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Criminal and Civil Liability for Refusing Emergency Medical Care in Indonesia: A Systematic Review

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Abstract

Refusal or delay of emergency medical care raises questions about professional and institutional responsibility under Indonesian criminal and civil law. This systematic literature review, with acknowledged gaps in the original search documentation, maps legal duties, liability regimes, and operational barriers reported in Indonesian and comparative scholarship. The source retrieval, conducted through Elicit using Semantic Scholar and OpenAlex materials, reported 5,000 records and 59 included studies: 27 examined in full text and 32 assessed from abstracts only. A qualitative thematic synthesis identifies emergency-assistance duties, criminal prohibitions, civil remedies, professional and hospital accountability, emergency consent, insurance administration, and resource constraints. The synthesis distinguishes criminal and civil legal pathways from the separate allocation of responsibility between clinicians and facilities. It identifies tensions between formal duties of emergency assistance and institutional conditions affecting timely care, without inferring the prevalence of unlawful refusals or causation from secondary sources. Search dates, reproducible query strings, independent screening, and formal critical appraisal were not documented in the original research record. Accordingly, findings are interpreted as transparent evidence mapping rather than a fully reproducible systematic review. The article proposes a two-axis accountability framework to guide further doctrinal verification and policy research.

Keywords

criminal liability, civil liability, emergency medical care, hospital accountability, patient refusal, systematic review.

1. Introduction

The right to health services forms part of Indonesia's constitutional framework. Article 28H(1) of the 1945 Constitution recognizes access to healthcare, while emergencies present a particularly urgent setting because a delay may affect survival or disability. The legal problem is therefore not simply whether treatment is commercially feasible, but how an institutional obligation to respond intersects with clinicians' professional duties, patients' rights, and available clinical resources. This review examines the legal debate about refusal and delayed provision of initial emergency medical assistance, rather than ordinary elective medical services.

Indonesia's Health Law No. 17 of 2023 places emergency assistance within the responsibilities of healthcare facilities and professionals. The earlier regulatory framework, including Law No. 36 of 2009 on Health, Law No. 44 of 2009 on Hospitals, and Minister of Health Regulation No. 47 of 2018 on Emergency Services, is also prominent in the studies reviewed. Legal sources must nevertheless be read in their temporal context: an article discussing a repealed or amended provision is evidence about earlier legal scholarship, not necessarily an accurate statement of the currently applicable rule. This distinction is particularly important for criminal provisions and institutional liability.

For the present legal context, the 2023 Health Law must be considered together with Government Regulation No. 28 of 2024, which implements the health statute. Criminal-law analysis also requires attention to Law No. 1 of 2023 on the Criminal Code, effective from 2 January 2026, and Law No. 1 of 2026 on criminal-law adjustment. These instruments are introduced as a statutory update to the original literature mapping; they are not additional studies included in the reported sample of 59. Whether a particular provision applies in an individual case depends on the date of conduct, governing offence, and relevant transitional rules (Republic of Indonesia, 2023a, 2023b, 2024, 2026).

The operational settings described in the scholarship complicate a straightforward account of illegal refusal. Patients may face requests for deposits, uncertainty about health insurance eligibility, referral difficulties, shortages of specialist physicians, inadequate critical-care beds, or unavailable ventilators. These explanations do not automatically establish that a refusal is legally justified. They instead call for careful separation of failures caused by deliberate non-assistance, clinical triage, lack of capacity, poor management, and external reimbursement arrangements. Wicaksono (2025), for example, examines tensions surrounding BPJS Kesehatan administration and emergency patient access.

Criminal law, private law, and medical ethics also ask different questions. Criminal adjudication ordinarily requires a clearly applicable prohibition and proof of the elements of a particular offence. Private claims can concern unlawful acts, negligence, damage, causation, or contractual duties. Professional standards and emergency decision-making help determine whether clinical conduct was reasonable under the circumstances. Damanik et al. (2023) discuss civil responsibility when hospitals refuse emergency patients, while Nursya et al. (2025) address criminal responsibility in light of the 2023 Health Law. These bodies of work overlap but cannot be treated as interchangeable.

A related difficulty concerns informed consent. Ordinarily, obtaining consent safeguards autonomy and determines whether a patient accepts the proposed intervention. During an emergency, inability to communicate, unconsciousness, and immediate threats to life can alter the legal analysis. Studies of emergency procedures and presumed consent indicate that urgent care may be legally justified despite the absence of ordinary written authorization, subject to relevant conditions and professional standards (Desyari et al., 2023; Baroto, 2023). Consequently, the law must protect both patients from improper denial of care and clinicians who provide appropriately indicated rescue treatment.

The existing scholarship includes doctrinal legal analyses, empirical examinations, hospital case studies, and discussions of judicial decisions. Individual publications frequently concentrate on only one liability regime or one exceptional context, such as inability to pay, DNR decisions, professional delegation, or government insurance claims. A systematic synthesis can compare those strands and identify whether they describe consistent legal duties or unresolved tensions. It can also reveal how far the evidence extends beyond doctrinal claims into actual institutional practice.

This review asks four connected questions: (1) what duties regarding emergency treatment appear in Indonesian legal literature; (2) how criminal and civil responsibility for refusal or delay is constructed; (3) which administrative, financial, and system-level barriers appear in the studies; and (4) what gaps remain in legal protection and accountability for patients, medical personnel, and hospitals. The intended contribution is a structured synthesis of the available literature, not an independent determination that particular clinicians or institutions committed a criminal or civil wrong.

The review's specific conceptual contribution is to separate two questions that are frequently conflated in the literature: which liability pathway may be available (criminal or civil) and whose legally relevant act or omission is at issue (individual clinician, management, or healthcare facility). This two-axis approach provides an interpretive map for organizing the reviewed evidence; it is not presented as a new rule of liability or as proof that concurrent liability arises in every incident.

2. Research Methods

Search strategy and study selection

The reported search used Elicit as a retrieval interface drawing on records available through Semantic Scholar and OpenAlex. The central Indonesian-language question concerned the criminal and civil regulation of refusal of emergency medical care by professionals or hospitals. The source research record reports 5,000 initially retrieved records. Selection proceeded through relevance filtering and title-and-abstract assessment, followed by assessment against thematic eligibility. The original search date, exact executed queries and filters, database-specific outputs, deduplication logs, and reviewer agreement records were not provided. Therefore, the search cannot be independently reproduced from the documentation available for this revision; no subsequent search or retrospective reconstruction is represented as part of the original procedure.

The recorded eligibility focus encompassed the legal duty to provide emergency assistance, treatment refusal or delay, provider or hospital accountability, legal remedies, and relevant discussions of cases and judicial proceedings. The original inventory also included adjacent legal contexts—emergency consent, resuscitation, delegation, financing, and healthcare capacity—where these shed light on emergency treatment decisions. The source states that records dealing solely with ethics, having no meaningful legal dimension, or lacking topical relevance were excluded. Although it mentions inaccessible material as an exclusion reason, the final inventory itself contains 32 abstract-only records; therefore, exclusion of all inaccessible full texts cannot be inferred. The precise application of each criterion, including stage-by-stage reasons, was not recorded.

The included inventory contains 59 records, comprising 27 identified as accessible in full text (45.8%) and 32 designated abstract-only (54.2%). Access status describes the evidence available to the original source review, not independently confirmed access for the present revision. The former group may support closer examination of arguments and qualifications when the full paper is actually checked; the latter supports only limited statements traceable to the abstract. Interpretations of statutory provisions, individual judicial outcomes, or research design should not be treated as independently established merely because they appear in the included inventory.

Figure 1. Reported record-selection counts (descriptive reconstruction of the source inventory; not a PRISMA-compliant flow diagram).

Screening stage	Records
Records identified through Elicit/Semantic Scholar/OpenAlex	5,000

Screening stage	Records
Records remaining after reported intermediate relevance filtering	2,370
Records remaining after title and abstract screening	942
Studies included in the synthesis	59
Included studies accessible in full text	27
Included studies assessed only from abstracts	32

Note. These are the only stage totals documented in the source. Numerical differences between stages must not be interpreted as audited duplicates or exclusions with known reasons. The final 27 + 32 items partition the 59 included records; those figures are not additional screening stages

Extraction, appraisal, and synthesis

The source review reports using a large language model (LLM) to assist extraction of descriptions of legal rules, liability mechanisms, remedies, accountable actors, cases, and operational conditions. The reported material was organized into thematic groups through narrative synthesis. The original research record does not identify the LLM version, prompts, extraction logs, human validation procedures, or item-level correction history. This disclosure describes what was reported, not what can be independently verified. In particular, LLM-generated summaries are treated as leads requiring confirmation from underlying studies, enacted law, or official judgments, rather than as primary evidence of a legal proposition.

The original record does not document duplicate independent extraction, a prespecified critical-appraisal instrument, adjudication of screening disagreements, or study-level risk-of-bias scores. Accordingly, the present manuscript does not claim that these activities occurred. Instead, it describes limitations by access status, study design, source proximity, and legal time period. No pooled estimates, study-quality ratings, or comparative causal claims are inferred. Before submission of a final version, the authors should verify the underlying extraction files and full-text access where feasible; undocumented procedures cannot properly be inserted as if completed.

Analytical categories were derived from the original extraction framework and the patterns reported across included materials: (a) legal duty and emergency access, (b) criminal liability, (c) civil remedies, (d) hospital versus individual responsibility, (e) informed and presumed consent, (f) administrative and resource barriers, and (g) protection for clinicians providing rescue treatment. Discussion of international Emergency Medical Treatment and Labor Act (EMTALA) literature provides comparative context; it does not establish that US rules directly govern Indonesian facilities.

Evidence hierarchy, source verification, and limits of inference

The narrative synthesis uses an interpretive hierarchy rather than a numerical critical-appraisal score. Authoritative enacted law is the appropriate basis for stating the content and temporal applicability of statutory provisions; official court judgments are the primary basis for describing holdings and procedural outcomes; full-text empirical work may support qualified observations about reported institutional practice; full-text doctrinal publications supply scholarly arguments; and abstracts alone provide only provisional summaries of what studies claim. Foreign-law analyses provide comparative context rather than binding Indonesian authority.

These distinctions were applied in drafting and qualifying the narrative, but they do not amount to a retrospectively performed formal risk-of-bias assessment. The sources available for this revision permit identification of key Indonesian legal instruments from official government repositories; they do not establish that the 59 individual research records or each cited court judgment have been checked against their originals. Where primary court texts are unavailable, the manuscript

attributes descriptions to the secondary literature and withholds independent findings about judicial holdings.

3. Results and Discussion

Characteristics of the evidence base

Of the 59 records in the source inventory, doctrinal or normative legal inquiry was the predominant design. A smaller portion used empirical legal inquiry, sociological approaches, interviews, or case-file analysis. Many of the records addressed Indonesian statutory obligations and older sectoral legislation, including the 2009 Health and Hospital Laws, while more recent work considered Law No. 17 of 2023. The review also captured related topics such as emergency orthopaedic surgery, resuscitation, DNR, medical delegation, hospital corporate responsibility, and the effect of BPJS Kesehatan rules.

The evidence base should be read as heterogeneous rather than as a uniform sample of directly comparable research. Doctrinal works contribute constructions of legal duty and liability; empirical and case-based reports may describe particular hospital practices but not population prevalence; judicial commentary may illuminate specific reasoning only where the underlying decision is reliable; and abstract-only items give restricted insight into methods and qualifications. International EMTALA publications in the references are comparative background, not Indonesian primary legal sources. This distinction guides the interpretation in Sections 3.2–3.9.

The inventory's breadth must not be confused with uniform evidentiary depth. Thirty-two items were available only as abstracts, limiting assessment of their legal reasoning, data collection, or qualifications. Even when full texts were available, a doctrinal discussion is not direct evidence of how frequently hospitals refused patients or the proportion of refusals attributable to specific motives. Thus claims about prevalence or the relative dominance of reasons for refusal remain propositions from the literature rather than pooled empirical estimates.

Table 1. Principal themes in the source literature synthesis.

Theme	Evidence focus	Interpretive caution
Emergency treatment duties	Constitutional access, emergency assessment and initial aid	Norms stated across earlier and 2023 health legislation
Criminal liability	Failure to provide legally required assistance; possible penalties	Requires identification of operative law and offence elements
Civil liability	Unlawful acts, negligent injury, contractual obligations and damages	Requires proof of relevant liability elements
Institutional responsibility	Hospital governance, delegation, oversight and staffing	Separate institutional fault from individual professional conduct
Consent in emergencies	Exceptions to routine consent procedures and patient best interests	Emergency necessity does not erase professional standards
Operational constraints	Payment, insurance classification, triage, ICU capacity and specialist shortages	Reported explanations do not determine legal exculpation
Clinician protection	Lawful rescue treatment under applicable standards	Protection depends on legal conditions and facts

Table 2. Evidentiary uses and interpretive limitations by source category.

Source category	Permissible contribution	Qualification required
Enacted law / official regulations	Text of duties, prohibitions, transitional framework	Check effective date, authoritative version, and provision applicable to conduct
Official court judgment	Verified facts, holdings, and disposition of a specific case	Do not generalize a small, non-random set of disputes
Full-text doctrinal scholarship	Legal interpretations, criticism, comparisons	Distinguish an author's argument from positive law
Full-text empirical/case study	Qualified observations within the study setting	Check sampling, methods, limitations, and context before extrapolation
Abstract-only record	Provisional description of the author's stated topic/results	No independent verification of methods, details, or case outcome
Foreign comparative source	Contextual legal or institutional contrast	Not a source of directly applicable Indonesian obligations

Note. This is an analytical distinction for cautious interpretation; it is not a completed formal quality-appraisal exercise.

Statutory duties to provide emergency assistance

The central point of agreement across the reviewed legal analyses is that a patient in need of urgent life-saving assistance must not be treated merely as a routine prospective customer. Article 28H(1) of the Indonesian Constitution provides the broader rights context. In earlier legislation, Article 32 of Law No. 36 of 2009 addressed emergency service obligations and the demand for advance payments, while Article 29 of Law No. 44 of 2009 addressed hospital duties. The source also discusses the newer framework under Law No. 17 of 2023, including provisions on facilities' emergency responsibilities and the obligation of clinicians to provide initial assistance.

The central provisions of the current Health Law are more specific than a general statement of healthcare access. Article 174(1) places the emergency-service obligation on government and non-government healthcare facilities, while Article 174(2) prohibits healthcare facilities from rejecting emergency patients, requesting advance payment, or prioritizing administration in a manner that delays care. Article 275(1) imposes a first-aid duty on medical and healthcare personnel practising in healthcare facilities in emergencies or disasters. Article 275(2) provides a qualified statutory protection from damages claims for emergency lifesaving or disability-prevention care. These provisions should be interpreted in the context of Law No. 17 of 2023 and its implementing framework, including Government Regulation No. 28 of 2024 (Republic of Indonesia, 2023b, 2024).

However, temporal precision is essential. Many included studies were written under repealed or amended laws. Treating their statutory quotations as contemporaneous legal authority would obscure transitions in the legal framework. The revised synthesis therefore understands older provisions as part of the development of the legal literature and locates the current statutory analysis primarily within the Health Law of 2023. Before publication, each section and article reference should be checked against the consolidated text and implementing regulations in force at the time of submission.

Law No. 36 of 2009 and Law No. 44 of 2009 were expressly repealed by Law No. 17 of 2023. Their provisions remain relevant to the chronology of the scholarship and potentially to the legal framework governing past conduct, but their wording cannot be cited as current operative law without temporal qualification. The 2026 commencement of the new Criminal Code and the criminal

adjustment legislation likewise require offence-by-offence analysis, rather than indiscriminate substitution of earlier punishment provisions (Republic of Indonesia, 2023a, 2023b, 2026).

Another distinction is that the legal duty to respond immediately does not necessarily imply that each hospital must provide every form of definitive specialist care regardless of capacity. The regulatory assessment must consider emergency examination, immediate stabilization, clinical prioritization, appropriate referral, transfer safety, and available resources. A claim that a transfer constitutes unlawful refusal requires analysis of the specific steps taken, their timing, their adequacy, and the clinical state of the patient, rather than the transfer label alone.

Criminal responsibility for refusal or omission

The reviewed research examines possible criminal liability when an actor subject to a duty to assist deliberately fails to provide necessary emergency help. The source manuscript lists older Indonesian Criminal Code provisions and the criminal prohibition in Article 190 of Law No. 36 of 2009, while discussing criminal sanctions under Law No. 17 of 2023. Since those earlier statutes are not interchangeable with the currently operative rules, a legal conclusion must identify the relevant date, the applicable criminal provision, and any transition provisions. Citations to earlier penalties should not be carried forward as current sentencing rules without verification.

More precisely, Article 438(1) of Law No. 17 of 2023 addresses failure by a facility leader, medical professional, or healthcare worker to provide legally required initial assistance to a patient in an emergency; Article 438(2) contains an aggravated consequence provision framed with reference to the facility leader where the prescribed outcome occurs. Separately, Article 440 addresses certain professionally negligent conduct causing serious injury or death. These distinct provisions should not be collapsed into a single general category of "medical malpractice." The exact operative penalty, culpability requirements, and consequences for the date of a particular event must be read alongside the applicable criminal-law framework (Republic of Indonesia, 2023a, 2023b, 2026).

A criminal liability analysis must identify the responsible natural or legal person, the precise duty breached, the conduct or omission, fault where required, and any causal element specified by the applicable offence. Hospital refusal may result from multiple interacting decisions: triage personnel, admitting staff, duty physicians, management policies, financial departments, or the availability of emergency facilities. Describing a negative outcome as hospital negligence does not automatically establish a particular individual's guilt. Conversely, an institutional policy that improperly conditions emergency rescue on deposit payment warrants investigation even where an individual clinician did not initiate that policy.

The original review refers to deliberate neglect, culpa or professional negligence, corporate criminal responsibility, and certain proposed strict-liability constructions. These are not identical doctrines. Strict liability should be presented as an argument made in some studies rather than an established universal rule in Indonesian criminal law. Similarly, restorative justice and penal mediation may be discussed as possible procedural routes only to the extent permitted by current law and the seriousness of the alleged offence. They cannot be assumed to replace prosecution for every emergency fatality.

The jurisprudence table in the source includes criminal proceedings involving patient abandonment and medical negligence. The source reports a conviction associated with Decision No. 381/Pid.B/2014/PN.TK and also includes broader malpractice cases. Such cases are important illustrations of legal reasoning, but the manuscript does not supply independently checked official court texts for each matter. The present review therefore does not make final declarations about unverified holdings beyond stating how the secondary literature describes them.

Civil liability and available remedies

Civil-law scholarship commonly identifies Articles 1365, 1366, and 1367 of the Indonesian Civil Code as bases for claims about unlawful acts, negligence, and responsibility related to others' conduct. Depending on the relationship and factual setting, a claim may also arise from contractual nonperformance. A successful claim generally requires analysis of an actionable wrong, loss and a legally significant link between the conduct and damage; the applicability of particular rules varies with the circumstances.

For analytic clarity, Article 1365 of the Civil Code is associated with unlawful acts, Article 1366 with negligence or carelessness, and Article 1367 with responsibility in legally specified relationships involving another's conduct. Invoking these provisions does not by itself resolve the identity of the defendant, standard of care, causation, damage, or available defence. The Health Law's emergency-protection provision in Article 275(2) is also relevant, but should not be characterized as unconditional immunity for all persons or all conduct in an emergency (Republic of Indonesia, 2023b).

The doctor–patient relationship is frequently characterized as a therapeutic obligation of professional effort rather than an absolute undertaking to cure. Consequently, a poor medical outcome alone does not establish breach of duty. In the emergency refusal context, the factual questions may instead concern whether the institution made timely examination available, whether necessary stabilization was attempted, whether staff communicated relevant information, and whether referral or transfer was clinically appropriate.

Under the institutional-liability discussion, a hospital can face accountability for organizational policies, supervision or harm arising from staff conduct, depending on the governing rule and the facts. Secondary sources discuss the former Article 46 of the 2009 Hospital Law and the doctrine often described as vicarious liability (Damanik et al., 2023). Such references illuminate doctrinal development but are not substitutes for checking the corresponding provisions under the 2023 legal regime.

Monetary damages are not automatic whenever emergency care is delayed. A claimant must demonstrate recoverable loss and the legal elements required by the selected cause of action. In addition to litigation, the literature describes negotiation, institutional complaint handling, mediation and other dispute-resolution processes. Their suitability depends on the nature of the dispute, patient protection, informed participation, and any applicable procedural requirements.

Dual accountability: professionals, management, and facilities

A significant contribution of the reviewed work is its emphasis that emergency-care accountability is often distributed. A clinician may decide on triage, medication or referral, while management controls staffing, intensive-care capacity, operating procedures and payment policies. A credible legal analysis therefore distinguishes the clinician's professional act from organizational omissions and avoids assuming that responsibility lies exclusively with either one.

This analytical distinction is especially important when doctors delegate tasks to general practitioners or nurses during urgent care. If an on-call specialist cannot be reached, a general practitioner may face decisions extending beyond ordinary routines. A nurse carrying out a delegated procedure may need to document the scope of authority, clinical urgency and standard of care. The studies identified by the source review discuss uncertainties in delegation and how poor communication can aggravate clinical and legal risks (Azis et al., 2025).

The term dual liability is consequently useful as a framework for asking whose conduct must be assessed, not as a presumption that both an individual and a hospital are liable in every case. Criminal and civil liability may rest on different requirements and evidentiary standards. Institutional

accountability may also involve administrative supervision and corrective action even where no criminal offence is ultimately proved (Cahyadi, 2014).

Table 3. Distinguishing liability pathways and responsible actors in emergency-care refusal.

Pathway / normative focus	Potential actors	Elements / factual questions	Consequences / cautions
Criminal: omission of required emergency first aid	Facility leader; medical/health personnel within statutory terms	Operative duty; failure to give first aid; applicable offence elements; date of conduct; consequences if legally required	Possible statutory criminal sanctions; no presumption of guilt from an adverse outcome
Criminal: negligent clinical harm	Qualifying medical / healthcare professional	Applicable professional duty; relevant negligence; injury/death and legally required causal connection	Distinct from deliberate refusal; check Article 440 and applicable rules
Civil: unlawful act / negligence	Professional and/or responsible facility, depending on claim	Wrongful act/negligence, damage, causal connection, applicable attribution/defences	Potential damages or other appropriate civil remedies, not automatic
Institutional / professional accountability	Facility management, supervisory systems, practitioners	Staffing, policies, delegation, documentation, triage/referral, standards	Administrative or professional review may coexist with or differ from civil/criminal pathways

Note. Conceptual mapping only. Each pathway depends on the operative legal text and the particular facts; the table does not assign liability in any reported case.

Consent, emergency necessity, and safeguards

Informed consent creates a general expectation that patients receive relevant information and can decide on proposed treatment. When immediate intervention is necessary but a patient is unconscious or otherwise unable to decide, the ordinary consent process may be impracticable. The source literature explains emergency exceptions through older Ministerial Regulation No. 290 of 2008 and provisions of the 2023 Health Law; studies also discuss presumed consent and action in a patient's best interests (Baroto, 2023).

Article 275(2) of Law No. 17 of 2023 is relevant to the protection of professionals engaged in specified emergency rescue activities from damages claims. Its wording should be read alongside the duties in Articles 274–275 and the distinct rules of criminal responsibility; it should not be expanded into a general exemption from professional standards or criminal accountability (Republic of Indonesia, 2023b).

An exception to prior written consent should not be treated as unrestricted discretion. The clinician should still act within the legal and professional conditions for emergency action, evaluate clinical necessity, record reasons, and communicate with the patient or family as soon as practicable. Decisions about withholding resuscitation and DNR orders introduce separate clinical and ethical questions, which must not be conflated with arbitrary refusal to provide initial emergency help.

The source reports anxiety among clinicians about later complaints when treatment takes place without standard written consent. That concern has a practical implication: training, clinical documentation, accessible ethics consultation, clear escalation procedures and legal guidance may

reduce defensive delays. A legal system that prohibits unjustified refusal while safeguarding good-faith, standards-compliant rescue practice helps align patient access with professional responsibility.

Financing, health insurance, and organizational capacity

The reviewed studies repeatedly connect disputes over emergency access to patients' ability to pay and to insurance administration. Some accounts involve demands for deposits, contested eligibility under BPJS Kesehatan, or disagreement over reimbursement classifications (Hakim et al., 2016). Other studies identify specialist shortages, inadequate staffing, bed availability, critical-care equipment and geographical disparities as constraints on a facility's effective response.

These different constraints have different legal implications. A routine administrative rule should not displace an emergency-assistance obligation, but a lack of essential equipment may require immediate stabilizing measures and safe referral rather than a clinically impossible procedure. Determining legality requires a close account of what was possible, who knew the relevant facts, whether action was timely, and whether barriers were preventable through governance or resource allocation.

The case commonly discussed as the Tiara Debora incident illustrates the way financial and administrative circumstances become intertwined with hospital capacity and critical-care referral. The narrative is supplied through secondary scholarship rather than a direct forensic reconstruction in this review. It should therefore be read as an illustration of a recurring legal problem, not as an independently adjudicated causal finding by this article.

Policy responses suggested by the synthesis include reliable emergency triage and referral pathways, reimbursement arrangements that do not create avoidable incentives to defer necessary initial care, transparent institutional complaint handling, and documentation of both clinical decisions and administrative interruptions. Such measures address systems that can generate repeated disputes without assuming that every adverse event is explained by wilful misconduct.

Evidence from judicial and institutional proceedings

The source review contains a small collection of cited proceedings relating to abandonment, malpractice, orthopedic emergency interventions and internal hospital disciplinary resolution. These heterogeneous matters do not form a representative sample of all Indonesian emergency-refusal disputes. They also differ substantially in the type of alleged conduct: an intentional abandonment case should not be merged analytically with a professional-negligence claim about treatment delivered.

The evidentiary status of the cited proceedings remains limited: references to Decision No. 381/Pid.B/2014/PN.TK and other disputes are retained as descriptions found in the secondary literature, not as verified findings from official case files. Without the full judgment, analysis cannot establish the complete procedural history, ratio decidendi, precise disposition, or subsequent appellate developments. Accordingly, such material illustrates legal questions and cannot be used to infer conviction patterns or validate particular causation claims.

The source reports that certain civil claims were rejected where a court found insufficient grounds for unlawful-act liability or where a medical professional was considered to have complied with procedural standards. Other records concern criminal negligence or professional discipline. As several descriptions rely on secondary studies rather than official judgments, readers should not infer broader conviction rates or the likely result of future litigation from this small and nonrandom set.

What can be drawn from the jurisprudential discussion is a conceptual lesson: allegations must be analyzed against particular duties, professional standards, the causation of harm, proof rules and the legally responsible actor. The judicial record also supports a practical research agenda focused on

obtaining full judgment texts, coding their fact patterns and comparing remedies, rather than relying on summary tables alone.

Synthesis, limitations, and legal research implications

The evidence is most coherent when organized into two interacting levels. At the first, law defines emergency access, professional duties, prohibitions on unjustified non-assistance and remedies for wrongful injury. At the second, hospitals operate within staffing, financing, insurance, referral and documentation systems. A legally sound intervention must address both. Criminal deterrence alone cannot repair an unavailable referral network; conversely, institutional shortages do not necessarily justify failures in stabilization that could reasonably have been performed (Fajrina et al., 2021).

The distinction between dual-track accountability and dual institutional–individual accountability also matters. Dual-track refers to criminal and civil responses, which pursue different outcomes; dual institutional–individual accountability asks which persons or bodies bear a particular obligation. These should not be collapsed into a single category, and administrative or professional disciplinary avenues constitute further possible mechanisms.

The proposed two-axis accountability map can be expressed as follows: the horizontal axis identifies the legal route (criminal prohibition, civil claim, and, where relevant, administrative/professional review); the vertical axis identifies the possible duty-bearer (individual clinician, management, or facility). Each intersection is an issue for evidence-based legal analysis—not a conclusion of liability. Its contribution is to prevent the recurrent conflation of liability regimes with attribution of responsibility and to organize the interactions between clinical decision-making and organizational policy.

The study has significant limitations. Thirty-two of 59 included works were analysed only from abstracts. The initial search was conducted through a retrieval interface rather than independently documented reproducible database strings; the original report does not specify search date, detailed deduplication, independent screening, or critical appraisal. A portion of the source literature addresses adjacent topics rather than direct refusal of emergency aid. Differences in legal period also complicate synthesis because some articles apply superseded statutes. These limitations prevent confident estimates of prevalence, causal proportions or the effectiveness of particular sanctions (Aldalati et al., 2021).

Future work should provide fully reproducible searches, dual screening, a prespecified risk-of-bias framework suited to doctrinal and empirical studies, a complete inventory of retrieved court decisions, and a study-level distinction between primary and secondary legal sources. Legislation should be consolidated and dated at the point of analysis, especially in view of the new Criminal Code and the 2023 Health Law. Multi-site empirical research could examine triage decisions, insurance procedures, referral timing and organizational accountability while protecting confidential patient information (Faqih & Arba, 2022).

The review therefore supports a restrained conclusion. The source literature identifies substantial legal obligations and liability mechanisms, but offers much more detailed doctrinal analysis than systematically observed evidence about why specific patients are denied emergency treatment. Legal and institutional reform should be evaluated with that asymmetry in mind.

Policy implications follow from this limited level of evidence: institutions may use documented emergency triage, initial stabilization, timely referral, financing escalation, and clear incident records as governance priorities. Such measures are reasoned implications of the thematic synthesis, not interventions whose effectiveness has been empirically established by this review. Further research should test them using reproducible searches, authenticated case law, and institution-level data.

4. Conclusion

This systematic review identifies a recurring dual-track approach to refusal of emergency care in Indonesia: criminal provisions address prohibited failures to assist, while private-law doctrines provide possible remedies for actionable injury. Both frameworks require case-specific legal and factual analysis. The literature also emphasizes that responsibility may be distributed between clinicians and hospitals, depending on duties, decisions, supervision and organizational policies. The synthesis links disputed emergency access to financial and administrative hurdles, insurance reimbursement, referral organization and resource constraints. The presence of these barriers does not itself settle whether any particular refusal is lawful. Emergency consent exceptions and safeguards for standards-compliant clinicians should be treated as complementary protections alongside patient rights. Interpretation is limited by incomplete full-text access and uneven documentation of review procedures. Stronger institutional protocols, verified legal analysis and primary case-law research are necessary to translate the reviewed doctrinal commitments into accountable emergency-care practice.

The contribution of this review is therefore a two-axis framework separating criminal/civil legal pathways from attribution of responsibility among clinicians, management, and facilities. This conceptual distinction can direct future verified case-law research and institutional assessment without implying automatic concurrent liability. Because the search history, abstract-only evidence, and primary-judgment access remain limited, conclusions should be read as a qualified mapping of scholarship rather than as prevalence estimates or independently adjudicated findings.

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