vulnerable to disputes because economic pressures make them more sensitive to the costs and outcomes of treatment. Furthermore, other factors, such as the number of blood transfusions, can also trigger disputes, as they often raise high expectations and risk additional complications. In contrast, variables such as gender, marital status, nationality, and length of service have a relatively small influence on the frequency of medical disputes. Overall, medical disputes cannot be explained by a single factor, but rather result from a combination of communication, medical personnel competence, the service system, and patient characteristics and expectations. Therefore, preventing medical disputes must be carried out comprehensively and holistically through increased communication and transparency between doctors and patients, ongoing training for medical personnel, and reforming the healthcare system to make it more responsive, professional, and aligned with patients' realistic expectations.

4. Medical Dispute Resolution Pathways and Institutions in Indonesia

Medical dispute resolution in Indonesia can essentially be achieved through two main channels: judicial (litigation) and non-litigation mechanisms. Litigation is a formal process carried

out through a judicial institution following applicable legal procedures. In contrast, non-litigation emphasizes amicable resolution to reach a mutual agreement, which aligns with Indonesian social and cultural values (Pipit Suwito et al., 2024). In practice, out-of-court dispute resolution is preferred because it offers a relatively shorter process, lower costs, simpler procedures, and maintains the confidentiality of the parties. This approach is oriented towards achieving peace and mutual satisfaction, so that the results obtained are not mutually exclusive but rather beneficial to both parties (win-win solution). This non-litigation mechanism is known as Alternative Dispute Resolution (APS), as regulated in Law Number 30 of 1999 concerning Arbitration and Alternative Dispute Resolution. The forms of APS include:

a. Consultation, namely the provision of professional opinions or advice by a party with expertise, without resulting in a binding decision.
b. Negotiation, namely the process of direct negotiations between the disputing parties without involving a third party.
c. Mediation, where a neutral mediator helps the parties reach a voluntary agreement without having the authority to decide the case.
d. Conciliation, which is similar to mediation, but the conciliator can propose alternative solutions that can become final if agreed upon by the parties.
e. Expert assessment, namely the use of objective opinions from independent professionals to assess the substance of the dispute that has occurred.

Apart from the APS mechanism, the Consumer Dispute Resolution Agency (BPSK) can also be used as a forum for resolving medical disputes, especially if the patient positioned as consumers of health services. The process at BPSK is fast, confidential, and low-cost, with final and binding decisions (final and binding), thus providing legal certainty without having to go through the court process. Meanwhile, litigation is generally taken as a last resort when non-litigation settlement efforts are unsuccessful. Lawsuits through the courts are usually filed by patients or their families who feel they have been harmed by Unlawful Acts (PMH) by medical personnel, as regulated in Article 1365 of the Civil Code. However, the court process is often considered ineffective due to its lengthy time, high costs, and complex procedures. Furthermore, the open nature of trials has the potential to harm the reputations of the parties, and court decisions tend to produce patterns ofwin-lose solutionwhich does not always satisfy both parties (Widjaja & Harry, 2025). In professional practice, ethical dispute resolution mechanisms are also available, particularly through the Indonesian Medical Disciplinary Honorary Council (MKDKI). From a physician's perspective, this mechanism is considered more convenient because it is handled by fellow professionals and the process is not widely publicized. However, for patients, this mechanism is often considered less than fair because its scope is limited to violations of professional discipline and ethics, without directly addressing the patient's interests (Kurniawati & Yusuf Daeng, 2023).

All of these medical dispute resolution mechanisms are supported by various legal basis, including:

a. The 1945 Constitution of the Republic of Indonesia;
b. Civil Code, especially Article 1365 concerning Unlawful Acts;
c. Law Number 29 of 2004 concerning Medical Practice;
d. Law Number 36 of 2009 concerning Health;
e. Law Number 44 of 2009 concerning Hospitals;
f. Law Number 36 of 2014 concerning Health Workers;
g. Law Number 30 of 1999 concerning Arbitration and Alternative Dispute Resolution;
h. Law Number 8 of 1999 concerning Consumer Protection;
i. Supreme Court Regulation Number 1 of 2016 concerning Mediation Procedures in Court; and
j. Regulation of the Indonesian Medical Council Number 50 of 2017 concerning Procedures for Handling Disciplinary Complaints of Doctors and Dentists.

Thus, medical dispute resolution in Indonesia should ideally be conducted in a hierarchical and proportional manner, starting with a non-litigation approach that emphasizes dialogue, mediation, and reconciliation, before resorting to judicial proceedings as a final step.

This approach is not only more efficient and equitable, but also aligns with humanitarian values in healthcare.

5. Reducing and Preventing Medical Errors That Cause Disputes

Medical errors are one of the dominant factors contributing to injuries, deaths, and legal conflicts in the field of health services, both globally and nationally. Principles of ethical health professionsprimum non nocere which emphasizes the obligation to do no harm to patients is the primary foundation for efforts to prevent medical errors. However, in many cases, errors are not solely caused by individual negligence, but rather by structural weaknesses in the care system, such as poor medication management, efficiency policies that increase workloads, and suboptimal hospital management.

Therefore, prevention strategies must be directed at improving the system to minimize the potential for errors from the outset. Effective prevention efforts begin with identifying and mapping the root causes. problems through incident reporting, root cause analysis (root cause analysis), as well as continuous evaluation of service outcomes. To support this, an open and supportive organizational culture is needed, where mistakes are seen as a means of shared learning, not as a basis for blaming individuals. Patient safety culture (patient safety culture) is a key element, one of which is realized through a confidential reporting system (confidential reporting system) so that medical personnel can report incidents without fear of sanctions or stigma. A collaborative work environment also encourages cross-professional cooperation between doctors, nurses, pharmacists, technicians, and other support staff in maintaining patient safety (Rodziewicz et al., 2024). In addition to a cultural approach, preventing medical errors also requires improving the competence of healthcare personnel, implementing consistent standard operating procedures, and utilizing health information technology. The use of systems such ascomputerized physician order entry (CPOE), barcode systems for medications, medication reconciliation, and electronic medical records have been shown to reduce administrative and clinical errors. In addition, the implementation of surgical safety checklist, re-verify verbal commands, and communication standards such as the SBAR method (Situation, Background, Assessment, Recommendation) can reduce the risk of errors stemming from miscommunication between healthcare workers (Rodziewicz et al., 2024). In Indonesia, the main challenges in implementing a patient safety system are still related to limited resources and a hierarchical work culture. Therefore, a crucial initial step is to build a safety culture across healthcare facilities through ongoing training, a "report to learn" campaign, and the implementation of a non-punitive patient safety incident (PSI) reporting system. Hospitals can also develop anonymous or digital-based reporting mechanisms to create a sense of security for healthcare workers in reporting incidents.

Work environment factors also influence the rate of medical error. Long working hours,

physical and mental fatigue, and excessive workload have been shown to increase the risk of errors. In line with recommendationsInstitute of Medicine (According to the International Organization for Mitigation (IOM), nurses' ideal work hours should not exceed 12 hours per day, with a minimum of 8 hours of rest between shifts. Therefore, hospital management needs to evaluate work scheduling policies and ensure a balance between the number of healthcare workers and patient volume. A conducive work environment with minimal distractions and optimal patient monitoring will contribute to a reduction in error rates. The success of medical error prevention efforts in Indonesia depends heavily on policy support, strong leadership, and organizational commitment. Patient safety must be placed as a strategic priority, with the involvement of all healthcare workers in quality improvement programs. Regular evaluations through safety audits, constructive feedback, and non- punitive team discussions will strengthen trust and a sense of collective responsibility.

Overall, reducing and preventing medical errors cannot be achieved simply by improving

individual skills; they require comprehensive reform of the service system and organizational culture. Through synergy between the use of technology, ongoing clinical

education, supportive policies, and cross-professional collaboration, the Indonesian healthcare system can be developed to be safer, more transparent, and more patient-safety- oriented, while also providing protection for healthcare workers from potential legal disputes.

Conclusion

Medical disputes are multidimensional issues that arise from differing perspectives or disharmony between healthcare professionals and patients or their families during the healthcare delivery process. These disputes can range from mild to severe complaints or dissatisfaction. These disputes range from verbally conveyed to serious conflicts related to alleged malpractice, permanent disability, and even patient death. Triggers for medical disputes generally include errors or negligence in medical procedures, medical practices that deviate from professional standards, adverse events that do not always stem from direct error, and failure to establish effective communication between healthcare professionals and patients. Poor communication often leads to the perception that patients are not involved in clinical decision-making, thus triggering disappointment and distrust. The occurrence of medical disputes is influenced by various interacting factors, including clinical aspects, healthcare system governance, patient characteristics and psychosocial conditions, and increasing public expectations along with advances in information technology. Furthermore, the type of service unit, duration of treatment, financing schemes, and the level of experience and competence of healthcare professionals also contribute to the frequency of disputes. This complexity demands a comprehensive approach to dispute prevention and resolution, focusing not solely on technical medical aspects but also on improving communication quality, strengthening the professional capacity of healthcare professionals, and improving the service system to align with reasonable patient expectations. In the Indonesian context, medical dispute resolution can be pursued through two main mechanisms: judicial (litigation) and non-litigation. Litigation is generally time-consuming, expensive, and confrontational, potentially causing emotional distress and damaging the reputations of the parties involved. In contrast, non-litigation mechanisms such as mediation, negotiation, and conciliation emphasize a dialogical and reconciliatory approach, aiming to reach mutually beneficial agreements, resolved in a relatively short time and at a more cost-effective rate. This approach aligns with Indonesian sociocultural values, which highly value deliberation and consensus. Preventing medical errors, a key source of disputes, requires systemic reform and a shift in organizational culture within healthcare facilities. Improving service procedures, strengthening a culture of patient safety, providing ongoing training for healthcare workers, and utilizing health information technology are key strategies to reduce the risk of errors. Implementing an open and non-punitive incident reporting system is crucial to ensure healthcare workers feel confident in reporting incidents, allowing institutions to engage in continuous learning and improvement. Furthermore,Healthy work environment management, including work hour management and workload distribution, also plays a significant role in reducing the potential for medical errors. Comprehensively, handling medical disputes requires an integration of improved healthcare quality, effective communication, fair and efficient dispute resolution mechanisms, and policy support that promotes a culture of patient safety. Through this integrated approach, it is hoped that the Indonesian healthcare system can develop to be safer, more professional, and optimally responsive to patient needs and expectations.

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