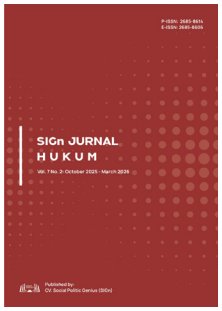

SIGn Jurnal Hukum

E-ISSN: 2685 – 8606 || P-ISSN: 2685 – 8614
https://jurnal.penerbitsign.com/index.php/sjh/article/view/v7n2-42

Vol. 7 No. 2: October 2025 - March 2026 Published Online: March 3, 2026

Article Title

Legal Position of the Professional Disciplinary Council: Central Authority for Disciplinary Enforcement of Medical and Healthcare Professionals in Hospitals

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How to cite:

Nurlaelah, S., Asgar, M. A., Arisman, A., & Sari, D. R. (2026). Legal Position of the Professional Disciplinary Council: Central Authority for Disciplinary Enforcement of Medical and Healthcare Professionals in Hospitals. *SIGn Jurnal Hukum, 7*(2), 1325-1340. https://doi.org/10.37276/sjh.v7i2.653

ABSTRACT

The transformation of national healthcare governance following the enactment of Law Number 17 of 2023 marks a radical shift in disciplinary enforcement from a regime of professional autonomy to a state-centred one. This centralization of power triggers administrative legal problems regarding the MDP's institutional independence, which is anomalous in its accountability to the Minister of Health, and gives rise to clashes between procedural authority and the managerial autonomy of healthcare facilities. This research aims to analyze the legal position, procedural supremacy, and material jurisdictional limitations of the MDP as the central authority for the disciplinary enforcement of medical and healthcare professionals. Employing a normative legal research method, this research examines the coherence of norms in the latest regulations. The research results demonstrate that the MDP possesses absolute attributive authority that legally annuls the tradition of collegial dispute resolution, including the prohibition on internal hospital mediation. Functionally, the Council acts as a prejudicial dispute determiner, obliged to issue a recommendation before criminal law enforcement is executed, with jurisdiction confined to 17 types of disciplinary violations. This research concludes that executive dominance in disciplinary enforcement provides legal certainty through the objectivity of violation parameters, yet demands a total restructuring of internal hospital regulations to submit to the supremacy of state administrative law.

Keywords: *Healthcare Administrative Law; Hospital; Medical Dispute; Professional Disciplinary Council; State-Centered Enforcement.*

INTRODUCTION

The transformation of global healthcare governance marks a significant paradigm shift in the oversight of medical and healthcare professionals. Developed countries such as the United States, the United Kingdom, and Singapore have long implemented a disciplinary enforcement model, closely integrated with state authorities, to ensure patient safety and professional accountability. In this comparative context, Indonesia is currently undergoing fundamental legal reform through the enactment of Law Number 17 of 2023, which radically alters the landscape of medical dispute resolution. As elaborated by Sudarmanto et al. (2025), harmonizing professional disciplinary regulations is an urgent necessity to align Indonesia's public protection standards with international best practices. This change demands a robust state instrument to ensure that every medical action performed in healthcare facilities is subject to measurable and objective competency standards.

The legal dynamics following the enactment of the latest healthcare regulations have sparked extensive academic discourse regarding the certainty of legal protection (Almufarrida & Malie, 2025; Irwanto et al., 2025). Awangga (2025) noted that integrating various sectoral laws into a single codification of healthcare laws aims to simplify bureaucracy while strengthening disciplinary enforcement mechanisms. However, the field implementation of this regulation still leaves complex challenges, particularly regarding the intersection of responsibilities between individual medical professionals and their affiliated institutions. Kacaribu et al. (2024) emphasized that the legal protection and liability of medical professionals in medical disputes

require strict boundaries to prevent overlap among administrative negligence, ethical violations, and unlawful acts. The ambiguity of this jurisdictional demarcation potentially creates legal uncertainty that disadvantages both healthcare professionals and patients seeking justice.

Prior to the emergence of the new healthcare legal regime, the discourse on professional disciplinary enforcement was dominated by studies on the existence of the Indonesian Medical Discipline Honorary Council (*Majelis Kehormatan Disiplin Kedokteran Indonesia* or MKDKI). Previous research by Lintang et al. (2021) provided a comprehensive overview of MKDKI's position as an autonomous institution with a central role in medical dispute resolution under Law Number 29 of 2004. Similarly, Indrawan et al. (2024) analyzed the vital role of the MKDKI in prosecuting violations of doctors' professional standards. This literature accurately captures the legal conditions at that time (*tempus delicti*), in which the independence of the disciplinary enforcement institution was closely tied to the autonomy of professional organizations and was separated from direct executive intervention.

However, the sociological validity of these previous studies now faces challenges of doctrinal relevance due to changes in the constitutional structure. Kastury (2024), in his analysis of the position of the disciplinary honorary council from the perspective of positive law, still focuses on the old institutional construction, which has now been revoked and declared invalid by the latest law. There is a clear analytical gap in current legal literature, where the majority of studies remain fixated on the paradigm of absolute independence of professional organizations. In fact, Law Number 17 of 2023 introduced a new entity named the Professional Disciplinary Council (*Majelis Disiplin Profesi* or MDP), which possesses the characteristics of state-centered enforcement and reports directly to the Minister of Health. This shift is not merely a change in nomenclature but a total overhaul of the administrative law architecture that has not been extensively studied in depth.

This literature gap becomes increasingly crucial when applied to hospital-level healthcare facilities. The presence of the MDP with strong attributive authority potentially collides with the autonomy of hospital governance, which has traditionally relied on internal, collegial dispute-resolution mechanisms through medical committees. State intervention reaching into the clinical practice space through binding Council decisions creates a new tension in healthcare administrative law. This situation requires normative research to reposition the state organ so as not to disrupt hospital risk management structures, while ensuring that disciplinary enforcement is not misused to criminalize medical professionals.

The urgency of this research lies in the need to provide a doctrinal foundation for operationalizing the MDP as the sole central authority for disciplinary enforcement.

Unlike previous research that is fragmented across issues of medical criminal law or mere moral ethics (Estrada, 2024; Indrawan et al., 2024; Kastury, 2024; Mahayani et al., 2024; Purwanto et al., 2026), this study specifically dissects the institution's administrative authority as the primary legal filter. This research will fill the legal vacuum by proving that the centralization of disciplinary authority is an absolute prerequisite for creating uniform healthcare service standards throughout Indonesia and for breaking away from the disparities in decision-making that frequently occurred under the past decentralized regime of professional organizations.

This research aims to analyze and identify the *ratio legis* governing the legal position of the MDP within the state administrative architecture, particularly in light of the paradigm shift toward centralization of authority and the anomaly of its institutional accountability to the Minister of Health. In addition, this research is intended to examine the procedural supremacy of the Council in annulling the tradition of collegial disciplinary resolution, by testing the coercive power of administrative actions against the autonomy of hospital-level healthcare facilities. Furthermore, this research dissects the limitations of the Council's material jurisdiction to establish an objective demarcation between disciplinary violations and ethical offenses or pure criminal offenses, while testing the functionalization of the Council as an absolute prejudicial determinant institution prior to the execution of further law enforcement.

METHOD

This research is a normative legal study focusing on the positive legal principles or norms applicable within the Indonesian constitutional system. This type of doctrinal research was specifically selected to examine the coherence of the normative system, the consistency of principles, and the hierarchy of laws and regulations regarding the position of quasi-judicial institutions within the state administrative structure (Qamar & Rezah, 2020). In contrast to sociological or empirical research that examines the functioning of law in society through field data, this research operates solely at the dogmatic legal level to address norm vacuums and jurisdictional conflicts between state organs and the institutional autonomy of healthcare facilities.

To dissect the complexity of the proposed legal issues, this research simultaneously applies two main approaches, namely the statute approach and the conceptual approach. The statute approach is utilized as a primary instrument to examine the *ratio legis* and ontology of the latest regulations governing professional discipline, to ensure the absence of contradictions between higher and lower regulations. Meanwhile, a conceptual approach is employed to construct a theoretical framework for the paradigm shift in disciplinary enforcement from a professional autonomy model to a state-centered model, and to analyze the doctrine of administrative supremacy in medical dispute resolution.

The data source used in this research is secondary data, classified into two types of legal materials with different binding powers (Sampara & Husen, 2016). Primary legal materials are authoritative, encompassing hierarchically structured laws and regulations, ranging from Law Number 17 of 2023, Government Regulation Number 28 of 2024, to technical regulations in the form of Minister of Health Regulations and Minister of Health Decisions that regulate mechanisms, work procedures, and types of disciplinary violations. Meanwhile, secondary legal materials include contemporary legal literature, reputable journal articles, and relevant legal scholars' doctrines to strengthen argumentation and provide analytical comparisons with primary legal materials.

The legal material collection technique is conducted through library research using a systematic inventory and identification mechanism. The collected legal materials are selected based on their relevance to material jurisdiction, particularly the attributive authority of the MDP, procedural law for examination, and the boundaries of liability in hospitals. This process involves tracing national regulatory databases and legal literature to ensure the validity and currency of the data used as the basis for analysis.

All collected legal materials are subsequently analyzed qualitatively and normatively (Irwansyah, 2020). This analytical technique does not employ statistical parameters or data quantification, but rather utilizes legal interpretation instruments, including grammatical interpretation to understand the textual meaning of regulations, systematic interpretation to connect articles within different regulations, and teleological interpretation to discover the purpose of the law's establishment. The drawing of conclusions is conducted using deductive logic, which begins by laying down a major premise in the form of positive legal rules, juxtaposed with a minor premise in the form of procedural legal facts, to produce a precise conclusion regarding the legal certainty of the MDP's position.

RESULTS AND DISCUSSION

A. Legal Position of the Professional Disciplinary Council within the State Administrative Architecture

The national healthcare governance reform, as manifested in Law Number 17 of 2023, marks the end of the era of absolute autonomy for professional organizations in the disciplinary enforcement of medical and healthcare professionals. The legislators consciously shifted the paradigm from a self-regulation model to a state-centered enforcement model. The legitimacy basis for this shift is explicitly enshrined in Article 304 section (2) of Law Number 17 of

2023, which grants direct attributive authority to the Minister of Health to establish a disciplinary council. This norm construction asserts that the MDP is no longer a complementary organ of professional organizations, but rather an administrative legal entity whose position is attached to executive power. This simultaneously annuls the old doctrine that placed ethics and discipline in an exclusive domain accessible only to a peer group.

This fundamental change invalidates the relevance of several previous literatures that still utilized the MKDKI as the ideal benchmark of independence. For instance, the study by Kastury (2024) portrayed the MKDKI as an autonomous institution, free from government intervention in medical dispute resolution. Similarly, Indrawan et al. (2024) emphasized the MKDKI's central role in maintaining doctors' professional standards independently. However, these analyses are now doctrinally invalid because the legal foundation establishing the MKDKI, namely Law Number 29 of 2004, has been revoked. In the new legal architecture, the absolute independence *a la* the MKDKI is deemed no longer adequate to address challenges of decision-making disparities and the slow execution of sanctions, necessitating the state's control through the establishment of an integrated MDP.

Indonesia's move to position the disciplinary institution under the executive branch aligns with the modernization trend in global healthcare governance. Sudarmanto et al. (2025), in their comparative study, found that developed countries such as the United States, the United Kingdom, and Singapore have previously implemented systems in which medical disciplinary enforcement institutions have clear lines of accountability to state healthcare authorities rather than to professional associations. The harmonization of this institutional model aims to ensure that patient safety standards take precedence over professional solidarity. Therefore, the presence of the MDP in Indonesia is not a democratic anomaly, but rather a form of adaptation to international administrative legal standards that demand greater public accountability.

Nevertheless, the legal position of the MDP within the Indonesian constitutional structure leaves a unique structural anomaly. Based on Article 712 section (3) of Government Regulation Number 28 of 2024, the Council is declared accountable to the Minister. However, in Article 712 section (4) of the same Government Regulation *juncto* Article 24 section (2) of Ministerial Regulation Number 12 of 2024, it is stated that the Council is established to support the duties and functions of the Indonesian Health Council and its accountability to the Minister must be conducted "through the Council". This legal construction creates an unusual hierarchical relationship: the Council possesses autonomy in adjudicating cases (judicial), yet is administratively subordinate to the Indonesian Health

Council and the Minister. Andira (2026) argued that the Council's independence is the key to legal certainty, but juridical facts demonstrate that such independence is limited by a tiered bureaucratic design.

This limitation on independence is further emphasized by the executive's policy intervention authority. Article 717 section (2) of Government Regulation Number 28 of 2024 grants authority to the Minister to make "adjustments" if the implementation of the Council's duties is deemed inconsistent with ministerial policies. This clause shows that the MDP lacks absolute immunity akin to that of pure judicial institutions (courts). As a state administrative organ, the discretion held by the Council in examining alleged disciplinary violations must remain within the corridors of national healthcare policies, considering that administrative law instruments play a vital role in compliance enforcement (Latemmamala & Fachri, 2026). This challenges the assumption that the professional disciplinary institution is a "state within a state"; rather, it is a government instrument for regulating healthcare services.

The state's effort to dilute the dominance of professional groups is also evident in the restructuring of the Council's membership. Rahman et al. (2025) highlighted that the restriction of professional organizations' authority post the latest Health Law constitutes a legal measure to prevent conflicts of interest. This is reflected in Article 26 section (1) of Ministerial Regulation Number 12 of 2024, which stipulates that out of the nine Council members, the professional element is limited to only two individuals. The remainder is filled by representatives from ministries, legal experts, healthcare facilities, and the public. This heterogeneous composition is designed to transform the face of disciplinary adjudication, which was previously elitist and closed, into a more participative and objective one, ensuring that the resulting decisions are no longer biased by peer interests.

With a centralized legal position and inclusive membership composition, the MDP possesses strong legitimacy to enforce service standards. However, institutional legitimacy alone is insufficient without effective coercive instruments in the field. The greatest challenge of this centralization is ensuring that the decisions and procedures established by the Council can be implemented at the level of healthcare facilities, which possess managerial autonomy. Therefore, subsequent analysis needs to dissect the procedural supremacy of the Council in penetrating the boundaries of hospital autonomy and annulling the internal dispute resolution mechanisms that have been operating thus far.

B. Procedural Supremacy of the Professional Disciplinary Council over Hospital Autonomy

The centralized institutional legitimacy of the MDP, as previously elaborated, will not have a significant impact without the presence of coercive procedural instruments. In the context of medical dispute resolution, Awangga (2025) found that the efficiency of resolving healthcare legal issues heavily depends on the clarity of the mechanisms implemented. However, this analysis needs to be sharpened by noting that Law Number 17 of 2023 does not merely offer a resolution mechanism but rather establishes state administrative procedural supremacy that transcends the boundaries of hospital managerial autonomy. The state intervenes in the internal governance of healthcare facilities by standardizing the due process of law that must be obeyed by the hospital board of directors and medical committees, thereby closing the door to local discretion that may deviate from national standards.

The most tangible manifestation of this procedural intervention is the centralization of the complaint entry point. Pursuant to Article 8 of Ministerial Regulation Number 3 of 2025, the complaint mechanism for alleged disciplinary violations is now integrated into the National Health Information System, which is managed directly by the Ministry of Health. Technically, this provision eliminates the screening mechanisms or undisclosed settlements that hospital management previously used to protect the institution's reputation. With a centralized system, every public complaint directly enters state jurisdiction without passing through hospital bureaucracy, forcing healthcare facilities to submit to transparent and accountable external examination procedures.

The enforcement of this procedural supremacy simultaneously serves as an absolute rebuttal to several academic views that still glorify dispute resolution through amicable means. Maryanto and Triadi (2025) suggested the use of non-litigation methods such as mediation and negotiation as the primary solution in healthcare disputes. This argumentation is deemed legally flawed when applied to the realm of professional discipline under the latest regulatory regime. Article 31 section (3) of Ministerial Regulation Number 12 of 2024 expressly prohibits the MDP from conducting mediation, reconciliation, and negotiation between the complainant and the reported party. This absolute prohibition affirms the public law character of disciplinary enforcement. The violation of professional standards is an administrative matter concerning public safety, not a private civil dispute that can be bargained for or resolved through the parties' compromise.

This uncompromising procedural firmness aligns with the principle of balanced legal protection. Kacaribu et al. (2024) highlighted the importance

of clear legal liability to protect medical professionals in disputes. From an administrative law perspective, such protection arises precisely from rigid procedural formalization rather than from negotiation flexibility. With the prohibition on mediation, medical professionals are protected from pressure from hospital management or patients to agree to disproportionate settlements. The disciplinary examination process becomes purely a proof of compliance with professional standards, where the MDP acts as an objective examiner bound by material facts, not by an amicable agreement between the parties.

The coercive power of the Council's procedure over hospital institutions is further strengthened by the legality of the examination team's formation. Article 32 section (1) of Ministerial Regulation Number 12 of 2024 stipulates that the appointment of the *ad hoc* examination team is conducted by the Chairman of the Council "on behalf of the Minister". The phrase "on behalf of the Minister" provides a very strong legal weight to government actions (*bestuurshandeling*). When this examination team investigates a hospital, they carry an executive mandate that hospital management cannot reject under the pretext of internal autonomy. The refusal or obstruction of the examination team's work may constitute defiance of state authority, which carries administrative consequences for the healthcare facility.

The executive power of this procedural supremacy reaches its peak in the resulting decision. Siregar et al. (2024) construed the MDP as the *primum remedium* or primary remedy in healthcare law enforcement. This construction aligns with Article 306 section (2) of Law Number 17 of 2023, which states that the results of the Council's examination are binding on Medical and Healthcare Professionals. This binding nature closes the loophole for hospitals to annul state disciplinary sanctions through a director's decision. Furthermore, the legal remedies of objection against the decision do not culminate in general courts, but rather through a Reconsideration mechanism to the Minister as stipulated in Article 23 and Article 26 of Ministerial Regulation Number 3 of 2025. This consolidates a closed resolution cycle within the executive realm (administrative finality).

This solidly built procedural supremacy, ranging from the centralization of complaints to final decisions, provides a strong formal foundation for the MDP. However, this formal strength must be balanced with clear material boundaries to prevent abuse of power that exceeds jurisdiction. The absolute authority to examine and adjudicate must not be construed as boundless freedom to try all types of acts by medical professionals. Therefore, the urgency of the subsequent analysis is to establish a strict demarcation regarding what dispute objects limitatively fall within the Council's authority, as well as its function as a prejudicial determinant before other legal realms operate.

C. Limitations of Material Jurisdiction and Functionalization of the Prejudicial Determinant

The procedural supremacy of the MDP does not necessarily make it an institution with absolute power capable of adjudicating all forms of deviation in healthcare facilities boundlessly. The construction of state administrative law requires clarity about the scope of material authority to prevent overlap with the jurisdiction of general courts. Therefore, Law Number 17 of 2023 functionalizes this Council as an absolute prejudicial determinant institution or prejudicial dispute. Fitira et al. (2025) construed this authority as a "quasi-investigation" mechanism, in which the state mandates a prior administrative assessment before entering the criminal or civil realms. This is a manifestation of the *ultimum remedium* principle, which positions criminal sanctions as a last resort after the disciplinary administrative mechanism has been exhaustively pursued.

The implementation of this prejudicial function is rigidly regulated through Article 308 section (1) and section (2) of Law Number 17 of 2023 *juncto* Article 29 of Ministerial Regulation Number 3 of 2025. These norms require law enforcement officers, both police and civil servant investigators, to obtain a written recommendation from the MDP before investigating medical professionals. Natalia et al. (2025) asserted that the *ratio legis* of this provision is to prevent the premature criminalization of medical actions that carry inherent risks. The state provides a binding time limit, namely 14 working days for the Council to issue the recommendation. If this deadline is exceeded, the Council is deemed to have provided the recommendation. This mechanism guarantees legal certainty for medical professionals, preventing them from experiencing uncertainty in protracted legal proceedings and a lack of clarity about their professional status.

This legal filter function is crucial for demarcating the fine line between disciplinary violations, medical negligence, and criminal unlawful acts. Mahayani et al. (2024) argued that not all adverse events qualify as criminal offenses. There must be proof of an element of intent or gross negligence that exceeds professional tolerance limits. Similarly, the necessity for legal protection that delineates acceptable medical risks from pure malpractice has emerged as a crucial discourse (Khalid, 2023; Estrada, 2024; Kamran & Syahrul, 2024; Purwanto et al., 2026). The MDP exists to draw this line of demarcation. If the Council decides that an action complies with professional standards, then the entry point to criminal prosecution and civil lawsuits becomes substantially closed, because the element of "unlawfulness" in the medical action has been nullified by the operation of administrative law.

In exercising its adjudicative function, the Council's discretion is strictly limited by material parameters. Ministerial Decision Number HK.01.07/ MENKES/775/2025 has stipulated 17 descriptive points of types of professional disciplinary violations that fall under the absolute jurisdiction of the Council. This restriction aims to prevent the Council from examining cases that fall within the realm of pure ethics (decorum) or pure criminal offenses (such as theft or assault). Wulan et al. (2025) emphasized the importance of clearly defining "dereliction of duty" in regulations to prevent disciplinary enforcement from being open to multiple interpretations. With the codification of these types of violations, the objectivity of the examination is guaranteed because every decision must refer to one or more of the 17 violation points standardized by the state, rather than being based on the examiner's subjective interpretation.

The objectivity of the violation assessment parameters is also applied to aspects of communication and emergency actions. Purba et al. (2024) found that the majority of disputes arise from communication failures, which are now expressly regulated as disciplinary violations if medical professionals fail to provide honest and adequate information. Meanwhile, in critical situations, Hanafi et al. (2025) and Rosnida et al. (2025) highlighted the importance of protecting medical professionals and midwives who perform life-saving procedures beyond their clinical authority. The latest disciplinary regulations accommodate this by stipulating that actions outside of competence are only considered violations if performed without medical indications or without adequate supervision under normal conditions, but are justifiable in emergency conditions in accordance with standard operating procedures.

Furthermore, legal analysis of Point 14 letter c of Ministerial Decision Number HK.01.07/MENKES/775/2025 opens a new dimension regarding the separation of liability between individuals and corporations. Rahma and Prayuti (2025) analyzed the implications of the health law on risk management in hospitals, concluding that compliance with Standard Operating Procedures (SOP) is the primary indicator. Point 14 explicitly states that although medical professionals are examined regarding the completeness of medical records, "the retention of medical records is the responsibility of the healthcare facility". This norm protects medical professionals from the burden of hospital managerial errors. The MDP has authority only to adjudicate doctors' non-compliance with medical record completion requirements, but cannot impose disciplinary sanctions for the loss of medical records caused by poor hospital archiving systems.

Thus, the construction of the MDP's material jurisdiction has been precisely designed to balance the interests of enforcing professional standards with the

legal protection of medical professionals. Through absolute prejudicial authority, limitative violation parameters, and the separation of individual and institutional liability, this Council consolidates itself as an objective central authority for disciplinary enforcement. The entire elaboration regarding its position within the state architecture, procedural supremacy in hospitals, and jurisdictional limitations affirms that a total transformation has occurred in the governance of healthcare professions in Indonesia, demanding compliance adaptation from all stakeholders.

CONCLUSIONS AND SUGGESTIONS

A comprehensive legal analysis of the healthcare governance architecture following the enactment of Law Number 17 of 2023 affirms that the MDP's position has fundamentally shifted from a regime of professional autonomy to one of state-centered enforcement. The state, through the direct delegation of authority from the Minister of Health, has taken absolute control over the disciplinary supervision of medical and healthcare professionals, thereby invalidating the previously applicable association-based institutional independence. However, this centralization of power creates an administrative anomaly: dual accountability, where the Council possesses judicial independence in adjudicating cases yet remains structurally subordinate because it is established to support the functions of the Indonesian Health Council and is accountable to the Minister through the said council. This construction positions the Council as a quasi-judicial entity operating under the shadow of executive policy, rather than as a pure, value-free judicative institution.

At the implementation level in healthcare facilities, the MDP is proven to possess procedural supremacy that legally annuls hospital managerial autonomy. The absolute prohibition on mediation, reconciliation, and negotiation mechanisms closes the door on the previously practiced, collegial dispute resolution mechanisms for undisclosed or collegial disputes. The disciplinary examination actions conducted by the *ad hoc* team are qualified as binding government actions (*bestuurshandeling*) because they are performed on behalf of the Minister. Therefore, any internal hospital decision that contradicts the Council's decision becomes null and void by operation of law, as the Council's decision possesses final executive power within the administrative realm and can only be challenged through the administrative remedy of reconsideration to the Minister, not through ordinary civil lawsuits.

The functionalization of the MDP as an absolute prejudicial determinant institution successfully creates legal certainty through the strict demarcation of material jurisdiction. The obligation of law enforcement officers to request the Council's recommendation before conducting an investigation positions disciplinary

assessment as the primary filter (*primum remedium*) that prevents premature criminalization of medical risks. The objectivity of this assessment is guaranteed by the restriction to 17 types of disciplinary violations, ensuring the Council does not possess unlimited discretion to adjudicate matters of pure ethics or pure criminal offenses. In addition, separating liability between professional individuals' procedural errors and hospital management's systemic failures, particularly in medical record management, provides proportional legal protection for medical professionals who work in accordance with standard operating procedures.

Based on these conclusions, it is recommended that the Ministry of Health immediately issue technical regulations clarifying the working relationship between the MDP and the Indonesian Health Council to eliminate potential conflicts of interest arising from the anomaly in the accountability line "through the council". The ambiguity of this chain of command risks weakening the Council's decision-making independence in the event of administrative intervention by the Council. Furthermore, for hospital management, the implications of this procedural supremacy require a complete revision of hospital and medical staff bylaws. Hospitals are obliged to eliminate internal mediation clauses for alleged disciplinary violations and replace them with an integrated reporting mechanism to the national information system to avoid administrative sanctions resulting from obstruction of state disciplinary enforcement. Finally, for professional organizations and educational institutions, the health ethics and law curriculum must be reoriented to no longer teach dispute resolution based solely on corps solidarity, but rather absolute compliance with the 17 state disciplinary parameters as the sole benchmark for professional practice safety.

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