

Resolving medical malpractice disputes through customary institutions: Between statutory law and local wisdom

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ABSTRACT

The transformation of medical dispute resolution in Indonesia reveals a critical paradox: while Law No. 17 of 2023 on Health mandates non-litigation mechanisms, the existing framework remains entrapped within a state-centric legal paradigm that systematically marginalizes customary institutions which have long served as accessible, socially legitimate, and restoratively-oriented dispute forums across diverse Indonesian communities. A fundamental research gap persists in the prevailing legal monism approach, which creates a normative vacuum by failing to recognize customary institutions operationally within health law, thereby forcing communities to choose between legally certain but inaccessible formal mechanisms and socially accepted but legally uncertain customary processes – a justice gap that disproportionately burdens economically vulnerable populations. This study employs a normative-prescriptive legal methodology integrating legislative, conceptual, and comparative approaches to reconstruct the positional framework of customary institutions within medical dispute resolution. The findings reveal that customary institutions hold strong constitutional legitimacy under Article 18B(2) of the 1945 Constitution yet operate within a normative vacuum in the medical domain, and introduce a Two-Tier Integrative Model positioning customary institutions as relational mediation forums at the first tier and MKDKI as technical verifier at the second tier, connected through a court homologation mechanism. This study provides a strategic normative blueprint recommending explicit revision of Law No. 17 of 2023 to accommodate customary institutions within the national medical dispute resolution system.

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INTRODUCTION

Medical malpractice is a health law issue that continues to evolve alongside the increasing complexity of modern healthcare services in Indonesia. Medical disputes involving healthcare

providers and patients not only result in financial losses but also impact public trust in healthcare institutions as a whole (Rusdi et al., 2025; Wiguna et al., 2025). In practice, medical disputes often arise from an information imbalance between healthcare providers and patients, leaving patients in a vulnerable position both legally and socially (Kurniawati & Fahmi, 2023). This situation is exacerbated by weaknesses in documentation and evidence systems, where medical records—as the primary evidence—are often not utilized optimally in the dispute resolution process (Daud et al., 2024).

Indonesia's positive legal system has, in fact, provided a number of mechanisms for resolving medical malpractice disputes, ranging from criminal and civil proceedings to administrative channels through the Indonesian Medical Disciplinary Honorary Council (MKDKI). However, these formal mechanisms are considered unable to provide effective, fair, and satisfactory resolutions for all parties (Sun & Yusuf, 2024; Widjaja & Harry, 2025). The lengthy litigation process, high costs, and the complexity of proving medical negligence make the court system not always the appropriate choice for the public, particularly economically disadvantaged groups (Anggraeni et al., 2025). On the other hand, the implementation of Law No. 17 of 2023 on Health has not fully accommodated dispute resolution mechanisms that are responsive to the social and cultural needs of Indonesia's diverse society (Widjaja, 2025).

The dominance of the legal monism paradigm in Indonesian health law is driven by several interrelated structural factors. First, the historical legacy of the colonial civil law tradition has deeply embedded positivist legal thinking within Indonesia's legislative and judicial institutions, positioning state law as the sole legitimate normative source and systematically marginalizing non-state normative orders such as customary law (Muyskens, 2024). Second, the centralized architecture of national health regulation, particularly as manifested in Law No. 17 of 2023 on Health and its implementing instruments, is designed with reference exclusively to formal legal institutions, namely courts, MKDKI, and licensed mediators, leaving no operational space for indigenous or community-based normative mechanisms (Drummond et al., 2022). Third, the absence of a legal pluralism framework within health law education and professional legal training perpetuates a state-centric judicial culture that reflexively treats customary norms as pre-modern or legally subordinate, foreclosing their recognition in sectoral health legislation. Fourth, the political economy of health law reform has been predominantly shaped by professional medical associations and formal legal institutions whose institutional interests structurally align with maintaining the primacy of the state-based dispute resolution apparatus, thereby sustaining the monist paradigm even as its inadequacies become increasingly evident in practice (Jodyvash, 2025; Lega et al., 2022).

Recognizing the limitations of the litigation process, the idea of resolving medical disputes through alternative approaches has garnered increasing attention in the discourse on health law in Indonesia. The restorative justice approach has begun to be promoted as a new paradigm that emphasizes the restoration of relationships between the parties, rather than merely punishment (Hafizah & Fitriasih, 2022; Riyanto, 2024). This concept is considered relevant because the relationship between healthcare providers and patients is fundamentally therapeutic and based on trust; thus, a restorative approach is better suited to restoring such relationships than the adversarial process in court (Ekawati et al., 2023; Putri, 2023). Following the enactment of the new Criminal Code, the implementation of restorative justice in the resolution of medical disputes has gained a stronger normative foundation, although in practice it still faces various technical and institutional challenges (Rizal & Ahzar, 2026).

Beyond these formal and semi-formal mechanisms, social reality shows that some Indonesians, particularly those living in areas with strong traditional ties, prefer to resolve disputes—including those with medical dimensions—through local customary institutions. Customary institutions such as the Tuha Peut in Aceh, the Desa Pakraman in Bali, and customary institutions in Papua have proven to serve as effective dispute resolution forums in maintaining

community social harmony (Alexander, 2021; Yulia et al., 2021). The strengths of customary institutions lie in their accessibility, social legitimacy, and their ability to integrate local wisdom values into a consultative and restorative dispute resolution process (Budiana et al., 2025; Mahardika et al., 2022). This phenomenon reflects the strength of legal pluralism in Indonesian society, where state law and customary law operate side by side and influence one another (Saptandari, 2022).

The existence of customary institutions as forums for dispute resolution is, in fact, firmly grounded in the Indonesian legal system. Article 18B(2) and Article 28I(3) of the 1945 Constitution explicitly recognize and respect the unity of customary law communities and their traditional rights. This normative recognition is reinforced by various local regulations that provide space for customary institutions to resolve disputes among residents (Hasmita et al., 2026). In the context of healthcare services, a culturally sensitive approach has proven effective in building trust between patients and medical personnel, while simultaneously reducing the potential for conflicts that could lead to formal disputes (Widjaja & Sijabat, 2025). Thus, the integration of customary law values into the medical dispute resolution system is not merely an idealistic discourse, but a practical necessity with a clear legal basis (Kusmiati, 2025).

Nevertheless, the involvement of customary institutions in the resolution of medical malpractice disputes is not without a number of critical normative tensions. The absence of explicit regulations governing the authority of customary institutions in the realm of health disputes raises fundamental questions about the legal certainty of any agreements reached through customary forums (Jauhani et al., 2022; Mahendra, 2025). The issue of technical-medical competence poses a distinct challenge, given that assessing medical service standards requires specific clinical knowledge and cannot always be evaluated solely through the lens of customary values (Yatindra et al., 2025). On the other hand, there is a risk that decisions by customary institutions may conflict with national health law standards, potentially creating legal uncertainty for the parties involved (Riyanto, 2024). This tension ultimately places customary institutions in an ambiguous position: socially recognized, yet not yet fully accommodated formally within Indonesia's health legal system (Siregar, 2025).

Compared to other non-litigation alternatives, including formal mediation through licensed mediators, arbitration under Law No. 30 of 1999, and hospital-based internal ombudsman mechanisms, customary institutions offer structurally distinct advantages that justify their specific integration into the health law system. Formal mediation and arbitration, while procedurally recognized, remain inaccessible to communities in rural or remote regions due to prohibitive costs, linguistic barriers, and the practical requirement for professional legal representation (Widjaja, 2025a). Hospital internal ombudsman mechanisms, though administratively convenient, operate under an inherent institutional conflict of interest that fundamentally undermines their independence and credibility from the patient's standpoint. Customary institutions, by contrast, are geographically embedded within the communities they serve, linguistically and culturally accessible, and socially trusted by virtue of their organic integration into local life – making them uniquely capable of reaching populations that all existing formal non-litigious mechanisms have systematically failed to serve (Anggraeni et al., 2025; Rizal & Ahzar, 2026). Furthermore, unlike mediation and arbitration that essentially replicate the adversarial logic of litigation in a milder procedural form, customary institutions employ fundamentally restorative processes grounded in communal values, relational restoration, and social harmony – an orientation more genuinely aligned with the therapeutic nature of healthcare relationships than any proceduralized alternative. The urgency of integrating customary institutions into the health law system therefore lies not merely in filling a normative gap, but in addressing a deep structural access-to-justice failure that no existing non-litigious alternative has been institutionally capable of resolving (Putri, 2023; Rizal & Ahzar, 2026; Wijaya & Jayanti, 2025).

Previous studies on medical disputes in Indonesia have generally focused on the analysis of positive law—from criminal, civil, and administrative perspectives—with restorative justice emerging as an alternative approach (Miarsa & Feliks, 2026; Windayani & Adipradana, 2020). Meanwhile, research on customary institutions typically addresses land disputes, inheritance, or general social conflicts, without specifically addressing the domain of health disputes or medical malpractice (Alexander, 2021; Mahardika et al., 2022). Although some studies have begun to address the integration of customary law-based restorative justice in the resolution of medical disputes, comprehensive and systematic analyses regarding the legal standing of customary institutions in this context remain very limited (Gunawan, 2025; Wijaya & Jayanti, 2025). It is this academic gap that serves as the starting point for this article: to conduct an in-depth analysis of how customary institutions can be positioned normatively and functionally within Indonesia's medical malpractice dispute resolution system within the framework of legal pluralism.

Based on the background described above, this article formulates two main research questions: first, what is the legal status of medical malpractice dispute resolution through customary institutions within the framework of Indonesian national law; and second, how can the relationship between local wisdom and positive law be harmonized to form an integrative and equitable model for medical dispute resolution. This study employs a normative legal research method using a statutory approach, a conceptual approach, and a comparative approach to map and analyze various relevant normative constructs (Kurniawati & Fahmi, 2023; Siregar et al., 2022). The legal materials used include primary legal materials in the form of legislation, secondary legal materials in the form of scientific literature and court decisions, as well as tertiary legal materials to complement the analysis. The results of this study are expected to provide a theoretical contribution to the development of the concept of legal pluralism in Indonesian health law, while also offering practical recommendations for the formulation of policies that integrate local wisdom into the national medical dispute resolution system (Handoko et al., 2026; Hasibuan et al., 2026; Siregar, 2025).

RESEARCH METHOD

This study is a normative legal research that examines legal issues based on an analysis of relevant legal materials, without conducting empirical hypothesis testing in the field. The choice of this research type is based on the characteristics of the issues under study, namely regarding the normative status of customary institutions within the medical malpractice dispute resolution system and the harmonization between positive law and local wisdom within the framework of Indonesia's national legal system (Kurniawati & Fahmi, 2023). Normative legal research is considered the most appropriate because the issues under examination center on the consistency and coherence of legal norms, rather than on social behavior requiring direct field observation (Siregar, 2025). In this study, law is conceptualized as a structured system of norms, so the analysis is directed toward the identification, interpretation, and evaluation of the norms governing the resolution of medical disputes and the recognition of customary institutions within the Indonesian legal system.

To obtain a comprehensive and multi-layered analysis, this study employs three research approaches simultaneously. First, the statutory approach, which involves examining all laws and regulations related to the resolution of medical disputes and the recognition of customary law, ranging from the 1945 Constitution, Law No. 17 of 2023 on Health, and regional regulations that recognize the existence of customary institutions in various provinces. Second, the conceptual approach, which is used to construct an analytical framework based on the doctrines of legal pluralism and restorative justice to map the normative relationship between state law and customary law in the context of medical disputes (Hafizah & Fitriasih, 2022; Riyanto, 2024). Third, the comparative approach, which is used to compare practices of resolving medical malpractice disputes based on customary institutions in several regions in Indonesia, particularly Aceh, Bali,

and Kalimantan, so that general patterns as well as the specific characteristics of each model can be identified. The selection of these three regions as the basis for comparative analysis was guided by three deliberate criteria: (1) the degree of formal legal recognition, with Aceh representing the highest level of explicit regulatory recognition through Qanun No. 9 of 2008, Bali representing strong provincial-level recognition through Regional Regulation No. 4 of 2019, and Kalimantan representing legitimacy based predominantly on social and cultural authority rather than formal statutory recognition; (2) geographic and cultural diversity, ensuring that the comparative framework encompasses different Indonesian legal-cultural traditions (Islamic adat in Aceh, Hindu-Balinese adat in Bali, and Dayak customary law in Kalimantan); and (3) the documented existence of customary dispute resolution practices with health-related dimensions in each region, allowing for substantive rather than merely formal comparison of the mechanisms in question (Alexander, 2021; Budiana et al., 2025; Yulia et al., 2021).

The choice of a normative-prescriptive approach in this study is specifically grounded in the nature of the legal problem being addressed. The absence of an adequate normative framework for integrating customary institutions into the health law system is not merely a descriptive gap to be documented, but a prescriptive challenge requiring the formulation of principled normative recommendations (Githaiga & Swartz, 2022). A purely descriptive normative analysis would be insufficient, as it would only map the existing legal vacuum without proposing a constructive structural solution. The prescriptive dimension – informed by the comparative legal analysis and doctrinal reconstruction carried out across the three research approaches above – enables this study to move beyond diagnosis toward norm-building, consistent with the tradition of legal scholarship that treats law not only as an object of analytical inquiry but as a field of purposive normative design. This dual normative-prescriptive orientation is particularly appropriate in the context of legal pluralism, where the analytical task requires both the mapping of competing normative orders and the articulation of principled frameworks for their coordinated institutional integration within the national health law system (Hasibuan et al., 2026; Patil et al., 2024).

RESULTS AND DISCUSSIONS

Research Result

A review of primary and secondary legal sources in this study yielded four interrelated key findings. These findings include: a regulatory framework for the resolution of medical disputes under Indonesian positive law; the existence and authority of customary institutions in various regions; a typology of medical disputes resolved through customary mechanisms; and a comparison of the characteristics of these two dispute resolution systems. These four findings are presented sequentially and systematically as the basis for analysis in the discussion section (Kurniawati & Fahmi, 2023; Siregar, 2025).

The first finding pertains to the legal framework governing the resolution of medical malpractice disputes in Indonesia. A normative analysis reveals that Indonesia actually possesses a multi-layered legal framework for regulating the resolution of medical disputes, ranging from the constitutional level to technical regulations at the ministerial level. At the constitutional level, Article 28H of the 1945 Constitution guarantees every citizen's right to health care, while Article 18B(2) explicitly recognizes the existence of customary law communities and their traditional rights. At the statutory level, Law No. 17 of 2023 on Health expands the scope of medical dispute resolution through non-litigation channels (Widjaja, 2025; Widjaja & Harry, 2025). On the other hand, Law No. 30 of 1999 on Arbitration and Alternative Dispute Resolution provides a legal basis for the use of mediation and arbitration in medical disputes, although its application in practice remains very limited (Anggraeni et al., 2025; Sun & Yusuf, 2024). Overall, this regulatory framework can be mapped as presented in Table 1 below.

Table 1. Regulatory matrix of medical dispute resolution in Indonesia

No	Legal Instrument	Year	Regulated Mechanism	Authorized Institution	Nature of Resolution
1	1945 Constitution Art. 28H & 18B	1945	Right to health & recognition of customary law	–	Constitutional
2	Law No. 30/1999	1999	Mediation & arbitration	BANI / Mediator	Civil
3	Law No. 17/2023	2023	Medical dispute resolution	Court / Mediation	Criminal & Civil
4	Law No. 6/2014	2014	Recognition of village customary law	Village Customary Institution	Administrative
5	Regional Regulations	Varies	Customary-based disputes	Local Customary Institution	Local

The second finding concerns the existence and authority of customary institutions as dispute resolution forums within the Indonesian legal system. The results of normative and comparative research indicate that recognition of customary institutions as dispute resolution mechanisms is not uniform but varies significantly across regions, depending on the strength of local regulations and the social legitimacy held by each institution (Budiana et al., 2025; Mahardika et al., 2022). In Aceh, the Tuha Peut institution holds relatively strong authority under Qanun No. 9 of 2008 on the Development of Customary Life and Traditions, which explicitly regulates the resolution of eighteen types of disputes through customary deliberation mechanisms (Yulia et al., 2021). In Bali, the Majelis Desa Adat, which oversees the Desa Pakraman system, holds strong legitimacy under Bali Provincial Regulation No. 4 of 2019, with the authority to resolve disputes related to the social and customary life of the local community (Budiana et al., 2025). Meanwhile, in Papua and Kalimantan, customary institutions operate with legitimacy based more on social and cultural authority than on explicit formal regulations (Alexander, 2021). The profiles and authorities of customary institutions in these various regions are summarized in Table 2 below.

Table 2. Profile of customary institutions and their authority in dispute resolution across several regions

No	Region	Customary Institution	Legal Basis	Type of Dispute	Mechanism
1	Aceh	Tuha Peut / Wali Nanggroe	Qanun No. 9/2008	Social, family, land	Customary deliberation
2	Bali	Majelis Desa Adat	Regional Reg. Bali No. 4/2019	Customary, social, inheritance	Paruman adat
3	West Sumatra	Kerapatan Adat Nagari (KAN)	Regional Reg. West Sumatra No. 7/2018	Land, inheritance, social	Ninik mamak deliberation
4	Kalimantan	Lembaga Adat Dayak	Regional Reg. Central Kalimantan No. 16/2008	Social, land, customary	Damang tribunal
5	Papua	Lembaga Masyarakat Adat (LMA)	Law No. 21/2001	Social, land, conflict	Customary deliberation
6	Lombok	Lembaga Adat Sasak	Regional Reg. NTB	Family, social	Customary adjudication

The third finding reveals that customary institutions in various regions have, in fact, handled medical disputes, even though such authority has never been explicitly stipulated in any regulation. The medical disputes referred to in this context are conflicts arising from acts or omissions in the healthcare process, whether committed by formal medical personnel or by traditional health practitioners such as traditional midwives, healers, and traditional circumcisers (Hasmita et al., 2026; Yatindra et al., 2025). In practice, individuals who feel wronged by medical actions tend to bring their issues to customary forums first, before – or even as an alternative to – formal legal channels, particularly in regions with strong customary ties (Kurniawati & Fahmi, 2023; Widjaja & Sijabat, 2025). This tendency is driven by factors such as accessibility, trust in traditional leaders, and a resolution orientation that prioritizes the restoration of social relationships over formal punishment. The typology of medical disputes identified in this study is presented in Table 3 below.

Table 3. Typology of medical-related disputes resolved through customary mechanisms

No	Type of Dispute	Context	Region	Customary Mechanism	Form of Resolution
1	Traditional delivery negligence	Traditional midwife / village midwife	Java, NTB	Customary elder deliberation	Compensation + formal apology
2	Traditional medicine harm	Herbalist / traditional healer	Kalimantan, Papua	Damang customary tribunal	Customary compensation
3	Customary circumcision dispute	Non-medical circumcision practice	Aceh, NTT	Tuha Peut deliberation	Customary fine / dowry
4	Medical staff negligence at primary facility	Doctor / midwife at puskesmas	Aceh, Bali	Customary mediation + village head	Peace agreement
5	Traditional birth attendance failure	Traditional delivery practice	Lombok, West Sumatra	KAN / customary council	Deliberation & compensation

The fourth finding is the result of a comparative analysis of the characteristics of statutory law and customary mechanisms in the resolution of medical disputes. This comparison was conducted across ten aspects deemed crucial in determining the effectiveness and fairness of a dispute resolution mechanism. In terms of accessibility and cost, customary mechanisms consistently demonstrate an advantage over formal channels, given their community-based processes, lack of requirement for professional legal representation, and generally no significant administrative costs (Jauhani et al., 2022; Miarsa & Feliks, 2026). In terms of legal certainty and human rights protection, however, positive law is far superior because it is supported by a measurable, testable normative framework and possesses clear appeal mechanisms (Hasibuan et al., 2026; Riyanto, 2024). The most critical aspect lies in the dimension of medical technical standards: customary mechanisms lack any instruments to assess whether a medical procedure meets applicable clinical standards, whereas this is precisely the core of every genuine medical malpractice dispute (Daud et al., 2024; Wiguna et al., 2025). A comprehensive comparison of the two systems is summarized in Table 4 below.

Table 4. Comparative characteristics of medical dispute resolution between positive law and customary mechanisms

No	Aspect	Positive Law (Formal)	Customary Mechanism
1	Legal basis	Laws, Government Regulations, Ministerial Health Regulations	Customary law, Qanun, Regional Regulations
2	Accessibility	Limited, procedural	Easy, community-based
3	Cost	High	Low / no cost
4	Resolution time	Months to years	Days to weeks
5	Medical technical standard	Available and measurable	Unavailable
6	Legal certainty	High	Low to moderate
7	Result orientation	Punitive	Restoration & social harmony
8	Social legitimacy	Formal-institutional	High within customary communities
9	Human rights protection	Structured & verified	Dependent on local norms
10	Continuity of parties' relationship	Tends to be adversarial	Restorative

Based on the four findings above, it can be concluded descriptively that Indonesia has two medical dispute resolution systems operating in parallel: a structured yet rigid and exclusive statutory system, and a flexible, inclusive, and restorative-oriented customary mechanism that is, however, weak in terms of legal certainty and technical medical standards. These two systems have complementary strengths and weaknesses, thereby opening the possibility for harmonization, which will be analyzed in greater depth in the discussion section (Gunawan, 2025; Windayani & Adipradana, 2020).

Discussion

The resolution of medical malpractice disputes in Indonesia faces a paradoxical reality: on the one hand, the statutory legal system has provided a multi-layered framework ranging from criminal and civil channels to administrative channels through the MKDKI; however, these formal mechanisms have proven unable to meet the needs of a socially and culturally diverse society. On the other hand, customary institutions, which have de facto served as dispute resolution forums in various regions, have yet to receive operational recognition within the national health law's sectoral regulations. It is this paradox that constitutes the primary urgency of this study: that Indonesia's health legal system has not been able to accommodate the legal pluralism that is actually alive and operating within society (Rusdi et al., 2025; Siregar, 2025).

From a normative perspective, customary institutions actually have a solid constitutional foundation. Article 18B, paragraph (2) of the 1945 Constitution explicitly states that the state recognizes and respects customary law communities and their traditional rights, as long as they remain active and are consistent with societal developments and the principles of the Unitary State of the Republic of Indonesia. Article 28I paragraph (3) of the 1945 Constitution reinforces this by affirming that the cultural identity and rights of traditional communities are respected in harmony with the times. At the statutory level, Article 95 of Law No. 6 of 2014 on Villages recognizes village customary institutions as government partners in preserving the social and cultural values of the community, including the resolution of disputes among residents based on local customary law (Hasmita et al., 2026; Kusmiati, 2025). At the regional level, this recognition is operationalized through Qanun No. 9 of 2008 in Aceh, which grants authority to the Tuha Peut to resolve eighteen types of community disputes, Bali Provincial Regulation No. 4 of 2019, which establishes the Traditional Village Council through the mechanism of the traditional assembly (paruman adat), and Regional Regulation No. 16 of 2008 in Kalimantan, which grants the authority to conduct damang hearings to the Traditional Village Chief (Damang Kepala Adat) (Budiana et al., 2025; Mahardika et al., 2022; Yulia et al., 2021).

However, there is a critical legal gap: no national legal instrument explicitly recognizes customary institutions as legitimate forums for resolving medical malpractice disputes. Law No. 17 of 2023 on Health, although it opens the door to non-litigation avenues, makes no mention whatsoever of customary institutions as recognized forums in this domain (Widjaja, 2025a; Widjaja & Harry, 2025). This issue is exacerbated by the absence of formal legal enforcement mechanisms for customary agreements, leaving patients or the families of victims in an unprotected position if medical personnel renege on the agreements reached. It is this condition that Siregar (2025) refers to as "institutional limbo" – where customary institutions operate in a legal gray area that offers no certainty to anyone – and which Kurniawati & Fahmi (2023) identify as a normative vacuum that lies at the root of the legal uncertainty experienced by the community to date (Jauhani et al., 2022).

The failure to formally recognize customary institutions within the national health law framework produces a cascade of interconnected social and legal implications that compound the access-to-justice gap already documented above. From a social standpoint, communities in regions with strong customary traditions are effectively forced to navigate a dual normative reality: they may reach a socially recognized customary resolution of a medical dispute, yet find themselves legally unprotected when the opposing party – typically the healthcare institution or its personnel – refuses to honor the agreement, since no enforcement mechanism exists under national law (Alexander, 2021; Yulia et al., 2021). This situation erodes trust in both legal institutions and healthcare systems simultaneously, deepening the therapeutic relationship deficit that customary mechanisms were organically equipped to repair. Socially marginalized groups, particularly women, patients of lower socioeconomic status, and elderly community members who rely disproportionately on traditional health practices, bear the greatest burden of this dual exclusion (Rizal & Ahzar, 2026). From a legal standpoint, the absence of formal recognition creates a bifurcated accountability structure in which formal medical personnel are subject to MKDKI

supervision and legal liability standards, while traditional health practitioners whose practice overlaps with customary dispute contexts operate in a virtually unregulated vacuum – generating inconsistent standards of care and irreconcilable outcomes across communities (Galvin et al., 2024). Moreover, the non-recognition of customary agreements as legally enforceable instruments means that victims who pursue customary resolution forfeit access to the state's remedial apparatus entirely, effectively treating participation in customary justice as a waiver of formal legal rights – an outcome fundamentally incompatible with the constitutional guarantee of equal access to justice under Article 28D of the 1945 Constitution.

This normative gap becomes even more significant when viewed through the lens of legal pluralism. From this perspective, the community's choice of customary forums is not merely a reflection of legal ignorance, but rather reflects a different value orientation regarding what constitutes justice in the context of disputes with relational and communal dimensions (Saptandari, 2022; Windayani & Adipradana, 2020). For indigenous communities, justice in medical disputes is not synonymous with punishing the perpetrator, but rather encompasses the restoration of the victim's dignity, the restoration of communal trust, and the maintenance of social harmony. Indigenous mechanisms possess structural comparative advantages in aspects that are precisely the greatest weaknesses of the formal litigation system: accessibility without significant administrative costs, the social legitimacy of indigenous leaders that fosters organic compliance, resolution speed within days to weeks, and a restorative orientation aligned with the restorative justice paradigm, which is increasingly gaining recognition in modern health law discourse (Anggraeni et al., 2025; Mahardika et al., 2022; Putri, 2023; Rizal & Ahzar, 2026).

Behind these strengths, customary mechanisms face fundamental and undeniable structural limitations: their inability to validly assess medical technical standards. Medical service standards as stipulated in Law No. 17 of 2023 on Health require assessments based on specific clinical knowledge, an understanding of medical protocols, and the ability to interpret medical records as primary evidence (Daud et al., 2024). Customary law is built upon a local knowledge system rooted in cultural values and communal experience, not in empirically verified biomedical science; thus, epistemologically, it lacks adequate instruments to produce accurate clinical assessments (Wiguna et al., 2025; Yatindra et al., 2025). Consequently, customary forums are prone to producing inaccurate decisions: acquitting medical personnel who were actually negligent, or conversely punishing medical personnel who acted in accordance with professional standards. The tension between the strengths and limitations of each of these systems ultimately demonstrates that positive law and customary mechanisms are complementary, not competitive; thus, the solution does not lie in choosing between them, but rather in designing an institutional model capable of synergistically integrating their respective strengths (Ekawati et al., 2023; Hafizah & Fitriasih, 2022; Widjaja & Sijabat, 2025).

Based on this analysis, this article proposes a Two-Tier Integrative Model as a framework for resolving medical malpractice disputes that harmonizes local wisdom and positive law within a coherent system. This model is built upon three principles: subsidiarity (customary institutions serve as the first forum before formal channels), complementarity (the two systems fill the gaps in each other's functions rather than replacing one another), and non-discrimination (the process and outcomes ensure the protection of the parties' fundamental rights). At the first level, customary institutions serve as relational mediation forums that facilitate dialogue, restore trust, and negotiate non-technical compensation in the form of formal apologies, mutually agreed-upon restitution, and commitments to prevent recurrence (Riyanto, 2024; Windayani & Adipradana, 2020). At the second level, the MKDKI serves as a technical verifier assessing whether professional disciplinary violations exist based on clinical standards as mandated by Law No. 17 of 2023, not to replace but to complement the process occurring at the first level (Hasibuan et al., 2026; Sun & Yusuf, 2024). To ensure these two levels are cohesively integrated, a liaison mechanism is required in the form of a cross-system facilitator team comprising certified mediators, independent medical

consultants, and traditional leaders who understand the national legal framework, with the resulting customary agreements subsequently ratified through

The implementation of this model requires four interrelated regulatory prerequisites. First, an amendment to Law No. 17 of 2023 to explicitly recognize customary institutions as legitimate non-litigious forums for resolving medical disputes, accompanied by provisions regarding the scope of their authority and functional limits (Widjaja, 2025; Widjaja & Harry, 2025). Second, the establishment of government regulations setting minimum procedural standards for customary mediation in medical disputes, including the obligation to involve independent medical consultants and an opt-out clause granting each party the right to transfer the resolution to formal channels if the customary process is deemed unfair (Handoko et al., 2026; Siregar, 2025). Third, strengthening local regulations that specifically define the types of health disputes that can be resolved through customary forums to prevent normative fragmentation and disparities in legal protection across regions (Budiana et al., 2025; Yulia et al., 2021). Fourth, institutional capacity building for customary institutions through structured training programs that equip customary leaders with a basic understanding of patients' rights, the limits of technical assessment authority, and coordination mechanisms with the MKDKI (Hasmita et al., 2026; Kusmiati, 2025).

This integrative model is not without precedent: in the areas of land and family disputes, similar mechanisms have been implemented in various regions and have proven to yield more acceptable and sustainable resolutions compared to pure litigation (Alexander, 2021; Mahardika et al., 2022). Gunawan (2025) and Miarso & Feliks (2026) assert that a paradigm shift from exclusive legal centralism toward coordinated legal pluralism is an urgent necessity in the development of contemporary Indonesian health law—namely, a system that is not only formally legal but also socially legitimate, technically sound, and substantively just for all segments of Indonesian society.

CONCLUSION

This study confirms that the resolution of medical malpractice disputes through customary institutions in Indonesia is constitutionally recognized but has not yet been operationally accommodated in national health law regulations, thereby creating a normative tension that lies at the root of the legal uncertainty experienced by the public to date. Theoretically, this study contributes to the development of legal pluralism in health law through three interrelated propositions: first, by reaffirming the constitutional legitimacy of customary institutions under Article 18B(2) and Article 28I(3) of the 1945 Constitution as a normatively grounded foundation rather than a sociological anomaly; second, by advancing the concept of coordinated legal pluralism as a paradigmatic alternative to exclusive legal centralism, positioning state law and customary law as functionally complementary rather than competing systems; and third, by proposing the Two-Tier Integrative Model as an original theoretical construct that operationalizes legal pluralism within the health law domain—assigning customary institutions the role of relational mediation forums at the first tier and the MKDKI the role of technical clinical verifier at the second tier, connected through court homologation. In practical terms, the regulatory revisions recommended in this study carry direct implications for the protection of both patients' and healthcare workers' rights: for patients, the explicit recognition of customary institutions within a revised Law No. 17 of 2023—accompanied by minimum procedural standards and legally enforceable homologation mechanisms—would eliminate the justice gap that disproportionately burdens economically vulnerable communities who currently face a forced choice between inaccessible formal mechanisms and legally uncertain customary processes; for healthcare workers, the clear delineation of customary institutions' jurisdictional limits, the mandatory involvement of independent medical consultants, and the designation of the MKDKI as the competent body for professional standards assessment would protect them from arbitrary or technically uninformed decisions, ensuring evaluation against clinically valid benchmarks rather than solely local norms. Therefore, this article recommends three interrelated harmonization measures: first, revising Law

No. 17 of 2023 to explicitly recognize customary institutions as forums for relational mediation in medical disputes, with clearly defined jurisdictional limits; second, issuing a government regulation establishing minimum procedural standards for customary mediation and mechanisms for the homologation of agreements through district courts; and third, strengthening the capacity of customary institutions through cross-sectoral training programs involving the Ministry of Health, medical professional organizations, and indigenous communities—so that Indonesia's medical dispute resolution system is truly not only formally legal but also socially legitimate, technically sound, and substantively just for all segments of society.

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