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Professional Disciplinary Authority, Institutional Independence, and Patient Safety Governance in Indonesia: A Qualitative Policy Analysis

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ABSTRACT

Introduction: Disciplinary arrangements form part of the way health systems protect patients and hold practitioners accountable. Changes to these arrangements can influence how unsafe practice is identified, how adverse events inform learning, and whether the public trusts professional oversight. This study examines the redistribution of disciplinary authority between profession-based oversight and state-linked administrative governance in Indonesia, with attention to patient safety, professional accountability, and health system legitimacy.

Methods: A qualitative policy analysis was conducted using Indonesian legislation, implementing regulations, ministerial regulations, and judicial decisions. Literature on health governance, professional regulation, and patient safety informed the interpretation. Documents were examined deductively for institutional independence, the redistribution of disciplinary authority, transparency, procedural fairness, epistemic adequacy, and accountability that supports learning.

Results: The documents indicate a move towards administrative consolidation and closer state-linked oversight of professional discipline. The reform changes both the location of disciplinary authority and how professional conduct is assessed. Better coordination and clearer accountability are possible, although the arrangements also raise questions about independent judgment, profession-specific expertise, and procedural fairness. The analysis identifies a plausible pathway connecting disciplinary design with reporting incentives, professional trust, organisational learning, and safety culture. Transparent and fair procedures that support learning may strengthen patient safety governance. Opaque or predominantly punitive processes may instead inhibit reporting and encourage defensive practice.

Conclusion: Professional discipline should be treated as part of public health regulation. In Indonesia, administrative consolidation needs to be accompanied by institutional independence, appropriate technical expertise, and transparent, fair procedures. Incorporating just-culture principles and opportunities for learning into disciplinary practice is a central policy priority for patient protection, professional and public trust, and accountable health system reform in low- and middle-income settings.

Keywords: Patient Safety Governance; Professional Disciplinary Authority; Institutional Independence; Health Professional Regulation; Indonesia

INTRODUCTION

Patient safety is a basic public health concern and an important determinant of healthcare quality. Preventable harm can cause illness and death, prolong hospital stays, and increase costs for patients and health systems. Recurrent safety incidents also weaken public confidence in healthcare institutions (1–3). Health practitioner regulation addresses these concerns by setting competence standards, controlling entry to practice, overseeing conduct, and responding when practice is unsafe (2–6). Comparative accounts of professional regulation describe how inadequate clinical competence, misconduct, and departures from accepted care standards can contribute to adverse outcomes. These relationships place professional oversight within the wider effort to protect patients (3,5,7,8).

Safety incidents may reveal weaknesses in health governance that extend beyond the actions of an individual clinician. Disciplinary and fitness-to-practise procedures provide a formal means of identifying unsafe practitioners, imposing sanctions where appropriate, and holding professionals accountable for the care they provide (3,5,8). Scoping and integrative reviews describe a substantial proportion of disciplinary investigations as directly involving patient safety concerns, including misconduct, inadequate clinical competence, and failures in professional performance (3,8). Yet disciplinary systems differ considerably in their mandates, legal powers, evidentiary requirements, and procedures. These differences make it difficult to compare regulatory effectiveness across jurisdictions or to determine how particular arrangements affect patient safety (3,8)).

Holding practitioners accountable does not, by itself, explain how regulation improves safety. Disciplinary systems also need to support learning from mistakes and changes in the conditions that allow harm to occur. Just culture offers a way to address this problem: it encourages reporting and organisational learning while retaining appropriate accountability for unsafe behaviour (9). Under this approach, an error prompts consideration of the wider system as well as the actions of the individual. The aim is to prevent similar harm elsewhere in the organisation or health system. This distinction matters when disciplinary arrangements are redesigned. Procedures that are punitive, opaque, or poorly explained may discourage disclosure, whereas fair assessment and opportunities for learning may support a stronger safety culture.

The relationship between regulatory design and patient safety is difficult to establish directly. Risk-based approaches, institutional reforms, and arrangements that cover several professions have all been proposed to improve oversight and support safer care (2–4,10). Evidence that a particular sanction, licensing change, or institutional restructuring produces measurable safety gains nevertheless remains limited and methodologically diverse (2–4). Policy analysis therefore needs to consider the steps that might connect reform with patient protection. Relevant questions include how authority is redistributed, who is held accountable, and whether the resulting procedures encourage practitioners to report concerns and learn from adverse events.

Regulation can influence patient safety through several connected functions. Regulators define competence and conduct standards, license or register practitioners, investigate complaints, and apply disciplinary measures when standards are breached (2,3,5,7,11,12). These functions are intended to deter unsafe practice and maintain acceptable professional performance. Continuing professional development and scope-of-practice rules provide additional safeguards by requiring practitioners to sustain their knowledge and work within defined professional boundaries (2,3,6,11). Within disciplinary governance, three processes deserve particular attention: detecting unsafe conduct, assessing professional responsibility, and communicating decisions that may shape subsequent practice. The signals conveyed by disciplinary decisions can affect how practitioners behave, whether concerns are reported, and how much confidence patients and professionals place in the system.

How regulatory institutions are organised may also affect their capacity to protect patients. Comparative studies discuss licensing, scope-of-practice rules, continuing professional development, and independent oversight as instruments that influence professional performance and care quality (2,13). Their usefulness depends on the arrangements through which they operate. Proportionate, or right-touch, regulation seeks to match intervention to public risk while avoiding restrictions that unnecessarily impede workforce mobility or access to services (2,6,13). Reorganising disciplinary authority brings this issue into focus. Administrative control can become excessive if it displaces the expertise needed to assess clinical conduct. Oversight can also be too weak to provide credible public accountability. The design problem is to preserve technical judgment while ensuring that decisions serve patient protection.

Many jurisdictions have reorganised professional regulation to improve public accountability. Changes have included regulatory bodies covering several professions, integrated oversight arrangements, and greater transparency in disciplinary decisions (1,3,6). Such reforms seek more consistent standards, stronger public trust, and better opportunities to learn across jurisdictions from patient safety incidents. At the same time, telemedicine and other digital services have required regulators to reconsider how established safeguards apply to newer forms of care (1,3). These developments show why the organisation of professional discipline matters to health governance. Decisions about institutional responsibilities also determine how professional expertise is brought into public accountability and how disciplinary experience can inform learning.

Less is known about these relationships in low- and middle-income countries (LMICs). Much of the published work comes from high-income settings and describes complaint patterns, disciplinary actions, or categories of sanctions. It gives less attention to how reform changes the conditions for patient safety governance (1,3,14). In LMICs, regulatory change takes place amid resource constraints, uneven institutional capacity, diverse service arrangements, and changing relationships between the state and professional groups. These conditions may influence what a new disciplinary framework can achieve. This study addresses the limited analysis of how reform in such a setting redistributes authority and affects institutional independence, and what those changes could mean for reporting, safety culture, and accountability.

Indonesia provides a relevant case because health sector reform has changed the setting in which professionals are regulated. Over the past two decades, reforms have sought to improve governance, public accountability, licensing, credentialing, and regulatory oversight. These developments sit within a wider programme of bureaucratic reform concerned with transparency and institutional performance (15–19). Reforms have also addressed the governance of telemedicine and digital health services, in response to the need for oversight to keep pace with changing models of care (20). Law Number 17 of 2023 on Health and its implementing instruments have brought renewed attention to the institutional location of disciplinary authority. In particular, they raise questions about the roles of professional bodies and administrative institutions linked to the state in overseeing professional conduct.

This study examines what Indonesia's disciplinary governance reforms may mean for patient safety and health system accountability. It considers the legal framework, institutional arrangements, and governance principles through which professional responsibility is assessed. The analysis treats professional regulation as a public health function that links accountability with patient protection and improvements in care. Its conceptual contribution is to examine discipline through the requirements of patient safety governance. Indonesia provides an LMIC case in which major health sector reform has redistributed disciplinary authority. Bringing legal and institutional analysis into conversation with governance theory and just-culture principles then allows the study to identify policy implications for Indonesia and comparable settings. These implications concern the design of regulatory institutions and the conditions needed for credible, fair, and safety-oriented professional oversight.

METHODS

Study Design and Analytical Orientation

This study used qualitative document-based policy analysis to examine Indonesia's professional disciplinary reform and its implications for patient safety, professional accountability, and health system governance. A socio-legal governance perspective guided the inquiry. The analysis concentrated on the regulatory architecture, institutional relationships, legal norms, and governance principles established through recent health sector reform; individual clinical outcomes were outside its scope. This approach allowed the study to consider how changes in law and institutional arrangements might shape the wider public health functions of disciplinary governance, particularly accountability, safety culture, and trust within healthcare systems.

Qualitative policy analysis suited the study's focus on governance reform, institutional design, and policy implications. These questions require an understanding of how regulation operates through institutions and practices, rather than a statistical estimate of causal effects. Research on health practitioner regulation and public health governance has used qualitative synthesis, integrative review, case-oriented policy analysis, and document interpretation to examine regulatory systems whose effects depend on structures, processes, and institutional practice. Policy studies in low- and middle-income countries have also combined document review with interpretive analysis to examine reform trajectories, implementation difficulties, and governance capacity (21,22). The study adopted an interpretivist epistemological position rather than a positivist one. Legal and policy documents were read as authoritative institutional texts, with their meaning and implications interpreted systematically through governance theory and patient safety scholarship.

Normative legal analysis formed part of the study's broader public health policy approach. Statutory interpretation, case analysis, and conceptual reasoning were used to examine what reform could mean for patient protection and system accountability. The method brought together doctrinal reading of legal texts, qualitative document analysis, and policy interpretation informed by governance theory. The findings and policy interpretations were organised thematically to reflect the materials examined: legal norms, judicial decisions, regulatory instruments, and conceptual literature on health governance. Combining these approaches helped address two limitations of exclusively doctrinal or theoretical work: insufficient engagement with positive legal texts and insufficient consideration of their implications for public health governance. The analysis therefore attended to both the legal basis of reform and its governance consequences.

Research Context and Scope of Inquiry

The study examined changes to professional disciplinary governance in Indonesia following Law Number 17 of 2023 on Health, together with the instruments that implemented and interpreted the law. Indonesia was selected as a critical policy case because its reform reflects regulatory modernisation, administrative consolidation, and greater state involvement in health professional governance seen across low- and middle-income countries. It also raises questions about institutional independence, fair procedures, and patient safety. The analysis placed the reform within debates on public-interest regulation, co-regulation, right-touch regulation, and professional accountability (1,11,13,23,24). This case offered an opportunity to examine how authority over professional discipline is redistributed between profession-based mechanisms and state-linked administrative structures in an LMIC health system.

The analysis covered matters directly relevant to disciplinary governance in healthcare services. It examined where the new legal framework placed disciplinary authority, how it might change the relationship between professional assessment and state administration, and what these changes could mean for patient safety governance, public trust, and accountability within health services. Neither the frequency of disciplinary cases nor the extent of patient harm was measured statistically. Legal texts, governance theory, and patient safety literature instead provided the basis for evaluating regulatory design and its plausible implications for health system governance. Statements about patient safety should therefore be read as implications derived from the analysis, not as findings from empirical measurement of safety outcomes.

Data Sources and Documentary Materials

Documentary sources comprised primary legal and policy materials and secondary literature. The primary sources covered national legislation, implementing regulations, ministerial regulations, and judicial decisions relevant to professional disciplinary reform. Six principal instruments were examined: Law Number 17 of 2023 on Health, Government Regulation Number 28 of 2024, Minister of Health Regulation Number 12 of 2024, Minister of Health Regulation Number 13 of 2024, Minister of Health Regulation Number 3 of 2025, and Constitutional Court Decision Number 156/PUU-XXII/2024 (16,24,25). These instruments establish the institutional arrangements, regulatory powers, and normative basis of disciplinary procedures for medical personnel and other health workers. Inclusion required three conditions: direct relevance to professional discipline or regulatory authority; formal legal or policy status within Indonesia's health reform framework after 2023; and relevance to at least one analytical dimension: institutional independence, transparency, procedural fairness, epistemic adequacy, or patient safety relevance. Documents concerned only with general health administration were excluded if they had no direct bearing on professional discipline or accountability pathways.

The secondary sources comprised peer-reviewed international and national literature on professional regulation and autonomy, health governance, patient safety, just culture, epistemic justice in healthcare, defensive medicine, and regulatory reform (1–3,13,14,17,22,23,26–36). This literature supplied concepts for interpreting the reforms beyond the wording of legal provisions. It also provided a comparative and theoretical context for considering Indonesian reform as an approach to public safety regulation. Priority was given to recent, peer-reviewed sources that addressed professional regulation or patient safety governance directly and helped explain the Indonesian case. Material with only an indirect connection was used sparingly; it did not serve as the primary evidence for claims about changes to Indonesian law (2,15–19).

Conceptual and Analytical Framework

The analytical framework combined public-interest regulation theory, Donabedian's structures-processes-outcomes perspective, just culture principles, and regulatory governance theory. Public-interest regulation and social contract perspectives framed professional regulation as an institution for protecting patients and maintaining public trust through a balance of professional autonomy and accountability safeguards (1,11,13,23,24)). Applied to disciplinary governance, these perspectives directed attention to whether the new legal design supported its public-protection purpose. The practical question was whether reform strengthened or weakened the institutional conditions for credible disciplinary accountability, or left those conditions unclear. This question connected the interpretation of legal arrangements to their governance implications.

Donabedian's structures-processes-outcomes framework organised the assessment of how regulatory design may affect patient safety and health system performance. Structures included regulatory institutions, legal mandates, and governance arrangements. Processes covered disciplinary assessment, complaint handling, transparency, due process, and professional oversight. Outcomes referred to anticipated implications for patient safety, accountability, and trust in the health system. No outcomes were measured empirically. The framework instead provided a systematic way to consider the public health consequences that might follow from structural and procedural change. For example, a provision relocating disciplinary authority was coded as a structural change, whereas provisions concerning complaint handling or adjudication were coded as changes in process. Possible consequences for reporting behaviour, trust, and learning were interpreted as propositions about outcomes, not as measured effects.

Just culture and learning health system perspectives helped assess whether disciplinary arrangements were likely to encourage safety reporting, learning, and improvement, or generate fear, concealment, and defensive responses to punishment (9,37). Meta-regulation and regulatory governance theory informed the examination of transparency, external oversight, procedural fairness, and relations between professional expertise and state administration (1,3,38,39). Proportionality and right-touch regulation provided normative criteria for considering whether regulatory intensity matched public safety risks and health system needs as Indonesia's governance arrangements evolved (2,14,40). Each perspective had a distinct purpose in the analysis. Public-interest regulation defined the purpose of discipline; Donabedian's model organised the assessment; just culture informed the interpretation of patient safety implications; and regulatory governance theory supported the evaluation of institutional legitimacy.

The analytical dimensions connected legal design with public health governance. Institutional independence concerned the extent to which disciplinary judgments could be made without inappropriate administrative domination. Transparency covered the clarity of procedures, explanations for decisions, and mechanisms for public accountability. Procedural fairness concerned due process protections, timely proceedings, and access to relevant documents. Epistemic adequacy addressed whether a regulatory forum could draw on relevant professional knowledge to assess clinical conduct, rather than relying solely on administrative reasoning. The accountability pathway traced how complaints and professional assessments connected disciplinary findings with administrative decisions. Patient safety relevance concerned the extent to which disciplinary design could plausibly support learning and accountability while protecting patients from preventable harm. These dimensions provided deductive codes for reviewing the documents and criteria for interpreting the legal and institutional arrangements identified in the review.

Data Collection and Document Review Procedure

Data collection involved systematically identifying relevant documents and reading them closely. The first step was to collect primary legal texts on health professional discipline and the associated institutional arrangements in Indonesia. These were examined in chronological and substantive order to trace the development of reform, the legal transition brought about by the 2023 Health Law, and the significance of the Constitutional Court's interpretation (16,24,25). The review concentrated on

provisions governing disciplinary authority, institutional mandates, complaint handling or adjudication, professional roles, administrative oversight, and the legal consequences of disciplinary findings.
Secondary literature was selected purposively to inform conceptual interpretation and provide a comparative context. Priority topics were health practitioner regulation, regulatory governance, patient safety, just culture, professional autonomy, defensive medicine, and Indonesian governance reform. Sources had different roles in the analysis. In keeping with qualitative policy analysis, legal texts provided the primary evidence on institutional arrangements, while scholarly literature helped interpret their implications, examine conceptual tensions, and relate the findings to health systems and regulation research (2,4,14). Maintaining this distinction was intended to limit reliance on international literature as evidence for claims about institutional change in Indonesia.

Analytical Procedure

Deductive thematic synthesis proceeded through four stages. First, core governance principles were drawn from legal, ethical, regulatory, and patient safety literature relevant to professional discipline. These principles were then translated into six analytical dimensions: institutional independence, transparency, procedural fairness, epistemic adequacy, accountability pathway, and patient safety relevance. Third, the primary documents were read and coded using these dimensions. Finally, the coded findings were brought together to develop institutional and policy implications for patient safety governance and health system accountability (1–3,13,14,17,22,23,26–36). This sequence addressed the risk that a strongly doctrinal analysis could overlook policy consequences, while an abstract philosophical account could lose contact with positive law. The design sought to maintain fidelity to legal texts while developing their analytical implications (1–3,13,14,17,22,23,26–36).
Thematic coding covered legal provisions and institutional arrangements across six dimensions: institutional independence, accountability pathway, transparency, procedural fairness, epistemic adequacy, and safety implications. The reasoning in the Constitutional Court decision was examined for its interpretation of the legality and scope of disciplinary recommendations (24). Documentary findings were then considered alongside conceptual work on regulation, professional autonomy, epistemic justice, and patient safety to develop an integrated interpretation of the reform's consequences. Coding reflected the substance of each provision. For example, centralisation of authority in state-linked structures was coded under "institutional independence" and "accountability pathway." Rules on complaint handling or decision-making were assigned to "procedural fairness" and "transparency," while provisions concerning professional expertise were coded under "epistemic adequacy." An interpretive claim was retained only if it could be traced to a primary legal document or a clearly identified theoretical framework.

Trustworthiness and Rigour

Rigour was addressed through source triangulation, explicit coding logic, auditability, reflexive limitation, and analytical coherence. Legislation, subordinate regulations, judicial decisions, and scholarly literature were considered together to support triangulation across source types. The analytical framework and evaluative dimensions were stated explicitly to make the conceptual approach transparent. For each major claim, the source category, relevant provision or policy issue, analytical code, and interpretive inference were documented to support auditability. Reflexive limitation involved separating findings about legal and institutional arrangements from propositions about possible patient safety implications. Linking each interpretation to documentary evidence or relevant theory supported analytical coherence. To limit interpretive bias, the same questions were asked of every primary document: Which institution receives authority? What procedural safeguards are specified? What role is given to professional expertise? How do disciplinary recommendations or sanctions connect to administrative decisions? What might follow for accountability, transparency, reporting behaviour, and learning about patient safety? These questions provided a consistent basis for comparing the documents and distinguishing descriptive legal findings from the study's interpretation of their governance implications.

Ethical Considerations

The study examined publicly available documents and published literature. It involved no human participants, collection of personal data, or direct intervention in healthcare settings. Because the materials were public legal and policy documents, formal ethical approval was not required. The analysis was guided by academic integrity, accurate citation, and careful interpretation of legal texts and scholarly arguments. Its purpose was to develop a rigorous policy account of how professional disciplinary governance may affect patient safety and public health accountability in Indonesia. Confidential disciplinary cases, identifiable practitioner information, and patient-level data were outside the materials analysed.

RESULTS

Reconfiguration of Professional Disciplinary Governance in Indonesia

Indonesia's health regulatory reforms after 2023 change the institutional organisation of professional discipline as well as its administrative procedures. Analysis of Law Number 17 of 2023 on Health, Government Regulation Number 28 of 2024, relevant ministerial regulations, and Constitutional Court Decision Number 156/PUU-XXII/2024 indicates a shift towards stronger state-linked administrative oversight of disciplinary authority. The significance of this change becomes clearer when the connected functions of disciplinary governance are considered: licensing or registration, setting standards, managing complaints, conducting investigations, adjudicating cases, and imposing sanctions. Through these functions, health systems establish the institutional means to identify unsafe practice, determine professional accountability, and protect patients from preventable harm (2,3,23).

Requirements for entry to practice, continuing competence, and disciplinary review are intended to work together to prevent professional misconduct and address breaches of professional standards. In the Indonesian reform, the organisation of these functions determines who can define professional fault, assess technical conduct, and decide the legal or administrative consequences of disciplinary findings. The reviewed instruments retain disciplinary oversight while changing where and how that authority operates. Five connected dimensions help explain this change: where authority is located, how professional expertise is used, the route followed by complaints and adjudication, the connection between disciplinary findings and administrative decisions, and the implications of these arrangements for patient safety. Examining these dimensions shows a redistribution of disciplinary authority within the health governance system, beyond any increase in the amount of regulation. In the post-reform framework, state-linked administrative oversight assumes a stronger role. At the same time, the relationship of professional expertise, procedural accountability, and public protection to the exercise of disciplinary authority is redefined. These changes concern both the institutions responsible for oversight and the basis on which they assess professional conduct.

The Indonesian pattern is consistent with international scholarship describing variation in the organisation of professional discipline. Some systems are led primarily by professions, others operate under state supervision, and others place several professions under a centralised umbrella regulator (1,3,41,42). Such arrangements shape institutional independence, public accountability, and the legitimacy attributed to regulatory decisions. The Indonesian reform appears to give administrative structures a larger role in disciplinary processes, moving away from a more differentiated professional disciplinary forum. This change raises two related questions: how profession-specific knowledge will be retained in assessments of clinical conduct, and how far disciplinary adjudication will remain protected from bureaucratic or managerial priorities. The answers matter because institutional structure affects both the technical basis of a decision and confidence in the process through which it is reached.

The reform also follows wider developments in health regulation towards integrated governance, stronger public accountability, and more formal oversight of professional conduct. International literature considers professional discipline in relation to transparency, fairness, and consistency across regulatory systems, alongside its role in sanctioning misconduct (1,23,42). From this perspective, Indonesia's reform can be understood within governments' broader efforts to modernise professional governance through public-interest regulation, administration focused on performance, and coordinated stewardship of health systems (15–19). The analysis nevertheless identifies a condition that limits this interpretation: consolidating administrative authority does not, by itself, establish stronger patient protection. That protection also requires professional expertise, procedural safeguards, clear reasons for decisions, and accountability arrangements that support learning.

Institutional Independence and the Changing Balance Between Professional Authority and State Oversight

The legal analysis identifies a change in the balance between professional self-governance and state-linked oversight. By bringing profession-based disciplinary processes more closely into the administrative structures of health governance, the reform makes disciplinary authority more dependent on state-linked institutions. It consequently changes both the meaning of institutional independence and the conditions under which that independence can be exercised. These consequences extend beyond the placement of a disciplinary body within an organisational structure. Independence matters to regulatory governance because it affects confidence that judgments about misconduct are impartial, technically sound, and directed towards public protection. Where such confidence is lacking, decisions may instead be understood as serving administrative or political objectives.

International scholarship describes the balance between professional self-regulation and government oversight as a recurring tension in health professional governance. Advocates of profession-led regulation emphasise the specialised knowledge needed to assess clinical competence, establish appropriate standards of care, and interpret complex practice. Critics caution that professional solidarity may take precedence over public accountability. They therefore call for transparency, participation by lay members, safeguards against conflicts of interest, and independent oversight to accompany self-regulation (1,23,24). These competing considerations take a concrete institutional form in the Indonesian reform. Moving disciplinary authority into a more centralised governance structure changes how profession-specific expertise and administrative control relate to one another, with consequences for how professional conduct is assessed.

The analysis points to two implications that may occur together. Greater state involvement may clarify administrative responsibility, connect discipline more closely with health system governance, and reduce fragmentation among professional regulators, thereby strengthening formal accountability. Research on umbrella and government-led models similarly suggests that centralisation can improve consistency of standards, portability, and public accountability when separate professional systems create duplication or incoherence (1,3,41). Yet closer ties to executive or administrative structures may weaken confidence in disciplinary decisions if managerial or political priorities take precedence over technical professional judgment. Comparative work identifies risks to public protection in both excessive government control and professional self-regulation with inadequate supervision. What matters is whether the arrangements retain impartiality, professional expertise, and a clear commitment to the public interest (1,23,24,43). For Indonesia, administrative consolidation therefore offers an opportunity to make regulation more coherent while creating a potential for administrative overreach. These possibilities need to be considered together when assessing the new allocation of disciplinary authority.

From a public health perspective, these institutional choices affect the wider culture of accountability in healthcare. Disciplinary systems assign responsibility for misconduct, but they also communicate whether unsafe practice will receive a credible response grounded in professional knowledge. Perceived dependence of disciplinary institutions may weaken trust among

professionals and the public alike. Professionals may view proceedings as susceptible to political influence or as tools of administration; patients may doubt that regulatory decisions place their protection first. The Indonesian case thus makes independence relevant to the credibility of safety governance. It is a condition affecting confidence in professional accountability as well as a legal feature of the institutions responsible for it.

Procedural Transparency, Due Process, and the Public Visibility of Accountability

Procedural transparency is another central feature of the reformed framework, although its implications are not uniformly positive. Across many regulatory systems, transparency takes the form of published disciplinary outcomes, accessible practitioner registers, explanations of regulatory decisions, and arrangements for independent scrutiny or lay oversight (1,23,42). These measures are intended to strengthen public trust and informed patient choice while opening disciplinary processes to institutional learning beyond professional circles. Read against this international context, the Indonesian legal reforms suggest greater emphasis on formal accountability and the visibility of administrative action. Whether that visibility improves patient protection, however, depends on fair procedures and clear interpretation. Transparency therefore needs to be assessed in terms of how disciplinary decisions are explained and reached, as well as how widely they are disclosed.

The document analysis indicates that visible decisions and centralised authority are insufficient measures of transparency. Stakeholders need understandable procedures, clearly assigned institutional responsibilities, and safeguards that allow them to follow how a complaint is received, assessed, and converted into a regulatory decision. Disclosure can otherwise leave the process obscure even when its outcome is public. International literature describes transparency as a means of overseeing regulation when it is connected to due process, consistent reasoning, and opportunities for organisational learning (1,3,31). In Indonesia, the reform appears to make administrative action more visible, but this does not necessarily settle concerns about fairness, consistency of interpretation, or the adequacy of professional knowledge used in assessment. A disciplinary decision may be legally accessible while the procedure that produced it remains difficult to understand. The analysis therefore distinguishes public access to an outcome from a clear account of the evidence, reasoning, and institutional steps behind that outcome.

This distinction matters because disciplinary systems must provide both professional justice and public accountability. Disclosure is unlikely to build confidence when complaint procedures are hard to access or assessments appear inconsistent or poorly reasoned. Excessively punitive disclosure may stigmatise practitioners, encourage defensive behaviour, or make them reluctant to report clinical errors. Comparative scholarship describes both possibilities: transparency can support legitimacy and learning, but its design can also intensify blame and reduce the openness needed to improve patient safety (2,3,31,42). Assessing transparency therefore requires attention to proportionality, protections for confidentiality, due process, and access to remediation. These features help determine how public disciplinary information affects the people and institutions involved.

For Indonesia, the analysis treats the reformed framework as a means of organising and communicating accountability throughout the disciplinary process. Public trust will depend on clear procedural rules, accessible complaint mechanisms, published reasons for decisions, and technical and legal explanations that stakeholders can understand. Changing the institutional structure alone cannot secure accountability. Transparency needs to work alongside due process, consistent interpretation, and an evident commitment to patient safety. This requirement applies across the connected stages of complaint handling, adjudication, administrative follow-up, and review. Each stage needs a clear procedural explanation, including how it relates to the others, so that stakeholders can understand how responsibility is established and acted upon. The finding therefore directs attention from formal institutional arrangements to the way those arrangements provide fair procedures, explain decisions, and maintain a patient safety orientation throughout the reformed disciplinary system.

Professional Oversight, Accountability Pathways, and Governance Performance

The reform also changes the routes through which healthcare professionals are held accountable. International research describes disciplinary mechanisms as a sequence that turns a concern about competence or conduct into a complaint, investigation, adjudication, and possible sanction. Such sequences can deter unsafe practice and indicate how seriously a health system takes professional standards and patient protection (3,23,25,33). The Indonesian analysis places disciplinary governance within the practical organisation of accountability: its value depends on the capacity to connect concerns with an institutional response. Legal recognition of the process is therefore only part of its function. Clear institutional responsibilities and procedures are needed for this form of accountability to operate effectively.

The reviewed documents show changes to the institutional routes through which accountability is initiated, interpreted, and given a disciplinary or administrative response. These changes have three implications for governance performance. Responsiveness depends on complaints being handled promptly and credibly. Coherence depends on clearly differentiated responsibilities, since overlapping mandates can create uncertainty about jurisdiction and authority. Legitimacy requires processes that are viewed as technically sound and directed towards the public interest. The documentary analysis traces a sequence beginning with a complaint or concern, followed by preliminary administrative handling and professional or technical assessment. This assessment may lead to a disciplinary recommendation or decision and subsequent administrative action. The sequence explains how the reformed framework converts a concern about competence or conduct into a response by the responsible institutions. It also provides a basis for distinguishing the descriptive legal finding from its wider implications for responsiveness, procedural clarity, professional accountability, and opportunities to learn about patient safety. Those implications concern the operation of the pathway; they are not measurements of its effects.

International reviews offer a similar account of professional oversight: clarifying standards, bringing disciplinary records together, and formalising sanctions may strengthen governance, but practical results depend on institutional quality and the capacity to implement reform. Evidence from several high-income jurisdictions suggests possible improvements in workforce distribution, regulatory consistency, or access to services. Direct causal evidence of better patient safety outcomes remains limited (1,14,23,41). In LMIC settings, formal accountability structures may likewise be established without measurable safety gains if enforcement and coordination are weak (1,41,43). The Indonesian findings should be read within these limits. They identify governance implications of the legal design and do not provide empirical evidence that the reform has improved or worsened patient safety.

The Indonesian case presents the same dependence on implementation. Bringing disciplinary procedures more firmly into state health governance may strengthen accountability, but the result will depend on how those procedures operate. Centralised oversight can add administrative complexity when technical capacity is insufficient, procedural mandates are unclear, or documentation systems are disconnected. Governance research therefore assesses disciplinary frameworks by their ability to deliver fair, timely decisions relevant to patient safety, alongside the formal authority conferred on them by law (4,14,33). The analysis identifies the institutional conditions supporting accountability as a central concern. For Indonesia, the reform's effectiveness will depend on the combined availability of workable procedures, reliable documentation systems, professional participation, and institutional capacity at different levels of the health system. Legal authority establishes the remit for oversight; these conditions determine how that remit can be carried out.

Implications for Patient Safety Governance and Safety Culture

The analysis identifies plausible connections between disciplinary reform and patient safety governance, especially incident reporting, safety culture, and learning from adverse events. Patient safety scholarship assigns disciplinary systems two responsibilities: identifying and sanctioning unsafe practice, and supporting a culture in which organisations learn about safety. This includes promoting a 'just culture' that allows errors to inform organisational learning while retaining appropriate accountability for reckless or negligent behaviour (37,44). These responsibilities suggest that disciplinary design may matter beyond individual cases. Because this study examines documents, the proposed connections are pathways informed by theory. They are not measured effects of the Indonesian reform.

The Indonesian reform appears to strengthen formal accountability, but how learning will be incorporated into disciplinary practice remains unresolved. International evidence links excessively punitive disciplinary environments to reduced incident reporting, less disclosure of near misses, and lower professional participation in safety investigations (2,37,44)). Reduced openness can hinder the detection of systemic risks and the learning needed to prevent harm, making it a public health concern as well as an organisational one. For Indonesia, this is a policy risk to monitor empirically; the analysis does not establish that the reform has already produced it. The proposed pathway begins with institutional design and its influence on how professionals and the public perceive disciplinary independence, procedural fairness, and professional expertise. Those perceptions may affect trust in institutions and practitioners' willingness to report incidents, disclose errors, or take part in accountability processes. Reporting then influences what healthcare organisations can learn from adverse events, near misses, and unsafe conditions. On this account, disciplinary governance may support patient safety through accountability arrangements that also enable organisational learning. The study proposes this sequence as a theoretically informed explanation requiring further empirical investigation. It does not demonstrate a direct causal relationship between the legal reform and patient safety outcomes.

Informal professional culture alone is insufficient to govern patient safety. Formal disciplinary processes are still needed to address persistent incompetence, serious misconduct, and repeated unsafe practice (3,23,45). The design question is how to make these processes support accountability and learning together. International discussions of just culture address this problem by distinguishing remediable error and system failure from culpable misconduct, with the aim of protecting patients while keeping institutions open to learning (9,37). Applied to Indonesia, this requires procedures capable of differentiating intentional misconduct, professional incompetence, human error, and failures arising from the system. These distinctions are relevant to the disciplinary response and to the lessons that healthcare organisations may draw from a case.

Indonesia's health law reform creates an opportunity to address these governance choices. Disciplinary mechanisms that are rigidly punitive or excessively bureaucratic may encourage defensive practice, reduce disclosure of errors, and limit reflective learning. Procedures based on transparent standards, fair adjudication, and appropriate opportunities for remediation may instead increase confidence in patient safety governance. Reform therefore affects the conditions under which healthcare organisations detect harm, disclose it, and learn from it. How legal accountability is implemented matters to these activities and to the relationship between professional discipline and patient protection.

Emerging Risks: Defensive Practice, Fragmentation, and Uneven Capacity

The analysis also considers risks and unintended consequences. International literature identifies possible effects of professional disciplinary reform on workforce flexibility, licensing delays, safety reporting, risk-averse professional behaviour, and administrative workload, particularly where resources are constrained (3,4,23,45). The Indonesian case suggests that these risks depend on how regulatory design interacts with institutional capacity. Legal change alone does not explain whether they will arise or how they will affect governance. The findings therefore treat them as plausible concerns that follow from the institutional analysis, with their occurrence and extent to be assessed through future empirical research.

Defensive practice is one concern. Professionals who regard disciplinary systems as opaque, punitive, or weak in professional expertise may place greater emphasis on avoiding complaints when making clinical decisions. Such practices may not

optimise patient care. As discussed in the literature on defensive medicine and professional accountability, overly cautious conduct may increase costs, complicate decisions, and discourage care for patients with complex or high-risk conditions, with consequences for both quality and access. International evidence also suggests that transparency and accountability measures can contribute to stigma, difficulties with morale, and reluctance to treat high-risk patients when poorly calibrated (2,3,31,42). In this study, the concern follows from the interaction of administrative consolidation, perceived procedural fairness, and professional expertise in disciplinary assessment. It remains an analytical implication of those arrangements rather than an observed change in Indonesian clinical practice.

Regulatory fragmentation presents a second concern. Consolidating authority may leave fragmentation unresolved, or even increase it, if institutional mandates, information systems, and procedural standards are poorly aligned. Comparative studies associate fragmented disciplinary records and inconsistent terminology with obstacles to learning across professions, weaker regulatory consistency, and reduced public confidence (1,3,14,33). The Indonesian model will consequently depend on coordination among disciplinary information systems, institutional responsibilities, and procedures throughout the health system. To use disciplinary information for system-wide learning, a shared classification is needed for complaints, findings, sanctions, remediation measures, and safety lessons. Without such alignment, bringing authority together may still leave the information required for learning divided across institutions.

A third challenge is uneven regulatory capacity. Research in LMIC settings links the achievement of oversight objectives to investment in enforcement, professional training, administrative infrastructure, and coordination among institutions (1,41,43). The Indonesian analysis points to the same implementation requirement. Legislation can alter formal structures quickly, but translating those changes into patient protection depends on the capacity to carry them out, especially at subnational and institutional levels. Inadequate resources or administrative capability may result in delays, inconsistent decisions, or compliance that is formal but ineffective. These concerns are particularly relevant where institutional readiness, workforce distribution, digital infrastructure, and administrative coordination vary between regions. Under such conditions, centralising regulatory authority does not remove the need to build the capacity through which accountability is exercised.

The findings describe Indonesia's disciplinary reform as a governance transition with opportunities and risks. It may improve regulatory consistency, formal accountability, and public oversight. Without strong institutional safeguards, however, it may also encourage defensive practice, discourage learning, and strain implementation. Professional discipline therefore needs to be examined through its role in public health governance alongside its legal provisions. Its design may influence the routes through which accountability is exercised, the safety culture of healthcare organisations, professional behaviour, and the confidence that professionals and the public place in the health system.

DISCUSSION

Indonesia's reform of professional disciplinary governance changes the institutional conditions that may influence patient safety, accountability, and trust, as well as the legal organisation of discipline. This reading accords with literature showing that governance arrangements shape the circulation of safety signals, the operation of accountability mechanisms, and trust among patients, professionals, and regulatory authorities (3,23,46,47). A Donabedian-informed perspective on health practitioner regulation connects institutional structures, such as regulatory bodies, formal mandates, and oversight arrangements, with the processes used to assess complaints and enforce professional standards, and ultimately with safety and quality outcomes. The findings therefore place Indonesia's disciplinary procedures within a wider set of institutional arrangements and governing principles through which patient protection, professional accountability, and health system legitimacy are established. Reorganising disciplinary authority has implications across these interconnected functions. The document-based design, however, cannot establish that the reform has produced changes in patient safety. It identifies legal and institutional pathways through which such effects may plausibly arise, providing an interpretation of the reform's potential consequences for health governance.

Institutional independence is a central requirement for credible patient safety governance. International experience identifies the balance between independence and accountability as a basis for the legitimacy and effectiveness of professional disciplinary systems (1,23,42,43). Profession-led self-regulation can retain technical expertise and the capacity to assess practice against profession-specific standards. To prevent regulatory capture and sustain public confidence, these arrangements also need effective transparency, lay oversight, and safeguards against conflicts of interest (1,23,24). Government-led and umbrella regulatory models may strengthen formal accountability, improve regulatory coherence, and support professional mobility. Professional judgment may nevertheless be weakened if bureaucratic control dominates or if administrative and political influence reach disciplinary decision-making (1,3,24,43). Indonesia's reform brings this tension into focus: disciplinary governance is moving towards stronger state-linked administrative oversight, while the arrangements for preserving professional expertise and independent adjudication remain important questions.

Public-interest and social contract theories provide a basis for this interpretation. The purpose of professional regulation is public protection: licensing, standard setting, continuing competence requirements, and disciplinary oversight translate specialised expertise into accountable clinical practice (1,11,13,23). Whether regulatory leadership rests with the profession or the state, the policy test is whether the institutional arrangements credibly serve that public purpose. In Indonesia, administrative consolidation therefore needs safeguards that secure impartiality, adequate technical assessment, and freedom from arbitrary interference. These findings support proportionate, or "right-touch," regulation. Under this approach, the intensity of regulation reflects the risks to patient safety, while its design protects procedural fairness and avoids discouraging learning or distorting workforce behaviour (2,6,14,40).

Transparency also matters for the credibility of disciplinary governance. International evidence identifies searchable professional registries, published disciplinary decisions, accessible licensing information, and clear procedural explanations as ways to strengthen trust, accountability, and public protection. These measures make safety governance easier to

understand and assess (4,23,31). Their value, however, depends on how disclosure is designed. Visibility without due process, proportionality, or attention to the circumstances of a case may stigmatise practitioners, encourage defensive clinical practice, and reduce openness (2,3,31,42). The Indonesian findings suggest that transparency can protect patients only when procedures are understandable, open to review, proportionate, and regarded as fair. Stakeholders need to be able to follow how a complaint was assessed, what the evidence meant, and why a particular sanction was imposed. Without those explanations, public visibility may create an appearance of accountability while offering little assurance that the disciplinary process protects patients.

Just-culture principles help explain the importance of procedural design for patient safety. Distinguishing culpable misconduct from remediable human error allows safety systems to learn from incidents while retaining accountability for reckless or persistently unsafe practice (2,37,44). The analysis suggests that Indonesia's disciplinary reform has yet to resolve this balance fully. A predominantly punitive or administratively rigid implementation may deter error reporting, increase practitioner anxiety, and make institutions less willing to reflect on incidents and learn from them. These are inferred policy concerns; the study did not measure such effects. Their relevance lies in the wider tasks of patient safety governance. Alongside sanctions for serious misconduct, institutions need conditions that allow near misses, unsafe circumstances, and systemic vulnerabilities to be identified before harm recurs. Just culture provides a governing principle for distinguishing human error, system failure, negligence, and intentional misconduct. It calls for these distinctions in the exercise of accountability rather than a general relaxation of responsibility (37,44)).

Indonesia offers an LMIC perspective on the relationship between regulatory reform, institutional trust, and governance capacity. Research on professional discipline and regulatory design has largely developed in high-income settings; empirical work from LMICs remains limited and often descriptive (1,41,46,48). In these settings, reform commonly pursues several aims at once: greater legitimacy, less opaque regulation, modernised administration, and stronger public protection. These aims may have to be met where regulatory infrastructure is incomplete or uneven. Indonesia's particular challenge is to implement legal change consistently throughout a decentralised health system with diverse institutions. Formal reform is necessary, but its effects depend on the capacity to put it into practice. Independence cannot guarantee better safety where regulatory capacity is lacking. Likewise, transparency may do little to build trust without reliable data systems, faithful implementation, and information that the public can access (1,15,41,43).

International models of professional discipline offer several lessons for interpreting Indonesia's reform. Profession-led self-regulation can support patient safety where public accountability, external oversight, and conflict-of-interest management are strong. Weak transparency and oversight, however, leave its legitimacy open to challenge (1,23,42,46). Government-led and umbrella multi-profession frameworks may improve consistency, portability, and common standards across professions. Their design must also limit excessive centralisation and retain meaningful professional involvement in technical adjudication (3,4,43). Multi-profession bodies and shared disciplinary taxonomies offer a further possibility for system learning by aligning categories of misconduct, sanctions, and safety indicators. For other LMICs, these comparisons suggest that the location of regulatory authority is only one criterion for assessing reform. Evaluation should also consider coherence, fairness, the use of professional expertise, the usability of regulatory data, and public protection (1,3,14,33).

Digital health adds further demands to disciplinary governance. Telehealth, virtual care, and other digitally mediated forms of practice challenge established assumptions about jurisdiction, competence, privacy, and accountability (1,2,14). Fragmented or poorly coordinated oversight may leave patients with uneven protection when cross-border practice, remote supervision, and digital platforms make responsibility harder to determine. The study did not examine telehealth cases empirically. Its findings nevertheless suggest that disciplinary reform should prepare for digital and hybrid care through interoperable data systems, clear lines of accountability, and explicit standards for technical adjudication. For Indonesia, this means extending regulatory planning beyond conventional service settings to telemedicine, hybrid models, and future practice across jurisdictional boundaries. Such preparation is needed to keep disciplinary governance responsive to changing patient safety requirements (2,14,20).

The analysis points to several priorities for policy. Institutional independence needs explicit legal guarantees, a clearly defined disciplinary jurisdiction, and mechanisms that protect professional judgment from political and corporate interference; formal structural separation alone cannot provide these protections. Transparency requires accessible complaint channels, public reporting of disciplinary outcomes, and understandable reasons for decisions, alongside due process, privacy protections, and proportionate sanctions (14,23,31). Fairness also depends on predictable procedures, timely adjudication, meaningful opportunities for defence, and protection against arbitrary or inconsistent sanctions. Indonesia should connect these safeguards to patient safety by establishing just-culture criteria, remediation pathways, standardised disciplinary taxonomies, and integrated information systems through which disciplinary cases can inform learning across the health system.

This study places professional disciplinary reform within public health governance and develops that perspective in three ways. Conceptually, it locates professional discipline within patient safety governance. Contextually, Indonesia provides an LMIC case in which major health sector reform has redistributed disciplinary authority. The integrative contribution brings legal and institutional analysis into conversation with public-interest regulation, procedural fairness, and just-culture principles. Examining the post-reform framework from this wider health systems perspective shows how disciplinary institutions form part of the arrangements for protecting populations from preventable harm and maintaining health system legitimacy. It also clarifies their role in balancing specialised professional expertise with democratic accountability.

The findings must be read in light of the study's limitations. This qualitative policy analysis draws on legal and documentary sources and contains no empirical post-reform outcome data on disciplinary case volumes, reporting behaviour, or patient safety indicators. The wider literature also notes the difficulty of establishing causal relationships between governance structures and safety outcomes. Inconsistent terminology, limited standardised indicators, and a shortage of longitudinal evaluations complicate such assessments, particularly in LMICs (1,3,14,41). The present findings are consequently limited to legal and institutional interpretation and theoretically plausible policy implications. They do not evaluate the reform's observed outcomes. Further research should examine investigation timeliness, practitioners' perceptions of fairness, reporting

behaviour, patient complaints, and safety culture across Indonesian healthcare institutions to assess how these aspects respond to disciplinary reform.

Governance design may shape the conditions that enable health systems to protect patient safety. Independence, transparency, fair procedures, and a regulatory culture that supports learning are basic requirements for effective disciplinary governance. Indonesia's reform offers an opportunity to improve regulatory coherence and public accountability, provided that reform extends beyond administrative centralisation. Its promise therefore depends on how these requirements are secured in practice. Disciplinary systems are most likely to support patient safety when institutions are credible, decisions have a sound technical basis, procedures are fair, and accountability is pursued alongside system learning. These conditions place disciplinary reform within the wider effort to strengthen public health systems in Indonesia and comparable LMIC settings.

CONCLUSION

This study examined Indonesia's professional disciplinary reform in relation to patient safety governance, professional accountability, and health system legitimacy. Its qualitative document-based analysis drew on legal materials, regulatory frameworks, judicial interpretation, and relevant scholarship. The analysis places disciplinary systems within the governance of national health systems: alongside their role in sanctioning misconduct, they provide institutional arrangements through which accountability, professional trust, and behaviour directed towards patient safety may be organised.

Recent Indonesian reforms have redistributed disciplinary authority between profession-based mechanisms and state-linked administrative oversight. This change in the relationship between professional autonomy and state oversight reshapes the connections among discipline, administrative control, and public protection. Closer integration with government structures may improve formal accountability and administrative coherence. Effective disciplinary governance, however, still requires institutional independence, profession-specific expertise, fair procedures, transparent reasoning, and safeguards against excessive administrative control. These conditions determine whether the reconfigured arrangements can serve their public purpose.

The study identifies plausible pathways through which disciplinary systems may influence patient safety governance; it does not measure safety outcomes directly. Credible investigation of complaints and action on unsafe professional conduct should be accompanied by support for a safety culture that encourages learning. Procedures perceived as excessively punitive, opaque, or lacking professional expertise may deter incident reporting and encourage defensive practice. Arrangements that combine transparency, due process, proportionate responses, remediation, and just-culture principles are more likely to enable organisational learning while maintaining accountability for harmful practice.

Policy design should bring together administrative coordination and institutional independence, transparency and due process, and accountability and learning. Priorities include making disciplinary information more accessible to the public, clarifying procedures for complaints and adjudication, establishing accountability mechanisms that support learning, and investing in institutions' regulatory capacity. These steps would align professional discipline more closely with public health objectives. They are especially relevant in LMIC settings, where the capacity of institutions and the legitimacy of governance arrangements strongly influence whether regulatory reform can achieve its aims.

The study extends analysis of professional disciplinary reform into public health governance through conceptual, contextual, and integrative contributions. It treats discipline as part of patient safety governance, examines Indonesia as an LMIC example of the redistribution of authority, and links legal and institutional reform to governance theory and just-culture principles. Connecting disciplinary structures with patient safety, accountability, and institutional trust provides a wider basis for evaluating health regulatory reform. This perspective is particularly relevant to LMIC health systems, where these relationships warrant attention alongside the legal and professional dimensions of regulation.

Empirical evaluation should now examine how disciplinary reform affects incident reporting, investigation timeliness, practitioners' perceptions of procedural fairness, and measurable patient safety indicators. Longitudinal and comparative studies would help establish how different regulatory models influence patient protection, professional behaviour, and safety culture across health system settings. Such work is needed to test the pathways proposed in this article and determine whether the implications identified through legal and institutional analysis are reflected in measurable changes within health systems.

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REFERENCES

1. Leslie K, Bourgeault IL, Carlton AL, Balasubramanian M, Mirshahi R, Short SD, et al. Design, delivery and effectiveness of health practitioner regulation systems: an integrative review. Hum Resour Health [Internet]. 2023;21(1):72. Available from: https://doi.org/10.1186/s12960-023-00848-y
2. Leslie K, Moore J, Robertson C, Bilton D, Hirschkorn K, Langelier MH, et al. Regulating health professional scopes of practice: comparing institutional arrangements and approaches in the US, Canada, Australia and the UK. Hum Resour Health [Internet]. 2021;19(1):15. Available from: https://doi.org/10.1186/s12960-020-00550-3
3. Foong-Reichert AL, Grindrod K, Houle SKD. Exploring Health Professional Criminality and Competence Using the Case of Canadian Health Care Serial Killer Elizabeth Wettlaufer. J Med Regul. 2021;107(3):19–27.
4. Leslie K, Myles S, Schiller CJ, Alraja AA, Nelson S, Adams TL. Protecting the Public Interest While Regulating Health Professionals Providing Virtual Care: A Scoping Review. Plos Digit Heal. 2023;2(4):e0000163.
5. Dresser S, Elgin KW. Hospital-Based Credentialing and Privileging. Clin Nurse Spec. 2023;37(3):133–8.
6. Trebilcock MJ. Paradoxes of Professional Regulation. 2022.
7. Obu RN, Bluwey LA. The Practice and Regulatory Effects on Naturopathy in Ghana: Qualitative Perspectives From Naturopathic Doctors in Training. Ip Indian J Libr Sci Inf Technol. 2022;7(2):124–31.
8. Archer J, Bere SR de, Nunn S, Clark J, Corrigan O. "No One Has Yet Properly Articulated What We Are Trying to Achieve": A Discourse Analysis of Interviews With Revalidation Policy Leaders in the United Kingdom. Acad Med. 2015;90(1):88–93.
9. Baarle E van, Hartman L, Rooijakkers S, Wallenburg I, Weenink JW, Bal R, et al. Fostering a Just Culture in Healthcare Organizations: Experiences in Practice. BMC Health Serv Res. 2022;22(1).
10. Seewald M, Martin L, Harris LH. Stigma and Abortion Care. 2021;240–52.
11. Yam CHK, Griffiths S, Liu S, Wong EL, Chung VCH, Yeoh E. Medical Regulation. J Med Regul. 2016;102(1):16–27.
12. Payne SR, Olatosi J, Mabedi C, Adeyoju A. Adaptations in models of urological regulation and their application to sub-Saharan Africa. Br J Urol. 2022;130(6):712–21.
13. Lemmens T, Ghimire KM. Regulation of Health Professions in Ontario: Self-Regulation With Statutory- Based Public Accountability. Rev Direito Sanitário. 2019;19(3):124–204.
14. Leslie K, Bourgeault IL, Carlton AL, Balasubramanian M, Mirshahi R, Short S, et al. Design, Operation and Strengthening of Health Practitioner Regulation Systems: A Rapid Integrative Review. 2022;
15. Widowati L, Setyowati K, Suharto DG. Dynamic Governance as Perspective in Indonesian Bureaucracy Reform: Qualitative Analysis of Indonesian Bureaucracy Reform Based on Dynamic Governance. J Bina Praja. 2023;15(2):403–15.
16. Arwanto A, Anggraini W. Good Governance, International Organization and Policy Transfer: A Case of Indonesian Bureaucratic Reform Policy. Jkap (Jurnal Kebijak Dan Adm Publik). 2022;26(1):33.
17. Harun H, Carter D, Mollik AT, An Y. Understanding the Forces and Critical Features of a New Reporting and Budgeting System Adoption by Indonesian Local Government. J Account Organ Chang. 2020;16(1):145–67.
18. Prasetiamartati B, Utomo TWW, Fatimah E, Sugiyanto S. Supporting Public Policymaking: Working and Thinking Politically for Policy Analysts. 2022;47–76.
19. Zen S. ADOPTION OF INTERNATIONAL EDUCATION POLICY IN INDONESIA: Impact to Teacher Education and Professional Development. Sukma J Pendidik. 2018;2(2):187–203.
20. Paluttri S. Comparative Approach in Public Health Social Security: A Legal Case Study of the Indonesian, France, and Singapore Health Systems. Int J Hum Rights Healthc. 2023;17(5):572–87.
21. Short S, Hawal NP, Albusaidi NS, Purwaningrum F. Streamlining and Modernising Medical Workforce Governance. Int J Heal Gov. 2019;24(3):194–205.
22. Dieleman M, Shaw DMP, Zwanikken P. Improving the Implementation of Health Workforce Policies Through Governance: A Review of Case Studies. Hum Resour Health. 2011;9(1).
23. Garrett B, MacPhee M. The Slippery Slope of Nursing Regulation: Challenging Issues for Contemporary Nursing Practice in Canada. Can J Nurs Leadersh. 2014;27(3):51–69.
24. Chaudhry HJ, Rhyne JA, Cain FE, Young A, Crane M, Bush F. Maintenance of Licensure: Protecting the Public, Promoting Quality Health Care. J Med Regul. 2010;96(2):13–20.
25. Chamberlain JM. Malpractice, Criminality, and Medical Regulation: Reforming the Role of the GMC in Fitness to Practise Panels. Med Law Rev. 2016;fww025.
26. Finocchio LJ, Dower C. Licensing Health Care Professionals: Strengthening an Overlooked Consumer Protection Mechanism. J Med Regul. 2003;89(2):69–74.
27. Gedeona HT, Trilestari EW. The Model for Implementing Bureaucratic Reform in the Ministry of Administrative Reform. 2021;
28. Gershuni O, Orr J, Vogel A, Park K, Leider JP, Resnick B, et al. A Systematic Review on Professional Regulation and Credentialing of Public Health Workforce. Int J Environ Res Public Health. 2023;20(5):4101.
29. Harun H, Peursem K Van, Eggleton IRC. Institutionalization of Accrual Accounting in the Indonesian Public Sector. J Account Organ Chang. 2012;8(3):257–85.
30. Hertz JC, Brinkerhoff DW, Nugroho Y. Knowledge Systems Theory, Development, and Application. 2022;1–22.
31. Hoffman SJ, Sossin L. Empirically Evaluating the Impact of Adjudicative Tribunals in the Health Sector: Context, Challenges and Opportunities. Heal Econ Policy Law. 2011;7(2):147–74.
32. Khan M, Rahman-Shepherd A, Bory S, Chhorn S, Durrance-Bagale A, Hasan R, et al. How Conflicts of Interest Hinder Effective Regulation of Healthcare: An Analysis of Antimicrobial Use Regulation in Cambodia, Indonesia and Pakistan. BMJ Glob Heal. 2022;7(5):e008596.
33. Kodate N. Events, Politics and Patterns of Policy-Making: Impact of Major Incidents on Health Sector Regulatory Reforms in the UK and Japan. Soc Policy Adm. 2011;46(3):280–301.
34. Locke S, Hadley C, Sherman JD, Hantel A, Senay E. Transparency in United States Healthcare Sustainability: A Scoping Review. Environ Res Heal. 2025;3(2):22001.
35. Cicchiello AF, Kazemikhasragh A, Perdichizzi S, Rey A. The Impact of Corruption on Companies' Engagement in Sustainability Reporting Practices: An Empirical Examination. Int J Emerg Mark. 2023;20(2):722–44.
36. Cunningham S, Lowe R, Footer C, Oo HWM, Omoding H, KOVALCHUK ON, et al. Assessing Global Access to Continuing Professional Development for Rehabilitation Professionals: A Mixed Methods Study of Current Practices and Perceived Needs. BMJ Open. 2024;14(11):e089079.
37. Dixon A, Peckham S, Ho APY. Informing UK Policy Development on the Regulation of CAM Practitioners: Lessons From Hong Kong? Soc Policy Adm. 2007;41(7):711–28.
38. Baig L, Ali SK, Sarfaraz S. Role of Politics, Guilds and Pedagogy in Defining Policies in Medical Education: The Pakistan Scenario. Pakistan J Med Sci. 2022;38(6).

39. Myles S, Leslie K, Adams TL, Nelson S. Regulating in the Public Interest: Lessons Learned During the COVID-19 Pandemic. Healthc Manag Forum. 2022;36(1):36–41.
40. Wardle J, Sibbritt D, Broom A, Steel A, Adams J. Is Health Practitioner Regulation Keeping Pace With the Changing Practitioner and Health-Care Landscape? An Australian Perspective. Front Public Heal. 2016;4.
41. Nyante F, - EAA, Addy A, Mensah G. Ghana's Health Professions Regulatory Bodies Act, 2013 (Act 857) and Its Adequacy in Governing Healthcare Delivery and Medical Negligence Issues. Int J Multidiscip Res. 2024;6(1).
42. Lynch J. Foucault on Targets. J Health Organ Manag. 2004;18(2):128–35.
43. Mahat A, Dhillon I, Benton D, Fletcher M, Wafula F. Health Practitioner Regulation and National Health Goals. Bull World Health Organ. 2023;101(09):595–604.
44. van Baarle E, Hartman L, Rooijakkers S, Wallenburg I, Weenink JW, Bal R, et al. Fostering a Just Culture in Healthcare Organizations: Experiences in Practice. BMC Health Serv Res [Internet]. 2022;22(1):1035. Available from: https://doi.org/10.1186/s12913-022-08418-z
45. Doherty T, Fawcus S, Brijlal V, Solanki G. Towards Developing New Private Sector Maternity Care Models in South Africa: Results From a Deliberative Stakeholder Dialogue. Global Health. 2025;21(1).
46. Elendu C, Omeludike E, Oloyede PO, Obidigbo B, Omeludike JC. Legal Implications for Clinicians in Cybersecurity Incidents: A Review. Medicine (Baltimore). 2024;103(39):e39887.
47. Aldhafeeri FM. Governing Artificial Intelligence in Radiology: A Systematic Review of Ethical, Legal, and Regulatory Frameworks. Diagnostics. 2025;15(18):2300.
48. Tiwari SK, Kalyan G, Silpa K, Murry L, Joshi P. National Nursing and Midwifery Commission Act, 2023 in India: Issues and the Way Forward. Policy Polit Nurs Pract. 2024;25(3):189–98.

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