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Institutional Responsibility of Hospitals for Medical Errors Committed by Healthcare Personnel

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ABSTRACT

This study examines the institutional liability of hospitals for medical errors committed by healthcare personnel through the application of the principle of vicarious liability within both public and private healthcare services in Indonesia. Employing a qualitative literature-based method with thematic synthesis, the research analyzes regulatory frameworks and institutional practices. The findings indicate that the legal foundation for institutional responsibility is rooted in Article 1367(3) of the Indonesian Civil Code, as well as statutory regulations such as Law No. 44/2009 and Law No. 17/2023. However, in practice, implementation faces several obstacles, including ambiguity in employment relationships, deficiencies in supervisory mechanisms, and inadequate documentation and internal reporting systems. From a managerial perspective, the implications highlight the necessity for hospitals to enhance risk management systems and internal oversight procedures. From a legal standpoint, the study underscores the need for regulatory revision to ensure greater clarity and certainty regarding institutional accountability. The study recommends the development of explicit internal guidelines, continuous patient safety training, and regular institutional audits to ensure that hospitals can fulfill their legal responsibility for medical errors in an effective and structured manner.

INTRODUCTION

Healthcare services delivered through hospitals constitute a critical component of public service systems that directly impact the lives of the population. As the primary providers of medical care, hospitals integrate various professional roles, including physicians, nurses, technicians, and allied health personnel, within complex institutional and operational frameworks. Under conditions of high demand, professional pressure, and inherent clinical risks, medical errors may arise, potentially resulting in physical or psychological harm to patients.

From a legal standpoint, it is increasingly recognized that responsibility for such errors should not be confined solely to individual healthcare workers, but may also extend to the hospital as the organizing institution. Hospitals play a central role in establishing clinical protocols, supervising medical personnel, and facilitating the delivery of care, thereby bearing structural responsibility when negligence occurs within their organizational boundaries. This notion is encapsulated in the legal doctrine of vicarious liability, which posits that an institution may be held accountable for the actions of its employees when such actions fall within the scope of their employment. Within the healthcare sector, this doctrine has gained traction as a mechanism to ensure institutional accountability. In Indonesia, emerging research suggests that hospitals can be held liable for the conduct of healthcare professionals under their administration, particularly in instances of medical negligence (Lethy et al., 2023).

From a managerial and regulatory perspective, both public and private hospitals face significant challenges in addressing the risks associated with medical errors. These challenges pertain to organizational structure, employment relationships between institutions and medical personnel (e.g., permanent staff versus contractors), enforcement of service standards, and internal oversight mechanisms (Khayru & Issalillah, 2022). A comprehensive understanding of institutional responsibility is therefore essential to uphold patient rights and ensure legal certainty for the healthcare provider.

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A central issue in this discourse is the scope of hospital liability for medical errors committed by healthcare personnel. Despite the existence of statutory provisions affirming institutional accountability, considerable ambiguity remains regarding the conditions under which such liability is triggered. For instance, the legal status of independently contracted physicians continues to generate uncertainty regarding their inclusion under institutional supervision. Pujiyono (2021) emphasizes that the application of vicarious liability to hospitals in Indonesia still encounters substantial obstacles.

Additional regulatory concerns relate to the implementation of institutional responsibility as outlined in national legislation and professional standards. While Article 1367 of the Indonesian Civil Code provides a normative basis for hospital liability, there is a lack of consistency in judicial interpretation and enforcement. Consequently, the effectiveness of these provisions is diminished by the gap between regulatory intent and practical application.

Moreover, on the managerial front, hospitals face difficulties in designing and executing internal mechanisms for monitoring and responding to incidents of medical error. Variations in organizational structure, institutional ethos, resource allocation, and supervisory capacity between public and private hospitals complicate the uniform application of institutional liability. This raises critical questions regarding the adequacy of systems for oversight, incident reporting, clinical auditing, and compensation in both types of institutions.

The relevance of this study is heightened by recent regulatory developments in Indonesia that expand the scope of institutional responsibility in the health sector. Contemporary analyses have demonstrated that hospitals are now normatively accountable for the clinical actions of their medical staff under existing legal frameworks. In parallel, growing demands for patient rights and the increasing complexity of medical services have accentuated the legal and operational risks associated with medical negligence.

A robust understanding of how vicarious liability is operationalized in both public and private hospitals is therefore essential to establish legal clarity for both patients and healthcare institutions. Accordingly, this study seeks to provide a critical analysis of the institutional legal responsibility of hospitals for medical errors committed by healthcare personnel, based on the doctrine of vicarious liability. It further aims to identify the key legal and managerial barriers that hinder effective implementation and to formulate both theoretical insights and practical recommendations for enhancing institutional accountability in healthcare delivery.

RESEARCH METHOD

This study employs a qualitative literature-based approach through thematic synthesis of regulatory frameworks and institutional practices concerning the legal responsibility of hospitals for medical errors. The initial stage involved a systematic literature search across academic databases such as PubMed, ScienceDirect, Google Scholar, and national legal journal portals in Indonesia. The search utilized a combination of keywords, including "vicarious liability hospital Indonesia," "tanggung jawab rumah sakit kesalahan medis," "hospital liability medical negligence institution Indonesia," along with equivalent terms in Bahasa Indonesia. The inclusion criteria encompassed scholarly publications from the past two decades that focus on institutional accountability in healthcare services, medical negligence, hospital regulation, and the application of the vicarious liability doctrine within the legal and managerial contexts of Indonesian or comparable jurisdictions. Publications lacking peer review or empirical and analytical legal grounding were excluded.

Subsequently, the selected literature was coded thematically. Initial codes covered categories such as "legal basis for institutional responsibility," "implementation of vicarious liability," "employment relationships in healthcare," "challenges in evidentiary standards," "hospital risk management," and "patient protection." Each article was examined to identify central issues, arguments, regulatory discussions, institutional typologies (public or private), and forms of accountability described. The thematic coding was conducted manually by the principal researcher and reviewed by a secondary analyst to enhance the reliability of interpretation.

To ensure methodological rigor, quality assurance was carried out through source triangulation involving legal and healthcare management literature, complemented by internal peer review. Analytical validity was strengthened by referencing established qualitative research methodologies in healthcare services, such as those articulated by Im et al. (2023) and Dalglish et al. (2020). Interpretive clarity was maintained by incorporating direct citations from relevant statutory provisions and judicial decisions, as well

as by systematically articulating the institutional context in which these norms operate. The final synthesis was organized into two major thematic sections: the application of vicarious liability within hospital institutions, and the legal and managerial challenges faced in the enforcement of institutional accountability.

RESULT AND DISCUSSION

The Application of the Doctrine of Vicarious Liability to Hospitals for Medical Errors Committed by Healthcare Personnel

The doctrine of vicarious liability establishes that an institution or employer may be held legally responsible for harm caused by subordinates or individuals under its supervision while performing their professional duties. Within the Indonesian legal framework, this principle is explicitly codified in Article 1367(3) of the Indonesian Civil Code (Kitab Undang-Undang Hukum Perdata), which stipulates that "employers and those who engage others shall be responsible for damages caused by their servants or subordinates." This formulation indicates that liability extends beyond the personal actions of the individual and encompasses structural responsibility borne by those who are legally obligated to exercise supervision within a hierarchical system.

The principle embodies the rationale that an entity vested with authority to regulate, control, and derive benefit from a particular activity must also bear the burden of any harm resulting from such activity. In civil legal practice, this doctrine has become a foundational basis for attributing legal responsibility within employment relationships, especially when the acts of subordinates are executed within the scope of their assigned duties. Moreover, vicarious liability serves as a preventive legal mechanism compelling institutions to reinforce their internal supervisory systems. Accordingly, a superior's responsibility arises not solely from formal employment status but from the legal obligation to manage risk through operational regulation and oversight.

In the domain of health law, the doctrine assumes particular relevance when hospitals function as healthcare providers by organizing and deploying medical personnel to deliver clinical services. The applicability of this principle affirms that legal risk is not confined to individual healthcare workers but also implicates the institutions that derive legitimacy and benefit from the health services they administer. Thus, vicarious liability operates as a structural accountability mechanism that enables the legal system to penetrate beyond formal distinctions between individual actors and institutional authorities.

The principle contributes to the evolution of legal doctrine toward a more progressive model that prioritizes victim protection, especially in circumstances where proving direct fault by individual practitioners is procedurally burdensome. Its implementation necessitates that institutions develop coherent legal and administrative frameworks aligned with principles of active supervision. Within evidentiary law, the doctrine facilitates claimants in directing legal action toward entities structurally positioned to provide redress. Ultimately, the doctrine reinforces the normative proposition that institutional authority must be commensurate with the legal responsibilities attached to such power.

In the healthcare sector, hospitals occupy a critical position as entities responsible for providing infrastructure, regulating medical personnel, and establishing clinical procedures. Law No. 44 of 2009 on Hospitals, specifically Article 46, stipulates that hospitals are legally accountable for harm resulting from the negligence of healthcare personnel operating within the institution. This provision implies that hospitals may be held institutionally liable for medical errors. The statutory mandate carries normative implications requiring institutions to uphold service quality by ensuring adherence to professional standards, patient safety protocols, and medical ethics (Sasmita et al., 2023). Legal accountability imposed upon hospitals reflects their strategic role in exercising systemic control over the conduct of healthcare professionals within their organizational domain. This form of liability transcends individual culpability and reinforces the expectation that institutions maintain an environment conducive to safe and effective care delivery. The legal framework thus incentivizes the development of internal mechanisms such as credentialing systems, clinical governance structures, and responsive incident reporting protocols. Ultimately, institutional liability functions as a catalyst for continuous improvement by embedding accountability within the operational fabric of healthcare service providers.

Accordingly, liability in such circumstances is not determined solely by individual fault, but rather by the structural relationship that exists between the hospital and the healthcare provider. Hospitals, as corporate entities, do not function merely as administrative units; they possess legal personhood and operate within the public domain,

thereby bearing both ethical and legal obligations. When a patient suffers harm resulting from the actions of healthcare personnel, the law logically views the hospital as the entity responsible for the legal consequences of events occurring within the system it administers. In this regard, hospitals cannot shield themselves behind individual contracts or the employment status of physicians, as legal responsibility derives from their inherent institutional role. Consequently, hospital accountability must be designed within a systemic framework encompassing internal supervision, validation of medical staff competencies, and accurate incident reporting mechanisms.

Article 46 of the Hospital Law establishes a direct correlation between organizational structure and legal accountability. This legal instrument underscores the importance of institutional integrity in delivering healthcare services that are both safe and of high quality. The implementation of this provision shifts the managerial orientation of hospitals from merely providing services to becoming entities responsible for upholding patient rights. Furthermore, this provision prevents the unilateral transfer of liability onto healthcare professionals in the absence of a clear oversight system. The norm provides a legal foundation for patients to pursue claims against institutions that derive direct benefits from clinical activities. Within this framework, hospitals are obligated to maintain internal policies aligned with principles of prudence and professional responsibility. This requirement simultaneously functions as a metric for assessing the quality of hospital governance in managing the risks associated with medical negligence (Lethy et al., 2023).

Consistent with these principles, recent studies in Indonesia have demonstrated the application of vicarious liability in medical malpractice disputes. For instance, Berakhnama Fakrulloh and Lubna (2023), in Hospital Liability and Patient Protection in Indonesian Law, report that hospitals are frequently held liable for the negligence of healthcare personnel operating under their coordination. Such application necessitates the presence of a sufficiently clear employment relationship or supervisory authority between the institution and the healthcare provider for institutional liability to be imposed. Budiman, Absori, and Rizka (2023) show that liability is more easily attributed when the physician in question is a permanent employee of the hospital rather than an independent contractor or affiliated partner.

A significant challenge lies in proving that the healthcare provider committed an act of negligence in the course of duty and that the institution exercised control or oversight over the individual. Lumunon and Maramis (2023) conclude that the concept of corporate negligence offers a complementary legal avenue by which hospital institutions can be held accountable beyond the confines of hierarchical employment relationships. This framework emphasizes institutional obligations to implement preventive systems, establish standards of care, and maintain operational vigilance, regardless of direct employment status. The doctrine allows courts to evaluate whether the hospital failed to provide an environment that minimizes foreseeable risks, which broadens the evidentiary basis beyond individual misconduct. Moreover, corporate negligence shifts the analytical focus toward systemic deficiencies such as inadequate staffing, poor training protocols, or the absence of safety monitoring mechanisms. As such, legal scrutiny becomes more comprehensive, addressing institutional liabilities that would otherwise be obscured by contractual technicalities. This perspective reinforces the duty of care expected from healthcare institutions as entities entrusted with public welfare. It further compels hospitals to institutionalize governance structures that are not only reactive but also anticipatory in identifying potential harms. Lastly, this approach strengthens the legal rationale for holding institutions accountable when operational failures contribute materially to adverse patient outcomes.

From the perspective of hospital management, the implications of applying vicarious liability include the necessity of implementing internal controls, conducting clinical audits, offering professional risk training, and maintaining comprehensive documentation of procedures and medical records (Issalillah & Khayru, 2023). Absent these mechanisms, institutions become increasingly vulnerable to litigation. Theoretically, the application of vicarious liability in hospital settings lies at the intersection of the respondeat superior doctrine and the theory of apparent or ostensible agency, whereby a hospital may be held responsible when patients reasonably rely on the institution, and medical personnel are perceived as acting on its behalf.

Recent regulatory developments in Indonesia have expanded the scope for institutional accountability. These changes reflect a paradigm shift in legal thought from an individualistic to a structural approach in assessing accountability

within healthcare services. For example, Article 193 of Law No. 17 of 2023 on Health stipulates that hospitals may be held accountable for the provision of quality and safe healthcare services, including instances involving medical errors. This provision affirms that service providers bear legal obligations equal to those of the technical executors in ensuring patient safety. Nevertheless, judicial practice remains inconsistent. The disjunction between legal norms and judicial outcomes indicates that the judicial system has yet to fully adopt the principle of collective institutional accountability. Fakrulloh, Zudan, and Lubna (2023) note that despite the clarity of the norm, court rulings often assign primary liability to individual physicians, allowing hospitals to evade institutional responsibility. This inconsistency suggests that the formal authority of legal norms is not always matched by judicial awareness of the need for structural justice in healthcare litigation.

As a result, legal uncertainty arises, placing patients, healthcare personnel, and hospital institutions at disproportionate risk. This imbalance highlights deficiencies in the legal system's capacity to provide equitable protection for all parties involved in healthcare delivery. Public and private institutions face distinct challenges regarding employment status, oversight, and procedural infrastructure. These structural differences underscore the need for regulatory approaches that are both flexible and capable of enforcing uniform accountability standards. Legal ambiguity in determining institutional responsibility can diminish trust in the adjudication process and discourage victims from seeking remedies. Inconsistent frameworks for delineating supervisory duties contribute to fragmented enforcement, allowing similar cases to yield disparate outcomes. Addressing these disparities requires not only statutory refinement but also an administrative architecture that ensures enforceability through standardized compliance and oversight mechanisms (Montefusco, 2012).

Managerial practices that fail to reinforce clear employment relationships, direct supervision, and systematic medical error reporting contribute to varied levels of institutional exposure to litigation. This condition indicates that fragmented oversight mechanisms undermine institutional resilience against legal claims. Institutions employing affiliated or independently contracted medical personnel are less likely to be held liable under the vicarious liability doctrine than those with permanent staff and defined supervisory structures. Such disparity reflects how organizational arrangements significantly shape the distribution of legal accountability. Therefore, the application of vicarious liability to hospitals for medical errors entails critical implications for risk management, employment relations, and regulatory compliance (Budiman et al., 2023). This framework reveals that liability attribution is inherently influenced by how institutions design and maintain their governance infrastructure. Institutions that neglect risk control systems and clarity in employment structures are more likely to face legal consequences. In this regard, inadequate institutional design may result in failure to meet judicial standards of accountability in malpractice adjudication.

Barriers and Legal–Managerial Challenges in Hospital Institutional Liability for Healthcare Personnel Medical Errors

One primary impediment to implementing institutional liability for hospitals is the employment relationship between the institution and healthcare personnel, notably the distinction between full time employees and independent partners. Budiman et al. (2023) demonstrate that hospitals encounter difficulties when physicians operate as partners because such contractual relationships do not inherently require active institutional oversight comparable to standard employment structures. Ambiguity in employment status thus creates a gray zone in liability attribution, as institutional responsibility typically rests on the extent of operational control exercised over the personnel. In independent contracting schemes, hospitals often contend that they merely provide the infrastructure without directly governing the medical conduct of such partners, which in turn complicates patients' ability to direct legal claims toward the institution (Hardcastle, 2010). From the legal protection perspective for patients, this structural ambiguity may generate gaps that undermine access to justice and compensation for those harmed. When the boundary between service provider and technical actor is not clearly delineated, accountability mechanisms lose a robust normative foundation. Consequently, employment models within healthcare delivery systems must be designed with transparency and explicitly reflected in hospitals' internal policies. Legal uncertainty surrounding the status of partner physicians can erode the efficacy of the vicarious liability doctrine in medical disputes. Over time, dual employment relationships of this nature may result in fragmented liability that conflicts with the principle of legal certainty. It is

therefore imperative that hospitals develop employment relationship management guidelines that are binding both administratively and ethically to prevent liability voids in the delivery of healthcare services.

A further challenge concerns the proof of healthcare personnel's negligence and the hospital institution's linkage thereto (Romadhoni & Suryono, 2018). When causation evidence is not structured systematically, the burden of proof becomes onerous for the injured party. Fakrulloh & Lubna (2023) note that, although the normative framework affirms institutional liability, court decisions frequently require specific proof of employment relationship and adequate institutional control. The upshot is that normative recognition of institutional liability has not automatically led to consistent judicial application (Zulkiflee, 2023).

From a regulatory standpoint, although Law No. 44 of 2009 on Hospitals Article 46 prescribes that hospitals are legally liable for damages caused by their healthcare personnel, studies show that not all hospitals comprehend or implement adequate internal mechanisms to respond to this obligation. The provision mandates systematic implementation in the form of standard operating procedures, periodic oversight of medical practice, and structured risk management. However, in practice institutions are still found that execute their legal obligations only partially or within administrative formalities without integration into service quality control systems (Litan et al., 2021). This discrepancy produces a mismatch between regulatory demands and institutional readiness to manage medical error risk in an accountable manner. When legal regulation is unaccompanied by institutional capacity strengthening, the substantive content of legal liability remains at the declarative level. Without a concrete institutional framework, the responsibility established by regulation becomes difficult to apply in factual scenarios.

This condition shows that regulation requires supporting operational instruments capable of being implemented and periodically monitored for effectiveness. Therefore, a comprehensive evaluation of hospital internal systems is necessary to assess the extent to which institutions are prepared to translate legal norms into organizational policy that can be operationalised. In addition, external oversight indicators need to be developed to examine the consistency of legal liability application. Failure of hospitals to build internal governance aligned with regulatory mandates will result in inadequate legal protection for patients. Such institutional lag potentially creates dual harm, for victims and for the credibility of the healthcare institution itself (Fakrulloh & Lubna, 2023).

Managerial limitations are also evident in the domains of risk management and medical incident reporting. Budiman et al. (2023) found that medical error reporting systems in Indonesia remain unstructured at the national level, rendering both public and private hospitals vulnerable to substantial legal claims without robust mitigation mechanisms. Furthermore, the disparities between public and private hospitals in terms of human resources, surveillance systems, and internal accountability constitute significant differentiating factors in managing institutional responsibility (Andrianto et al., 2021). For example, while private hospitals often benefit from greater operational flexibility, they may lack the comprehensive internal audit systems more commonly implemented in government hospitals.

From a legal standpoint, regulatory changes present institutional adaptation challenges. Every modification to legal norms necessitates adjustments to internal structures, procedures, and policies, none of which can be accomplished instantaneously. With the enactment of Law Number 17 of 2023 on Health, hospitals are now subject to an expanded scope of responsibility encompassing service provision, supervisory functions, and accountability mechanisms. This expansion requires a reconstruction of governance frameworks aligned with the principles of positive law and patient safety standards. However, the implementation of such regulatory transformations in hospital management practice demands significant time and resource investment. Each policy adaptation encompasses technical, administrative, and cultural dimensions that must be gradually harmonized through systematic capacity building, stakeholder socialization, and periodic evaluation (Wijaya et al., 2023).

Organizational culture also poses barriers in hospitals, particularly concerning error reporting, transparency, and internal accountability mechanisms. When an institution's culture does not support openness and critical evaluation, the likelihood of undocumented medical errors increases significantly. Hospitals that have not cultivated a culture of patient safety and risk control will find it more difficult to demonstrate that adequate supervision and preventative measures have been undertaken. In such circumstances, legal claims for institutional responsibility are more susceptible to being dismissed due to the absence of verifiable structural oversight (Nabila et al., 2023).

Deficiencies in documentation and internal procedures are frequently cited in medical litigation involving hospitals. Without documented risk management protocols, clinical monitoring systems, medical committee proceedings, and structured training programs, hospital institutions are placed in a significantly vulnerable position in the event of legal action. These limitations contribute to legal uncertainty for all stakeholders: patients, healthcare professionals, and the hospital itself (Park et al., 2016). Patients may experience compromised rights, healthcare workers may feel inadequately protected, and hospital institutions face elevated exposure to legal risk in the absence of effective mitigation strategies.

For hospital institutions, the managerial implications necessitate the reinforcement of risk control units, the implementation of regular training programs for healthcare personnel and administrative staff, the establishment of a transparent and standardized incident reporting system, the integration of professional oversight mechanisms, and enhanced coordination between legal and managerial departments. Institutions that neglect these critical elements will encounter substantial difficulties in demonstrating that they have fulfilled the standards of institutional oversight required for accountability (La Russa et al., 2021).

A recurring challenge involves striking an equitable balance between patient protection and the rights of healthcare professionals. When institutional liability is broadly assigned without clear regulations governing the employment status of medical personnel and the mechanisms of compensation, tension may arise between hospital institutions and healthcare professionals. Such discord can adversely impact the culture of service delivery and compromise patient safety standards (Njoto, 2023).

Thus, although the concept of institutional liability (vicarious liability) is underpinned by a robust theoretical and regulatory foundation, in practical terms, both public and private hospitals continue to face significant legal and managerial obstacles that must be addressed for the doctrine to be effectively operationalized. The disconnect between normative legal frameworks and institutional preparedness creates a systemic gap that undermines the overall accountability of healthcare services. This condition underscores the necessity of aligning legal structures, technical capacities, and organizational cultures to ensure the successful implementation of institutional liability principles.

CONCLUSION

This study establishes that both public and private hospital institutions are legally positioned to be held accountable for medical errors committed by healthcare personnel under their supervision, pursuant to the doctrine of vicarious liability and national legislation such as Article 46 of Law No. 44/2009 and Article 1367 of the Indonesian Civil Code. Practical implementation demands that hospitals maintain clear employment relationships and robust supervisory mechanisms over their medical personnel to ensure effective accountability. Nonetheless, a multitude of legal and managerial barriers persist, generating uncertainty for patients, healthcare providers, and institutions alike.

From both a scientific and practical standpoint, hospitals must enhance their risk management frameworks, oversight systems, procedural documentation, and error-reporting mechanisms in order to credibly bear institutional liability. Legally, existing regulations require greater operational specification to improve legal certainty for all stakeholders involved.

It is therefore recommended that hospitals revise or establish internal policies that clarify employment relationships and supervisory responsibilities over medical personnel, while simultaneously strengthening the national regulatory framework to ensure the definition of institutional liability in cases of medical error is specific, accessible, and actionable. Furthermore, the development of comprehensive accountability systems, patient safety training programs, and routine institutional audits constitutes a critical path toward transforming institutional liability from a theoretical construct into a practical legal standard.

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