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Autonomy of Health Worker Professions and Hospital Governance from a Positive Legal Perspective in Indonesia

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Abstract

This article examines the dialectical tension between medical clinical autonomy and hospital corporate governance in Indonesia. By analyzing the paradigm shift brought by Health Law No. 17 of 2023 and Government Regulation No. 28 of 2024, this study redefines clinical autonomy not as a private privilege, but as a public legal mandate designed to protect patient safety. The research employs a normative legal method to dissect the implementation of Corporate Clinical Governance (CCG) and its collision with corporate efficiency models (managed care). The findings reveal that CCG inherently requires organizational subordination, fundamentally invalidating the "pure partnership" illusion often utilized by hospitals to externalize liability. The study proposes the concept of "Bifurcation of Authority," which functionally separates a doctor's clinical-professional sovereignty from the hospital's administrative-managerial authority. This bifurcation necessitates a shift from personal liability to enterprise liability, ensuring that legal protection and clinical immunity align with fair labor practices under a permanent employment contract (PKWTT).

Keywords: Bifurcation of Authority; Clinical Autonomy; Corporate Clinical Governance; Enterprise Liability; Health Law.

A. INTRODUCTION

The clinical autonomy of the medical profession and the corporate governance of hospitals are frequently positioned as two opposing poles. On one side, the physician takes refuge behind scientific sovereignty (*Lex Artis Medica*), while on the other, the hospital corporation is required to apply managerial efficiency to sustain the institution's operational continuity. This tension culminates when hospitals shelter behind the construct of an "independent partnership" to absolve themselves of employment obligations and liability for medical malpractice, on the pretext that clinical autonomy bars the hospital from intervening in (subordinating) the physician's actions.

The enactment of Law Number 17 of 2023 on Health brought a fundamental shift in the governance of health law in Indonesia. This regulation, together with its implementing rules, quietly dismantles the legal fiction of pure partnership by introducing the doctrine of Corporate Clinical Governance (CCG) and clinical immunity. This article therefore aims to reconstruct the ontological understanding of clinical autonomy, to analyze its relationship with corporate governance, and to offer the concept of Bifurcation of Authority as a middle path for synchronizing the sovereignty of the medical profession with the managerial authority of the hospital.

B. RESEARCH METHOD

This study is normative legal (doctrinal) research employing a statute approach and a conceptual approach. The selection of this method rests on the distinctive characteristics of normative legal research, which focuses on the synchronization of legal norms, principles, and doctrines. The primary legal materials rest upon Law Number 17 of 2023 on Health and Government Regulation Number 28 of 2024, complemented by secondary legal materials in the form of legal-dogmatic literature, jurisprudence, and related journals. The analysis is conducted prescriptively to dissect the tension between medical autonomy and managed care, and to construct a proportionate framework of liability.

C. RESULTS AND DISCUSSION

1. The Ontology of Clinical Autonomy (Lex Artis Medica) as a Public Legal Mandate

The physician's clinical autonomy although historically often celebrated as a professional "privilege" must, within the contemporary dogmatic paradigm of health law, be understood fundamentally as a public legal

mandate, rather than a private-personal right of the physician that may be negotiated in the contractual sphere. This construction means that clinical autonomy is attached by law to the medical profession not for the benefit of the physician as an individual, but for the protection of a greater public interest namely the safety and welfare of the patient (*salus aegroti suprema lex*) and the integrity of medical science as a body of knowledge devoted to humanity. In other words, clinical autonomy is in essence a public obligation wrapped in the form of authority; it is not a privilege that may be waived, traded, or negotiated within the private sphere between a physician and a corporate employer.

This normative construction crystallizes in several mutually reinforcing legal instruments. First, Articles 2 and 3 of the Health Law establish the principles of health administration that place patient safety, professional ethics, and humanity as the normative foundation. Second, Article 271 of the Health Law explicitly guarantees the right of medical personnel to practice in accordance with professional standards, service standards, and standard operating procedures (SOP), as well as the right to refuse acts contrary to ethics, law, religion, and conscience. Third, the Indonesian Medical Code of Ethics (KODEKI) carries binding professional force and is integrated into the professional standards that the statute explicitly references. Fourth, Evidence-Based Medicine (EBM), as the modern scientific paradigm of medicine, provides the epistemic foundation for clinical decisions and forms the epistemic sovereignty of the medical profession that cannot be overridden by the non-medical authority of the corporation.

The dogmatic consequences are firm. First, such autonomy cannot be diminished or waived through a contractual agreement between the physician and the hospital; any such clause is *nietig van rechtswege* (null and void by operation of law). Second, the hospital corporation has no juridical competence to order a physician to perform medical acts contrary to the *Lex Artis Medica*. Third, a physician's refusal to perform a medical act contrary to professional standards is a protected action and cannot serve as a basis for termination of the employment relationship or disciplinary sanction.

2. Corporate Clinical Governance (CCG) After Law Number 17 of 2023

The enactment of Law Number 17 of 2023 and Government Regulation Number 28 of 2024 constitutes a fundamental milestone of dogmatic transformation. One of the central doctrines codified is Corporate Clinical Governance (CCG) a governance paradigm that positions the hospital corporation as an entity institutionally responsible for the quality and safety of clinical services, rather than a mere passive provider of facilities. The phenomenon of disguising the employment relationship through the construct of a partnership agreement is not foreign to contemporary labour law; studies of the relationship of platform-based drivers demonstrate how partnership agreements are frequently used to disguise the actual employment relationship in order to evade employer obligations.

Articles 173 and 174 of the Health Law stipulate that hospitals are obliged to administer good hospital governance and good clinical governance. Government Regulation Number 28 of 2024 details this into obligations to establish medical committees, quality committees, safety-incident reporting systems, clinical SOPs, clinical pathways, an institutional drug formulary, a credentialing system, and quality oversight.

The dogmatic implications of the CCG regime for the status of the physician's employment relationship are unavoidable. First, the hospital's institutional obligation to ensure clinical quality can only be executed if the hospital possesses administrative-managerial authority over the physician (setting internal standards, clinical audits, disciplinary sanctions). This authority is compatible only with the paradigm of an employment relationship (organizational subordination), not with the paradigm of an equal partnership. Second, the operational instruments of CCG are a full manifestation of organizational subordination (*formele subordinatie*). Third, this institutional obligation of the hospital indicates that clinical risk is an enterprise risk that gives rise to enterprise liability (corporate responsibility). The doctrine of CCG intrinsically presupposes the existence of an employment relationship; without it, the CCG apparatus becomes a juridically suspended construction.

3. Dialectical Tension: Medical Autonomy vs. Corporate Efficiency (Managed Care)

The codification of the CCG regime does not eliminate the inherent dialectical tension between clinical autonomy (patient safety) and corporate rationality (efficiency and financial sustainability). This tension culminates in the managed care paradigm a service model that places cost containment as the frame of medical practice.

The hospital corporation structurally has incentives to limit the cost of services, while the physician has the obligation to optimize the patient's clinical benefit. These two logics can collide acutely when corporate efficiency pressure restricts medical services beyond the bounds of scientific soundness. The dogmatic resolution of this tension demands two steps: (1) recognition of an employment status based on a permanent contract that affords job security so that physicians dare to uphold professional standards; and (2) a shift of the liability regime from personal to corporate (enterprise liability), so that physicians do not bear the burden of malpractice alone when following the hospital's managerial system.

4. The Doctrine of Clinical Immunity (Article 273 of the Health Law): Scope and Limits

Article 273 codifies the doctrine of clinical immunity: medical personnel who perform their duties in accordance with professional standards, SOPs, and informed consent cannot be legally prosecuted for unintended outcomes. This is the state's recognition that medicine operates upon an obligation of effort (*inspanningsverbintenis*), not an obligation of result (*resultaatsverbintenis*). This accords with international jurisprudence that distinguishes an adverse outcome from medical negligence.

However, clinical immunity is not absolute immunity. First, immunity lapses where there is a deviation from the standard without valid clinical justification (*justifiable deviation*). Second, immunity does not protect gross negligence (*culpa lata*) or intent (*dolus*). Third, immunity is a personal right of the physician but does not negate the corporate liability of the hospital for systemic negligence in clinical governance. Fourth, immunity does not preclude ethical examination by the Indonesian Medical Disciplinary Honorary Council (MKDKI). This clinical immunity logically requires an enterprise liability paradigm to prevent an accountability gap that harms patients.

5. Toward the Concept of Bifurcation of Authority

The synergy among clinical autonomy, CCG, and clinical immunity crystallizes in the dogmatic concept of Bifurcation of Authority. This concept affirms that the relationship between physician and hospital is not qualified within the binary dichotomy of "pure partnership versus pure employment," but rather as a hybrid relationship that divides authority along two axes.

On the first axis, clinical-professional authority rests entirely with the physician, protected by clinical autonomy and immunity. On the second axis, administrative-managerial authority rests with the hospital corporation as the organizer of clinical governance and the instrument of organizational subordination. It is this bifurcation of authority that becomes the foundation for the paradigmatic shift of liability from personal liability toward enterprise liability.

D. CONCLUSION

The clinical autonomy of the medical profession is not a privilege that may be privately waived, but a public legal mandate aimed at protecting patient safety. The enactment of Corporate Clinical Governance (CCG) through the latest health regulations juridically requires a bond of organizational subordination between the hospital and the physician, which in essence nullifies the fiction of an "independent partnership." The tension between medical autonomy and corporate efficiency (managed care) must be resolved through the concept of Bifurcation of Authority. This concept balances the physician's clinical sovereignty with the hospital's managerial authority, necessitating full recognition of employment status while transforming the system of liability toward enterprise liability.

E. RECOMMENDATION

1. The practice of drafting contracts between hospitals and medical personnel must be promptly reformed from a quasi-partnership model into a Permanent Employment Agreement (PKWTT) that explicitly accommodates a Bifurcation of Authority clause, in order to guarantee legal certainty and labour protection.
2. Courts and law enforcement officials are recommended to apply the principle of enterprise liability consistently in handling medical disputes, whereby legal responsibility for systemic failures is borne by the hospital corporation rather than solely by the physician who has acted in accordance with the standard.

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