

Clinical Authority Limits and Hospital Business Sustainability in Exceptional Circumstances

Mutia Sylvana, Yeni Vitrianingsih, Fayola Issalillah

Universitas Sunan Giri Surabaya, Indonesia

ARTICLE INFO

Article history:

Received 22 December 2024

Revised 28 December 2024

Accepted 04 January 2025

Key words:

Hospital management,
Article 286,
Clinical privilege,
Medical authority,
Legal risk,
Hospital reputation,
Business sustainability.

ABSTRACT

Article 286 of Indonesian Law Number 17 of 2023 on Health permits medical and health personnel, under specified circumstances, to provide services beyond their ordinary authority. This article examines how hospitals should manage the legal, ethical, and business risks arising from this exception and how such management affects institutional reputation and business sustainability. A normative legal method is employed using statutory and conceptual approaches, with particular attention to Law Number 17 of 2023 and Government Regulation Number 28 of 2024. The analysis indicates that Article 286 constitutes a limited exception rather than a general expansion of professional authority. Hospitals must distinguish emergency or officially recognized exceptional situations from routine service delivery and support such decisions through credentialing, clinical privileging, training, assignment, supervision, documentation, consultation, and referral systems. Weak governance may transform an otherwise lawful exception into institutional liability and reputational harm. Conversely, properly governed exceptional practice can support timely patient care while preserving accountability. Clinical authority management is therefore closely connected to patient safety, legal compliance, public trust, professional retention, and the long-term sustainability of hospital operations.

INTRODUCTION

Hospitals are healthcare organizations possessing a dual character as professional service institutions and entities that must maintain their operational continuity (Harmoni et al., 2022). Service quality heavily depends on the hospital's ability to ensure that Medical Personnel and Health Personnel work in accordance with their assigned competencies and authorities (Ustani et al., 2024). Law Number 17 of 2023 concerning Health establishes competence as the basis for practice authority through Article 285, but Article 286 provides exceptions under certain circumstances. Article 286 paragraph (1) states that Medical Personnel and Health Personnel may provide services outside their authority under specific circumstances. These circumstances at least include the absence of personnel in the assigned region, government program requirements, medical emergencies, as well as outbreaks, plagues, and disaster emergencies. This norm remains valid and forms part of the national health legal framework after Law Number 17 of 2023 revoked a number of previous health laws.

Legal room to act outside one's authority cannot be understood as a general permission for medical personnel to perform every action beyond their competence (Fibrini, 2024). Article 286 is an exception norm that arose from the need to keep services accessible when normal conditions cannot be met (Tampil et al., 2023). This need is most visible where a hospital must still provide emergency services around the clock despite limited access (Mohamad et al., 2024). The structure of the article still treats certain circumstances as the main requirement. Government Regulation Number 28 of 2024 then clarifies this framework. Article 742 of the regulation affirms that practice must follow authority based on competence, while Article 743 requires that certain personnel who provide direct services or services affecting patient safety hold clinical authority obtained after credentialing and determined by the head of the health care facility. Article 744 only then opens the possibility of services outside authority in certain circumstances with more detailed requirements.

Government Regulation Number 28 of 2024

* Corresponding author, email address: fayolaissalillah@gmail.com

provides operational limits that clarify Article 286. The absence of Medical Personnel or Health Personnel in an area must be determined by the head of the regional apparatus that handles health affairs at the regency or city level. Services outside authority, whether due to the absence of personnel or the needs of a government program, are carried out by personnel who have completed training or orientation from the Central Government or Regional Government. In medical emergencies, action may be taken immediately to prioritize saving lives and preventing disability, whether at the pre-facility, intra-facility, or inter-facility level. For extraordinary events (KLB), outbreaks, or disaster emergencies, the provision of services relates to response activities and requires an assignment framework as set out in regulations. This structure shows that the exception remains bound by the goal of safety, practical competence, and institutional authorization (Pramudito & Widjaja, 2022). When rules and institutional practice do not match, protection of public health becomes weak (Khayru et al., 2024).

For hospitals, this arrangement has major managerial consequences. A hospital cannot be satisfied with confirming that personnel hold a registration certificate (STR) and a practice license (SIP). It must also manage clinical authority based on credentials, actual ability, service needs, and safety risks. The quality of human resources affects job performance, so competence must be checked and maintained continuously (Darmawan et al., 2020). Decisions about who may perform certain procedures are part of clinical governance. Minister of Health Decree Number HK.01.07/MENKES/1596/2024 on hospital accreditation standards defines the granting of authority, or privileging, as determining current clinical competence and deciding which clinical services medical personnel are permitted to provide. The document stresses that granting clinical authority is one of the hospital decisions that matter most for patient safety and service quality. Information on education, recommendations, competence, and evaluation of professional practice is used as the basis for granting and maintaining that authority. Changes in how services are delivered also need clear implementation strategies so that new practices do not run ahead of the rules (Sarif & Issalillah, 2022).

From an ethical perspective, the issue of services outside authority brings together two moral demands. First, health personnel must respect the limits of their ability and avoid actions that increase patient risk. Second, an emergency or the absence of personnel can

make inaction produce even greater harm. Government Regulation Number 28 of 2024 affirms that health personnel bear a moral responsibility to devote themselves according to their field of knowledge, behave according to professional ethics, put the interests of patients and society first, and give their best effort according to norms, service standards, professional standards, and patient needs. Clear regulation of how services are delivered is a basic condition for protecting patients (Sasmita et al., 2023). This framework shows that a decision to step outside routine authority cannot be judged through administrative formalities alone. The decision must consider the factual situation, urgency, available ability, safety, documentation, and the referral or consultation alternatives that can realistically be pursued. Complete medical records serve as an important legal record of why a decision was made (Kholis et al., 2023).

Legal risk for hospitals arises when the limits of the exception are not managed well (Budhiartie, 2009). A service that actually meets the conditions of Article 286 can still lead to a dispute if the hospital fails to prove the particular circumstances, the competence of the personnel, the assignment, the procedure, or the clinical reason for the action. In such disputes, corporate liability usually turns on causation and on who must prove what (Sopyan et al., 2024). The risk is greater when services outside authority are carried out in ordinary circumstances without a basis of need recognized by law. The problem then does not end with the individual action of the medical personnel. The credentialing system, the determination of clinical authority, staff scheduling, supervision, emergency policy, documentation, and referral mechanisms can be assessed as part of the organization's responsibility (Mening et al., 2023). Health workers also carry legal responsibility toward the users of their services when they act beyond their role (Setiawan et al., 2023). A hospital without adequate control over these systems can face the risk of disputes, administrative sanctions, declining patient trust, disrupted cooperation with payers, and higher risk management costs. Weak institutional control can also create liability in a hospital's dealings with insurers (Eskandar et al., 2025; Ambarwati et al., 2024). Patients who suffer harm from clinical errors may also seek compensation, so the basis of each decision must be traceable (Mokoginta et al., 2024).

The link between patient safety and the hospital business makes this issue even more relevant. A hospital needs a reputation as a competent and safe facility to retain patients, professional staff, insurance partnerships, referrals, and its competitive

position. Service quality shapes patient satisfaction and patients' willingness to keep using a facility (Darmawan et al., 2022). An authority error that draws public attention can create the perception that the problem comes not from one individual but from a failure of the hospital's system. Public trust also depends on the social setting in which a facility operates (Amri & Khayru, 2022). Because patients are consumers of health services, what a hospital communicates about its competence must match its actual capacity (Sahidu et al., 2023). At the same time, policies that are too rigid can hinder a quick response when staff shortages or emergencies demand immediate action. A hospital must be able to distinguish between legitimate clinical flexibility and a violation of authority that cannot be justified. The ability to make this distinction is part of risk management because it affects safety, compliance, reputation, and the continuity of business activities.

This paper aims to analyze the position of Article 286 of Law Number 17 of 2023 in managing hospital risk when services are provided outside the routine authority of medical personnel or health personnel, as well as to assess its impact on the reputation and business sustainability of the hospital. The analysis focuses on the relationship between legal exceptions, competence, clinical authority, credentialing, governance, ethics, and business decisions. The position of this paper is that Article 286 needs to be read as a safety mechanism under special circumstances, not as a permanent expansion of professional authority. Based on this objective, the research problem formulation consists of two questions: (1) how do hospitals manage legal and ethical risks in the implementation of Article 286 of Law Number 17 of 2023 when Medical Personnel and Health Personnel provide services outside their authority? (2) how does the management of such services outside authority affect the reputation and business sustainability of the hospital?

RESEARCH METHOD

This study uses a normative legal research method with statutory and conceptual approaches. The normative approach was chosen because the main issue relates to the interpretation of the relationship between professional authority norms, service exceptions under specific circumstances, hospital clinical authority, and institutional responsibility. Marzuki (2017) explains legal research as the process of examining rules, principles, and doctrines to build arguments regarding a legal issue. Ibrahim (2006) places the statutory and conceptual approaches as a way to read the relationships between rules and

principles forming a legal regime. Primary legal materials include Law Number 17 of 2023 concerning Health, Government Regulation Number 28 of 2024, and current health regulations or policies related to accreditation, clinical authority, credentialing, and hospital governance. Regulations that have been revoked are not used as positive legal bases.

The analysis is carried out through the inventory of norms, examination of validity status, grouping of obligations, and systematic interpretation of the relationship between Article 285, Article 286 of the Health Law, and Articles 742 to 746 of Government Regulation Number 28 of 2024. Soekanto and Mamudji (2015) explain that normative legal research uses written legal materials to identify principles, systemization, and the relationships of rules relevant to the research problems. Literature on corporate negligence, credentialing, clinical authority, patient safety, hospital reputation, and performance transparency is used to build conceptual analysis. The materials are then divided according to the two problem formulations. The first group is used to assess the legality of services outside authority and hospital mitigation systems. The second group is used to analyze the relationship between safety, reputation, trust, dispute risk, and business sustainability. The synthesis is carried out argumentatively without claiming to be a systematic review or meta-analysis.

RESULT AND DISCUSSION

Legal and Ethical Risk Management in the Implementation of Article 286

Article 286 must be read together with Article 285 of Law Number 17 of 2023. Article 285 establishes the general rule that practice is carried out according to authority based on competence, while Article 286 provides exceptions under certain circumstances. This general rule and exception structure has interpretive consequences. Services outside authority do not become lawful merely because a patient requires a specific action. Hospitals must be able to demonstrate that the circumstances faced fall under legally recognized specific circumstances and that the requirements for implementation are met. Government Regulation Number 28 of 2024 clarifies that some circumstances require local government determination, training or orientation, assignment letters, as well as time or location limitations. Risk management should begin with event classification. Hospitals need to determine whether an action occurs during an emergency, the predetermined absence of personnel, government program requirements, or the mitigation of outbreaks,

plagues, or disaster emergencies.

The distinction between professional authority and clinical authority is decisive. Competence is attached to professional ability obtained through education or training, while clinical authority is a special right to provide certain services within a health facility after a credentialing process. Organizational effectiveness also depends on clear roles and lines of authority (Darmawan, 2024). Government Regulation Number 28 of 2024 requires certain personnel who provide direct services or services affecting patient safety to obtain clinical authority after credentialing and determination by the head of the facility. In hospital practice, this boundary means that a health worker may hold a certain academic competence but does not automatically obtain the right to perform all such procedures in a particular hospital. Brenner, Bal, and Brenner (2014) explain that credentialing and privileging are the main instruments of a hospital's corporate responsibility to ensure staff competence and to limit the scope of actions each worker may perform.

Legal risk rises when management fails to distinguish actions outside authority that are permitted by Article 286 from routine practice that exceeds clinical privileges. An emergency gives wider room for immediate action because delay can threaten life or cause disability. That room cannot be used as a reason to perform procedures outside authority repeatedly in the normal operation of a hospital. If a hospital knows that a staff shortage is continuous but still uses the emergency exception to cover regular needs, this pattern can indicate a failure of human resource planning and clinical governance. When the basis for an action is unclear, errors in diagnosis or procedure can lead to legal liability for the doctor (Setiyadi et al., 2023). Patients also have the right to be informed about, and to agree to, the actions taken on them, including who performs those actions (Chairul et al., 2023). The exception norm should be used to respond to circumstances defined by law, while routine service needs should be met through recruitment, scheduling, cooperation, referral, or adjustment of service capacity.

Credentialing becomes the main preventive mechanism because it gives the hospital an opportunity to assess actual ability before clinical authority is granted (Yulius et al., 2023). The assessment should cover education, registration, experience, procedural skills, ethical and disciplinary records, and evaluation of professional practice. Documents that are not verified carry ethical and

even criminal consequences when they turn out to be false (Hartika et al., 2023). Credentialing that only checks the completeness of documents can create a false sense of security. Hospitals need a process that links evidence of competence to the type of action to be performed. Lumunon, Viany, Tampi, and Waha (2020) discuss corporate negligence and credentialing in private hospitals and show the relationship between organizational liability and the supervision of professionals working in the hospital. That study also warns that economic considerations may enter the credentialing process, so decisions on clinical authority must remain centered on professional standards and safety.

Business pressure can create conflict when a hospital lacks specialists or wants to keep services that generate revenue. Management may face a choice between limiting services, referring patients, or allowing available staff to take broader action (Veronica Komalawati, 2018). Any limit or referral must still be applied fairly to every patient (Napu et al., 2024). Article 286 gives an answer only in certain circumstances that have been determined. It does not justify expanding authority because of revenue considerations, volume targets, or the wish to hold a market. Under ordinary conditions, business needs must yield to competence and clinical authority. Corporate responsibility in health also means that access to care should not be decided by commercial interest alone (Hartono et al., 2024). Profit orientation in hospital management can weaken fair access when it is not balanced with service obligations (Amalia & Issalillah, 2025). Allowing procedures for commercial reasons when the conditions of the exception are not met creates legal risk as well as an ethical problem (Vitrianingsih & Budiarsih, 2019). Patient satisfaction depends on service quality, so volume or convenience should not replace competence as the measure of a good service (Mardikaningsih, 2022). A hospital may gain short-term revenue from such services, but it bears the potential for greater losses if an incident, dispute, or regulatory inspection occurs (Sibuea et al., 2023). Public opinion about an incident can also spread quickly and change how patients view the hospital (Aisyah & Issalillah, 2021).

Emergency management requires a different policy because Article 744 of Government Regulation Number 28 of 2024 explicitly directs immediate action to save lives and prevent disability. Hospitals should have protocols that explain how personnel recognize an emergency, the minimum actions that may be taken, consultation patterns, escalation to more competent personnel, documentation, and referral after the patient's condition is stable (Sutarih,

2018). Services outside authority in this situation must be directed at the urgent need and must not become a justification for continuing the whole course of therapy after a more competent alternative becomes available (Susanti et al., 2024). A patient's right to appropriate care remains in force after the emergency phase, so follow-up care should pass to competent personnel (Mengga et al., 2024). The time limit and purpose of the action are elements that help distinguish a legitimate emergency intervention from practice beyond authority. Documentation of the reason for the action, the patient's condition, the availability of personnel, and the clinical decision becomes important evidence if legal questions arise later (Sibuea et al., 2023).

The absence of personnel requires more formal management. Government Regulation Number 28 of 2024 stipulates that the absence of personnel in the area of assignment is determined by the regency or city health apparatus. Services outside authority for this situation are carried out by personnel who have completed training or orientation organized by the Central Government or Regional Government. Gaps in service access and health development are often the reason facilities lean on exceptions like this (Harianto et al., 2024; Khayru & Issalillah, 2022). Social and regional inequality makes such staffing gaps harder to close (Mardikaningsih, 2021). Even so, a patient's right to needed care should not depend on where the patient lives or on whether staff happen to be available (Rahawain et al., 2024). A hospital cannot unilaterally declare an internal shortage to be an "absence of personnel" in order to obtain room for the exception. This arrangement provides an external control function so that the exception is not used as a permanent staff substitution mechanism. In hospital management, the implication is the need to keep the determination documents, proof of training or orientation, assignment letters, and assignment periods as part of the compliance system.

Government program needs, extraordinary events (KLB), outbreaks, and disaster emergencies also require assignment governance. Such conditions can make the service structure change quickly, staff be moved, and actions be performed in large volumes. Clear administrative frameworks are needed for crisis response so that these changes remain controlled (Vitrianingsih et al., 2022). The risk of error rises when personnel work outside their routine, facilities are under pressure, or communication becomes poor. Hospitals need to prepare a special authority matrix for emergency periods, a division of roles, a chain of command, access to consultation, and procedures for ending

the additional authority after the situation ends. The flexibility granted by law must have a starting point and an ending point that can be traced. Without such control, temporary authority can turn into a habit that no longer has a basis in the exception (Sutarih, 2018).

The delegation of authority needs to be distinguished from services outside authority under Article 286. Government Regulation Number 28 of 2024 regulates mandate and delegation separately in Article 745. In a mandate, responsibility remains with the authority grantor, whereas in delegation, responsibility lies with the recipient according to a determined structure. Facility leaders must determine the types of services that can be delegated. This distinction has major significance in risk management. Hospitals must not use the term "delegation" to justify actions that cannot actually be delegated or use Article 286 when the fact is that there is a pattern of routine interprofessional assignments. Every form of task shifting must be categorized appropriately because its legal basis, supervision, and liability differ.

Professional ethics remain a boundary when exception norms are used. The need to save a patient does not eliminate the obligation to make best efforts, recognize personal limitations, seek help, and avoid taking disproportionate risks. Personnel who have never possessed practical skills for a procedure are not automatically safe ethically simply because an emergency occurs. Considerations in facing such conditions must be directed toward choices of action that are safest and most proportional to the patient's condition and the capabilities of the available personnel, namely taking actions within the limits of one's own capabilities, waiting for more competent personnel, performing initial stabilization, or referring the patient to a healthcare facility with appropriate resources and competencies (Susanti et al., 2024). Ethical values emerge in the assessment of real benefits and risks to the patient. Hospitals can assist personnel through simulation training, emergency protocols, remote consultation, supervision, and referral systems so that legal exceptions do not turn into situations where personnel are forced to act without adequate support.

Organizational liability becomes stronger when service failures are not solely caused by individual errors, but also originate from systemic weaknesses within the hospital's control, such as supervision, governance, prevention, and accountability mechanisms (Gunena et al., 2024). If management neglects credentialing, fails to re-evaluate, permits

staff to work beyond their privileges, or fails to provide supervision, the issue can no longer be positioned solely as an individual action. The concept of hospital corporate liability positions the hospital as an organization that has a direct obligation to maintain staff competence and boundary of authority. Literature on hospital corporate responsibility emphasizes that credentialing and privileging function as forms of oversight regarding staff quality, including professionals who may not have direct employee status. This is relevant for private hospitals because the contractual structure of partner physicians does not automatically erase the institution's obligation to control the services provided within its facilities.

Legal and ethical risks in the implementation of Article 286 are managed through the classification of circumstances, verification of exception requirements, credentialing, clinical authority, training, assignment, supervision, documentation, consultation, referral, and post-incident audits (Mubarak et al., 2023). Article 286 does not eliminate the principle of competence, but rather provides a limited space when safety and public needs require flexibility. Hospitals must be able to demonstrate why actions outside authority are necessary, who permitted them, what capabilities the personnel possess, how safety is maintained, and when the exception ends. Weak management can transform a legitimate legal space into a source of organizational liability. Conversely, a documented and competency-based system allows clinical flexibility to function as a safety tool without eliminating accountability.

Reputation and Business Sustainability of Hospitals in the Management of Services Outside Authority

Hospital reputation is formed through patient experiences, public perception, clinical quality, safety, professional competence, and the organization's ability to respond to problems. Services outside authority have reputational impacts because the public does not always distinguish in detail between individual errors and system failures. If an incident occurs, public questions usually shift to the reasons why the hospital permitted personnel to perform the action, the quality of credentialing, supervision, and management response. Fulfilling safety standards and service quality is important because failure to meet these standards can cause harm to patients while opening up the possibility of legal liability for healthcare providers (Risman et al., 2024). Mira, Lorenzo, and Navarro (2014) found a positive relationship between hospital reputation,

perceived competence of healthcare personnel, treatment outcomes, and patient perceptions of clinical environmental safety. These findings indicate that safety and competence have a direct relationship with how patients evaluate the institution.

Where Article 286 is applied properly, acts outside one's authority do not always damage reputation. A quick response in an emergency can strengthen the perception that a hospital is able to put patient safety first. The justification for such emergency action relates to presumed consent and the urgent need to save the patient (Abdullah et al., 2023). Problems arise when the public sees that an act was carried out without a basis, without adequate competence, or because the hospital failed to provide staff who should have been available (Sirenden et al., 2024). The reputational meaning depends on the reasons and the quality of management. Public perception is also shaped by the quality of service that patients experience (Khayru & Issalillah, 2022). A hospital that transparently explains the special circumstances, the mitigation procedures, and the evaluation results can maintain trust better than an organization that withholds information or blames individual staff without assessing the system. Reputation in this situation relates to an organization's ability to show that professional flexibility takes place within an accountable framework.

Service disputes carry business costs that go beyond paying compensation. A hospital may face legal costs, management time, internal audits, the need for system improvements, higher liability insurance premiums, disrupted partnerships, and lower staff productivity. Misdiagnosis and service disruptions can create legal liability whose costs are also borne by the hospital (Setiyadi et al., 2023; Yatno et al., 2023). Cases that attract media attention can influence the decisions of patients and prospective professionals. Low malpractice claims do not always mean few errors, because normative factors can prevent patients from filing claims (Kurniawan et al., 2024). These conditions show that risk management needs to be preventive, through strengthening quality systems and oversight before an incident causes greater loss. Spending on quality systems, audits, training, and professional evaluation can be seen as an investment in preventing losses (Setyorini et al., 2024). A hospital that cuts costs in the credentialing process may gain short-term administrative efficiency, but it raises its exposure to events that cost far more.

The link between reputation and business performance can be seen in how quality information shapes public perception. Hibbard,

Stockard, and Tusler (2005) studied the impact of hospital performance reporting and found that publishing performance information was associated with changes in quality and affected hospitals' reputations in the eyes of consumers. This finding is relevant to managing services outside authority because clinical incidents increasingly enter the public sphere through official reports, media, and digital platforms. Hospitals can no longer rely on patients' limited access to information. The quality of governance and the way an organization handles incidents can become part of a public image that influences consumer preferences. Health insurance participants' satisfaction with service quality is also a measure that the public pays attention to (Issalillah et al., 2021).

Transparency needs to be managed with balance. Hospitals must protect patient confidentiality and professional processes, but overly defensive reputation management can create the perception that the institution is hiding problems. When an incident related to authority occurs, communication can explain the handling process without disclosing protected data. Protection of patient rights in law and medical ethics serves as the guide for such communication (Herisasono et al., 2023), including the duty to keep patient data confidential (Rahmani et al., 2024). Information about audits, policy improvements, retraining, or changes to the credentialing mechanism can show institutional responsibility. A communication strategy that only stresses that "the staff acted on their own" can become a problem if the hospital's system actually allowed the action to take place. Long-term reputation is stronger when communication is in line with internal changes that can be verified.

Business sustainability is also influenced by the hospital's relationship with doctors and health workers. An organization with clear credentialing gives certainty about the limits of action, supervision mechanisms, and legal protection for health workers when they must carry out emergency action under legitimate special circumstances (Juliarto et al., 2023). Lack of clarity can make staff reluctant to make emergency decisions for fear of personal liability, or conversely too free in interpreting their authority. Both situations harm the organization. The division of legal responsibility between doctors and the hospital needs to be understood from the start (Kaseger et al., 2023), as do the limits of patient consent and autonomy in emergency action (Issalillah et al., 2023). Hospitals need to build a

culture that encourages staff to ask for help, report near misses, and state their limitations without fear of losing their positions. Such a system helps detect risks before they turn into incidents that damage reputation.

Staff availability is part of the business risk that must be managed strategically. Private hospitals may face shortages of certain specialists, especially in areas that are less attractive to professionals (Veronica Komalawati, 2018). This shortage is related to inequality in access to health services based on socioeconomic conditions (Rojak & Khayru, 2024). Article 286 gives room in certain conditions, but management cannot turn it into a permanent operating model. Continuous dependence on exceptions shows a mismatch between the service portfolio and human resource capacity. A persistently high workload can also trigger empathy fatigue among service staff (Khayru & Darmawan, 2023). In facing limited staff and access to services, hospitals can consider using teleconsultation as one alternative to optimize health resources and widen access to medical services (Aisyah & Sarif 2024). Adequate social support is also needed so that vulnerable groups, such as the elderly, continue to receive services (Khayru, 2022). The decision to close or reduce services can affect revenue, but maintaining services without sufficient competence carries more serious risks to patients and the company (Lastini et al., 2020).

Cooperation with guarantors and payers can also be affected by the quality of clinical governance. Insurance companies, corporations, and health financing institutions have an interest in services being provided by legitimate staff and according to standards (Sibuea et al., 2023). A good understanding of claim submission procedures helps hospitals avoid rejections and disputes with guarantors (Hakim et al., 2024). Authority incidents can trigger claim audits, review of partnerships, or higher quality requirements (Vitrianingsih & Budiarsih, 2019). These audits matter because fraud and forgery in claims can be prosecuted under Indonesian positive law and harm business parties (Setiawan et al., 2023). A hospital with strong credentialing, documentation, and incident-handling systems is in a better position to explain that certain services were provided under a legitimate legal exception (Rachim et al., 2024). Systematic evidence can distinguish clinical events that cannot be fully avoided from governance failures. In business relationships, the ability to provide evidence of compliance is as important as public reputation.

Article 286 also affects the design of corporate

risk management. Hospitals should include services outside authority in the risk register rather than treating them as a purely clinical matter. Risks can be mapped by the likelihood of staff shortages, types of emergencies, high-risk services, substitute competence, training needs, referral readiness, and potential impact on patients. Each category is then given a clear mitigation. This mapping needs to pay attention to the patient groups most vulnerable to health burdens (Issalillah & Mardikaningsih, 2022). This approach allows the board to see the link between human resource decisions and legal and financial risks. The accountability of health facilities, including in terminal patient care services, also needs to be reflected in the risk register (Wahyusetiawan et al., 2024). Investment in staff, training, communication systems, or referral partnerships can be compared with the possible costs of incidents and service shutdowns.

Reputation also affects the ability to recruit and retain qualified staff. Doctors and health workers tend to consider the clinical environment, management support, team quality, and safety systems when choosing where to work. High work pressure can affect staff health, so management support becomes an important consideration (Issalillah, 2022). A hospital known for allowing acts outside authority because of revenue targets may lose its professional appeal. Conversely, an organization with a clear privileging system that supports staff when they must take legitimate emergency action can build an image as a safe and professional workplace. This impact relates directly to business sustainability because staff quality is one of the main sources of a hospital's competitiveness.

The announcement of administrative violations also carries reputational potential. Government Regulation Number 28 of 2024 provides that Medical Personnel, Health Workers, and Health Service Facilities that do not carry out administrative sanctions may be placed on a list of violators and announced to the public through social media. This provision shows that compliance is not merely an internal matter. Violations of patient rights are one of the grounds of assessment that hospitals need to anticipate (Issalillah & Khayru, 2023). Failure to correct a violation can develop into public information that affects the organization's image. Hospitals need a rapid response mechanism for regulator findings, including investigation, a corrective action plan, a responsible person, a completion deadline, and verification of implementation. The speed and quality of corrections become part of reputation protection.

Business sustainability ultimately requires a balance between clinical courage and discipline over authority. Hospitals must not create a culture that makes staff afraid to help patients in emergencies, because Article 286 does recognize the need for flexibility. Hospitals also must not let that flexibility turn into the normalization of acts beyond competence or privilege. A good system distinguishes emergencies from normal operations, temporary authority from permanent authority, and patient needs from revenue pressure. The needs of vulnerable patients must still be protected within the social security system (Wuryani et al., 2023), and revenue management, including cross-subsidies, needs to comply with legal rules (Nurhandayani et al., 2024). This distinction enables hospitals to sustain services in critical situations while maintaining safety and certainty for all parties.

The business impact of services outside authority depends on the quality of their management. The legitimate, documented, and safety-oriented implementation of Article 286 can support the hospital's image as an institution responsive to critical situations. Conversely, using exceptions to cover routine staffing shortages, pursue revenue, or ignore credentialing can damage trust and increase litigation costs. Literature shows that perceptions of competence and safety are related to hospital reputation, while public performance information can influence the image and behavior of organizations (Mira et al., 2014; Hibbard et al., 2005). The management of clinical authority is therefore part of the business sustainability strategy because it connects quality, compliance, trust, professional personnel, and market relationships.

CONCLUSION

Article 286 of Law Number 17 of 2023 provides limited exceptions for Medical Personnel and Health Personnel to provide services outside their authority under specific circumstances, namely the absence of personnel, government program requirements, medical emergencies, as well as outbreaks, plagues, or disaster emergencies. Such exceptions do not abolish the principles of competence and clinical authority. Hospitals must manage them through credentialing, privileging, circumstance verification, training, assignment, supervision, documentation, consultation, and referral. Legal risks increase when exceptions are used in routine services without a legitimate basis or when system failures allow personnel to work beyond boundaries continuously. From a business dimension, the quality of such management affects

safety, disputes, patient trust, relationships with payers, ability to recruit personnel, and reputation. Clinical compliance ultimately becomes part of the hospital's business sustainability.

Article 286 needs to be understood through the relationship between health law, clinical governance, professional ethics, and organizational risk management. Authority exceptions cannot be assessed solely from individual personnel actions because hospitals determine many conditions that enable actions to take place through credentialing, assignment, scheduling, and supervisory systems. Academically, the findings of this study open space for the development of the concept of corporate clinical responsibility, which links hospital responsibility with the ability to control professional risks without eliminating medical discretion during emergencies. Practically, hospital boards of directors need to treat clinical authority as a strategic issue included in management oversight, rather than merely an administrative matter for the medical committee. Any expansion of actions due to special circumstances must have a basis, documentation, risk evaluation, and a cessation mechanism when the circumstances justifying it have ended.

REFERENCES

- Abdullah, I. S. T., Hardyansah, R., & Khayru, R. K. (2023). Presumed Consent and the Doctrine of Necessity as the Basis for Emergency Medical Treatment Without Informed Consent. *Journal of Social Science Studies*, 3(1), 343-354.
- Aisyah, N., & Issalillah, F. (2021). The Relationship between Social Media Use and Mental Health in Users with FoMO. *Journal of Social Science Studies*, 1(2), 33-38.
- Aisyah, N., & Sarif, N. H. B. (2024). Effectiveness of Medical Technology Implementation to Improve Health System Efficiency and Reduce Disparities in Access to Health Services. *Bulletin of Science, Technology and Society*, 3(1), 63-70.
- Ambarwati, A., Issalillah, F., & Vitrianingsih, Y. (2024). The Criminal Law Construction for Health Insurance Claim Payment Failure: A Synergy between Health Law and Financial Sector Regulation. *Journal of Social Science Studies*, 4(2), 489-502.
- Amri, M. W., & Khayru, R. K. (2022). Keeping Tradition in the Midst of Modernity: The Social Life of Indigenous Communities in Urban Areas. *Journal of Social Science Studies*, 2(1), 135-138.
- Brenner, L. H., Bal, B. S., & Brenner, A. T. (2014). Physician Competence and Skill: The Role of Hospital Corporate Liability. *Clinical Orthopaedics and Related Research*, 472, 1042-1048.
- Budhiartie, A. (2009). Pertanggungjawaban Hukum Perawat dalam Penyelenggaraan Pelayanan Kesehatan di Rumah Sakit. *Jurnal Penelitian Universitas Jambi: Seri Humaniora*, 11(2), 434-38.
- Chairul Z, Hardyansah, R., Suwito, Waskito, S., & Khayru, R. K. (2023). Informed Consent as a Fundamental Right of Patients: The Law and Medical Ethics Perspective. *Journal of Social Science Studies*, 3(2), 209-214.
- Darmawan, D. (2024). Distribution of Six Major Factors Enhancing Organizational Effectiveness. *Journal of Distribution Science*, 22(4), 47-58.
- Darmawan, D. (2024). From Individual Minds to Collective Decisions: The Function and Contribution of Cognitive Mapping. *Journal of Social Science Studies*, 4(2), 467-476.
- Darmawan, D., Issalillah, F., Khayru, R. K., Herdiyana, A. R. A., Putra, A. R., Mardikaningsih, R., & Sinambela, E. A. (2022). BPJS Patients Satisfaction Analysis Towards Service Quality of Public Health Center in Surabaya. *Media Kesehatan Masyarakat Indonesia*, 18(4), 124-131.
- Darmawan, D., Mardikaningsih, R., Sinambela, E. A., Arifin, S., Putra, A. R., Hariani, M., Irfan, M., Al Hakim, Y. R., & Issalillah, F. (2020). The Quality of Human Resources, Job Performance and Employee Loyalty. *International Journal of Psychosocial Rehabilitation*, 24(3), 2580-2592.
- Eskandar, H., Issalillah, F., & Vitrianingsih, Y. (2025). Legal Liability of Hospitals for Fraud in the National Health Insurance Program. *Journal of Social Science Studies*, 5(1), 1-14. <https://jos3journals.id/index.php/jos3/article/view/394>
- Fibrini, D. (2024). Perlindungan Hukum Terhadap Tenaga Kesehatan dalam Melakukan Tindak Medis. *Iuris Studia: Jurnal Kajian Hukum*, 5(1), 147-156.
- Gunena, C. S., Gautama, E. C., Issalillah, F., & Khayru, R. K. (2024). Government and Private Sector Responsibility for Public Health in Large Infrastructure Development: A Review of the Legal Framework and Accountability Mechanisms in Indonesia. *Journal of Social Science Studies*, 4(2), 157-168.
- Hakim, A. Z., Waskito, S., & Khayru, R. K. (2024). Policy Comprehension and Procedures in Health Insurance Claim Submission. *Studi Ilmu Sosial Indonesia*, 4(2), 217-246.
- Hariato, A. V., Vitrianingsih, Y., Issalillah, F., & Mardikaningsih, R. (2024). Challenges and Changes Concerning National Health

- Development in Indonesia: Legal Perspectives, Service Access, and Infectious Disease Management. *International Journal of Service Science, Management, Engineering, and Technology*, 5(2), 22-26.
- Harmoni, D., Fahmi, F., & Yetti, Y. (2022). Tanggung Jawab Rumah Sakit Atas Kelalaian Tenaga Medis dalam Pelayanan Kesehatan. *Journal Of Science and Social Research*, 5(2), 302-311.
- Hartika, Y., Saputra, R., Pakpahan, N. H., Darmawan, D., & Putra, A. R. (2023). A Study on the Falsification of Health Certificates: Perspective of Criminal Law and Professional Ethics. *Journal of Social Science Studies*, 3(2), 175-180.
- Hartono, R., Darmawan, D., & Saputra, R. (2024). Regulation and Pharmaceutical Corporate Responsibility: Generic Drug Distribution, Patent Rights, and Their Impact on Equity of Access in the National Health Insurance System. *Journal of Social Science Studies*, 4(2), 303-318.
- Herisasono, A., Darmawan, D., Gautama, E. C., & Issalillah, F. (2023). Protection of patient rights in the perspective of law and medical ethics in Indonesia. *Journal of Social Science Studies*, 3(2), 195-202.
- Hibbard, J. H., Stockard, J., & Tusler, M. (2005). Hospital Performance Reports: Impact on Quality, Market Share, and Reputation. *Health Affairs*, 24(4), 1150-1160.
- Ibrahim, J. (2006). *Teori dan Metodologi Penelitian Hukum Normatif*. Bayumedia Publishing.
- Issalillah, F. (2022). Exploring the Neurobehavioral Nexus Between Psychological Stress and Cardiovascular Risk Across Clinical Settings. *Journal of Social Science Studies*, 2(2), 291-298.
- Issalillah, F., & Khayru, R. K. (2023). Legal Perspective on Patient Rights in Complementary and Alternative Medicine (CAM). *Legalis et Socialis Studiis* (L355), 1(2), 1-13.
- Issalillah, F., & Mardikaningsih, R. (2022). Environmental Justice and Health Burdens in Marginalized Communities Near Waste Sites. *Studi Ilmu Sosial Indonesia*, 2(1), 145-168.
- Issalillah, F., Rachmawati, E., & Kemarauwana, M. (2021). The role of service quality on satisfaction of BPJS participants. *JESS*, 1(2), 41-48.
- Issalillah, F., Ustani, T., Baktiasih, D. G. S., Indayanti, L. W., & Wuryani, A. I. (2023). Medical treatment consent and patient autonomy rights in clinical practice. *Studi Ilmu Sosial Indonesia*, 3(1), 293-320.
- Juliarto, T. S., Riyanto, A., Darmawan, D., Pakpahan, N. H., & Kholis, K. N. (2023). Legal Basis for Doctor Protection in Emergency Situations without a License to Practice. *Studi Ilmu Sosial Indonesia*, 3(2), 35-54.
- Kaseger, H., Baktiasih, D. G. S., Harianto, A. V., Indaryanti, N., & Issalillah, F. (2023). The Interplay of Legal Responsibilities in Cesarean Operations: A Study of Doctor-Patient Relationships within Hospital Settings. *Legalis et Socialis Studiis* (L355), 1(3), 26-34.
- Kementerian Kesehatan Republik Indonesia. (2024). Keputusan Menteri Kesehatan Republik Indonesia Nomor HK.01.07/MENKES/1596/2024 tentang Standar Akreditasi Rumah Sakit.
- Khayru, R. K. (2022). Social Support Systems and its Implication for Healthcare Provision for the Elderly Population, *Studi Ilmu Sosial Indonesia*, 2(2), 333-360.
- Khayru, R. K., & Darmawan, D. (2023). Collective Empathy Fatigue Governance in Public Service Care Workforces and Systems. *Studi Ilmu Sosial Indonesia*, 3(1), 237-268.
- Khayru, R. K., & Issalillah, F. (2022). Service quality and patient satisfaction of public health care. *International Journal of Service Science, Management, Engineering, and Technology*, 1(1), 20-23.
- Khayru, R. K., & Issalillah, F. (2022). The Equal Distribution of Access to Health Services Through Telemedicine: Applications and Challenges. *International Journal of Service Science, Management, Engineering, and Technology*, 2(3), 24-27.
- Khayru, R. K., & Issalillah, F. (2022). The Impact of Social Media on Mental Health: An Analysis of the Effects on Anxiety, Depression, and Sleep Disorders in Adolescents and Young Adults. *Journal of Social Science Studies*, 2(1), 95-102.
- Khayru, R. K., Marsal, A. P., & da Costa, L. (2024). Legal Coherence and Institutional Gaps in Medical Waste Governance and Public Health Protection in Indonesia. *International Journal of Service Science, Management, Engineering, and Technology*, 5(3), 17-22.
- Kholis, K. N., Chamim, N., Susanto, J. A., Darmawan, D., & Mubarak, M. (2023). Analyzing Electronic Medical Records: A Comprehensive Exploration of Legal Dimensions within the Framework of Health Law. *International Journal of Service Science, Management, Engineering, and Technology*, 4(1), 36-42.
- Kurniawan, R., Saputra, R., & Khayru, R. K. (2024). Normative Factors Behind Low Malpractice Claims for Patients Harmed by Errors. *Studi Ilmu Sosial Indonesia*, 4(1), 197-228.
- Lastini, K., Sutrisno, E., & Sugiarti, T. (2020).

- Perlindungan Hukum Profesi Bidan dalam Pelimpahan Wewenang Tindakan Medis. *Mimbar Keadilan*, 13(2), 131–140.
- Lethy, Y. N., Issalillah, F., Vitrianingsih, Y., Darmawan, D., & Khayru, R. K. (2023). Legal protection for patients against negligence of medical personnel. *International Journal of Service Science, Management, Engineering, and Technology*, 4(2), 39–43.
- Lumunon, T. H. W., Viany, L. Z., Tampi, B., & Waha, C. J. J. (2020). Implementasi dari Corporate Negligence dan Relevansi Quasi Economic Credentialing dalam Praktik di Rumah Sakit Swasta. *Jurnal Magister Hukum Udayana (Udayana Master Law Journal)*, 9(1), 182–194.
- Mardikaningsih, R. (2021). Urbanization and Social Inequality: Challenges in Building Social Cohesion in a City-Based Environment. *Journal of Social Science Studies*, 1(1), 135–140.
- Mardikaningsih, R. (2022). Patient Satisfaction Based on Quality of Service and Location. *Journal of Islamic Economics Perspectives*, 4(1), 31–37.
- Marzuki, P. M. (2017). Penelitian hukum: Edisi revisi. Prenada Media.
- Mengga, M., Vitrianingsih, Y., & Issalillah, F. (2024). Legal Aspects of Home Care and Protection of Terminal Patients' Rights to Palliative Care. *Journal of Social Science Studies*, 4(1), 165–172. <https://jos3journals.id/index.php/jos3/article/view/303>
- Mening, Y., Hardyansah, R., & Khayru, R. K. (2023). Institutional Responsibility of Hospitals for Medical Errors Committed by Healthcare Personnel. *Journal of Social Science Studies*, 3(2), 187–194.
- Mira, J. J., Lorenzo, S., & Navarro, I. (2014). Hospital Reputation and Perceptions of Patient Safety. *Medical Principles and Practice*, 23(1), 92–94.
- Mohamad, Y., Dirgantara, F., & Khayru, R. K. (2024). Legal Analysis of Hospitals' Obligation to Provide 24/7 Emergency Services in Areas with Limited Access. *Journal of Social Science Studies*, 4(1), 137–144.
- Mokoginta, A. S., Issalillah, F., Saputra, R., Vitrianingsih, Y., & Mujito, M. (2024). Telemedicine Diagnosis Error Compensation Mechanism: Normative Analysis of Patient Health Law. *Journal of Social Science Studies*, 4(2), 37–54.
- Mubarak, M., Darmawan, D., & Saputra, R. (2023). Legal and Ethical Arrangements for Medical Record Filling by Doctors: A Normative Study. *Bulletin of Science, Technology and Society*, 2(1), 33–38.
- Napu, H. R., Khayru, R. K., & Hardyansah, R. (2024). Principles of Anti-Discrimination and Fairness in Health Services: A Study of Regulations and Practices for Patients with Infectious Diseases in Indonesia. *Journal of Social Science Studies*, 4(2), 517–526.
- Pramudito, D., & Widjaja, G. (2022). Tanggung Jawab Hukum Dalam Pelimpahan Wewenang Beda Profesi Kesehatan. *Cross-border*, 5(1), 365–384.
- Rachim, R., Hardyansah, R., & Khayru, R. K. (2024). The Obligation of Medical Cost and Risk Information Transparency by Private Healthcare Providers in Indonesian Legal Construction. *Journal of Social Science Studies*, 4(2), 207–222.
- Rahawain, R., Herisasono, A., & Darmawan, D. (2024). Legal Analysis of Rare Disease Patients' Rights to Access Therapy in the BPJS Health System Based on Applicable Regulations. *Journal of Social Science Studies*, 4(2), 527–538.
- Rahmani, M. F., Gautama, E. C., & Issalillah, F. (2024). Legal Framework for Free Contraception in Community Clinics: Consent and Data Protection. *Journal of Social Science Studies*, 4(1), 465–482.
- Republik Indonesia. (2023). Undang-Undang Nomor 17 Tahun 2023 tentang Kesehatan.
- Republik Indonesia. (2024). Peraturan Pemerintah Nomor 28 Tahun 2024 tentang Peraturan Pelaksanaan Undang-Undang Nomor 17 Tahun 2023 tentang Kesehatan.
- Risman, R., Darmawan, D., Khayru, R. K., Saktiawan, P., & Mujito, M. (2024). Construction of Consumer Rights and Business Liability for Losses Resulting from Defective or Dangerous Medicines and Medical Devices in Indonesian Positive Law. *Journal of Social Science Studies*, 4(2), 333–350.
- Rojak, J. A., & Khayru, R. K. (2024). Socioeconomic Based Inequality in Healthcare Access: A Conceptual Analysis. *International Journal of Service Science, Management, Engineering, and Technology*, 6(3), 66–75.
- Sahidu, S., Putra, A. R., & Darmawan, D. (2023). Medical advertising regulations and patient protection as consumers of healthcare services. *Journal of Social Science Studies*, 3(1), 331–342.
- Sarif, N. H. B., & Issalillah, F. (2022). Healthcare Transformation Through Medical Technology: Opportunities, Challenges, and Implementation Strategies. *Bulletin of Science, Technology and Society*, 1(3), 53–60.
- Sasmita, B., Darmawan, D., & Khayru, R. K. (2023). Telemedicine Regulation in Indonesia: Enhancing Patient Safety and Protection. *International Journal of Service Science, Management, Engineering, and Technology*, 4(3), 29–35.

- Setiawan, R. A., Khayru, R. K., Mardikaningsih, R., Issalillah, F., & Halizah, S. N. (2023). Implementation of Indonesian Positive Law in Combating Fraud and Forgery in Health Insurance and Protection against Industrial Losses. *Journal of Social Science Studies*, 3(1), 271-280.
- Setiawan, S., Hardyansah, R., Khayru, R. K., Putra, A. R., & Suwito, S. (2023). Consumer Protection in the Health Sector: The Legal Responsibilities of Pharmacists. *Journal of Social Science Studies*, 3(2), 131-138.
- Setiyadi, G. B., Negara, D. S., Khayru, R. K., Darmawan, D., & Saputra, R. (2023). Misdiagnosis and Legal Liability of Doctors: A Normative Juridical Study in the Indonesian Health System. *Journal of Social Science Studies*, 3(2), 215-220.
- Setiyadi, G. B., Negara, D. S., Khayru, R. K., Darmawan, D., & Saputra, R. (2023). Misdiagnosis and Legal Liability of Doctors: A Normative Juridical Study in the Indonesian Health System. *Journal of Social Science Studies*, 3(2), 215-220.
- Setyorini, E. H., Vitrianingsih, Y., & Issalillah, F. (2024). Enforcement of Consumer Protection Laws in Traditional Medicine Products: Aspects of Supervision, Business Accountability, and Dispute Resolution. *Studi Ilmu Sosial Indonesia*, 4(1), 33-50.
- Sibuea, H. P., Wijanarko, D. S., Wirogioto, A. J., Syahrudin, E., & Siagian, K. (2023). Kedudukan Hukum Tenaga Medis dan Tenaga Kesehatan Perawat sebagai Pemangku Profesi Kesehatan dalam Pelayanan Kesehatan. *Krtha Bhayangkara*, 17(3), 567-586.
- Sirenden, M. T., Issalillah, F., & Vitrianingsih, Y. (2024). Legal Prescriptions and the Effectiveness of Sanctions for Harassment and Malpractice in Traditional Medicine Clinics. *Journal of Social Science Studies*, 4(2), 247-260.
- Soekanto, S., & Mamudji, S. (2015). *Penelitian Hukum Normatif: Suatu Tinjauan Singkat*. Rajawali Pers.
- Sopyan, A. W., Herisasono, A., Issalillah, F., Mardikaningsih, R., & Vitrianingsih, Y. (2024). Legal Construction of Corporate Liability for Occupational Diseases: The Principles of Causality, Burden of Proof, and Effectiveness of
- Hospitals' Legal Responsibility for Service Disruptions due to Information System Failures. *Journal of Social Science Studies*, 3(1), 319-330.
- Yulius, A., Mubarak, M., Hardyansah, R., Darmawan, Remedies in the Indonesian Legal System. *Journal of Social Science Studies*, 4(2), 365-380.
- Susanti, A., Issalillah, F., & Gautama, E. C. (2024). The Validity of Implied Consent in Medical Emergencies: Legal Construction and Accountability under the Health Law. *Journal of Social Science Studies*, 4(2), 439-452
- Sutarih, A. (2018). Sinkronisasi Pengaturan Pelimpahan Wewenang Tindakan Medis Kepada Perawat untuk Pelayanan Kesehatan di Rumah Sakit. *HERMENEUTIKA: Jurnal Ilmu Hukum*, 2(1), 1-64.
- Tampil, V. C., Mubasyiroh, A., Khayru, R. K., Darmawan, D., & Prasetyo, B. A. (2023). Legal Protection for Patients in Health Services at Community Health Centers. *Studi Ilmu Sosial Indonesia*, 3(2), 85-100.
- Ustani, T., Vitrianingsih, Y., & Mardikaningsih, R. (2024). Legal Implication and Challenge of Using Medical Record as Evidence in the Indonesia's Justice System. *Bulletin of Science, Technology and Society*, 3(1), 40-45
- Veronica Komalawati, S. H. (2018). Kompetensi dan Kewenangan Praktik Kedokteran: Perspektif Hukum di Indonesia. *Jurnal Ilmiah Hukum DE'JURE: Kajian Ilmiah Hukum*, 3(1), 147-166.
- Vitrianingsih, Y., & Budiarsih, B. (2019). Pelimpahan Wewenang Dokter Kepada Profesi Perawat dalam Tindakan Medis dari Perspektif Hukum. *Jurnal Hukum Magnum Opus*, 2(2), 457081.
- Vitrianingsih, Y., Gautama, E. C., & Sulani. (2022). Administrative Frameworks for Health System Management and Crisis Response. *Journal of Social Science Studies*, 2(2), 189-194.
- Wahyusetiawan, R., Herisasono, A., Khayru, R. K., Vitrianingsih, Y., & Issalillah, F. (2024). Health Facility Accountability for Terminal Patient Palliative Care Services Under Health Law. *International Journal of Service Science, Management, Engineering, and Technology*, 6(2), 45-57.
- Wuryani, A. I., Kaseger, H., Tamaka, R. S., Tampil, V. C., & Issalillah, F. (2023). Juridical Review of Government Legal Measures for Ensuring Rights of Patients with Mental Disorders in Social Security Administration. *Bulletin of Science, Technology and Society*, 2(3), 28-36.
- D., & Yasif, M. (2023). Legal Protection for Nurses in Medical Practice in Hospitals. *International Journal of Service Science, Management, Engineering, and Technology*, 4(3), 18-22.

* Sylvana, M., Y. Vitrianingsih, F. Issalillah. (2025). Clinical Authority Limits and Hospital Business Sustainability in Exceptional Circumstances, *Journal of Social Science Studies* 5(1), 271 - 282.