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The Ultimum Remedium Doctrine and The Absolute Obligation to Treat: Constructing A Normative Line of Demarcation in Emergency Department Services

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Abstract : *This study examines the normative tension between the absolute prohibition on refusing emergency patients under the Health Law and the subsidiarity principle of the National Criminal Code, which treats criminal punishment as a measure of last resort (ultimum remedium). The tension arises because the Health Law admits no explicit exception for resource constraints, whereas the Criminal Code requires criminal instruments to be activated only after non-criminal avenues fail, leaving Emergency Department (ED) staff exposed to legal uncertainty amid overload, limited specialists, and equipment shortages. Unlike prior studies examining patient refusal or medical negligence separately, this study's novelty lies in integrating the ultimum remedium doctrine with the absolute obligation to treat, to construct a normative line of demarcation between criminally actionable refusal and medically justifiable delay. The study uses an empirical juridical method combining statutory, conceptual, historical, and socio-legal approaches; primary data were obtained through in-depth interviews, observation, and documentation involving six informants at a Type B hospital in Banyuwangi, analyzed using an interactive model. Findings show that delays attributable to triage, overload, facility limitations, and documented referral procedures do not constitute criminally actionable refusal; criminal prosecution is warranted only where there is demonstrable intent, gross negligence, or disregard for patient safety without valid medical grounds. Accordingly, this study formulates a normative line of demarcation based on six assessment parameters: the presence of initial emergency care, the mens rea element, the medical and procedural basis, completeness of documentation, a proportionate legal response, and the relevant normative foundation.*

Keywords : *ultimum remedium; criminalization; emergency; subsidiarity*

Abstrak : Penelitian ini mengkaji ketegangan normatif antara larangan mutlak menolak pasien gawat darurat sebagaimana diatur dalam Undang-Undang Kesehatan dan asas subsidiaritas dalam Kitab Undang-Undang Hukum Pidana Nasional, yang menempatkan pemidanaan sebagai

upaya terakhir (ultimum remedium). Ketegangan ini muncul karena Undang-Undang Kesehatan tidak memberikan pengecualian eksplisit atas keterbatasan sumber daya, sementara KUHP mensyaratkan instrumen pidana baru diaktifkan setelah upaya non-pidana terbukti gagal, sehingga tenaga kesehatan di Unit Gawat Darurat (UGD) rentan menghadapi ketidakpastian hukum di tengah kondisi kelebihan beban, keterbatasan dokter spesialis, dan kekurangan alat medis. Berbeda dari penelitian terdahulu yang mengkaji penolakan pasien atau kelalaian medis secara terpisah, kebaruan penelitian ini terletak pada pengintegrasian doktrin ultimum remedium dengan kewajiban mutlak untuk memberikan pertolongan, guna menyusun garis demarkasi normatif antara penolakan yang dapat dipidana dan keterlambatan yang secara medis dapat dibenarkan. Penelitian ini menggunakan metode yuridis empiris yang menggabungkan pendekatan yuridis, konseptual, historis, dan sosiologis; data primer diperoleh melalui wawancara mendalam, observasi, dan dokumentasi terhadap enam informan di sebuah rumah sakit tipe B di Banyuwangi, dianalisis menggunakan model interaktif. Temuan menunjukkan bahwa keterlambatan akibat triase, kondisi kelebihan beban, keterbatasan fasilitas, dan prosedur rujukan yang terdokumentasi tidak merupakan penolakan yang dapat dipidana; tuntutan pidana hanya dibenarkan apabila terdapat niat, kelalaian berat, atau pengabaian keselamatan pasien tanpa dasar medis yang sah. Oleh karena itu, studi ini merumuskan garis demarkasi normatif berdasarkan enam parameter penilaian: ada tidaknya perawatan darurat awal, unsur mens rea, dasar medis dan prosedural, kelengkapan dokumentasi, respons hukum yang proporsional, dan landasan normatif yang relevan.

Kata kunci : ultimum remedium, kriminalisasi, kegawatdaruratan, subsidiaritas

Introduction

The reform of Indonesian criminal law was marked by the enactment of Law Number 1 of 2023 on the National Criminal Code, which represents a historic milestone in the trajectory of the national legal system. The National Criminal Code heralds a fundamental paradigm shift: from a penological model that formerly treated imprisonment as the primary response to every normative violation to one that prioritizes proportionality, restoration, and prevention.[1]

This paradigm shift has ultimately reinforced the ultimum remedium doctrine, namely the principle that criminal law may be invoked only as a last resort, once all non-criminal avenues have demonstrably proven incapable of delivering adequate justice.[2] As thus enshrined, this doctrine ceases to be a mere philosophical axiom confined to academic texts; it becomes part of a broader effort to reform national criminal law by demanding selectivity, caution, and proportionality in every exercise of the state's punitive power.

[1] Faisal et al., "Genuine Paradigm of Criminal Justice: Rethinking Penal Reform within Indonesia New Criminal Code," *Cogent Social Sciences* 10, no. 1 (2024), https://doi.org/10.1080/23311886.2023.2301634.

[2] Jan Remmelink and Tristam Pascal Moeliono, *Hukum Pidana: Komentar Atas Pasal-Pasal Terpenting Dari Kitab Undang-Undang Hukum Pidana Belanda Dan Padanannya Dalam Kitab Undang-Undang Hukum Pidana Indonesia* (Gramedia Pustaka Utama. Jakarta., 2003).

One of the most sensitive arenas in this ultimum remedium doctrine will ultimately be put to a real test within healthcare facility institutions that operate Emergency Departments (ED), where the Emergency Department serves as the frontline (first gate) of the healthcare service system, as it generally interfaces directly with the constitutional rights of all citizens. As stipulated in Article 28H paragraph (1) of the 1945 Constitution of the Republic of Indonesia, which reads: "*Every person shall have the right to live in physical and spiritual prosperity, to have a home and to enjoy a good and healthy environment, and shall have the right to obtain medical care.*" Accordingly, Emergency Department services carry direct consequences for the preservation of human life. The tension between legal obligations and the reality of resource constraints can reach its most critical point: the threat of criminalizing healthcare workers. This is because, within the Emergency Department, cases of delay and/or refusal of service remain highly likely.

According to Ombudsman RI, cases of perceived refusal and/or delay in ED services continue to occur, driven by various underlying causes, including limited bed capacity, the unavailability of specialist physicians, shortages of medical equipment, and administrative or financing issues.[3] In each such instance, there exists a potential for criminal charges to be filed, whether against individual healthcare professionals or against the healthcare facility as an institution. In this context, the fundamental question is not merely whether a legal violation has occurred, but rather something far more consequential: does the application of criminal instruments to such cases genuinely reflect the ultimum remedium principle as intended by the National Criminal Code, or does it instead constitute premature criminalization of healthcare professionals working under objectively constrained conditions?

These issues give rise to complex legal problems, exacerbated by an expanding informational asymmetry among patients, ED healthcare professionals, and the healthcare facility institutions. When a patient is perceived as not receiving immediate treatment, lay members of the public tend to characterize the event as a criminal offense directly, without considering that the delay may well have been grounded in valid, measured, and scientifically defensible medical reasons. In this context, the ultimum remedium doctrine within the national criminal law reform serves as a normative instrument to protect healthcare professionals from criminalization for conditions that are, objectively speaking, beyond their control. Regrettably, however, understanding of this doctrine remains very limited among the general public and even among law enforcement officials, with the result that criminal proceedings are still frequently employed as a first response rather than a last resort.

Law Number 17 of 2023 on Health, which supersedes Law Number 36 of 2009, further complicates this normative landscape. Article 174 paragraph (2) of the Health Law imperatively affirms that: *'In an emergency condition as referred to in paragraph (1), Healthcare Facilities owned by the Central Government, Regional Government, and/or the community are prohibited from refusing Patients and/or requesting advance payment, and are prohibited from prioritizing all administrative*

[3] Kabar Perwakilan, "Ombudsman RI: Fasilitas Kesehatan Langgar Regulasi Jika Tolak Pasien Dalam Kondisi Gawat Darurat," *12/06*, 2025, https://ombudsman.go.id/perwakilan/news/r/pwkmedia--ombudsman-ri--fasilitas-kesehatan-langgar-regulasi-jika-tolak-pasien-dalam-kondisi-gawat-darurat?utm_source=chatgpt.com.

matters in a manner that causes the delay of Healthcare Services.' This prohibition is absolute in character and appears to admit of no exception whatsoever. Should every violation of this prohibition automatically trigger criminal punishment, such logic would manifestly contradict the spirit of the ultimum remedium principle that forms the soul of the National Criminal Code. A sharp normative tension thus emerges: the Health Law constructs a prohibition that appears absolute against refusal without lawful grounds, while the National Criminal Code, through the subsidiarity principle, requires that criminal punishment be imposed only when no other available course of action can be pursued.

The normative vacuum at the level of implementing regulations constitutes a distinct problem.[4] Although Government Regulation No. 28 of 2024 and subsequently Ministry of Health Regulation No. 6 of 2026 on Hospitals have since been enacted as implementing instruments of the Health Law, reaffirming the obligation to provide comprehensive 24-hour emergency services without upfront payment, neither has provided comprehensive detail regarding the boundaries between legally prohibited refusal and medically and juridically justifiable delay. This vacuum creates a dangerous zone of legal uncertainty: ED healthcare professionals lack clear normative guidance to distinguish legally protected actions from those that may incur criminal liability, while law enforcement officials lack a definitive standard for determining when criminal instruments should be activated. As a result, the reformist spirit of criminal law, which situates ultimum remedium as a guiding principle, risks being repudiated in the practical handling of ED service cases.

Several prior studies have addressed patient refusal, medical negligence, and service disputes in the ED, yet none have fully addressed the specific focus of this study. Azis, Susetio, and Dwinanto examined legal accountability for ED patient refusal under health regulations and hospital rules, but did not address criminal law reform or the ultimum remedium doctrine[5]. Fahruddin, Yuningsih, and Febriansyah characterized ED service refusal based on financial Standard Operating Procedures (SOPs) as constituting dolus eventualis, but their analysis was not linked to the paradigm shift in the National Criminal Code[6]. Ramadhani addressed negligence in emergency services under Article 438 of the Health Law[7], while Wicaksono analyzed the conflict between Social Security Administering Body (BPJS) regulations and

[4] Presiden RI, "Peraturan Pemerintah (PP) Nomor 28 Tahun 2024 Tentang Peraturan Pelaksanaan Undang-Undang Nomor 17 Tahun 2023 Tentang Kesehatan," *Kemenkes RI*, no. 226975 (2024): 656, https://peraturan.bpk.go.id/Details/294077/pp-no-28-tahun-2024.

[5] Rizka Amelia Azis, Wasis Susetio, and Rafi Rajendra Dwinanto, "Pertanggungjawaban Hukum Atas Penolakan Pasien Di Instalasi Gawat Darurat: Analisis Berdasarkan UU Kesehatan, UU Praktik Kedokteran, Dan Peraturan Rumah Sakit," *Lex Jurnalica* 22, no. 2 (2025): 150–59, https://doi.org/10.47007/lj.v22i2.9671.

[6] Rafi Fahruddin, Henny Yuningsih, and Artha Febriansyah, "Analisis Perlindungan Hukum Terhadap Penolakan Pasien Dalam Keadaan Gawat Darurat Oleh Rumah Sakit," *Inovasi Pembangunan: Jurnal Kelitbangan* 14, no. 1 (2026): 1–25.

[7] Aisyah Kurnia Ramadhani et al., "Kelalaian Dalam Pelayanan Gawat Darurat Dan Pertanggungjawaban Hukumnya Dalam Perspektif Undang-Undang Nomor 17 Tahun 2023 Tentang Kesehatan," *Equality: Law and Social* 1, no. 3 (2026): 205–11, https://doi.org/ejournal.risetanakbangsa.id/jhs.

hospitals' legal obligations[8]. Brouwer, Darodjat, and Immanuel examined imprisonment as ultimum remedium in medical malpractice[9], and Nugroho positioned mediation as primum remedium in healthcare disputes[10]. Susanti and Zurnetti specifically analyzed the application of the ultimum remedium principle in resolving medical disputes that failed mediation, finding that non-litigation channels must be prioritized before criminal sanctions are imposed and that cross-stakeholder collaboration is essential for fair dispute resolution; however, their analysis was not linked to the normative tension arising from the absolute prohibition under Article 174 of the Health Law within ED service contexts[11]. In sum, no existing study has comprehensively analyzed the relationship between the ultimum remedium doctrine in national criminal law reform and the absolute obligation under Article 174 of the Health Law in the context of ED services.

The novelty of this study lies in positioning the ultimum remedium doctrine as the primary conceptual lens for evaluating the normative tension between the absolute obligation under Article 174 of the Health Law and the subsidiarity principle of the National Criminal Code, specifically within the context of ED services confronted with resource limitations. Unlike preceding studies, which are partial in character, this research integrates the formulation of a normative line of demarcation between legally prohibited refusal and medically and juridically justifiable delay, offering a conceptual framework intended to guide the proportionate and consistent application of criminal law while protecting patients' rights without exposing healthcare professionals to the threat of premature criminalization.

Building on this background and the identified research gap, this study aims, first, to analyze the correlation between the ultimum remedium doctrine as the animating spirit of criminal law reform in the National Criminal Code and the normative construction of the absolute obligation under Article 174 of the Health Law, together with the tensions this relationship generates in the conduct of ED emergency services; and second, to formulate a normative line of demarcation between criminally accountable ED service refusal and medically and juridically justifiable delay, and to articulate how the ultimum remedium principle should be applied proportionately in the handling of emergency cases.

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[8] Emirza Nur Wicaksono, "Penolakan Pasien Emergency Oleh Rumah Sakit Akibat Regulasi BPJS Kesehatan: Perspektif Hukum Dan Etika," *Jurnal Humaya* 5, no. 1 (2025): 60–73, https://doi.org/10.33830/humaya.v5i1.12602.

[9] Darryl Evan Brouwer, Rafan Darodjat, and Beatrice Briliany Immanuel, "Pidana Penjara Sebagai Ultimum Remedium Dalam Kasus Malapraktik Medis: Perspektif Filosofis Pemidanaan," *Unes Journal of Swara Justisia* 10, no. 1 (2026): 27–40, https://doi.org/10.31933/cxtnz882.

[10] Hari Pudjo Nugroho, "Mediasi Sebagai Asas Primum Remidium Dalam Penyelesaian Sengketa Pelayanan Kesehatan Berbasis Keadilan Proporsional: Mediation As The Primum Remidium Principle In Health Service Dispute Resolution Based On Proportional Justice," *Jurnal Hukum Dan Etika Kesehatan* 5, no. 1 (2025): 1–15, https://doi.org/10.30649/jhek.v5i1.235.

[11] Yulia Susanti et al., "Implementation Of The Ultimum Remedium Principle In Resolving Unsuccessful Medical Disputes With Mediation Faculty of Law , Andalas University , Indonesia," *DE LEGA LATA: Jurnal Ilmu Hukum* 10, no. 1 (2025): 57–66, https://doi.org/10.30596/dll.v10i1.22497.

Methods

This study employs an empirical juridical method that integrates three normative approaches: statutory, conceptual, and historical, with a socio-legal approach to analyze the gap between legal norms and actual ED service practice in the field. The study was conducted at a Type B hospital in Banyuwangi, East Java. Primary data were obtained through in-depth interviews, observation, and documentation with six informants purposively selected for their direct involvement in the ED service system: hospital management, the Head of the ED, an ED attending physician, an ED duty nurse, a triage officer, and a referral officer. The number of informants was determined by the principle of information adequacy rather than statistical representation[12]. Secondary data were drawn from legislation and scholarly literature. Data validity was tested through source and method triangulation, followed by normative-interactive analysis to construct the line of demarcation between criminally accountable refusal and medically and juridically justifiable delay.

To strengthen the credibility of the findings, the roles and relevant experience of the six informants are briefly described below, while their personal identities remain confidential. Informant 1 (hospital management) is the Coordinator of Medical Services, who concurrently chairs the hospital's Risk Management Team and is directly involved in real-time coordination during ED patient surges. Informant 2 (Head of the ED) was represented at interview by a senior ED staff member deputized for this role, responsible for day-to-day operational coordination, including triage flow, bed management, and staffing adjustments. Informant 3 (ED attending physician) has served as an ED duty physician at the hospital for more than ten years, since December 2012. Informant 4 (ED duty nurse) holds Basic Trauma and Cardiac Life Support (BTCLS) certification, the minimum competency standard for ED nursing staff, and works within a mobile team of approximately five nurses per shift. Informant 5 (triage officer) has substantial practical experience, such that rapid, color-coded (red, yellow, green, black) prioritization has become routine practice. Informant 6 (referral/transfer officer) is responsible for accompanying and escorting patients to receiving hospitals, with assignments adjusted flexibly according to patient acuity and staff availability.

Result And Discussion

Based on the results of juridical analysis within the framework of the ultimum remedium doctrine of the National Criminal Code and its normative tension with the absolute obligation under Article 174 of Law No. 17 of 2023 on Health, the summary of field findings from the six informants is presented in Table 1 below:

[12] John W Creswell, *Research Design: Qualitative, Quantitative, and Mixed Methods Approaches* (Sage publications.Thousand Oaks, 2017).

Table 1. Empirical Findings Matrix on ED Service Delivery and Legal Implications

	Informant	Interview Focus	Key Findings	Legal Category / Issue	Legal Consequences
1.	**Hospital Management**	Hospital policies, institutional accountability, and response to ED operational limitations	ED patients may not be refused; triage must be carried out even with limited resources.	ED services are absolute in nature; resource constraints do not eliminate corporate responsibility and institutional criminal liability under Law No. 17/2023.	Limitations anticipated through structured procedures do not automatically satisfy criminal elements; prosecution should be a last resort when procedures are proven to have been disregarded.
2.	**Head of ED**	ED operational governance, service capacity, and management mechanisms for overload conditions	ED manages 18–19 beds; overload is handled through inter-ward coordination, not patient refusal.	ED capacity and operational limitations; minimum service standards (MSS); obligation to ensure specialist physician availability.	150% overload still serviced, demonstrating good faith. However, the absence of digital monitoring and formal evaluation constitutes a structural weakness that may increase the risk of negligence.
3.	**ED Attending Physician**	Clinical decision-making, initial stabilization procedures, and emergency management in the ED	ABCD (Airway, Breathing, Circulation, and Disability) triage protocol; red-category (critical) patients must be attended to within 5	Clinically justifiable medical delay within the 5-minute standard; the distinction between refusal and medically justified delay is critical.	Delays grounded in objective medical reasons and accompanied by initial care do not satisfy criminal elements; criminal liability applies only if delay occurs without

			minutes, not refused.		reason and without initial intervention.
4.	**ED Duty Nurse**	Independent nursing interventions, delegation, and simultaneous management of critically ill patients	Nurses act independently per SOP before physician arrival; escalation is performed via telephone.	Scope of independent nursing authority; clinical delegation system; workload and service risk during overload.	Nurses acting within competence and SOP cannot be criminalized; overload risks are more appropriately evaluated through ethical and administrative channels before criminal proceedings.
5.	**Triage Officer**	Initial triage assessment, patient prioritization, and management of triage overload conditions	Priority is determined by life-threatening status; during overload, triage may be conducted directly in the ambulance.	Medical basis for service prioritization; triage system as justification for proportionate delay; delineation of responsibility among ED staff.	Triage performed in accordance with procedure constitutes a justification for delay; proportionate delay does not satisfy criminal elements as long as there is no intent to refuse without grounds.
6.	**Referral/Transfer Officer**	Patient referral procedures, clinical handover of information, and readiness of transfer support resources	Referrals are made after stabilization and confirmation in the Integrated Referral Information System (SISRUTE); unstable patients may not be referred.	Referral constitutes a legal obligation, not a refusal; duty of care applies throughout the transfer until handover at the receiving hospital.	Procedurally compliant referrals do not constitute criminally actionable refusal; legal responsibility continues until handover at the receiving hospital.

Source: Compiled from interview results, observation, and research document analysis

Correlation between the Ultimum Remedium Doctrine and the Absolute Obligation under Article 174 of the Health Law in ED Services

The findings from the interview with the healthcare facility's institutional management informant, as presented in Table 1, confirm that the facility policy prohibits the refusal of ED patients under any circumstances. That triage must be conducted notwithstanding limitations in healthcare human resources. These findings demonstrate normative compliance with the absolute prohibition affirmed in Article 174, paragraph (2), of the Health Law, which provides that, in emergencies, both government-owned and privately owned healthcare facilities are prohibited from refusing patients or requesting advance payment. The commitment to comply with Article 28H, paragraph (1), of the 1945 Constitution, which guarantees every person's right to live in prosperity and to receive healthcare services, confirms that the ED's obligation to provide initial emergency care has robust constitutional foundations[13]. That said, informants acknowledged the existence of objective operational constraints, such as overcapacity, the occasional unavailability of certain specialist physicians, and shortages of medical equipment, which cannot be resolved solely by institutional policy.

It is here that the most pronounced normative tension between two concurrently applicable legal policies becomes evident. Article 174 of the Health Law constructs a prohibition that appears absolute and admits of no exception. By contrast, the systematic conception manifested in the General Explanatory Note of the National Criminal Code, as reflected in the sentencing purpose provisions of Article 51 and the sentencing provisions of Article 64, explicitly sets forth the subsidiarity principle, meaning that criminal law is to be employed only as a last resort in combating crime. As Jan Remmelink argued, criminal law is in essence the ultimum remedium, a coercive measure of last resort, to be deployed only after all other legal instruments have demonstrably failed to restore public order[14]. In the integrative theory of punishment, prosecution that lacks the foundation of proportionality and selectivity is counterproductive, as it disregards the rehabilitative and restorative purposes that constitute the core of modern criminal law[15]. Within this framework, anticipated resource limitations, as reflected in standardized operating procedures (SOPs) and structured triage mechanisms, do not ipso facto satisfy the criminal elements that give rise to criminal accountability.

This finding is also consistent with the philosophical view that punishment should be positioned as an ultimum remedium in cases of medical malpractice, as the use of criminal sanctions must always be assessed against three questions: whether the act is contrary to the values of society, whether it is truly necessary, and whether it is effective in achieving its purpose[16]. Applying Sudarto's three questions to the context of resource limitations in the ED, it is highly probable that criminal prosecution would lead to an erroneous conclusion, since criminal law is itself a dangerous weapon and must therefore

[13] Deborah Johana Rattu and Selamat Widodo, "Transforming Health Insurance Law : Toward Substantive Justice for Health Social Security Administering Body," *DE LEGA LATA: Jurnal Ilmu Hukum* 11, no. 1 (2026): 65–77, https://doi.org/10.30596/dll.v11i1.26491.

[15] Arief Muladi and Barda Nawawi, *Teori-Teori Dan Kebijakan Pidana* (Alumni. Bandung., 1998).
[16] Sudarto, *Hukum Dan Hukum Pidana* (Alumni. Bandung., 1977).

be employed with extreme care and selectivity[17]. This means that the absolute obligation under Article 174 of the Health Law cannot be mechanically interpreted as an automatic gateway to criminal prosecution, but must instead be read harmoniously with the ultimum remedium principle as set out in the National Criminal Code. The tension can be moderated, though a normative vacuum persists at the level of implementing regulations, since Government Regulations have yet to comprehensively delineate the boundaries between legally prohibited refusal and medically and juridically justifiable delay.

The Normative Line of Demarcation: Criminally Actionable Refusal versus Justifiable Delay

One of the most crucial findings of this study, as evidenced by the empirical data summarized in Table 1 and systematized in Table 2, is the necessity for a clear normative line of demarcation between criminally accountable patient refusal and medically and juridically justifiable delay in service delivery. The ED attending physician (Table 1, Informant 3) explained that triage management follows the ABCD protocol, under which red-category (critical) patients must be attended to within 5 minutes of arrival. This is consistent with Ministry of Health Regulation No. 47 of 2018 on Emergency Services, which establishes triage response time standards and the obligation for initial stabilization before further intervention. Accordingly, delays that occur within certain standard timeframes, provided they are accompanied by initial emergency care. They are grounded in objective, measurable medical reasons, but do not, juridically speaking, satisfy the criminal elements. To render an act criminally punishable, both actus reus (an unlawful act) and mens rea (fault in the form of intention or negligence) must be simultaneously established[18]. Where delay results from or is caused by the valid execution of a medical procedure or protocol, such delay does not satisfy the requisite mens rea element.

The findings from the interview with the triage officer (Table 1, Informant 5) further reinforce this analysis. In overload conditions, triage may also be conducted directly inside the ambulance, as a form of prioritization solely to preserve the patient's life. Although this may be characterized as a proportionate delay with a valid medical justification, a delay of this nature does not satisfy the criminal elements as long as there is no mens rea, that is, no intent to refuse without accountable grounds. Legal accountability for ED patient refusal must consider the objective factors underlying the event rather than mechanically imposing strict liability [19]. In criminal law, there is no punishment without fault. Thus, criminal prosecution for conditions beyond the control of healthcare professionals constitutes an impermissible deviation [20]. Furthermore, Article 438 of the Health Law, which governs liability for

[17] Roslan Saleh, *Perbuatan Dan Pertanggungjawaban Pidana, Dua Pengertian Dasar* (Liberty. Jakarta., 1989).
[18] Moeljatno, *Asas-Asas Hukum Pidana* (Rineka Cipta. Jakarta., 2002).
[19] Azis, Susetio, and Dwinanto, "Pertanggungjawaban Hukum Atas Penolakan Pasien Di Instalasi Gawat Darurat: Analisis Berdasarkan UU Kesehatan, UU Praktik Kedokteran, Dan Peraturan Rumah Sakit."
[20] Wirjono Prodjodikoro, *Asas-Asas Hukum Pidana Di Indonesia* (Refika Aditama.Bandung., 2003).

negligence in emergency service delivery, requires proof of concrete negligence and cannot be predicated on mere public perception.

From the perspective of nursing actions (Table 1, Informant 4), nurses act independently in accordance with SOPs before the physician's arrival and conduct escalation by telephone. Nurses acting within the scope of their competence and in conformity with SOPs cannot be criminalized. As progressive legal theory reminds us, good law serves human beings, not the other way around [21]. Should criminalization be imposed on ED healthcare professionals who have worked diligently and in good faith despite knowing they operate under constrained conditions, such criminalization would itself represent a failure of legal implementation to serve its primary purpose. Furthermore, Article 35 of Law No. 38 of 2014 on Nursing explicitly provides that, in emergencies, nurses may perform medical acts beyond their ordinary authority to preserve a patient's life, thereby conferring a clear legal basis for independent nursing actions in overloaded ED conditions.

Regarding the referral procedure (Table 1, Informant 6), referrals are made only after stabilization and confirmation in the Integrated Referral Information System (SISRUTE); patients who are not in a stable condition may not be referred. A procedurally compliant referral, juridically speaking, does not constitute a criminally actionable refusal; rather, it forms part of the duty of care. The legal responsibility of healthcare professionals continues until handover at the receiving hospital, consistent with Article 29 of Law No. 44 of 2009 on Hospitals, which obliges hospitals to comply with service standards, to provide emergency services to patients in accordance with their service capacity, and to refer patients when the required facilities are unavailable. This construction confirms that a referral is not a refusal but rather an alternative means of fulfilling a legal obligation.

Based on the totality of the foregoing findings, a normative line of demarcation can be systematically formulated, as set out in Table 2 below:

Table 2. Normative Line of Demarcation: Criminally Actionable Refusal vs. Legally and Medically Justifiable Delay in ED Service Delivery

Assessment Parameter	Criminally Actionable Refusal	Legally And Medically Justifiable Delay
Initial Emergency Care	No initial emergency care whatsoever; patient is left without any clinical response.	Initial stabilization is provided in accordance with competence and SOP; delay applies only to subsequent interventions.
Fault Element (Mens Rea)	Dolus (intentionality) or culpa lata (gross negligence) is demonstrable; there is intent to disregard patient safety.	No intent to disregard patient safety; actions are grounded in valid clinical judgment.
Medical and Procedural Basis	No valid medical or legal grounds; refusal is motivated	Grounded in valid triage protocols, objectively documented overload

[21] Satjipto Rahardjo, *Membedah Hukum Progresif* (Penerbit Buku Kompas. Jakarta., 2006).

	solely by administrative or financial considerations.	conditions, or documented facility limitations.
Documentation	No adequate medical records documenting the reason for delay or the patient's condition upon arrival.	All interventions and reasons for delay are documented in medical records verifiable by independent parties.
Appropriate Legal Response	Criminal proceedings under Article 190 and/or Article 438 of the Health Law (after all non-criminal avenues have been exhausted).	Ethical review/MKDKI, administrative sanctions, or mediation; criminal instruments are not activated (ultimum remedium principle).
Normative Basis	Article 174 of Law No. 17/2023 (absolute prohibition); Article 190 of the Health Law (institutional criminal sanctions).	Law No. 1 of 2023 on the National Criminal Code (subsidiarity principle, Articles 51 and 64); MOH Regulation No. 47 of 2018 on Emergency Services (triage standards).

Source: Compiled from interview results, observation, and research document analysis

Table 2 above explicitly shows that the distinction between criminally actionable refusal and justifiable delay is not merely a factual one but a normative one, requiring careful analysis of the relevant legal elements. Criminal accountability must always be grounded in the principle of individual responsibility, meaning that not every party in the medical service chain can be automatically held criminally accountable simply because an undesired outcome has occurred[22]. Accordingly, dolus eventualis may be applied in cases of SOPs-based financial refusal only where there is evidence that the actor was aware of the possibility of a legally prohibited consequence, yet permitted it to occur in the interest of other unlawful objectives.

Framework for Proportionate Application of the Ultimum Remedium Principle in ED Emergency Cases

This study finds that healthcare professionals' and law enforcement officials' understanding of the ultimum remedium doctrine remains uneven and inconsistent. As reported by the Head of the ED (Table 1, Informant 2), the ED has experienced overload conditions reaching 150% of normal capacity, yet managed to handle them by optimizing inter-ward coordination. Nevertheless, the absence of an integrated digital monitoring system and a formal evaluation mechanism constitutes a structural weakness that could potentially undermine the hospital's legal standing in the face of criminal charges. Legal certainty can only be achieved when existing legal norms are formulated clearly, without ambiguity, and supported by adequate implementing instruments[23]. The absence of implementing regulations that

[22] Eddy O S Hiariej, *Prinsip-Prinsip Hukum Pidana* (Cahaya Atma Pustaka. Jakarta., 2022).
[23] Jimly Asshiddiqie, *Pengantar Ilmu Hukum Tata Negara* (Konstitusi Press. Jakarta., 2006).

operationalize the boundaries of Article 174 of the Health Law creates legal uncertainty incompatible with this principle. It directly undermines the function of ultimum remedium as a normative safeguard.

Drawing on Nugroho's finding, which positions mediation as primum remedium in healthcare dispute resolution, and reinforced by the mechanism provided under Law No. 30 of 1999 on Arbitration and Alternative Dispute Resolution, this study proposes a tiered framework for the application of ultimum remedium in the ED service context[24]. At the first tier: a mechanism for clarification and dialogue between the hospital and the patient and their family, supported by a transparent medical documentation system. At the second tier: mediation through the Indonesian Medical Disciplinary Honor Council (MKDKI) [25] or a complaint mechanism directed to the Hospital Supervisory Board, as provided under Articles 29 and 55 of Law No. 44 of 2009 on Hospitals. At the third tier: administrative sanctions against the healthcare facility, as enabled by Articles 395 and 447 of the Health Law. Criminal instruments, as ultimum remedium, are activated only at the final tier, that is, where there is clear evidence of intentionality, gross negligence, and actual harm to the patient. Drawing on legal systems theory, the effectiveness of law depends not only on the substance of the norms but also on the structure of the enforcement institutions and the legal culture of society[26]. If law enforcement officials fail to understand the ultimum remedium principle, no normative provision, however robust, will be able to protect healthcare professionals from disproportionate criminalization.

This framework also addresses the question raised by Fahruddin, Yuningsih, and Febriansyah regarding the construction of dolus eventualis in cases of refusal based on financial procedures[27]. Where a delay in ED service is motivated solely by administrative procedures that prioritize financial interests over patient safety, only then can the dolus (intentionality) element required for criminal prosecution be satisfied. The conflict between BPJS regulations and hospitals' legal obligations remains a recurrent root cause of delays, with an administrative-financial tendency[28]. Conversely, delays attributable to objectively limited capacity and managed through a valid triage procedure do not satisfy the mens rea standard required for criminal prosecution. The proportionate application of the ultimum remedium principle, therefore, demands careful, context-specific analysis of each case. These findings collectively fill the research gap that has hitherto existed, and reaffirm that the absolute obligation under Article 174 of the Health Law and

[24] Nugroho, "Mediasi Sebagai Asas Primum Remidium Dalam Penyelesaian Sengketa Pelayanan Kesehatan Berbasis Keadilan Proporsional: Mediation As The Primum Remidium Principle In Health Service Dispute Resolution Based On Proportional Justice."

[25] The Indonesian Medical Disciplinary Honor Council (Majelis Kehormatan Disiplin Kedokteran Indonesia, MKDKI) is a statutory body established under Law No. 29 of 2004 on Medical Practice, tasked with determining the disciplinary liability of physicians and dentists alleged to have violated professional standards; see Khadafi Indrawan, M. Fakih, and Budiyono, "Peran Majelis Kehormatan Disiplin Kedokteran Indonesia Dalam Kasus Pelanggaran Standar Profesional Dokter," *JUSTICIA SAINS: Jurnal Ilmu Hukum* 9, no. 2 (2024): 456–69, https://doi.org/10.24967/jcs.v9i1.3249.

[26] Lawrence M Friedman, *The Legal System: A Social Science Perspective* (Russell Sage Foundation. New York., 1975).

[27] Fahruddin, Yuningsih, and Febriansyah, "Analisis Perlindungan Hukum Terhadap Penolakan Pasien Dalam Keadaan Gawat Darurat Oleh Rumah Sakit."

[28] Wicaksono, "Penolakan Pasien Emergency Oleh Rumah Sakit Akibat Regulasi BPJS Kesehatan: Perspektif Hukum Dan Etika."

the ultimum remedium principle of the National Criminal Code need not be set in opposition to one another; they can be reconciled through systematic and harmonious interpretation.

The implications of this framework extend beyond law enforcement to encompass regulation and legal education. On the regulatory side, these findings reinforce the urgency of promulgating a Government Regulation or Ministry of Health Regulation that explicitly operationalizes the boundaries of Article 174 of the Health Law. Such an implementing regulation must set out measurable criteria for conditions that may serve as grounds for lawful delay, minimum documentation standards that EDs must satisfy, and escalation and referral procedures capable of protecting the legal position of healthcare professionals. In the absence of an implementing instrument, the existing normative vacuum will continue to generate legal uncertainty that burdens healthcare professionals and potentially harms patients, thereby undermining the comprehensive legal protection to which patients are entitled in health service settings[29]. On the legal education side, the findings of this study indicate that understanding of the ultimum remedium doctrine must be integrated into training for investigators, prosecutors, and judges handling health-related cases, so that criminal instruments are genuinely positioned as a measure of last resort rather than as a reflexive first response to every complaint about ED services. The tiered framework proposed in this study is therefore not merely an analytical tool but also an urgent agenda for normative and institutional reform.

Conclusion

In answer to the study's objectives, the findings show that the normative tension between the absolute obligation under Article 174 of the Health Law and the subsidiarity principle of the National Criminal Code is resolved not by treating every violation of Article 174 as automatically punishable, but by distinguishing delays grounded in triage, overload, facility limitations, and documented referral procedures, which do not satisfy the elements of criminally actionable refusal, from refusal marked by demonstrable intent, gross negligence, or disregard for patient safety without valid medical grounds. Building on this distinction, the study's principal conceptual contribution is a normative line of demarcation based on six assessment parameters, offered as an initial framework, subject to further validation across other institutions, for determining when criminal instruments are proportionately activated in ED service cases.

Given that primary data collection was concentrated in a single Type B hospital in Banyuwangi, the field findings cannot yet be considered representative of the diversity of ED conditions across different hospital classifications, geographical regions, and resource contexts throughout Indonesia. The normative line of demarcation proposed in this study must therefore be understood as an initial conceptual framework open to testing,

[29] Wirandi Dalimunthe and Marice Simarmata, "Patient Legal Protection in the Digital Era and Study of Telemedicine Services in Indonesia Master of Health Law , Panca Budi Development University , Medan , North," *DE LEGA LATA: Jurnal Ilmu Hukum* 10, no. 1 (2025): 40–49, https://doi.org/10.30596/dll.v10i1.22494.

verification, and refinement through subsequent multi-site, inter-regional comparative research. Such multi-site research will strengthen or revise the delineation parameters formulated herein, ultimately yielding normative guidance that is more representative and contextually attuned for law enforcement officials and regulatory authorities at the national level.

Recommendation

The Government should promptly enact implementing regulations that clarify the distinction between ED patient refusal and justifiable delay in service delivery. Hospitals must also strengthen their triage, medical records, referral, capacity monitoring, and internal evaluation systems. Law enforcement officials must apply the ultimum remedium principle by giving precedence to clarification, ethical review, mediation, and administrative sanctions. Criminal prosecution is warranted only where intentionality, gross negligence, or disregard for patient safety has been demonstrated.

References

Asshiddiqie, Jimly. Pengantar Ilmu Hukum Tata Negara. Konstitusi Press. Jakarta, 2006.

Azis, Rizka Amelia, Wasis Susetio, and Rafi Rajendra Dwinanto. "Pertanggungjawaban Hukum Atas Penolakan Pasien Di Instalasi Gawat Darurat: Analisis Berdasarkan UU Kesehatan, UU Praktik Kedokteran, Dan Peraturan Rumah Sakit." Lex Jurnalica 22, no. 2 (2025): 150–59. https://doi.org/10.47007/lj.v22i2.9671.

Brouwer, Darryl Evan, Rafan Darodjat, and Beatrice Briliany Immanuel. "Pidana Penjara Sebagai Ultimum Remedium Dalam Kasus Malapraktik Medis: Perspektif Filosofis Pemidanaan." Unes Journal of Swara Justisia 10, no. 1 (2026): 27–40. https://doi.org/10.31933/cxtnz882.

Creswell, John W. Research Design: Qualitative, Quantitative, and Mixed Methods Approaches. Sage publications.Thousand Oaks, 2017.

Dalimunthe, Wirandi, and Marice Simarmata. "Patient Legal Protection in the Digital Era and Study of Telemedicine Services in Indonesia Master of Health Law , Panca Budi Development University , Medan , North." DE LEGA LATA: Jurnal Ilmu Hukum 10, no. 1 (2025): 40–49. https://doi.org/10.30596/dll.v10i1.22494.

Fahruddin, Rafi, Henny Yuningsih, and Artha Febriansyah. "Analisis Perlindungan Hukum Terhadap Penolakan Pasien Dalam Keadaan Gawat Darurat Oleh Rumah Sakit." Inovasi Pembangunan: Jurnal Kelitbangan 14, no. 1 (2026): 1–25.

Faisal, Andri Yanto, Derita Prapti Rahayu, Dwi Haryadi, Anri Darmawan, and Jeanne Darc Noviayanti Manik. "Genuine Paradigm of Criminal Justice: Rethinking Penal Reform within Indonesia New Criminal Code." Cogent Social Sciences 10, no. 1 (2024). https://doi.org/10.1080/23311886.2023.2301634.

Friedman, Lawrence M. The Legal System: A Social Science Perspective. Russell Sage Foundation. New York, 1975.

Hiariej, Eddy O S. Prinsip-Prinsip Hukum Pidana. Cahaya Atma Pustaka. Jakarta, 2022.

Indrawan, Khadafi, M. Fakih, and Budiyono. "Peran Majelis Kehormatan Disiplin Kedokteran Indonesia Dalam Kasus Pelanggaran Standar Profesional Dokter." JUSTICIA SAINS: Jurnal Ilmu Hukum 9, no. 2 (2024): 456–69. https://doi.org/10.24967/jcs.v9i1.3249.

Kabar Perwakilan. "Ombudsman RI: Fasilitas Kesehatan Langgar Regulasi Jika Tolak Pasien Dalam Kondisi Gawat Darurat." 12/06, 2025. https://ombudsman.go.id/perwakilan/news/r/pwkmedia--ombudsman-ri--fasilitas-kesehatan-langgar-regulasi-jika-tolak-pasien-dalam-kondisi-gawat-darurat?utm_source=chatgpt.com.

Moeljatno. Asas-Asas Hukum Pidana. Rineka Cipta. Jakarta, 2002.

Muladi, Arief, and Barda Nawawi. Teori-Teori Dan Kebijakan Pidana. Alums. Bandung, 1998.

Nugroho, Hari Pudjo. "Mediasi Sebagai Asas Primum Remidium Dalam Penyelesaian Sengketa Pelayanan Kesehatan Berbasis Keadilan Proporsional: Mediation As The Primum Remidium Principle In Health Service Dispute Resolution Based On Proportional Justice." Jurnal Hukum Dan Etika Kesehatan 5, no. 1 (2025): 1–15. https://doi.org/10.30649/jhek.v5i1.235.

Presiden RI. "Peraturan Pemerintah (PP) Nomor 28 Tahun 2024 Tentang Peraturan Pelaksanaan Undang-Undang Nomor 17 Tahun 2023 Tentang Kesehatan." Kemenkes RI, no. 226975 (2024): 656. https://peraturan.bpk.go.id/Details/294077/pp-no-28-tahun-2024.

Prodjodikoro, Wirjono. Asas-Asas Hukum Pidana Di Indonesia. Refika Aditama.Bandung, 2003.

Rahardjo, Satjipto. Membedah Hukum Progresif. Penerbit Buku Kompas. Jakarta, 2006.

Ramadhani, Aisyah Kurnia, Darania Anisa, Ayesha Noureen, and Zakha Sabda Legowo. "Kelalaian Dalam Pelayanan Gawat Darurat Dan Pertanggungjawaban Hukumnya Dalam Perspektif Undang-Undang Nomor 17 Tahun 2023 Tentang Kesehatan." Equality: Law and Social 1, no. 3 (2026): 205–11. https://doi.org/ejournal.risetanakbangsa.id/jhs.

Rattu, Deborah Johana, and Selamat Widodo. "Transforming Health Insurance Law : Toward Substantive Justice for Health Social Security Administering Body." DE LEGA LATA: Jurnal Ilmu Hukum 11, no. 1 (2026): 65–77. https://doi.org/10.30596/dll.v11i1.26491.

Remmelink, Jan, and Tristam Pascal Moeliono. Hukum Pidana: Komentar Atas Pasal-Pasal Terpenting Dari Kitab Undang-Undang Hukum Pidana Belanda Dan Padanannya Dalam Kitab Undang-Undang Hukum Pidana Indonesia. Gramedia Pustaka Utama. Jakarta, 2003.

Republic of Indonesia, Ministry of Health. Regulation of the Minister of Health of the Republic of Indonesia Number 47 of 2018 concerning Emergency Health Services.

Republic of Indonesia, Ministry of Health. Regulation of the Minister of Health of the Republic of Indonesia Number 6 of 2026 concerning Hospitals. State Gazette of the Republic of Indonesia Year 2026 Number 382.

Republic of Indonesia. Law Number 1 of 2023 concerning the Criminal Code. State Gazette of the Republic of Indonesia Year 2023 Number 1, Supplement to the State Gazette of the Republic of Indonesia Number 6842.

Republic of Indonesia. Law Number 12 of 2011 concerning the Establishment of Legislation. State Gazette of the Republic of Indonesia Year 2011 Number 82, Supplement to the State Gazette of the Republic of Indonesia Number 5234.

Republic of Indonesia. Law Number 17 of 2023 concerning Health. State Gazette of the Republic of Indonesia Year 2023 Number 105, Supplement to the State Gazette of the Republic of Indonesia Number 6887.

Republic of Indonesia. Law Number 30 of 1999 concerning Arbitration and Alternative Dispute Resolution. State Gazette of the Republic of Indonesia Year 1999 Number 138, Supplement to the State Gazette of the Republic of Indonesia Number 3872.

Republic of Indonesia. Law Number 36 of 2009 concerning Health. State Gazette of the Republic of Indonesia Year 2009 Number 144, Supplement to the State Gazette of the Republic of Indonesia Number 5063.

Republic of Indonesia. Law Number 38 of 2014 concerning Nursing. State Gazette of the Republic of Indonesia Year 2014 Number 307, Supplement to the State Gazette of the Republic of Indonesia Number 5612.

Republic of Indonesia. Law Number 44 of 2009 concerning Hospitals. State Gazette of the Republic of Indonesia Year 2009 Number 153, Supplement to the State Gazette of the Republic of Indonesia Number 5072.

Republic of Indonesia. The 1945 Constitution of the Republic of Indonesia, Article 28H paragraph (1).

Saleh, Roslan. Perbuatan Dan Pertanggungjawaban Pidana, Dua Pengertian Dasar. Liberty. Jakarta, 1989.

Sudarto. Hukum Dan Hukum Pidana. Alums. Bandung, 1977.

Susanti, Yulia, Aria Zurnetti, Padang City, West Sumatera, and Email Corresponding Author. "Implementation Of The Ultimum Remedium Principle In Resolving Unsuccessful Medical Disputes With Mediation Faculty of Law , Andalas University , Indonesia." DE LEGA LATA: Jurnal Ilmu Hukum 10, no. 1 (2025): 57–66. https://doi.org/10.30596/dll.v10i1.22497.

Wicaksono, Emirza Nur. "Penolakan Pasien Emergency Oleh Rumah Sakit Akibat Regulasi BPJS Kesehatan: Perspektif Hukum Dan Etika." Jurnal Humaya 5, no. 1 (2025): 60–73. https://doi.org/10.33830/humaya.v5i1.12602.