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Legal pluralism in the practice of informed consent among indigenous communities

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ABSTRACT

The transformation of individual autonomy standards in modern health law often creates a conflict of norms when implemented within the communal social structures of indigenous peoples. This research aims to analyze the dialectics of legal pluralism in the practice of medical informed consent to find a middle ground between centralistic state regulations and the "living law" within indigenous communities. This study employs an empirical legal research method with a socio-legal approach using a descriptive-qualitative design. The results reveal the phenomenon of "collective autonomy," where the validity of medical consent does not merely rely on individual will but is significantly determined by the legitimacy of customary authority and family deliberation mechanisms. Findings indicate that current informed consent practices tend to be legalistic-formal and fail to translate medical risks into local cultural logic, thereby creating judicial vulnerability for both medical personnel and indigenous patients. It is concluded that a reconstruction of the informed consent model based on "Integrative Legal Pluralism" is required, which accommodates communal consent and the use of cultural mediators as a legitimate part of medico-legal procedures. This model offers a strategic solution to achieve a more inclusive healthcare service, respecting the constitutional rights of indigenous peoples while ensuring equitable legal certainty in Indonesia.

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INTRODUCTION

The current transformation of the global health system is not only focused on improving the quality of medical care, but also places the protection of human rights at the core of every health intervention (Muyskens, 2024). One of the key instruments symbolizing this protection is the informed consent mechanism. Consent for medical procedures is not merely an administrative formality to be fulfilled before a procedure is performed, but a concrete manifestation of the principle of individual autonomy universally recognized in modern health law (Wahyuni et al., 2021). In Indonesia, the strengthening of regulations through Law No. 17 of 2023 on Health further reinforces the obligation of healthcare providers to provide patients with complete, accurate, and understandable information before any procedure is performed (Kesuma, 2024). However, the implementation of these global standards does not always proceed smoothly. Challenges arise when the principle of individual autonomy clashes with the heterogeneous social structure of society, where communal values still serve as a guiding principle in various regions (Parmar & Rathod, 2025). Thus, informed consent in Indonesia is not merely a matter of compliance with written law, but also a matter of how that law interacts with complex social realities.

From a sociological perspective, this phenomenon can be analyzed through the theory of legal pluralism, which acknowledges the existence of more than one legal system within a single social space. This theory asserts that state law is not always the sole authority to which people adhere in their daily practices (Patil et al., 2024). In indigenous communities, decision-making mechanisms are often based on living law—that is, law that evolves in accordance with local values, where collective consensus takes precedence over individual will (Shrinkhal, 2021). The interaction between the centralized state law and the decentralized customary law creates a dynamic space for negotiation, but often leads to legal ambiguity. This tension demonstrates that informed consent is not merely a legal document but an arena of value contestation between modernity, which emphasizes individualism, and tradition, which upholds collectivism (Patil et al., 2024; Tham et al., 2022). In other words, the practice of informed consent in Indonesia must be understood as a dialectical process between two distinct legal systems that both possess social legitimacy.

At the heart of this tension lies a fundamental conceptual gap between individual autonomy, as constructed by positive law, and collective autonomy as practiced in indigenous communities. Individual autonomy presupposes that medical decisions rest solely with the patient as a rational, independent subject, whereas collective autonomy distributes decision-making authority across family networks, clan structures, or traditional leaders whose consent carries equal or greater social legitimacy than that of the individual patient (Patil et al., 2024; Shrinkhal, 2021). This conceptual divergence is not merely a cultural difference but a structural legal incompatibility, wherein a single signed consent document cannot adequately capture the communal deliberation processes that define medical decision-making in indigenous contexts.

Observations in various indigenous communities reveal a disconnect between hospital standard operating procedures (SOPs) and local cultural realities. Healthcare workers often face ethical and legal dilemmas when patients fully delegate medical decisions to traditional leaders or tribal elders (Drummond et al., 2022; Feng et al., 2024). From a state legal perspective, such actions are deemed to violate individual autonomy, but sociologically, compliance with traditional authority constitutes a form of collective truth that holds strong legitimacy (Lega et al., 2022). This uncertainty has the potential to trigger medical disputes in the event of unintended risks, given that legal protection for healthcare providers is highly dependent on the validity of such consent. Field conditions indicate that a one-size-fits-all approach to implementing informed consent is no longer relevant for indigenous communities (Githaiga & Swartz, 2022; Tham et al., 2022). Therefore, a more flexible legal framework that is sensitive to cultural diversity is needed so that healthcare providers are not placed in a legally vulnerable position.

A number of previous studies have attempted to explore the sociological dimensions of medical practice, but their focus has remained limited (Bahiyah & Septiana, 2025; Galvin et al., 2024; Kirchhoffer, 2023; Tropman, 2026). A study by Bahiyah & Septiana (2025) highlights language barriers as a major obstacle to fulfilling the right to information for remote communities. Another study by Kirchhoffer(2023) emphasizes the effectiveness of mediation in resolving medical disputes within communal societies. Meanwhile, Tropman (2026) study focuses more on the civil liability of doctors in cases of failed informed consent. Although this literature provides valuable insights, most studies still focus on the technical aspects of communication or legal liability after a dispute has occurred (Galvin et al., 2024). Thus, there are not yet many studies that deeply link the practice of informed consent with the framework of legal pluralism as an integrative approach.

There is a clear research gap in that the aspect of legal pluralism as an integrative framework in the practice of informed consent among indigenous communities has not yet been comprehensively addressed. Most studies still position state law as the dominant entity and view customary law as an obstacle, rather than as an equal legal subject in a dialectical process (Jodyvash, 2025; Patil et al., 2024). No in-depth study has yet offered a model synthesizing modern medical procedures with indigenous decision-making structures to minimize legal risks for both parties. The absence of operational guidelines grounded in legal pluralism leaves medical personnel frequently in a legally vulnerable position (Bailie et al., 2024). Furthermore, the conceptual gap between individual autonomy and collective autonomy remains theoretically unresolved in existing health law scholarship. Prior models of informed consent have been designed exclusively around the liberal subject—a singular, autonomous decision-maker—thereby rendering them structurally ill-equipped to accommodate communal deliberation processes without producing legal uncertainty for healthcare providers (Bailie et al., 2024; Patil et al., 2024). This unresolved gap not only undermines the legal validity of consent obtained in indigenous settings but also exposes both patients and healthcare providers to heightened risk in the event of medical disputes. This underscores the urgency of research capable of formulating an informed consent model that is more adaptable to the legal pluralism in Indonesia.

The novelty of this article lies in its proposal to reconstruct the informed consent model to accommodate the concept of "collective autonomy" among indigenous communities without undermining the formal legality of state law. Unlike previous approaches that either apply state law uniformly, thereby marginalizing customary practice, or treat customary law as a purely informal mechanism outside the legal system, the integrative legal pluralism model proposed in this article operates on a fundamentally different premise: it positions both state law and customary law as co-equal, mutually legitimating legal systems within a single operational framework. Concretely, this model introduces the mechanism of cultural mediation as a legally recognized procedural step within the informed consent process, thereby bridging the structural gap between individual autonomy—as required by positive law—and collective autonomy—as practiced in indigenous communities.

This is a departure from prior scholarship, which has treated mediation and legal compliance as separate and sequential, rather than as integrated and concurrent dimensions of valid medical consent (Kirchhoffer, 2023; Tropman, 2026). This article not only highlights legal conflicts but also offers a middle ground through the perspective of integrative legal pluralism, which aligns with the spirit of deculturalizing health services (Bahiyah & Septiana, 2025; Tropman, 2026). The research focuses on how cultural mediation mechanisms can be made an integral part of legally valid medical consent documents. Thus, this study is expected to contribute to the development of a national health law that is more inclusive, adaptive, and sensitive to cultural diversity in Indonesia.

RESEARCH METHOD

This study employs an empirical legal approach within a socio-legal framework. This approach was chosen because it can explain how state legal norms interact with the living law within indigenous communities, particularly in the practice of informed consent. Using a socio-legal method, the research does not merely stop at a normative analysis of statutory texts but also examines how the law is internalized, negotiated, and practiced in daily life. The research focuses on the social dynamics that emerge when the principle of individual autonomy—which forms the basis of modern health law—clashes with the communal values that remain strong in indigenous communities. Therefore, this study is an exploratory qualitative study, aiming to delve deeply into legal phenomena as complex and layered social phenomena.

Primary data was collected through in-depth interviews using purposive sampling with key informants, namely traditional leaders as holders of communal authority, health workers stationed in traditional territories, and members of indigenous communities who had undergone medical procedures. The selection of informants was guided by a set of deliberate criteria designed to ensure representativeness and depth of data. Traditional leaders were selected based on three criteria: (1) formal recognition by the indigenous community as a legitimate holder of customary authority, either through hereditary position or community deliberation; (2) a minimum of five years of active involvement in communal decision-making processes, including decisions related to health matters; and (3) direct experience in mediating or being consulted during medical procedures performed on community members.

Healthcare workers were selected based on: (1) a minimum of two years of active service within or in direct proximity to indigenous territories; (2) demonstrated experience managing cases in which patients delegated consent to traditional leaders or extended family structures; and (3) willingness to reflect on the ethical and legal dilemmas encountered during such interactions. Community members were selected based on: (1) having personally undergone or accompanied a family member through a medical procedure requiring informed consent at a health facility; (2) active participation in customary decision-making practices; and (3) ability to articulate their experience in communicating with health personnel regarding medical procedures. These criteria collectively ensured that each informant category provided data that was contextually grounded, legally relevant, and culturally embedded, thereby strengthening the validity and representativeness of the findings.

The interviews were conducted using a semi-structured guide to allow researchers to explore the informants' experiences, perceptions, and legal and ethical dilemmas, while also providing space for them to freely express their views. Additionally, participatory observation was conducted in the field to observe communication dynamics, the process of negotiating values, and the interaction between elements of individual and collective autonomy when medical consent is given. Secondary data included primary legal materials such as Law No. 17 of 2023 on Health and its implementing regulations, as well as secondary legal materials such as academic literature, international journals, and previous research relevant to legal pluralism and informed consent practices.

Data analysis was conducted using the Miles & Huberman interactive model, which consists of data reduction, data presentation, and inductive conclusion-drawing. Data reduction was performed by sorting relevant information from the interviews and observations, which was then presented in the form of a thematic matrix to map the interactions between state law and customary law. Conclusions were drawn inductively by formulating patterns, relationships, and a conceptual model of informed consent based on legal pluralism. To ensure the validity of the findings, this study employed source and methodological triangulation, as well as member checking with informants to ensure interpretations align with the realities they experience. Using a systematic and valid methodology, this study aims to produce a model for reconstructing informed consent based on legal pluralism that accommodates the collective autonomy of indigenous communities without disregarding the formal legality of state law, thereby contributing to the development of a national health law that is more inclusive and sensitive to cultural diversity.

RESULTS AND DISCUSSIONS

Research Result

The data from this study are categorized into two main aspects: field findings obtained through interviews and observations (primary data), and an analysis of regulations and legal documents relevant to informed consent practices (secondary data). In summary, these findings are presented in the following table:

Table 1. Comparison of primary and secondary data findings in informed consent practices

Observation Aspect	Primary Data Findings (Empirical)	Secondary Data Findings (Normative)
Decision-Making Subject	Decisions are made collectively through extended family deliberation or with the approval of the Traditional Leader.	Law No. 17 of 2023 stipulates that consent must come from the patient concerned or their closest family (spouse/child/parent).
Information Delivery Process	Health workers often engage in "cultural negotiation" by explaining medical procedures first to the traditional leader in order to gain community trust.	Minister of Health Regulation No. 290/2008 requires doctors to provide direct explanations to patients individually.
Risk Understanding	Medical risks are often associated with supernatural aspects or violations of customary taboos, so clinical information is not fully internalized.	Legal standards require patients to understand medical risks rationally and scientifically as a prerequisite for valid consent.
Function of the Document	The informed consent form (signature/thumbprint) is perceived merely as an administrative requirement to access services at community health centers or hospitals.	Juridically, the document serves as the primary legal evidence protecting health workers from malpractice claims.
Main Obstacles	Language barriers (local dialects) and social structures that position individuals as inseparable parts of the community (communal rights).	State regulations are centralized and tend to overlook differences in social structures within indigenous communities (individual rights).

This presentation of the research findings focuses on the dichotomy between normative health law standards and empirical realities in indigenous communities. Based on the data in Table 1, it was found that the subject of medical consent in indigenous communities has shifted from individual autonomy toward collective autonomy. Although Law No. 17 of 2023 on Health explicitly emphasizes that consent must come from the patient concerned or their immediate family (Siahaan, 2024), the reality on the ground indicates that the approval of the Traditional Chief or tribal elders is the primary determinant (Arini et al., 2021). This pattern confirms that within communal social structures, individual rights often merge into group decisions as a form of compliance with living customary law (Lega et al., 2022). The discrepancy between regulatory mandates and the practices of local authorities creates ambiguity regarding the legal standing of the patient in medical procedures.

The process of providing information within the informed consent mechanism also reveals the use of "cultural negotiation" strategies by healthcare providers to bridge differences in values. Normatively, doctors are required to provide direct explanations to patients in accordance with medical competency standards (Arini et al., 2021). However, primary findings indicate that medical personnel often must first hold consultations with traditional leaders to ensure that medical procedures gain the community's trust (Partama et al., 2025; Yatindra et al., 2025). This strategy constitutes a form of procedural hybridization in which medical operational standards adapt to local social hierarchies so that healthcare services can be accepted without resistance. This phenomenon demonstrates that the successful communication of medical information is highly dependent on recognition of traditional authority structures existing outside the state's legal system (Galvin et al., 2024).

The aspect of understanding medical risks is a crucial point where there is a gap between clinical logic and the cultural logic of indigenous communities. Legal standards require patients to understand risks rationally and scientifically as a prerequisite for valid consent (Indradi & Syafitri, 2023). However, observational findings reveal that indigenous communities tend to associate medical risks with supernatural aspects or violations of cultural taboos prevalent in their regions (Priyono et al., 2022). This situation results in medical information provided by doctors not being fully internalized, but rather merely accepted as part of hospital administrative procedures (Wardani, 2021). The inability of regulations to accommodate these culturally-based risk perceptions often leads to a failure to fulfill the right to substantive information for indigenous patients (Rahmawati, 2022). This divergence between medical logic and cultural logic produces a compounding impact on risk understanding that operates at three levels. At the cognitive level, patients who interpret medical risks through the lens of supernatural causation are structurally unable to engage with clinical probability frameworks. This implies that even a technically correct explanation by a physician fails to generate the informed understanding that the law presupposes. At the communicative level, the mismatch creates a situation in which the formal act of consent, such as signing a document or providing a thumbprint, becomes decoupled from any meaningful comprehension of consequence. This transforms consent into a performative gesture rather than a substantive decision. At the legal level, this disconnect produces a structural injustice where patients who have not genuinely understood the risks they consented to bear the full legal consequences of that consent, while healthcare providers who obtained it remain formally protected. Together, these three levels of impact demonstrate that the failure to bridge cultural and medical epistemologies does not merely impede communication but fundamentally compromises the legal legitimacy of the consent process itself (Galvin et al., 2024; Shrinkhal, 2021).

Furthermore, the role of the informed consent document at the research site has been reduced in significance, from a tool for protecting rights to a mere bureaucratic formality. From a formal legal standpoint, this document serves as the primary evidence for medical personnel to mitigate future malpractice claims (Parmar & Rathod, 2025). However, for indigenous communities, signing or placing a thumbprint on the consent form is viewed merely as a prerequisite for accessing healthcare services so that medical procedures can be performed promptly (Shrinkhal, 2021). The low level of understanding regarding the legal consequences of this document places indigenous communities in a vulnerable position in medico-legal disputes (Asmara et al., 2022). This demonstrates that the protective function of informed consent has not yet been optimally implemented in communities that still place a higher value on verbal agreements than on written documents.

Finally, the research findings highlight the existence of structural barriers rooted in the centralistic nature of the state's legal system. Current national health regulations are designed with a rigid, individualistic approach, thereby failing to accommodate the communal rights recognized by the constitution (Drummond et al., 2022). The social structure of indigenous communities, which views the individual as an inseparable part of the community, creates a systemic clash with highly autonomous modern medical procedures. The absence of specific clauses in health service SOPs that accommodate legal pluralism often leaves healthcare workers in a state of uncertainty regarding whether to comply with state procedures or respect customary norms (Lega et al., 2022; Okyere Asante et al., 2023). Therefore, this data underscores the need for a more inclusive informed consent model that is sensitive to the evolving legal dynamics within indigenous communities.

Discussion

An interpretation of the research findings suggests that legal pluralism in the practice of obtaining consent for medical procedures among indigenous communities is a concrete manifestation of strong legal pluralism. Primary data findings showing the dominance of the "traditional leader's consent" over individual will demonstrate that customary law, as a living law, is not merely a complement but the primary filter for the effectiveness of state law (Muyskens, 2024). This phenomenon of "collective autonomy" confirms Sally Falk Moore's theory that indigenous communities operate within a semi-autonomous social field, where they are capable of producing internal rules and enforcing compliance that, in practice, can override the applicability of formal norms as stipulated in Article 293(1) (1) of Law No. 17 of 2023 on Health, which stipulates that every medical procedure must obtain the patient's consent following a full explanation (Jin et al., 2021; Kesuma, 2024).

The substantive legal significance of this shift from individual to collective consent is profound and multidimensional. In terms of the subject of law, the shift challenges the foundational assumption that legal validity requires an individual and identifiable consenting party. When consent is embedded in a collective deliberative process, the legal subject is no longer a single person but rather a social unit. This represents a configuration that current health law is structurally unprepared to recognize (Osborne, 2026). In terms of validity, collective consent derives its legitimacy not from the formal requirements of state law but from the social authority of customary structures, which nonetheless command genuine compliance and social enforcement. This means that collective consent may be substantively more legitimate, in the sense of reflecting the actual and informed will of those affected, than individual consent obtained from a patient who lacks genuine comprehension or social agency to decide independently. In terms of legal protection, the unrecognized status of collective consent creates a paradox where healthcare providers who adapt to communal decision-making practices to obtain genuinely informed consent risk operating outside the formal protections afforded by state law. Conversely, those who rigidly follow formal individual consent procedures may secure legal protection at the expense of substantive patient understanding. This paradox underscores the urgency of recognizing collective consent as a legally valid form of legitimacy within the framework of integrative legal pluralism (Lega et al., 2022; Patil et al., 2024).

However, the norms in that article contain a fundamental flaw because they are based on the universal assumption that legal subjects are autonomous and rational individuals. This assumption is not fully compatible with the social structure of indigenous communities, which views the individual as an integral part of the community. Consequently, this individualistic construction of the norm has the potential to result in the normative exclusion of indigenous communities, as it fails to recognize the existence of collective consent mechanisms as a valid form of legitimacy. The lack of explicit recognition of customary authority in this article creates a legal gap that, in practice, is filled by customary norms as the primary source of legitimacy. This demonstrates that state law is not fully capable of functioning effectively without the support of the living law within (Parmar & Rathod, 2025; Tropman, 2026). The dominance of traditional leaders' authority in the consent process carries specific and serious implications for the legal validity of medical consent across three dimensions. First, regarding the chain of consent authorization, when the final decision rests with the traditional leader rather than the patient, the legal chain of consent which must run from the informed individual to the signed document is effectively broken. The document that exists at the end of this process does not accurately represent who made the decision or on what basis. This creates a validity gap that could be exploited in future medico-legal disputes (Drummond et al., 2022; Jodyvash, 2025). Second, regarding accountability allocation, if a medical adverse event occurs and the consent obtained was substantively the product of the traditional leader's authority rather than the patient's individual will, the question of who bears legal responsibility becomes legally ambiguous.

State law assigns responsibility based on the documented individual consent, yet the actual decision was made communally. This mismatch is a situation that neither the patient, the healthcare provider, nor the traditional leader is formally equipped to resolve within the existing legal framework. Third, regarding evidentiary weight, a signed consent form carries formal evidentiary weight in a court proceeding regardless of the process by which it was obtained. This means that the dominance of traditional authority, however substantively legitimate it may be within the community, leaves no legally admissible trace in the formal record. Consequently, it is rendered legally invisible while it remains socially determinative. These implications collectively demonstrate that without explicit legal recognition of the role of traditional authority in the consent process, the dominance of that authority does not strengthen legal validity but instead silently undermines it (Arini et al., 2021; Lega et al., 2022; Shrinkhal, 2021).

Furthermore, from a positive law perspective, the mechanism of informed consent is also regulated in Ministry of Health Regulation No. 290/MENKES/PER/III/2008, specifically Articles 3 and 4, which require physicians to provide a direct explanation to the patient or their immediate family regarding the diagnosis, the purpose of the procedure, the risks, and alternative treatments (Pramesuari, 2024). Normatively, this provision appears comprehensive, but it has a structural weakness because it recognizes only a linear relationship between doctor and patient, without considering the presence of other social actors such as traditional leaders or community figures who hold substantive authority in the decision-making process (Saptandari, 2022).

Another weakness of this regulation is the lack of normative flexibility in the methods of conveying information, which should be adaptable to local cultural and linguistic contexts. As a result, these provisions tend to be procedural and formalistic, potentially overlooking the substantive effectiveness of communication. Research findings indicate that healthcare providers actually engage in "cultural negotiation" as a form of constructive deviation from these norms—deviations that are normatively deemed deviant but sociologically serve as a prerequisite for the success of healthcare services (Patil et al., 2024; Windayani & Adipradana, 2020). This situation underscores that the rigidity of state legal norms without room for cultural adaptation actually has the potential to hinder the tangible fulfillment of patients' rights (Feng et al., 2024.; Hasliani & Wulandari, 2023). These findings collectively reveal three interrelated structural weaknesses in the existing regulatory framework. First, the architecture of health regulations — spanning Law No. 17 of 2023, Ministerial Regulation No. 290/2008, and Article 1320 of the Civil Code — is constructed upon a monist legal assumption that recognizes only one legitimate legal subject: the autonomous individual. This assumption systematically excludes communal decision-making structures from the formal scope of legal validity. Second, none of these instruments contain any transitional or adaptive clause that would allow healthcare providers to formally accommodate customary authority without breaching existing procedural obligations, thereby producing what may be termed a "regulatory vacuum of pluralism." Third, the enforcement orientation of these regulations — which prioritizes documentary compliance over substantive understanding — reflects an inherent structural bias toward procedural formalism, making them structurally ill-equipped to generate substantive justice in contexts where legal culture is predominantly oral and communal (Patil et al., 2024; Shrinkhal, 2021).

Disparities in the understanding of medical risks also reveal serious limitations in the normative approach to health law. Legally, the principle of consent to medical procedures requires an informed decision that meets the validity requirements for contracts under Article 1320 of the Civil Code, particularly the element of "mutual agreement" between the parties, which must be free from error and based on adequate understanding. However, in the context of indigenous communities, consent is not always based on individual rationality, but rather through a collective process involving considerations of values, beliefs, and customary norms (Shrinkhal, 2021).

The fundamental flaw in this Civil Code approach lies in its abstract and individualistic nature, which renders it incapable of addressing the complexity of social relations within communal societies. Consent that formally satisfies the element of "agreement" under civil law risks becoming pseudo-consent, as it is not grounded in a substantive, contextual understanding. This creates a situation where state law recognizes the formal validity of consent, yet simultaneously fails to ensure justice for the party giving such consent (Putri, 2023; Sistini, 2023). Thus, existing legal standards represent procedural justice rather than substantive justice (Muyskens, 2024).

In the context of the function of documents, informed consent is legally positioned as the primary means of evidence in the legal protection of healthcare workers. However, the weakness of this approach lies in the dominance of the written evidence paradigm, which is not fully compatible with the legal culture of indigenous communities, which places greater emphasis on oral and collective legitimacy (Parmar & Rathod, 2025). Normative provisions do not allow for forms of non-documentary legitimacy, thereby implicitly discrediting customary legal mechanisms as invalid. This results in an imbalance in legal protection, where healthcare providers rely on formal documents, while indigenous communities do not fully understand the meaning and consequences of such documents (Hasmita et al., 2026; Patil et al., 2024; Saptandari, 2022).

As a result, the state's legal system remains trapped within the paradigm of procedural justice—that is, the fulfillment of administrative requirements without ensuring genuine understanding and awareness. This gap between "law in books" and "law in action" indicates that positive law has not yet been able to fully encompass social reality (Okyere et al., 2023). In this context, substantive justice can only be achieved if the state's legal system creates space for the recognition and integration of customary law as an alternative source of legitimacy (Muyskens, 2024). Therefore, the findings of this study clearly demonstrate that the shortcomings in state legal norms—whether in the Health Law, the Minister of Health Regulation, or the Civil Code—cannot be resolved solely through internal normative revisions, but rather require a pluralistic approach that recognizes the existence of customary law as a living and effective legal system (Patil et al., 2024). Customary law functions not merely as a supplement, but as a corrective mechanism capable of filling legal gaps and addressing the rigidity of state norms. In this context, the reconstruction of an informed consent model based on integrative legal pluralism becomes an imperative.

This model must accommodate collective autonomy as a legitimate part of medico-legal procedures, in which the consent of traditional leaders is not viewed as an obstacle, but as a form of social legitimacy that reinforces the validity of individual consent (Tropman, 2026). Furthermore, the presence of a cultural mediator serves as a crucial instrument in bridging the epistemological gap between the modern medical system and local belief systems, ensuring that the informed consent process fulfills not only formal but also substantive requirements (Jodyvash, 2025). This approach ultimately strengthens state law, as it provides legal certainty that is not only normative but also contextual and responsive to social realities.

Thus, this reconstruction affirms that justice in the practice of informed consent can no longer be measured solely by compliance with administrative procedures as stipulated in legislation. Justice must be understood as the fulfillment of comprehensive understanding, awareness, and social legitimacy, which can only be achieved through the integration of state law and customary law. Within this framework, customary law becomes an essential element in realizing substantive justice, while simultaneously correcting the limitations of state law, which has historically tended to be formalistic (Kirchhoffer, 2023; Miarsa & Feliks, 2026; Muyskens, 2024; Putri, 2023).

CONCLUSION

This study concludes that the practice of informed consent among indigenous communities is a tangible manifestation of legal pluralism in Indonesia, where there is an unresolved dialectic between the doctrine of individual autonomy in state law (Law No. 17 of 2023) and the doctrine of collective autonomy in the living law of indigenous communities. The findings indicate that the validity of consent for medical procedures in the field is not merely determined by the signing of administrative forms, but is heavily dependent on social legitimacy through the endorsement of traditional leaders and communal consensus. Information asymmetry and differing perceptions of medical risks underscore that current informed consent standards remain centralized and have yet to adequately accommodate the constitutional rights of indigenous communities. Therefore, it is recommended that policymakers and healthcare practitioners reconstruct an inclusive-pluralistic informed consent model by legitimizing the mechanism of "communal consent" as an integral part of formal medical procedures. Additionally, subsidiary regulations under the Health Law are needed to specifically govern the role of cultural mediators in bridging therapeutic communication, thereby creating legal certainty that respects cultural diversity while ensuring the protection of human rights for indigenous communities and healthcare workers. At the policy level, integrating customary law into the national health system requires revising subsidiary regulations under Law No. 17 of 2023 to formally recognize communal consent and the role of traditional leaders, mandating culturally adaptive SOPs in health facilities within indigenous territories, and embedding legal pluralism literacy into medical professional training. The principal theoretical contribution of this study lies in repositioning collective autonomy from a peripheral complement to a co-equal source of legal legitimacy within the medico-legal consent process, thereby offering an integrative legal pluralism framework that directly corrects the procedural formalism embedded in existing health regulations. For healthcare workers, the communal consent model carries three practical implications: it provides formal legal recognition for culturally adaptive practices already undertaken informally; it reduces legal vulnerability arising from consent documents that do not reflect actual communal deliberation; and it establishes the cultural mediator as a formally recognized procedural safeguard, ensuring that substantive patient understanding and formal legal compliance are achieved simultaneously.

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