Presumed Consent and the Doctrine of Necessity as the Basis for Emergency Medical Treatment Without Informed Consent

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ABSTRACT

Informed consent has been recognised as a key prerequisite for the validity of medical actions, but emergencies often force doctors to act without explicit consent. This article analyses the application of the principle of presumed consent and the doctrine of necessity as the legal basis for medical actions without informed consent in emergency situations, using a normative legal approach based on qualitative literature studies. Primary and secondary legal materials in the form of legislation, professional codes of ethics, health law literature, and bioethics writings were analysed through thematic synthesis. The results of the study show that the principle of presumed consent functions as a legal fiction that replaces actual consent when the patient is unable to make decisions and delaying action would pose a serious threat to life or health. Meanwhile, the doctrine of necessity provides justification for actions that violate the integrity of the patient's body if they are intended to prevent greater harm by fulfilling the condition of proportionality. In the Indonesian legal system, this structure is reinforced by Article 1320 of the Civil Code, Articles 48 and 50 of the Criminal Code, Article 45 paragraph (2) of the Medical Practice Law, and ethical obligations in the Indonesian Medical Code of Ethics, which place patient safety as the primary consideration. However, this study emphasises that the principle of presumed consent and the doctrine of necessity must be treated as strictly limited exceptions through the criteria of genuine emergency, patient incapacity, proportionality of action, and adequate documentation. This article recommends the formulation of detailed operational guidelines and the strengthening of legal ethics education for medical personnel, so that emergency actions without informed consent are legally protected without eroding the autonomy and dignity of patients as subjects of rights.

INTRODUCTION

The development of modern health law places informed consent as the main pillar of the relationship between medical personnel and patients. The shift from a paternalistic pattern towards recognition of individual autonomy makes medical actions without consent an exception that must be strictly limited and normatively justified. Within the framework of biomedical ethics, respect for autonomy, beneficence, non-maleficence, and justice are established as the foundations that guide how clinical decisions are made, including when doctors encounter patients who are unable to give conscious consent (Beauchamp & Childress, 2019). In various jurisdictions, the obligation to obtain informed consent has evolved not only as an ethical standard but also as a legal obligation that can be tested through civil and disciplinary accountability mechanisms. Amidst these developments, emergency situations give rise to tensions between the obligation to protect life and the obligation to respect the right to self-determination, thus requiring systematic review from a health law perspective.

In clinical practice, emergency units often encounter patients who arrive unconscious, with severe cognitive impairment, or in imminent danger of death, requiring immediate intervention (Jauhani et al., 2022). In such conditions, standard procedures for providing information and obtaining explicit consent are often impossible to carry out without causing dangerous delays. The clinical ethics literature shows that the need for immediate action presents healthcare professionals with a dilemma between waiting for proper consent and preventing avoidable harm (Grady, 2015). On the one hand, doing nothing can be seen as a neglect of the duty to

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protect the patient. On the other hand, acting without clear consent could potentially be qualified as a violation of patient rights and open the door to lawsuits. It is this configuration of tensions that underlies the emergence of the principle of assumed consent and the doctrine of necessity in health law theory and practice.

The assumption of consent is based on the assumption that rational individuals will generally agree to actions necessary to save lives or prevent serious harm if they are conscious and capable of making decisions. Thus, when patients are unable to give consent, the law allows doctors to act on the assumption that patients would hypothetically consent to the intervention. In addition, the doctrine of necessity is used to justify actions that deviate from normal procedures when such measures are necessary to prevent serious harm and there are no other less intrusive alternatives. In both common law traditions and legal systems that adopt similar principles, these two constructs are used to define the limits to which healthcare professionals can act without explicit consent, while still protecting the integrity of the patient's body.

Within the framework of health law, regulations concerning medical actions without informed consent in emergency situations are strategically important because they touch on the intersection between legal certainty for medical personnel and the protection of patient rights. If the limits on the use of the principle of presumed consent and the doctrine of necessity are not clearly defined, there is a risk of excessive criminalisation of life-saving actions, or conversely, a risk of overly broad justification for invasive interventions without proper consent. In countries with healthcare systems that are seeking to strengthen accountability, clarity on emergency criteria, standards of proof, and documentation mechanisms is crucial to ensure that the application of these two principles does not become a general excuse for actions that disregard patient autonomy. On that basis, scientific studies on the construction and application of the principle of presumed consent and the doctrine of necessity as the legal basis for medical actions without informed consent should be developed systematically in the field of health law.

The first issue relates to the definition of emergency situations that justify bypassing the informed consent procedure. Legal and bioethical literature shows variations in interpretation of what constitutes an immediate threat to life or risk of serious harm, resulting in considerable discretion for medical personnel (Manson & O'Neill, 2007). Without more operational criteria, doctors have the potential to interpret almost any clinical uncertainty as an emergency that gives them the authority to act without consent, while courts or disciplinary bodies may assess the opposite after the event has passed. It is this difference in perspective between snap judgements in the field and retrospective assessments in legal forums that often creates vulnerability for medical personnel and the potential for violations of patient rights.

The second issue concerns the structure of evidence and accountability when patients or families sue for medical actions taken without informed consent on the grounds of an emergency. Reliable documentation is a very important foundation in this case, given that in various areas of healthcare, data accuracy and traceability are the main foundations for ensuring accountability and performance evaluation (Malaihollo, 2022). In many cases, claims that the actions were performed based on the principle of presumed consent or the doctrine of necessity must be tested through medical records, healthcare worker testimony, and applicable practice standards (Pope, 2014). Crucial questions arise regarding who bears the burden of proof for the existence of an emergency, and to what extent the court is willing to accept subjective clinical judgements as a basis for justification. Uncertainty regarding the division of the burden of proof and assessment standards can place patients in a difficult position when trying to test the reasonableness of actions, while also causing excessive concern among medical personnel regarding the risk of litigation.

The third issue relates to the position of the doctrine of necessity and the principle of presumed consent in the landscape of patient autonomy protection in the era of modern healthcare. Several studies highlight that although written rules place informed consent as a primary obligation, practices in the field still show a tendency to prioritise professional judgement, especially in situations of time pressure or prognostic uncertainty (Moskop, 1999; Dickert & Sugarman, 2017). This raises the question of whether the assumed principle of consent and the doctrine of necessity are truly treated as narrow exceptions, or whether they have shifted to become a normal pattern that is rarely challenged. If the latter tendency is the case, then there is a risk that legal instruments originally intended to protect patients in emergencies will become loopholes that weaken the principles of autonomy and accountability in healthcare.

Changes in the healthcare landscape, including increased access to emergency services and the use of clinical decision support technology, have made the

issue of medical treatment without informed consent in emergencies increasingly frequent and complex (Khayru & Issalillah, 2022). Technological transformations in healthcare bring new opportunities, challenges, and implementation strategies, including in redefining the clinical and ethical relationship between doctors and patients (Sarif & Issalillah, 2022). On the other hand, equal access to healthcare services through innovations such as telemedicine also poses its own challenges in terms of ensuring the ethical and legal quality of clinical processes carried out remotely (Khayru & Issalillah, 2022). A society that is increasingly educated about patient rights tends to demand greater transparency, while also asking critical questions about the legitimacy of any invasive interventions they undergo. Amidst these dynamics, the principle of presumed consent and the doctrine of necessity cannot be left as abstract doctrines without careful re-examination, as their application involves a balance between saving lives and respecting bodily integrity. Studies examining the normative foundations of these two principles, their relationship with legal provisions, and their implications for emergency clinical practice are becoming increasingly relevant to the development of responsive health law.

In addition, developments in jurisprudence and professional ethics indicate an increased sensitivity to issues of autonomy violations, including in emergency situations. Various medical disputes involving claims of actions without consent provide an illustration of how courts and ethical institutions interpret the limits of emergency and necessity. Without a scientific mapping of the principles, arguments, and criteria used in such assessments, health law risks developing in a fragmented manner. A systematic review of the application of the assumed principle of consent and the doctrine of necessity can help to develop a more coherent understanding of the relationship between written norms, clinical practice, and the decisions of norm-enforcing institutions, so that future policy development can be based on a more solid analytical foundation.

This study aims to analyse, from a normative legal perspective, how the principles of presumed consent and necessity are constructed as the legal basis for medical actions without informed consent in emergency situations, as well as to examine their impact on the protection of patient autonomy and the accountability of medical personnel. Theoretically, this study is expected to enrich health law studies on the limits of medical intervention without explicit consent. Practically, the results of the analysis are expected to provide an argumentative basis for the formulation of clinical guidelines and decision-making in the field, so that health workers have clearer legal guidelines when facing emergencies that require immediate action.

RESEARCH METHOD

This study uses a qualitative approach with a literature study design based on normative legal analysis. Primary and secondary legal materials in the form of legislation, court decisions, professional ethical guidelines, and academic writings in the field of health law and bioethics are analysed to formulate the construction of the assumed principle of consent and the doctrine of necessity in emergency medical treatment. Qualitative literature study was chosen because it allows for argumentative examination of legal concepts and ethical principles scattered across various sources, which are then reorganised into a coherent body of thought (Creswell & Poth, 2018). Reference materials were obtained through searches of electronic databases such as PubMed, Scopus, HeinOnline, and catalogues of leading academic book publishers. The publication range was focused on the last two decades to ensure relevance to current debates, while still including classic works that are still used as primary references if they have recent editions.

The literature search strategy was carried out systematically in stages of identification, screening, and final selection. In the identification stage, all articles and books that appeared from the combination of keywords were stored in a reference management tool to avoid duplication. The screening stage involved reading the titles and abstracts to assess their direct relevance to the issues of informed consent, emergency measures, and the legal basis for medical actions without consent. The inclusion criteria included: publication in reputable scientific journals or academic publishers; focus on health law, bioethics, or legal research methodology; and use of an explicit analytical framework. Exclusion criteria included: popular publications without peer review, policy reports without normative analysis, and writings that only provided practical descriptions without clear theoretical arguments (Snyder, 2019). This selection aimed to ensure that the analysis was based on sources of proven scientific quality.

After the final selection, the selected articles and book chapters were analysed using thematic synthesis. This process began with repeated readings to identify initial themes related to the definition of emergencies, the assumed structure of consent, the limits of the doctrine of necessity, and patterns of

liability in medical disputes. These themes were then coded and grouped into broader analytical categories, which were subsequently used to construct arguments in the results and discussion sections (Braun & Clarke, 2006). To ensure traceability, each conclusion drawn was always linked back to explicit quotations from relevant sources. The validity of the analysis is maintained through triangulation between types of sources, namely by comparing findings from legal writings, bioethics, and professional guidelines to avoid reliance on a single tradition of thought (Bowen, 2009). Thus, the method used is expected to produce a consistent reading of the assumed position of the principle of consent and the doctrine of necessity in health law.

RESULT AND DISCUSSION

The Construction of Implied Consent and the Doctrine of Necessity in Emergency Situations

The principle of presumed consent affirms the balance between emergency medical needs and the protection of patient rights. Understanding the principle of presumed consent stems from the idea that patient consent is an instrument for protecting bodily integrity as well as a mechanism for legitimising medical intervention. In health law literature, consent is seen as a meeting point between personal sovereignty and professional authority, so that any deviation from the requirements of informed consent must have a strong and measurable justification (Berg et al., 2001). There are three basic criteria required for informed consent: the patient must be competent to understand and evaluate the information provided; be sufficiently informed, at a minimum, about the diagnosis, procedure, risks, benefits, and alternatives; and not be coerced (Cocanour, 2017). In emergency situations, the moral basis often cited is the assumption that almost every rational person would agree to accept the necessary measures to prevent death or serious harm (Babakhanlou et al., 2020). From a legal perspective, the principle of presumed consent functions as a legal fiction that replaces actual consent, provided that objective circumstances indicate that delaying action to seek consent would place the patient at serious risk. Legally, simple consent protects patients from assault and abuse in the form of unwanted medical intervention and protects patients' rights to autonomy, self-determination, and non-interference (Hall et al., 2012). Thus, the construction of this principle serves as a bridge that connects the necessity to act immediately with maintaining formal respect for the concept of autonomy. With this construction, health law seeks to maintain the legitimacy of intervention while guaranteeing patient autonomy.

The patient's decision-making capacity is an important factor in determining recognition in the application of the principle of presumed consent. The aspect of decision-making capacity has a major influence on the application of the principle of presumed consent. Patients who come to the emergency department are often in a state of impaired consciousness, disorientation, or severe pain that interferes with their ability to understand information and weigh treatment options (Nelson et al., 2014). Competency studies confirm that capacity is not a permanent binary attribute, but rather a condition that can change according to the clinical situation and the type of decision faced (Appelbaum, 2007). This means that a patient must demonstrate greater ability to process and analyse complex information related to high-risk decisions than when making decisions for low-risk situations (Bester et al., 2016). Within this framework, when decision-making capacity is inadequate and no legal representative is available, the principle of presumed consent is commonly invoked to fill the void. However, its application requires that the actions taken are truly in the patient's best interests within a narrow time horizon, so that clinicians are not free to expand the type of intervention beyond what is necessary to stabilise the situation. Affirming this condition is important so that the principle of presumed consent does not become a general licence to act without limits. Strict restrictions ensure that this principle remains an emergency mechanism, not a legitimisation of uncontrolled actions.

A normative analysis of the principle of presumed consent emphasises the importance of balancing the speed of medical action with the fairness of the conditions of consent. From a normative structural perspective, the principle of presumed consent is closely related to discussions on fair transaction models in consent, where attention is focused not only on the form of consent, but also on the fairness of the surrounding conditions (Miller & Wertheimer, 2011). Informed consent encompasses two obligations, namely disclosing information to the patient and their representative, and obtaining legal permission before performing any intervention (Katz et al., 2016). In an emergency, it is impossible to fully comply with all components of informed consent, such as explaining alternative therapies and long-term risks. However, it is questionable whether omitting some elements of information for the sake of speed is still within the bounds of a fair transaction

(Wahjuni & Sari, 2021). The fair transaction approach directs analysis towards the question of how much reduction in information is still acceptable when life and vital functions are threatened. This helps to establish parameters that the principle of consent is assumed to be related to modifications to the ideal standard of communication due to time constraints, rather than the total removal of the patient's right to a proper explanation. Within the fair transaction framework, this principle is understood as a situationally forced adjustment to communication, not a removal of the patient's rights.

Exceptions to informed consent reinforce both ethical and operational boundaries in medical practice. In the emergency literature, exceptions to informed consent are often discussed through the "emergency exception to informed consent" scheme, which is formulated as a combination of urgent circumstances, patient incapacity, and the unavailability of a representative who can be contacted within a reasonable time (Dickert & Kass, 2009). These criteria provide a more detailed operational framework for the principle of assumed consent, as they require doctors to document that all three elements are truly fulfilled. In addition, some guidelines add the requirement that the expected benefits of the action must be significant compared to the possible risks, so that the principle of presumed consent cannot be used for procedures whose clinical benefits are speculative (Jauhani et al., 2022). In this way, the emergency exception to informed consent is positioned as an additional protective mechanism that prioritises the interests of the patient, rather than as a benefit of flexibility for medical personnel. Within this framework, the principle of presumed consent continues to function as a protection for patients, rather than as a legitimisation of uncontrolled actions.

The doctrine of necessity in criminal law provides limited legitimacy for medical actions that deviate from standard procedures. The doctrine of necessity has a broader position in criminal law theory, but is often mobilised to justify medical actions that deviate from normal procedures, including the absence of consent. In dogmatic studies, necessity is understood as a situation that compels a person to commit a minor violation of a legal interest in order to prevent a greater harm to another interest that has a higher or at least comparable value (Simester et al., 2016). Applied to healthcare, invasive procedures on the body without consent can be seen as a violation of the right to bodily integrity, which is justified if the primary objective is to protect the patient's life or health from an imminent threat. This doctrine places proportionality as a key requirement: the level of invasion and risk of the procedure must be commensurate with the severity of the danger faced. Thus, the construction of necessity requires a layered assessment, not merely the existence of an emergency. With an emphasis on proportionality, the doctrine of necessity ensures that emergency interventions remain within the bounds of legal protection.

In health law practice, the doctrine of necessity is positioned carefully so as not to reduce the protection of patient rights. In the field of health law, authors such as Herring emphasise that necessity must be understood narrowly, because overly broad justifications will erode the protection of autonomy and bodily integrity (Herring, 2018). He points out that courts tend to be cautious when doctors claim necessity to perform procedures that have long-term implications, such as permanent sterilisation, without clear consent. This approach shows that although emergencies may justify immediate action to preserve life, the doctrine of necessity does not automatically justify every intervention that has permanent consequences for the patient's body. The distinction between immediate stabilisation measures and elective or long-term procedures is key in determining the extent to which necessity can be claimed as a justification. This distinction between emergency interventions and permanent procedures ensures that necessity is not used as an unlimited justification.

The link between the principle of presumed consent and the doctrine of necessity highlights the limits of a doctor's authority when faced with unexpected conditions in the operating theatre. The link between the principle of presumed consent and the doctrine of necessity is evident in discussions about the limits of a doctor's authority to extend procedures in the operating theatre when encountering unforeseen conditions. Jackson explains that courts in some jurisdictions are willing to accept the extension of actions if doctors can demonstrate that delaying to obtain explicit consent would place the patient at significant risk, and that the additional actions are rationally necessary to prevent that harm (Jackson, 2019). In such situations, the patient's initial consent to a specific procedure is often considered to contain implicit room for additional actions that are closely related and necessary for the main success. The combination of the principle of assumed consent and the doctrine of necessity serves to fill the gap when decisions must be made in real time, while re-communication with

the patient is not possible. The collaboration of the two ensures that emergency medical decisions remain based on legal legitimacy and patient protection.

The modern approach to health law emphasises that the principle of presumed consent must be aligned with the individual values of the patient. In addition to normative constructs in the literature, the modern approach to health law seeks to link the principle of presumed consent with the principle of respect for the values and preferences of the patient. A doctor needs to respect the rights, wishes, expectations, and decisions of patients regarding their bodies and care (Desai & Kapadia, 2022). McLean suggests that assumptions about patients' rational choices should not be based solely on the doctor's views, but rather on evidence of the patient's previously known values, for example through prior verbal statements, advance directives, or discussions with close family members (McLean, 2009). Thus, the principle of presumed consent is not understood as generic consent from "people in general", but rather as hypothetical consent from specific patients with unique value backgrounds. This approach refines the construction of this principle so that it is more in line with the principle of personal autonomy, although there is still room for debate regarding the extent to which doctors are obliged to explore these preferences in urgent situations that require speed. Thus, its application maintains the principle of personal autonomy even under the pressure of an emergency situation.

The dimension of medical research in emergency situations shows how the principle of presumed consent is governed by the principle of collective prudence. The discussion regarding the need for and assumption of consent also intersects with the dimension of medical research in emergency situations (Jauhani et al., 2022). Biros highlights that clinical research in emergency units is often conducted on patients who are unable to give consent, so regulators have developed an "exception from informed consent" scheme that requires additional safeguards such as community consultation and delayed information provision (Biros, 2007). Although the focus is on research, this framework shows that the application of necessity and assumed consent in emergency situations is guided by the principle of collective caution, not merely the individual considerations of researchers or doctors. For routine care, the lesson to be learned is that claims of necessity and presumed consent should be supported by professional standards and internal oversight mechanisms, so that difficult clinical decisions have a stronger basis than mere personal intuition. The application of this principle in healthcare must always be grounded in professional standards and oversight mechanisms.

The interpretation of the principles of presumed consent and necessity into internal hospital guidelines requires procedural clarity and accountability. The normative construction of the principles of presumed consent and necessity will influence how hospitals design internal guidelines and risk management. Greenhalgh and colleagues point out that the implementation of a principle in healthcare is highly dependent on the extent to which it is translated into clear operational procedures, training for medical personnel, and adequate documentation system support (Greenhalgh et al., 2017). In relation to emergency actions without informed consent, this means that the decision to rely on presumed consent or necessity needs to be supported by rapid assessment procedures, standard recording formats, and post-event review mechanisms. In this way, doctrinal construction does not stop at the abstract level, but guides practices that can be audited and reviewed for the purposes of learning and dispute prevention. With assessment and post-event review mechanisms, this principle is not only normative but also operational and preventive

The combination of the principle of presumed consent and the doctrine of necessity reflects the efforts of health law to balance the values of life and autonomy. At a theoretical level, the combination of the principle of presumed consent and the doctrine of necessity can be seen as an attempt by health law to mediate two equally strong values, namely the protection of life and respect for autonomy. On the one hand, the law would be considered cruel if it criminalised doctors who delayed life-saving measures solely to comply with complete consent procedures. On the other hand, the law loses its function as a protector of human dignity if it accepts every claim of necessity or hypothetical consent without critical examination. Constructs that have emerged in the literature and professional guidelines attempt to position these two principles as limited exceptions bound by conditions of urgency, proportionality, the best interests of the patient, and, as far as possible, consistency with the patient's known values. Under strict conditions, these two principles are positioned as limited exceptions that still preserve the dignity of the patient.

The practical tension in the application of the principle of presumed consent and the doctrine of necessity highlights the complexity of medical responsibility. Ultimately, understanding the principle of presumed consent and the doctrine of necessity

requires sensitivity to the practical tensions faced by clinicians in the field. Decisions to act or refrain from acting rarely occur in a vacuum, but rather under time pressure, prognostic uncertainty, and often concern about future litigation. In such situations, a clear normative construct can provide guidance, although it still leaves room for professional judgement that cannot be fully reduced to a formula. The discussion in this section shows that these two principles are not designed to eliminate informed consent, but rather to provide limited channels for life-saving actions in truly urgent circumstances. The next section will examine how the application of these principles affects the protection of patient autonomy and the accountability of medical personnel within the framework of health law. Thus, these principles function as an emergency mechanism that maintains autonomy and legal accountability.

The Impact of Applying the Principle of Presumed Consent and the Doctrine of Necessity on Patient Autonomy and Medical Accountability

The application of the principle of presumed consent in emergency situations creates a dilemma between respect for autonomy and clinical needs. The application of the principle of presumed consent in emergency medical procedures has direct consequences for the patient's autonomy. Therefore, in addressing this dilemma, it is important to understand the legal basis that protects doctors when they have to make life-saving decisions outside of explicit consent procedures, as this is also part of the obligation to act in the best interests of the patient (Juliarto et al., 2023). On the one hand, this principle seeks to maintain formal respect for the patient's choice by assuming that a rational person would consent to life-saving measures (Rady et al., 2008). On the other hand, its practical application is highly dependent on the doctor's interpretation of what is considered "best" for the patient. Health law literature warns that when consent is replaced by presumed consent, there is a risk of a shift back towards paternalistic patterns that prioritise professional judgement over individual preferences, especially when information about the patient's values and beliefs is very limited (Brazier & Cave, 2016). Therefore, although emergencies may override informed consent procedures, the principle of autonomy still requires doctors to make use of every available indication of the patient's wishes, including family statements, previous medical records, or documented verbal statements. In this way, the principle of presumed consent is practised as hypothetical consent oriented towards a specific patient, rather than an abstraction about the "average patient". By orienting itself towards the will of a specific patient, this principle maintains its ethical legitimacy while avoiding paternalism.

The Indonesian legal framework places the principle of presumed consent in close relation to the principles of contract and criminal law. Within the Indonesian legal framework, the influence of this principle on patient autonomy is influenced by the general character of contract law and criminal provisions. Article 1320 of the Civil Code requires the agreement of the parties as a valid element of a contract, including therapeutic agreements between doctors and patients. Under normal circumstances, this supports the idea that any invasive medical procedure requires consent that is freely given and based on adequate understanding. However, when an emergency triggers the application of the principle of presumed consent, the requirement of actual agreement is replaced by a construction of the patient's hypothetical will. In the criminal sphere, Articles 48 and 50 of the Criminal Code open up opportunities for justifiable and excusable reasons for actions taken to deal with emergencies or to implement the provisions of the law (Wicaksana & Budhisulistyawati, 2019). By linking these provisions to the presumed consent mechanism, it can be argued that emergency medical treatment without explicit consent is not considered a violation of autonomy in the legal sense, as long as it is genuinely intended to prevent serious harm and is within the bounds of reasonable necessity (Brazier & Cave, 2016). This argument affirms the legitimacy of emergency medical treatment as long as it meets the criteria of urgency and proportionality.

The Medical Practice Act demonstrates how positive law is consistent with the principle of presumed consent. The same influence is evident in the specific provisions of the Medical Practice Act. Section 45(2) provides an exception that medical consent is not required in emergency situations to save the patient's life. This norm emphasises that lawmakers accept the applicability of the principle of presumed consent and the doctrine of necessity as part of the health law structure (Wahjuni & Sari, 2021). However, the provision is very concise and does not specify the criteria for emergencies, the types of actions permitted, or the documentation procedures, so its operational elaboration depends on professional standards and the interpretation of law enforcement agencies (Jauhani et al., 2022). The experience of other legal systems shows that uncertainty regarding the parameters of material risk and disclosure obligations can lead to major changes through court decisions that shift the emphasis from a professional perspective to a

patient perspective (Heywood & Miola, 2017). A similar situation could potentially arise when Indonesian courts are faced with disputes related to emergency actions without consent and are forced to fill in the gaps in the law. The potential for disputes emphasises the need for clarity on parameters so that the application of norms remains consistent and measurable.

Medical professional ethics emphasise that the obligation to help emergency patients has a strong normative basis. From a professional ethical point of view, the Indonesian Medical Code of Ethics, which emphasises the obligation of doctors to help patients in emergency situations, even without written consent, provides an additional normative basis for the application of the principle of presumed consent and the doctrine of necessity. The principle of salus aegroti suprema lex places patient safety as the primary consideration in clinical decision-making. However, legal ethics literature emphasises that an orientation towards safety does not negate the importance of autonomy, but rather requires a careful balance between protection from harm and respect for personal choice (Herring & Wall, 2015). Thus, the ethical obligation to help in an emergency must be read alongside the obligation to promptly restore the informed consent process once the patient's condition allows, for example through post-procedure explanations, ongoing monitoring, and opportunities for patients or families to ask questions and raise objections. This balance ensures that safety is maintained without neglecting the patient's right to autonomy.

Accountability for emergency medical treatment without consent highlights the legal responsibility of doctors. Another important implication concerns the accountability of doctors when emergency treatment without consent is challenged in civil court. Civil law regarding compensation for damages resulting from unlawful acts or breach of contract requires the plaintiff to demonstrate a breach of legal duty, damages, and a causal link between the two. In disputes concerning consent, the central question usually revolves around whether the patient received adequate information and whether the action exceeded the scope of consent. Miola points out that the doctrines of materiality of risk and patient preference have shifted the assessment from a purely professional standard to one based on what a reasonable patient would want to know in similar circumstances (Miola, 2007). In emergency actions without consent, this shift can be reflected in the judge's examination of a hypothetical question: would a reasonable patient refuse life-saving treatment if given the opportunity to consider it? The answer to this question influences the assessment of whether the lawsuit should be granted or dismissed. The judge's consideration of the reasonable patient's attitude is the main determinant of the direction of the decision in such disputes.

The doctrine of necessity in criminal law has direct consequences for the limits of medical personnel accountability. The application of the doctrine of necessity as a justification in criminal law also has consequences for accountability. It is important to remember that patient conditions vary, and in different contexts such as pregnancy, anxiety can arise from uncertainty about the medical care and procedures to be undergone, where clear information and communication are part of the much-needed support (Issalillah & Khayru, 2022). Samanta and Samanta highlight that the use of overly broad justifications or excuses can reduce the function of the law to protect patients from excessive practices, while overly narrow application can make medical personnel reluctant to take bold action in critical situations for fear of prosecution (Samanta & Samanta, 2015). In this context, the interpretation of Articles 48 and 50 of the Criminal Code must consider the balance between protecting potential victims and supporting doctors who act reasonably to save lives. Claims of reasonable necessity require an assessment of proportionality: whether the action taken was the only realistic option to prevent greater harm, and whether the level of intervention was commensurate with the threat faced (Wahjuni & Sari, 2021). Proportionality is important so that justifications maintain a balance between patient protection and the legitimacy of actions.

Cross-system legal comparisons reveal caution in applying the principles of presumed consent and necessity. Comparative legal literature shows that the doctrines of presumed consent and necessity are treated with caution in both the common law tradition and other systems. Devereux explains that in Australia, the justification of emergency treatment without consent is linked to the positive obligation of doctors to provide timely care, provided that the components of necessity and patient incapacity are genuinely met (Devereux, 2018). Courts tend to examine whether doctors have acted in accordance with customary professional standards, while also considering whether reasonable efforts were made to obtain consent from the patient or their legal representative when circumstances permitted. A similar approach could inspire the development of judicial practice in Indonesia, where emergency justification is not seen as a get-out-of-jail-free card, but rather as an argument that must be tested against clinical evidence and ethical standards. Testing against clinical

evidence and ethical standards is crucial to ensure that emergency justification remains legally controlled.

Patient consent is understood as a dialogical process that emphasises the quality of communication, not merely a formality. In the debate on autonomy, Herring and Wall assert that the meaning of consent goes beyond simply signing a form; consent relates to the quality of interaction, understanding, and respect for the patient–doctor relationship as a dialogical process (Herring & Wall, 2015). When this view is applied to emergency situations, the evaluation of accountability should not stop at the question of whether consent forms are available, but rather whether the doctor has done their best, given the limitations of the situation, to communicate with the patient or their representative. In many cases, a few seconds or minutes to provide a brief but meaningful explanation may still be available, and a total disregard for communication is difficult to justify on the grounds of necessity. This type of assessment ties the principle of presumed consent to standards of communication prudence, not just to internal clinical judgements. Prudent communication standards ensure that the principle of presumed consent remains oriented towards patient dignity.

Court rulings in various jurisdictions show a shift in standards towards the patient's perspective. Court rulings in other jurisdictions indicate that strengthening the patient orientation tends to raise the standard of pre-procedure information disclosure. Heywood and Miola analysed the major changes following a landmark ruling that placed the obligation on doctors to disclose material risks from the patient's perspective, rather than simply what the profession considered material (Heywood & Miola, 2017). Although the ruling dealt with consent in elective circumstances, its implications extend to the assessment of emergency procedures as courts began to demand a more precise explanation of the reasons for waiving consent. For Indonesian health law, this pattern teaches that strengthening patient rights in general regulations will have an impact on the court's attitude towards all forms of exceptions, including the principle of assumed consent and the doctrine of necessity. This confirms that strengthening patient rights will affect how exceptions are assessed legally.

Internal hospital guidelines are an important instrument for maintaining a balance between medical needs and patient autonomy. In the realm of internal hospital policy, medical law literature emphasises that clarity of guidelines regarding consent, emergencies, and record-keeping has a direct impact on the level of disputes and the psychological burden on medical personnel (Brazier & Cave, 2016; Devereux, 2018). Although the detailed regulation of guidelines is in the hands of management, their normative direction is determined by how the law and ethics interpret the relationship between autonomy and necessity. If the principle of presumed consent and the doctrine of necessity are formulated as narrow exceptions that must be documented with clear clinical reasons, doctors will be encouraged to apply high standards of reflection before overriding informed consent. Conversely, if both principles are loosely understood as general justifications for any action "in the best interests of the patient," accountability tends to weaken and public trust in the healthcare system can erode. Clear rules ensure that accountability is maintained while strengthening public confidence in healthcare services.

This description highlights the complexity of applying the principle of presumed consent and the doctrine of necessity in healthcare law practice. From the above description, it appears that the application of the principles of presumed consent and necessity has an ambivalent effect on patient autonomy and medical personnel accountability. Both principles provide a legal umbrella for life-saving actions in less than ideal circumstances, but at the same time open up the potential for abuse if not bound by strict criteria. The combination of written legal sources in Indonesia (Civil Code, Criminal Code, Medical Practice Law), professional ethical provisions (KODEKI), and the globally developed doctrines of presumed consent and necessity can be combined into a framework that requires doctors to prove the existence of a real emergency, the patient's limited capacity, and the proportionality of the action. Within this framework, the principle of presumed consent and the doctrine of necessity are positioned as protective shields in extreme situations, not as broad justifications for paternalistic practices. This framework emphasises the function of both as limited protections, not as legitimisation for arbitrary actions.

The management of discretionary space in emergency situations is a determining factor for the continuity of patient autonomy. Ultimately, the most important impact on patient autonomy lies in how the legal system and the medical profession manage the discretionary space inherent in emergency situations. If this space is filled with high standards of care, honest documentation, and a commitment to promptly reinstate the informed consent process once the acute threat has passed, then the principle of presumed consent and the doctrine of necessity can

function as a lifesaving mechanism without eroding patient dignity. Conversely, if claims of emergency and necessity are left unchecked, autonomy is easily reduced to a slogan that has no impact on actual practice. The challenge is to maintain a balance where the law is flexible enough to accommodate rapid clinical decisions, yet remains firm in protecting the patient's right not to be treated merely as an object of medical intervention. The balance between legal flexibility and the protection of patient rights is a key requirement for the legitimacy of medical practice.

CONCLUSION

This study shows that the principle of presumed consent and the doctrine of necessity form an important basis for justifying medical actions without informed consent in emergency situations. Theoretically, both seek to maintain a balance between protecting life and respecting patient autonomy, with hypothetical consent serving as a bridge when actual consent cannot be obtained. In Indonesian law, this structure is supported by the general principle of agreement in Article 1320 of the Civil Code, justifiable and excusable reasons in Articles 48 and 50 of the Criminal Code, emergency exceptions in Article 45 paragraph (2) of the Medical Practice Act, and the ethical obligation to help patients in the Indonesian Medical Code of Ethics (Civil Code; Criminal Code; Law No. 29 of 2004; KODEKI). However, the applicability of these principles depends on the fulfilment of strict conditions regarding the existence of a real emergency, the patient's incapacity, the proportionality of the action, and the orientation towards the patient's best interests, so that both must be understood as narrow exceptions, not broad justifications for paternalistic practices.

Theoretically, this study clarifies that the principle of presumed consent and the doctrine of necessity can only be upheld when framed by explicit normative parameters, whether in the realm of civil law, criminal law, or professional ethics. This opens up space for further development of the theory of patient autonomy that is sensitive to emergency situations without erasing the dignity of individuals as subjects of law. In practical terms, these findings point to the need for operational guidelines that detail the criteria for emergencies, capacity assessment measures, the scope of permissible actions, and standards for documenting clinical decisions. Strengthening ethical and health law education for medical personnel, accompanied by post-event clinical audit mechanisms, will help build a culture of emergency decision-making that is responsible, transparent, and accountable to patients and law enforcement agencies.

First, policymakers are advised to formulate derivative provisions that elaborate on Article 45 paragraph (2) of the Medical Practice Law and explicitly refer to the principle of presumed consent and the doctrine of necessity, with clear operational indicators for doctors and hospitals. Second, medical professional organisations need to develop emergency clinical practice guidelines that combine ethical, legal and documentation procedures, so that decisions that override informed consent are always accompanied by clinical reasons and traceable records. Third, health law researchers are encouraged to develop jurisprudential studies of court decisions related to disputes over emergency actions without consent, in order to map the patterns of judges' arguments and formulate recommendations for regulatory improvements based on actual judicial practice.

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