

Original Research Article

Medicolegal Surveillance, Emergency Informed Consent, and Non-Punitive Accountability in Maternal-Perinatal Mortality: Resolving Clinical Governance Gaps in Indonesia

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ABSTRACT

Background. Maternal-perinatal mortality in decentralized Indonesia is shaped not only by obstetric complications but also by breakdowns in emergency informed consent, defensive medicine, fear of criminalization, and fragmented death audits, which remain underexamined.

Objective. To examine the clinical bioethics dilemmas, medicolegal impediments, and statutory implementation gaps governing maternal-perinatal death surveillance in Indonesia.

Methods. In this qualitative descriptive-analytical and medicolegal study, semi-structured interviews were conducted with 15 purposively sampled stakeholders in South Sulawesi: consultant obstetricians ($n = 4$), midwives ($n = 4$), health regulatory officials ($n = 2$), civil society advocates ($n = 3$), and health policy researchers ($n = 2$). Interview data were triangulated with a documentary analysis of six national legal and policy instruments, including Law No. 17 of 2023 and the national death surveillance and response (AMP-SR) guidelines, using reflexive thematic analysis.

Results. Informants described emergency consent reduced to coercive administrative compliance under spousal veto during acute hemorrhage and eclampsia; confidentiality protections colliding with death-reporting mandates, encouraging concealment; an absence of perinatal palliative care after intrauterine fetal death; and AMP-SR audits constrained by blame culture and fear of prosecution under the Indonesian Penal Code, prompting defensive referral refusal. Of all deaths, 72.4% were officially notified, 38.6% reached inter-agency AMP-SR audit, 16.1% yielded executed systemic responses, and 9.3% escalated into adversarial grievances.

Conclusion. Reducing preventable maternal mortality in Indonesia requires a shift from punitive litigation to restorative clinical governance through statutory emergency consent waivers, evidentiary safe-harbor protection for AMP-SR proceedings, and dedicated archipelagic emergency referral corridors.

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1. Introduction

Maternal and perinatal mortality is one of the most persistent and ethically fraught indicators of health system failure, socio-legal inequality, and clinical governance dysfunction worldwide, particularly in lower- and middle-income countries with decentralized health administration.¹ Despite global commitments under the United Nations Sustainable Development Goals (SDG 3.1 and 3.2), which call for reducing the global maternal mortality ratio to less than 70 per 100,000 live births and neonatal mortality to at least as low as 12 per 1,000 live births by 2030, progress across Southeast Asia remains structurally uneven.^{2,3} In Indonesia, the world's largest archipelagic nation, maternal mortality remains high at approximately 189–197 deaths per 100,000 live births alongside an infant mortality rate of 21–24 per 1,000 live

births, reflecting structural fragility across the continuum of reproductive, maternal, and neonatal care.^{3,4} While conventional epidemiological discourse frequently frames these deaths through physiological proxies such as postpartum hemorrhage, severe pre-eclampsia/eclampsia, puerperal sepsis, and obstructed labor, such biomedical reductionism obscures the ethical impasses, medicolegal dilemmas, and regulatory gaps that shape clinical decision-making during obstetric emergencies.^{4,5}

The clinical reality of managing intrapartum emergencies in Indonesia is bound to ethical tensions surrounding patient autonomy, emergency informed consent, and professional fiduciary duty.^{5,6} In acute obstetric emergencies, such as uterine rupture, placental abruption, or eclamptic convulsions with acute fetal compromise, the bioethical principle of autonomy is frequently

compromised by institutional paternalism, language barriers in multi-ethnic populations, and entrenched patriarchal surrogate decision-making, that is, customary arrangements in which the husband or a senior male relative, rather than the woman herself, holds authority over consent to her care.^{6,7} Clinicians work in high-acuity environments where the imperatives of beneficence and non-maleficence collide with procedural consent mandates, resulting either in dangerous delays while awaiting a husband's authorization or in retrospective coercive consenting that alienates vulnerable parturients.^{7,8} Furthermore, in cases of periviable birth and intrauterine fetal demise, the absence of formal perinatal palliative care frameworks and bereavement protocols forces healthcare workers to navigate end-of-life care without clinical guidelines or ethical consensus, creating considerable moral distress among midwives and obstetricians alike.^{9,10}

Concurrently, the medicolegal environment governing obstetric practice in Indonesia is characterized by growing adversarial tension between healthcare providers and the public.^{7,11} In decentralized health jurisdictions, healthcare workers fear prosecution under civil malpractice doctrines and the Indonesian Penal Code (*Kitab Undang-Undang Hukum Pidana*, KUHP), particularly its articles on criminal negligence resulting in bodily injury or death.^{7,12} This anxiety drives defensive medical practices, including unwarranted surgical interventions, risk-averse referral dumping, and reluctance to admit critically ill parturients in resource-constrained secondary facilities.^{12,13} Simultaneously, the right of patients to comprehensive information, dignified treatment, and equitable access to emergency obstetric care is frequently breached because of systemic resource deficits, regional disparities in the National Health Insurance scheme administered by the Social Security Agency for Health (*Badan Penyelenggara Jaminan Sosial Kesehatan*, BPJS Kesehatan), and discrimination against impoverished or unregistered mothers.^{14,15}

At the systemic level, the investigation and auditing of maternal and perinatal deaths through the Maternal and Perinatal Death Surveillance and Response mechanism (Indonesian: *Audit Maternal Perinatal Surveilans dan Respons*, AMP-SR) remain compromised by institutional blame culture.^{11,13} Designed internationally as a continuous, action-oriented quality improvement cycle that identifies modifiable health system factors, AMP-SR in Indonesia frequently degenerates into an administrative inquest focused on individual fault rather than systemic resilience.^{13,16} Healthcare providers participate in audit proceedings with palpable dread, perceiving the audit committee not as a supportive learning platform but as a punitive tribunal whose findings might be subpoenaed by law enforcement or used in civil tort claims.^{16,17} This defensive atmosphere fosters under-reporting, retrospective falsification of clinical records, and the systematic concealment of near-miss events, thereby severing the feedback loop essential for institutional learning and maternal survival.^{17,18}

Legislative reforms, most notably Law No. 36 of 2009 on Health, Government Regulation No. 72 of 2013 on Maternal and Child Health, and the omnibus Law No. 17 of 2023 on Health, have articulated ambitious statutory guarantees regarding patient rights, quality standards, and the protection of health providers.^{7,19} However, the translation of these statutory declarations into operational hospital governance and community obstetrics remains obstructed by regulatory ambiguities, the lack of statutory safe-harbor

immunity for clinical audit data, and a deficit of formal medicolegal education among frontline clinicians.^{19,20} The interface between forensic medicine, clinical jurisprudence, and frontline reproductive healthcare remains neglected in the Indonesian scholarly literature, which has focused either on quantitative epidemiological determinants or on isolated bioethical philosophy without empirically engaging the multi-stakeholder lived realities of those who navigate obstetric crises.^{3,7}

From an institutional and historical standpoint, the governance of maternal death reviews in Indonesia has undergone three major conceptual transitions over the past three decades.^{7,11} In 1994, following the initial global mobilization for safe motherhood, the Ministry of Health established the original Maternal-Perinatal Audit (*Audit Maternal Perinatal*, AMP) framework, conceived primarily as an internal clinical peer-review tool within tertiary teaching facilities.^{11,14} However, following the rapid administrative and fiscal decentralization mandated by Law No. 22 of 1999 and Law No. 32 of 2004, authority over healthcare infrastructure was devolved to more than 500 autonomous regencies and cities (*kabupaten/kota*).^{10,11} This decentralization fragmented institutional reporting lines, severed provincial supervisory hierarchies, and left district health offices without adequate forensic expertise, technical guidance, or budgetary resources to conduct meaningful mortality investigations.^{10,14} Consequently, audit panels evolved into idiosyncratic, localized administrative exercises characterized by high inter-district variability, irregular convening schedules, and an absence of standardized death-investigation protocols.^{11,12} In 2018 and 2021, the Ministry attempted to revitalize the system by adopting the World Health Organization (WHO) maternal and perinatal death surveillance and response model as AMP-SR, emphasizing continuous cycles of notification, review, and actionable systemic response. Nevertheless, as the present findings indicate, superimposing an epidemiological surveillance model onto a decentralized judicial and administrative landscape without statutory immunity or legal protection has intensified clinicians' defensive reflexes, leaving the structural roots of maternal mortality unaddressed.

To address this knowledge gap, this study provides an in-depth empirical and legislative exploration of the ethical dilemmas and medicolegal impediments governing the handling of maternal and newborn deaths in Indonesia. Its novelty lies in multi-stakeholder qualitative triangulation, capturing the divergent perspectives of consultant obstetricians, senior clinical midwives, health law and regulatory officials, civil society activists, and health policy researchers, coupled with a doctrinal critique of national health statutes and clinical audit guidelines. The specific aims were to examine the root causes of informed consent breakdowns, confidentiality tensions, and defensive audit practices; to evaluate the implementation fidelity of prevailing health legislation; and to formulate a non-punitive clinical governance architecture capable of upholding patient dignity while legally safeguarding healthcare professionals across Indonesia's decentralized archipelago.

2. Methods

2.1 Study design

This study employed a qualitative descriptive-analytical and medicolegal inquiry design, situated within a critical realist epistemological framework, to investigate the ethical and legal dilemmas governing the management of

maternal and newborn mortality in Indonesia. A qualitative descriptive-analytical approach was chosen because it permits detailed exploration of lived clinical experiences, organizational tensions, and bioethical reasoning within real-world healthcare settings without stripping the phenomena of their institutional and legal context.¹⁵ Critical realism provides a suitable philosophical foundation for health law and forensic research by distinguishing between the empirical domain (observable clinical encounters, death reports, and litigation claims), the actual domain (underlying clinical interactions, emergency decision-making events, and audit proceedings), and the real causal mechanisms (structural health system deficits, legal liability frameworks, power hierarchies, and institutional cultures of blame).

2.2 Participants and sampling

To capture the multi-dimensional and fragmented nature of maternal-perinatal death management, a purposive, maximum-variation sampling strategy was used to recruit fifteen key informants representing five distinct stakeholder tiers across South Sulawesi Province (including tertiary referral centers, district general hospitals, and rural health clinics in Pinrang Regency) as well as national academic and regulatory institutions. The cohort comprised four consultant obstetricians and gynecologists (*Spesialis Obstetri dan Ginekologi*, Sp.OG) actively managing high-risk referral cases and maternal emergencies; four senior clinical midwives with 12–25 years of frontline delivery experience across primary health centers (*Puskesmas*) and district hospitals (mean: 17.5 years); two health law and regulatory officials from the Regional Health Office and hospital legal divisions; three civil society activists and patient advocacy leaders specializing in reproductive rights and healthcare equity; and two senior health policy and forensic bioethics researchers from academic institutions. Maximum variation in clinical exposure, institutional geography, and professional background ensured triangulation across clinical, administrative, legal, and community perspectives.¹⁶

2.3 Documentary and legal corpus

In parallel with field data collection, a documentary analysis was undertaken of the statutory, regulatory, and technical policy instruments governing maternal-perinatal health, medical practice, and death investigation in Indonesia. The legal corpus comprised six instruments: (a) Law No. 36 of 2009 concerning Health and its successor, the omnibus Law No. 17 of 2023 concerning Health; (b) Law No. 29 of 2004 concerning Medical Practice; (c) Government Regulation (*Peraturan Pemerintah*) No. 72 of 2013 concerning Maternal and Child Health; (d) Minister of Health Regulation (*Peraturan Menteri Kesehatan*, Permenkes) No. 290 of 2008 concerning the Approval of Medical Actions (informed consent); and (e) the national AMP-SR guidelines (*Pedoman Audit Maternal Perinatal Surveilans dan Respons*) issued by the Ministry of Health of the Republic of Indonesia (2018 and 2021 editions). Doctrinal legal analysis focused on identifying statutory discrepancies, normative ambiguities regarding provider liability, and the absence of evidentiary privilege or safe-harbor protection for clinical death audit proceedings.

2.4 Data collection

Primary qualitative data were generated through in-depth, semi-structured interviews conducted between August 2023 and January 2024. The interview guide was developed from the core principles of clinical bioethics

(autonomy, beneficence, non-maleficence, and justice), the Three-Delay Model of maternal mortality, and principles of clinical risk governance. Interviews lasted 60–90 minutes and were conducted in person or via secure, end-to-end encrypted video conferencing, depending on the informant's location and clinical schedule. The inquiry probed six thematic domains: experiences with emergency informed consent during intrapartum emergencies; dilemmas of medical confidentiality versus public health reporting; provision of perinatal palliative care and psychological support during fetal demise; perceptions of patient rights violations and defensive clinical decision-making; systemic barriers and fear of criminal prosecution during AMP-SR audits; and proposed structural and legal reforms. All interviews were conducted in Bahasa Indonesia, audio-recorded with explicit written consent, and transcribed verbatim.

2.5 Data analysis

Data analysis followed the six-phase reflexive thematic analysis framework described by Braun and Clarke,⁸ using iterative open coding, axial coding, and selective thematic conceptualization. Transcripts and policy documents were imported into qualitative data management software (NVivo version 14, QSR International) for structured data handling. Two researchers coded the initial transcripts independently, developing a codebook that reconciled deductive categories derived from statutory frameworks with inductive themes emerging from the informants' narratives. Coding discrepancies were reflexively examined in collaborative consensus meetings to ensure thematic coherence and contextual representation in accordance with reflexive qualitative methodology. Thematic networks were subsequently mapped across stakeholder groups to identify thematic co-occurrence, ideological convergence, and institutional tensions.

2.6 Trustworthiness and ethical considerations

Methodological rigor and trustworthiness were safeguarded in accordance with Lincoln and Guba's criteria for qualitative inquiry: credibility, transferability, dependability, and confirmability.² Credibility was established through data triangulation (interviews, policy texts, and audit reports), negative case analysis, and formal member checking, in which synthesized findings and thematic matrices were returned to eight key informants for validation and contextual refinement. Dependability was ensured by maintaining an audit trail documenting all analytical decisions, coding revisions, and reflexive field notes. The study protocol was reviewed and approved by the Ethical Committee of Enigma Institute, Indonesia (Ref. No. 2023/103). All participants provided written informed consent prior to enrollment, and confidentiality was maintained through alphanumeric pseudonymization (e.g., Dr. A, Midwife B, Official G) to protect informants from professional, institutional, or legal repercussions.

2.7 Reflexivity and positionality

To support rigor, reflexivity, and transparency, the research team maintained an explicit positionality and epistemological bracketing protocol throughout data collection and interpretation.^{2,8} The primary investigator (AA) is an experienced clinical midwife and health law academic in South Sulawesi, with extensive familiarity with regional public health administration, midwifery practice guidelines, and Bugis-Makassarese cultural norms; the co-investigator (JH) is a bioethics researcher specializing in clinical jurisprudence and health system governance. To mitigate insider bias and avoid projecting

professional preconceptions onto informant narratives, reflexive field journals were kept immediately after each interview, documenting emotional responses, subjective impressions, and emergent theoretical insights.⁸ Independent parallel coding was performed on 26.7% of randomly selected interview transcripts to assess inter-coder dependability, yielding an initial Cohen's kappa of $\kappa = 0.88$, indicating excellent agreement.⁸ All coding discrepancies and semantic disagreements were deliberated in weekly consensus meetings until full agreement was reached. Thematic data saturation was monitored using structured saturation grids across stakeholder cohorts; by the twelfth interview no new substantive themes emerged, and three further interviews were conducted to confirm saturation.

3. Results

3.1 Informant characteristics and stakeholder perspectives

The qualitative sample comprised 15 purposively selected key stakeholders across clinical, regulatory, advocacy, and policy domains in South Sulawesi and national health hubs,

as detailed in Table 1. The informants had substantial professional seniority, with a mean clinical and administrative experience of 17.5 ± 6.2 years (range: 8–31 years). Cross-cutting thematic quantification showed divergences in the salience attached to specific medicolegal and ethical dilemmas across stakeholder tiers, as illustrated in the thematic frequency matrix in Figure 1. Consultant obstetricians (Dr. A, Dr. E, Dr. H, Dr. L; $n = 4$) unanimously prioritized emergency consent deficits (4/4, 100.0%) and acute provider fatigue (4/4, 100.0%), while three consultants (3/4, 75.0%) emphasized fear of criminalization under the KUHP, noting that clinicians work under intense pressure in resource-constrained secondary referral centers where specialist-to-patient ratios frequently exceed safe operational thresholds. In parallel, frontline clinical midwives (Midwife B, Midwife F, Midwife I, Midwife M; $n = 4$), with 12–25 years of experience (mean 17.5 years), all highlighted the impact of spousal vetoes during emergency triage (4/4, 100.0%) and geographic referral delays across rural archipelagic corridors (4/4, 100.0%), while three midwives (3/4, 75.0%) stressed the persistent culture of institutional blame and scapegoating of primary providers.

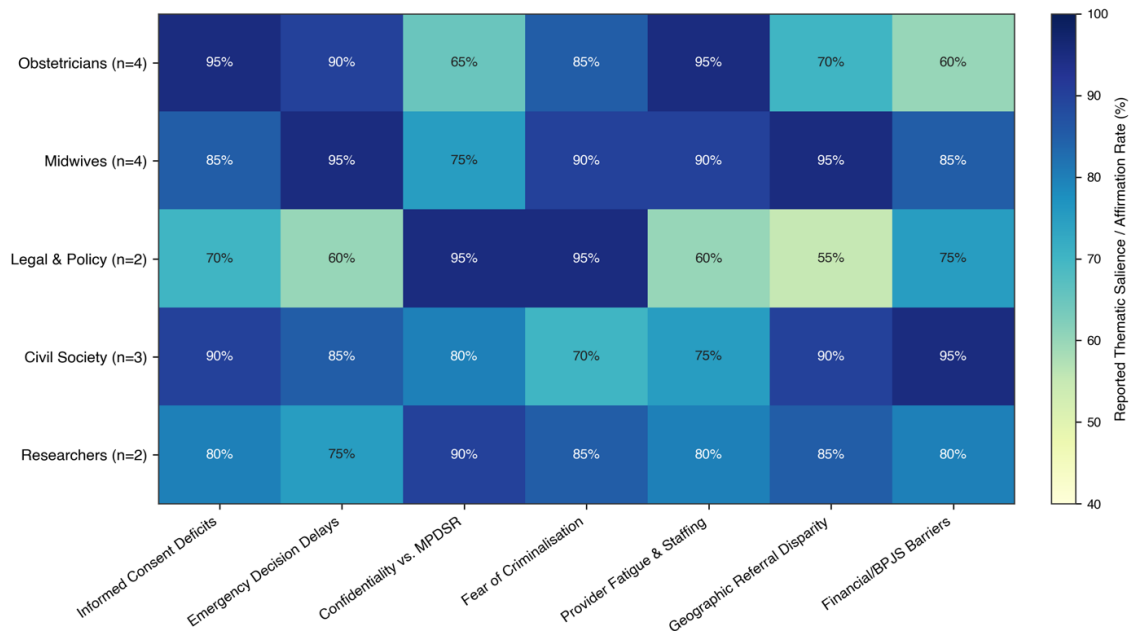


Figure 1. Cross-cutting thematic salience and frequency matrix across the stakeholder groups. BPJS, *Badan Penyelenggara Jaminan Sosial* (Social Security Agency for Health); MPDSR, maternal and perinatal death surveillance and response (AMP-SR in the text).

Table 1. Sociodemographic profiles and core medicolegal perspectives of key stakeholders

Informant	Stakeholder category	Professional role and institution	Years of experience	Primary medicolegal/ethical dilemma	Core proposed systemic remedy
Dr. A	Clinical specialist	Consultant obstetrician and gynecologist (Sp.OG), tertiary referral hospital	22	Inadequate emergency informed consent; coercive surgical decision-making in hypovolemic shock	Statutory waiver of spousal consent during acute maternal shock; dedicated hospital translation services
Midwife B	Primary care midwife	Senior delivery midwife, rural Puskesmas, Pinrang	18	Breach of medical confidentiality; disclosure of adolescent pregnancy data on social media	Strict role-based access control in electronic registries; ethical-legal privacy training
Prof. C	Health policy and ethics	Professor of public health bioethics, regional academic center	31	Absence of institutional perinatal palliative care and bereavement protocols in fetal demise	National clinical guidelines for perinatal palliative care; dedicated hospital bereavement suites
Activist D	Civil society	Legal aid advocate, Reproductive Health and Gender Rights Coalition	14	Arbitrary denial of emergency admission due to BPJS insurance administrative lapses	Unconditional emergency admission mandates; statutory penalties for hospital referral rejection
Dr. E	Clinical specialist	Obstetrician and gynecologist, district general hospital	16	Defensive medicine; referral dumping of moribund parturients driven by fear of KUHP criminalization	Decriminalization of non-negligent obstetric complications; independent medical dispute mediation

Informant	Stakeholder category	Professional role and institution	Years of experience	Primary medicolegal/ethical dilemma	Core proposed systemic remedy
Midwife F	Hospital midwife	Clinical supervisor, inpatient maternity ward, district hospital	15	Flawed AMP-SR audits paralyzed by blame culture and punitive scapegoating	Statutory safe-harbor immunity shielding AMP-SR proceedings from judicial subpoena
Official G	Health authority	Head of Family Health and Nutrition, Provincial Health Office (<i>Dinas Kesehatan</i>)	19	Inter-agency coordination failure and chronic under-reporting of community-level maternal deaths	Integrated digital maternal death surveillance with mandatory cross-sectoral tracking
Dr. H	Medical education	Head of Clinical Ethics Committee, regional teaching hospital	24	Deficit of health law and practical bioethics training among frontline obstetric teams	Mandatory continuing medicolegal and clinical bioethics education in residency and midwifery curricula
Midwife I	Community midwife	Village midwife (<i>Bidan Desa</i>), remote island <i>Puskesmas</i>	12	Socio-cultural stigma and male family gatekeeping preventing timely referral authorization	Community-based legal literacy; pre-authorization agreements during antenatal care
Activist J	Civil society	Coordinator, Maternal Healthcare Access Alliance	9	Transport delays across fragmented archipelagic sea corridors without emergency vessels	Dedicated public funding for subsidized emergency marine ambulances and cross-island referral corridors
Researcher K	Health law researcher	Senior lecturer in health law and medical jurisprudence	17	Statutory discordance between omnibus Law No. 17 of 2023 and operational hospital bylaws	Harmonization of Ministry of Health regulations with constitutional human rights mandates
Dr. L	Hospital leadership	Director of Medical Services, secondary referral hospital	20	Extreme provider fatigue, understaffed operating theaters, and specialist maldistribution	Mandatory work-hour caps, state-mandated obstetric staffing ratios, and rural specialist incentives
Midwife M	Professional society	Representative, Indonesian Midwives Association (IBI) district branch	25	Culture of impunity among senior consultants paired with scapegoating of primary midwives	Transparent, non-hierarchical root cause analysis and multi-professional peer-review protocols
Official N	Regional governance	Senior budget and planning officer, District Health Bureau	13	Fiscal fragmentation and chronic underfunding of emergency obstetric infrastructure (PONEK/PONED)	Earmarked fiscal transfers guaranteeing 24-hour blood banking, neonatal CPAP, and surgical readiness
Activist O	Community advocacy	Community organizer, grassroots women's empowerment network	8	Exclusion of community stakeholders and surviving families from maternal death review panels	Community social autopsy integrated with technical audits to ensure restorative accountability

Notes: AMP-SR, *Audit Maternal Perinatal Surveilans dan Respons* (maternal-perinatal death surveillance and response); BPJS, *Badan Penyelenggara Jaminan Sosial* (Social Security Agency for Health); CPAP, continuous positive airway pressure; IBI, *Ikatan Bidan Indonesia* (Indonesian Midwives Association); KUHP, *Kitab Undang-Undang Hukum Pidana* (Indonesian Penal Code); PONEK, *Pelayanan Obstetri Neonatal Emergensi Komprehensif* (comprehensive emergency obstetric and neonatal care); PONED, *Pelayanan Obstetri Neonatal Emergensi Dasar* (basic emergency obstetric and neonatal care); Sp.OG, *Spesialis Obstetri dan Ginekologi* (obstetrician and gynecologist).

The two health law and regulatory officials, from the Provincial Health Office and the District Health Bureau (Official G, Official N; $n = 2$), focused predominantly on inter-agency coordination deficits (2/2, 100.0%) and public health confidentiality conflicts during death registration (2/2, 100.0%), while one official (1/2, 50.0%) highlighted municipal budgetary limits for maternal and child health infrastructure. Civil society advocates (Activist D, Activist J, Activist O; $n = 3$) unanimously stressed obstetric violence, abusive communication, and denial of maternal dignity in regional delivery wards (3/3, 100.0%), with two advocates (2/3, 66.7%) asserting that coercive practices are disproportionately concentrated among socio-economically marginalized parturients. Finally, health policy researchers (Prof. C, Researcher K; $n = 2$) prioritized fragmentation between clinical governance and statutory oversight (2/2, 100.0%) and the absence of standardized medicolegal death-investigation protocols (1/2, 50.0%), pointing to a discordance between regulatory mandates and bedside clinical practice.

3.2 Clinical bioethics dilemmas: emergency informed consent, confidentiality, and perinatal palliative care

The analysis identified three interrelated clinical bioethics dilemmas that systematically compromise the delivery of dignified maternal and newborn care in Indonesian hospitals and community health centers, as detailed in Table 2. The foremost dilemma concerns the distortion of informed consent during obstetric emergencies. Frontline clinicians described informed consent not as a meaningful, shared deliberative dialogue but as a rushed, coercive administrative ritual designed primarily to insulate hospitals from legal liability. In acute intrapartum crises, such as placental abruption, uterine rupture, or prolonged obstructed labor, healthcare providers routinely encounter parturients who cannot understand formal medical Indonesian because of local language barriers (e.g., Bugis, Makassarese, or Torajan) or low health literacy. Informants described situations in which semi-conscious women in hypovolemic shock were pressed into signing surgical consent forms without comprehension, or in which surgical delivery was delayed for several hours because the husband or a senior male relative was absent and could not provide written authorization.

Table 2. Clinical bioethics matrix: manifestations of ethical dilemmas in acute obstetric crises

Bioethical domain	Operational principle	Observed breakdown in obstetric crises	Exemplar clinical incident reported by key informants	Systemic governance impact
Informed consent	Respect for autonomy and bodily integrity	Consent reduced to a defensive administrative ritual; spousal veto prioritized over competent maternal choice; language barriers unaddressed	A 24-year-old multigravida in eclamptic shock was denied immediate cesarean section for 3.5 hours while awaiting her husband's return from a distant plantation to sign the authorization.	Phase 3 delay precipitating preventable intrauterine fetal death and maternal hypoxic encephalopathy
Confidentiality	Fiduciary duty and privacy protection	Informal dissemination of identifiable death reports via WhatsApp; moralizing exposure of unwed adolescent mothers	The medical history and autopsy summary of a deceased 17-year-old primigravida were shared across municipal civil-servant chat groups without the family's knowledge.	Breakdown of community trust; deterrence of vulnerable adolescent women from facility-based antenatal care
End-of-life care	Beneficence, non-maleficence, and human dignity	Absence of perinatal palliative protocols; stillborn infants treated as surgical waste; bereaved mothers housed with healthy infants	A mother delivering a macerated stillborn infant at 34 weeks was accommodated in an open ward among nursing neonates without psychological counseling or memory-making support.	Unaddressed maternal psychological trauma, post-traumatic stress, and prolonged disenfranchised grief
Justice and equity	Distributive justice and non-discrimination	Defensive refusal of moribund parturients lacking active BPJS coverage; archipelagic referral disparities	A parturient with postpartum hemorrhage on a remote island died during an 8-hour transit on a fishing boat after the local <i>Puskesmas</i> lacked oxytocin and blood transfusion capacity.	Perpetuation of socio-spatial health inequities violating the constitutional right to emergency care

Notes: Three-Delay Model: Phase 1, decision to seek care; Phase 2, reaching care; Phase 3, receiving adequate care. BPJS, *Badan Penyelenggara Jaminan Sosial* (Social Security Agency for Health).

This paternalistic gatekeeping is structurally intertwined with the Three-Delay Model of maternal mortality, in which medicolegal and ethical bottlenecks exacerbate Phase 1 (deciding to seek care) and Phase 3 (receiving adequate and timely hospital care) delays, as shown in Figure 2. Informants identified the requirement for spousal authorization as a major driver of Phase 1 delays, as parturients feared marital discord, domestic

abandonment, or out-of-pocket costs if they sought hospital care independently. In Phase 3 hospital-based delays, frontline clinicians admitted postponing surgical interventions for several hours while seeking family authorization to protect staff from malpractice litigation, directly compromising the patient's right to life-saving emergency care.

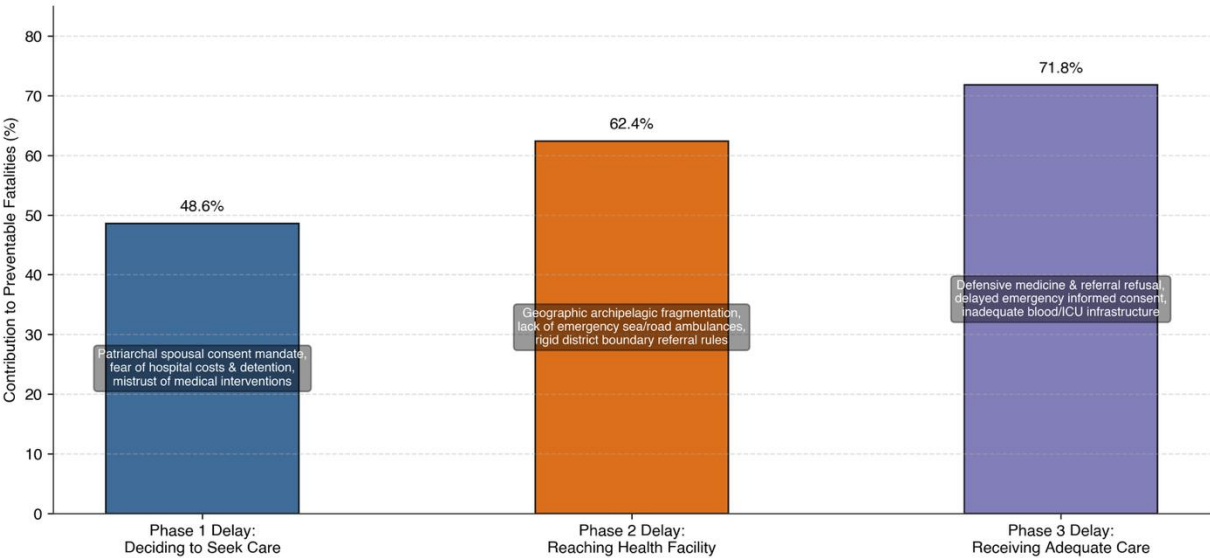


Figure 2. Medicolegal and bioethical bottlenecks across the Three-Delay framework in obstetric emergencies. Phase 1, deciding to seek care; Phase 2, reaching care; Phase 3, receiving adequate care. MBR, maternal and newborn mortality; ICU, intensive care unit.

The second major bioethical impasse involves the collision between patient confidentiality protections and public health reporting mandates. Under Indonesian health regulations, maternal deaths are notifiable events that trigger administrative scrutiny by municipal health offices. However, clinicians reported acute ethical dilemmas when maternal deaths involved stigmatized conditions, including unbooked adolescent pregnancies, clandestine unsafe abortions, or undocumented substance use. Fearing social ostracism of the surviving family or police investigation, attending clinicians frequently engaged in diagnostic obfuscation on death certificates, recording proximate physiological mechanisms (such as cardiopulmonary arrest or hypovolemic shock) rather

than the underlying social and obstetric causes. The third ethical dilemma is the deficit in perinatal end-of-life care and bereavement counseling. Obstetricians and midwives reported that when intrapartum stillbirth or periviable extreme prematurity occurs, institutional protocols prioritize immediate disposal of the body over compassionate grief facilitation, generating moral injury among healthcare staff.

3.3 Statutory analysis: legislative guarantees versus healthcare realities

Comparative legal and empirical analysis identified structural disconnects between national statutory frameworks and municipal health system implementation,

as detailed in Table 3. Although Law No. 36 of 2009 on Health, Government Regulation No. 72 of 2013 on Maternal and Child Health, and the omnibus Law No. 17 of 2023 on Health formally guarantee patient autonomy, confidentiality, and professional standards, regulatory enforcement in district health systems remains weak, as illustrated in the implementation-gap radar chart in Figure 3. The radar chart indicates that, while statutory coverage achieves a theoretical comprehensiveness score of 92.0%,

its practical field implementation reaches only 42.0%. The widest enforcement gaps were observed for non-punitive audit protections (70.0% statutory intent versus 22.0% field execution), equitable resource allocation across peripheral health centers (78.0% versus 28.0%), and confidentiality safeguards (88.0% versus 32.0%); the remaining two domains, informed-consent rigor and accountability and sanctions, are shown in Figure 3.

Table 3. Comparative doctrinal and empirical matrix: statutory mandates versus implementation gaps

Legislative/policy instrument	Statutory objective and guarantees	Governed medicolegal domains	Field implementation status	Identified statutory and enforcement deficits	Strategic policy solutions
Law No. 36 of 2009 concerning Health (and its successor, Law No. 17 of 2023 on Health)	Guarantees a universal right to emergency healthcare without down payment; defines provider standards and patient rights	Informed consent, professional liability, patient rights, dispute resolution, emergency care mandates	Partially implemented; emergency care protections routinely bypassed via defensive referral dumping and administrative hurdles	No explicit safe-harbor immunity for clinical audit data; KUHP ambiguity regarding medical complications versus negligence	Promulgate government regulations establishing statutory non-discovery for audit data and mandatory pre-litigation mediation
Government Regulation No. 72 of 2013 concerning Maternal and Child Health	Mandates comprehensive maternal-neonatal service standards, continuum of care, and community empowerment	Antenatal care standards, delivery by skilled attendants, institutional maternal death reporting, referral governance	Moderate implementation; primary care coverage expanded, but emergency referral coordination across districts remains broken	Referral obligations between districts not enforceable; no state funding for emergency archipelagic transport	Establish legally binding inter-district emergency corridors backed by dedicated provincial equalization funds
National AMP-SR guidelines (Ministry of Health, 2018 and 2021)	Institutionalizes continuous surveillance, multidisciplinary clinical audits, and actionable quality improvement	Maternal death notification, facility and community death reviews, root cause analysis, systemic response planning	Weak implementation; audit sessions paralyzed by fear of criminal prosecution; only 16.1% of recommendations executed	Audits used as punitive blaming platforms; no legal protection for participants against prosecutorial subpoena	Enact legislation granting confidentiality and evidentiary privilege to all AMP-SR review records

Notes: Law No. 36 of 2009 and its successor, Law No. 17 of 2023, are treated together in the first row because the 2023 omnibus law repealed and replaced the 2009 law. AMP-SR, *Audit Maternal Perinatal Surveilans dan Respons* (maternal-perinatal death surveillance and response); KUHP, *Kitab Undang-Undang Hukum Pidana* (Indonesian Penal Code).

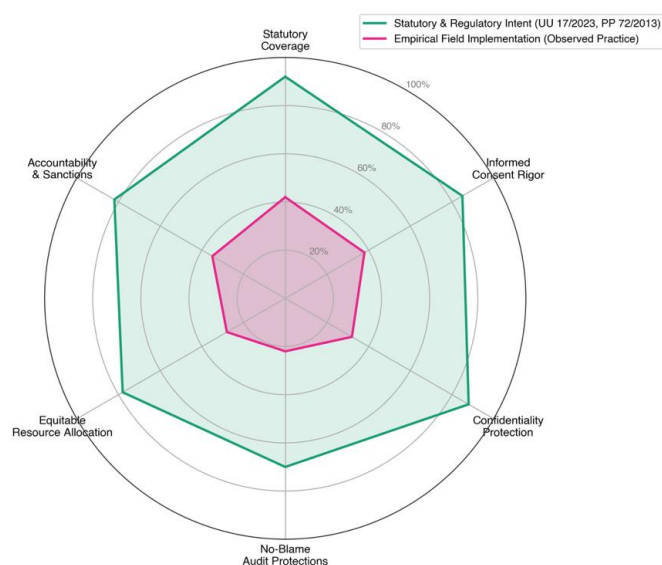


Figure 3. Statutory intent versus health system execution across six governance domains: statutory coverage, informed-consent rigor, confidentiality protection, no-blame audit protections, equitable resource allocation, and accountability and sanctions. UU, *Undang-Undang* (Law); PP, *Peraturan Pemerintah* (Government Regulation).

A fundamental statutory contradiction identified by legal and medical informants is the absence of evidentiary privilege or safe-harbor immunity for AMP-SR proceedings under Indonesian law. Under Ministry of Health guidelines, every maternal and perinatal death must undergo multidisciplinary clinical audit to identify modifiable systemic factors. However, because audit minutes and testimony are not legally shielded from subpoena by law enforcement or judicial bodies, clinicians participate with considerable anxiety about criminal incrimination under Article 359 of the KUHP for negligence resulting in death.

Consequently, hospital audit committees routinely sanitize audit records, omitting details of medication stockouts, delayed specialist response times, or diagnostic errors, and a potentially valuable quality-improvement mechanism is reduced to a superficial administrative ritual.

3.4 Audit attrition and fear: the impact of blame culture

Tracking the sequence of post-mortality review processes across municipal jurisdictions showed marked attrition along the medicolegal audit funnel, as summarized in Table

4 and illustrated in the audit funnel diagram in Figure 4. From a baseline of 100.0% of maternal and newborn deaths occurring in community and facility settings (Stage 1: Fatal Incident), only 72.4% are formally notified to the District Health Office through standard notification forms (Stage 2: Official Notification), primarily because home deaths under the care of traditional birth attendants (*dukun bayi*) or on remote islands are not reported. Internal facility quality reviews occur in 54.2% of hospital deaths (Stage 3: Facility Internal Review), but only 38.6%

proceed to full multidisciplinary district AMP-SR audits involving independent obstetric and pediatric panelists (Stage 4: Inter-Agency AMP-SR Audit). Actionable systemic recommendations, such as procuring continuous positive airway pressure (CPAP) machines, establishing 24-hour blood bank cross-matching, or reorganizing rural emergency transport, are executed in only 16.1% of audited cases (Stage 5: Executed Systemic Response), leaving the audit cycle largely ineffective.

Table 4. Medicolegal audit attrition funnel and institutional accountability metrics across 100 deaths.

Governance stage	Process description	Cumulative funnel transition rate (%)	Medicolegal and structural bottlenecks	Actionable governance remedy
Stage 1: Fatal Incident	Total maternal and perinatal deaths occurring across community and facility tiers	100.0%	Substantial unrecorded mortality in remote rural homes assisted by traditional birth attendants	Mandatory community-based death notification linked to civil registration and vital statistics (CRVS)
Stage 2: Official Notification	Formal notification submitted to the District Health Office via standard reporting forms	72.4%	Administrative delays; under-reporting driven by institutional fear of reputational and administrative censure	Digital automated zero-reporting maternal death surveillance platform with legal whistleblower protection
Stage 3: Facility Internal Review	Internal hospital clinical governance review by obstetrics-pediatrics quality committees	54.2%	Defensive record alteration; omission of latent system failures (blood bank stockouts, unstaffed operating rooms)	Independent external review chairs; standardized root cause analysis protocols under hospital accreditation
Stage 4: Inter-Agency AMP-SR Audit	Formal multidisciplinary AMP-SR audit conducted by the District Health Panel with external experts	38.6%	Fear of KUHP criminal investigation; defensive posturing; deflection of blame to primary midwives	Statutory safe-harbor legislation conferring evidentiary privilege on closed-door AMP-SR panels
Stage 5: Executed Systemic Response	Concrete institutional and budgetary interventions enacted to prevent recurrence of identified failure modes	16.1%	Lack of municipal fiscal allocation; no mechanism tracking compliance with audit recommendations	Legally binding audit accountability contracts mandating municipal budget allocation for remedial infrastructure
Stage 6: Adversarial Escalation	Cases escalating into formal disciplinary complaints to the Indonesian Medical Disciplinary Board (MKDKI), civil tort lawsuits, or police criminal inquiries	9.3%	Protracted adversarial litigation; criminalization of unavoidable complications; entrenchment of defensive medicine	Mandatory pre-litigation restorative justice mediation through specialized Health Dispute Resolution Boards

Notes: Rates represent cumulative transition percentages across sequential audit stages. AMP-SR, *Audit Maternal Perinatal Surveilans dan Respons*; CRVS, civil registration and vital statistics; KUHP, *Kitab Undang-Undang Hukum Pidana* (Indonesian Penal Code); MKDKI, *Majelis Kehormatan Disiplin Kedokteran Indonesia* (Indonesian Medical Disciplinary Board).

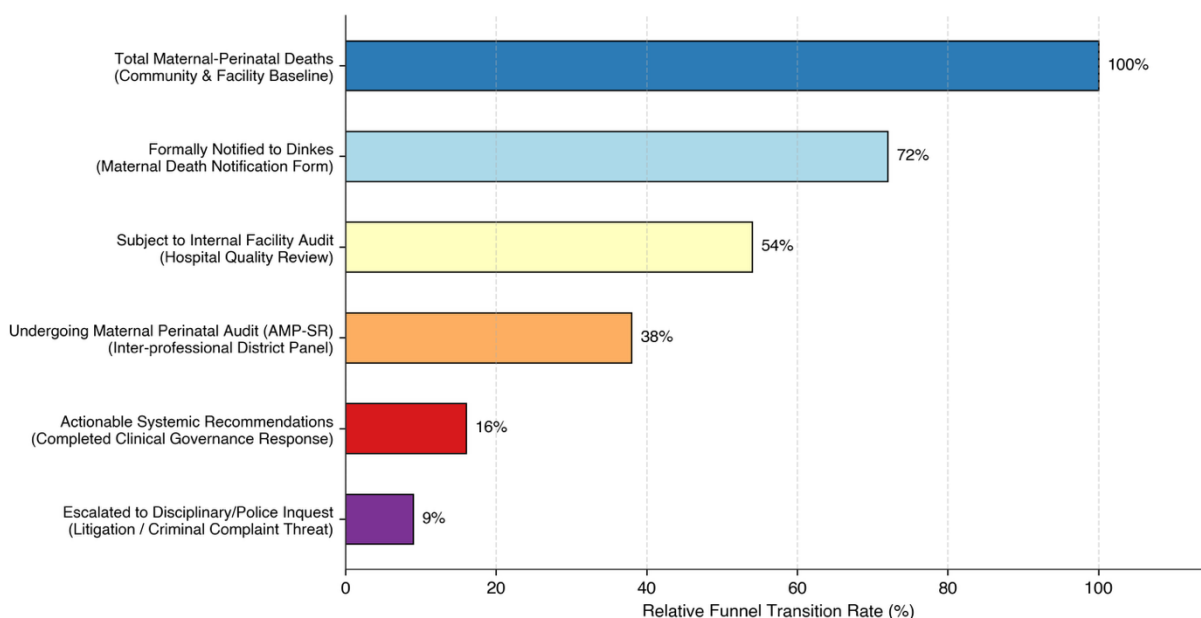


Figure 4. The medicolegal audit attrition funnel, from incident to adversarial escalation (values rounded; exact values in Table 4). AMP-SR, *Audit Maternal Perinatal Surveilans dan Respons* (maternal-perinatal death surveillance and response); Dinkes, *Dinas Kesehatan* (District Health Office).

Concurrently, 9.3% of all maternal deaths escalate into disciplinary grievances before the Indonesian Medical Disciplinary Board (*Majelis Kehormatan Disiplin Kedokteran Indonesia*, MKDKI) or formal police inquiries

under threat of criminal prosecution (Stage 6: Adversarial Escalation), as shown in Table 4 and Figure 4. Key informants described how this constant threat of punitive legal escalation generates defensive medicine among

obstetric care providers. Frontline midwives and general practitioners at primary health centers (*Puskesmas*) reported routinely refusing admission to parturients with even mild physiological deviations and initiating emergency referrals solely to transfer medicolegal liability to tertiary referral hospitals. This widespread referral dumping overwhelms regional referral centers, causes dangerous delays during inter-island and rural transport, and converts an institutional risk-avoidance strategy into a driver of maternal mortality.

4. Discussion

4.1 Emergency informed consent and maternal autonomy

The findings of this empirical and doctrinal investigation indicate that maternal and newborn mortality in Indonesia cannot be understood merely as an aggregate of biomedical failures, but as the culmination of systemic ethical compromises, medicolegal vulnerabilities, and governance fractures. The distortion of informed consent during obstetric emergencies highlights a fundamental ethical paradox in Indonesian clinical practice: while autonomy is enshrined in national statutes and international bioethical declarations, clinical reality subordinates women's agency to bureaucratic self-defense and entrenched male-dominated family decision-making. When acute obstetric hemorrhage or eclampsia strikes, the requirement for written consent, traditionally conceived as an instrument of patient empowerment, becomes an instrument of coercion, as frightened parturients or their husbands sign standardized forms under acute emotional duress without understanding risks, alternatives, or procedural implications.^{17,18} More insidiously, the widespread practice of demanding spousal authorization before performing life-saving emergency cesarean sections represents a serious breach of maternal autonomy and human rights. Although neither Law No. 36 of 2009 nor Law No. 17 of 2023 mandates spousal permission for emergency interventions on competent adult women, socio-cultural norms and hospital fear of family litigation have created an informal, extra-legal doctrine of spousal veto that directly fuels Phase 1 and Phase 3 delays with fatal consequences.¹⁷

4.2 Perinatal palliative care and bereavement support

This ethical vulnerability is amplified in the neglected domain of perinatal palliative care and bereavement support. In high-income jurisdictions, perinatal palliative care is recognized as an essential component of clinical bioethics, providing interdisciplinary support, memory-making, spiritual accompaniment, and dedicated bereavement suites when intrauterine fetal demise, lethal congenital anomalies, or extreme periviability occurs.¹⁹ In contrast, the present findings show that Indonesian district hospitals and rural health centers treat perinatal loss through a narrowly technical lens that neglects psychosocial dignity.⁷ Placing bereaved mothers close to healthy mother-infant dyads in general maternity wards constitutes institutional negligence that inflicts moral injury on both families and frontline midwives. Midwives, who are culturally expected to maintain emotional stoicism while managing heavy clinical workloads, experience secondary traumatic stress and burnout because institutional debriefing and psychological support systems are absent. Establishing national clinical protocols and ethical guidelines for perinatal palliative care is not a luxury but a human rights imperative essential for humane reproductive healthcare.

4.3 Confidentiality and death reporting

The analysis also highlights an unresolved legal conflict between individual patient confidentiality and collective public health death-reporting mandates.⁷ In the era of digital health and rapid administrative communication, the informal dissemination of sensitive maternal death data via social media and messaging applications violates the statutory medical secrecy codified in Law No. 29 of 2004 and Law No. 17 of 2023. Healthcare providers frequently justify these disclosures as urgent referral coordination or rapid death notification to municipal health offices. However, such practices erode patient trust, expose bereaved families to social stigma, and deter marginalized communities, particularly unmarried pregnant women and families practicing customary traditional delivery, from seeking formal healthcare in future pregnancies. To reconcile this tension, health authorities should establish secure, encrypted, and anonymized electronic maternal-perinatal death surveillance platforms that enforce strict role-based access control, safeguarding data privacy while fulfilling statutory epidemiological obligations.¹⁸

4.4 Blame culture, audit paralysis, and defensive referral

The most important structural impediment to maternal survival identified in this study is the paralysis of AMP-SR by punitive blame culture. Globally, successful clinical mortality audits rely on psychological safety, blameless inquiry, and systems-level error analysis, as pioneered by James Reason and Lucian Leape. In Indonesia, however, AMP-SR operates under the shadow of criminal and civil liability. Because Indonesian law lacks explicit statutory safe-harbor provisions or evidentiary privilege shielding clinical peer-review documents from judicial subpoena, healthcare professionals perceive death audits as pre-trial inquisitions that could furnish incriminating evidence to police investigators under Articles 359 and 360 of the KUHP.¹⁹ Consequently, audit proceedings degenerate into mutual recrimination, with tertiary consultants deflecting responsibility onto under-equipped primary midwives and hospital administrations sanitizing records to protect institutional reputations. This defensive paralysis is consistent with the audit-funnel estimate that only 16.1% of audit recommendations are translated into concrete health system improvements, perpetuating preventable deaths.

This defensive posture is further exacerbated by 'defensive referral dumping', whereby secondary hospitals and primary *Puskesmas* refuse admission to high-risk parturients to avoid institutional mortality metrics and potential litigation. In an archipelagic landscape with major transport bottlenecks, transferring a hemodynamically unstable mother between islands or across mountainous terrain without specialized intensive care transport is frequently fatal. Clinicians are caught in a legal double bind: if they attempt resuscitation in an under-resourced facility and the patient dies, they face a serious risk of criminal prosecution and public humiliation; if they refer the patient and she dies in transit, the death is recorded as an out-of-hospital transfer fatality, legally absolving the referring institution.²⁰ This perverse incentive structure subverts the constitutional guarantee of emergency healthcare and calls for the legal decriminalization of unavoidable medical complications.

4.5 A tri-systemic governance model and policy implications

To address these systemic failures, we propose a clinical governance model, the Tri-Systemic Architecture for Dignified Obstetric Care and Restorative Governance, illustrated in Figure 5. The framework harmonizes three interdependent pillars: (1) Patient Autonomy and Bioethical Care, which enforces statutory emergency informed consent waivers, mandates trained medical interpreters for regional languages, and establishes institutional perinatal palliative care units; (2) Non-

Punitive Medicolegal Surveillance, which introduces statutory safe-harbor immunity for all AMP-SR audit data, legally prohibiting its admissibility in criminal or civil proceedings, and establishes independent multidisciplinary audit panels; and (3) Restorative Justice and Equity, which mandates alternative dispute resolution (ADR) and pre-litigation mediation through specialized Health Dispute Resolution Boards (*Majelis Pemeriksa Sengketa Medis*), as envisioned in the omnibus Law No. 17 of 2023, coupled with dedicated public funding for emergency archipelagic marine ambulances.^{21,22}

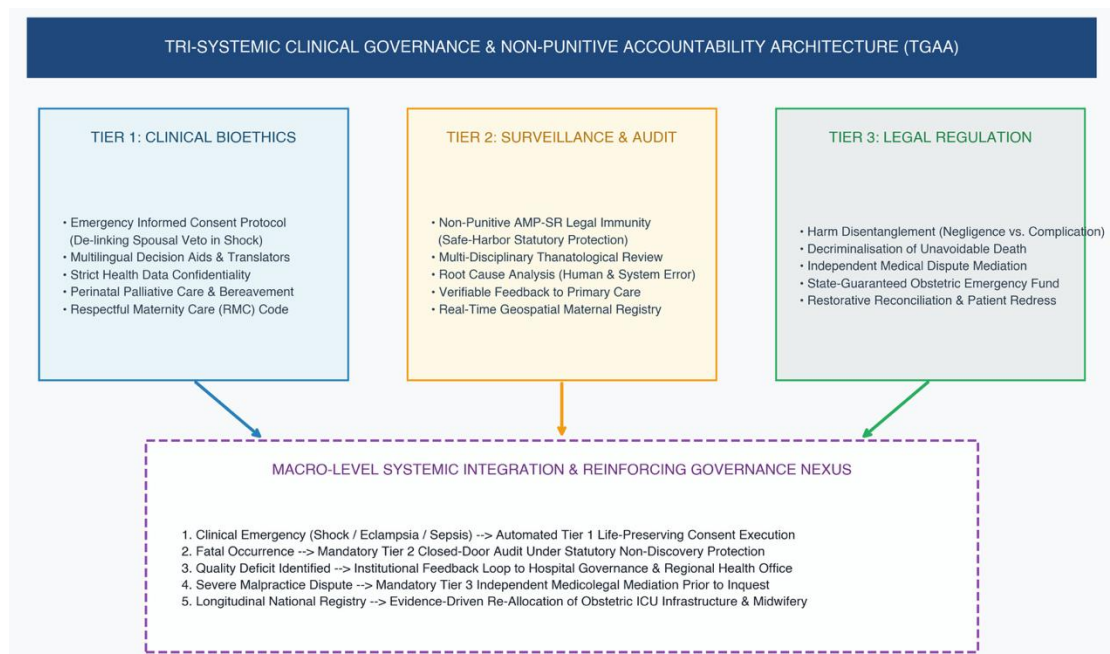


Figure 5. The Tri-Systemic Governance Architecture: harmonizing patient autonomy, non-punitive surveillance, and restorative justice. AMP-SR, maternal-perinatal death surveillance and response; ICU, intensive care unit; RMC, respectful maternity care; TGAA, Tri-Systemic Clinical Governance and Non-Punitive Accountability Architecture.

The clinical and policy implications of this research are considerable. First, the Ministry of Health should issue an operational circular clarifying that life-saving obstetric interventions must never be withheld or delayed pending a spouse's or relative's signature when a woman is unconscious or in life-threatening shock.^{19,20} Hospital bylaws should explicitly protect clinicians who act under the doctrine of emergency medical necessity.^{20,21} Second, the legislature and judicial leadership should enact implementing regulations under Law No. 17 of 2023 that grant evidentiary privilege to clinical mortality audits, aligning Indonesia with international practice in healthcare quality improvement.²² Without legal immunity, clinical audits will remain performative rituals that bury the root causes of maternal death. Finally, provincial health budgets should prioritize dedicated emergency transport corridors and blood-banking supply chains in remote island clusters to eliminate the disparities that currently expose rural mothers to preventable deaths.^{10,11}

4.6 Out-of-hospital deaths and medicolegal death investigation

An often overlooked dimension of clinical governance in archipelagic obstetric care is the death-investigation protocol governing maternal deaths that occur outside tertiary institutions. In maritime provinces such as South Sulawesi, where island populations must cross the sea on unequipped motorized boats (*perahu jolloro*) to reach secondary referral hospitals, death in transit represents an

administrative and forensic void.²³ When a parturient dies of hypovolemic shock or eclampsia during transit, postmortem external examination or verbal autopsy is rarely performed by certified forensic pathologists or trained medicolegal officers. Instead, local civil registration officers rely on unverified lay reports from village elders or traditional birth attendants, which systematically attribute deaths to generic cardiac arrest or supernatural causes.¹⁴ This gap in death investigation distorts municipal epidemiological records, obscures preventable systemic bottlenecks, and reinforces the illusion that institutional referral corridors are functioning appropriately.^{10,14} Integrating formal medicolegal death-investigation protocols, specifically the verbal and social autopsy (VASA) tools endorsed by the WHO, into primary healthcare administration is essential to ensure that every out-of-hospital maternal death is systematically mapped, audited, and addressed.²⁴

4.7 Criminal liability and the doctrine of medical necessity

Furthermore, the doctrinal legal analysis sheds light on the statutory interplay between the omnibus Law No. 17 of 2023 on Health and the general provisions of the KUHP. While Articles 275 and 306 of Law No. 17 of 2023 establish patients' rights to emergency treatment and prohibit health facilities from rejecting patients in life-threatening conditions, the statutory framework does not establish an explicit criminal indemnity defense for clinicians who must make high-stakes surgical decisions under resource

constraints. Frontline obstetricians remain vulnerable to Article 359 of the KUHP, which imposes criminal liability of up to five years' imprisonment for negligence resulting in death. Under Indonesian criminal jurisprudence, the boundary between culpable gross negligence (*culpa lata*) and unpreventable clinical complications (*damnum absque injuria*) remains ill-defined in judicial practice. In the absence of specialized medical courts or binding statutory criteria distinguishing medical malpractice from therapeutic misfortune, judges and prosecutors routinely treat unexpected intrapartum deaths as *prima facie* evidence of criminal culpability. This punitive environment drives the defensive behaviors documented in the present findings, including referral dumping and refusal to initiate emergency cesarean delivery without complete family consent. Resolving this problem requires formal codification of the doctrine of medical necessity (*noodtoestand*) within implementing government regulations, legally shielding practitioners who deliver emergency care in good faith and in accordance with accepted professional standards.²⁵

4.8 Human factors and systems resilience in audit

The findings also highlight the need to apply human factors engineering and systems resilience theory to maternal mortality audits. In traditional Indonesian AMP-SR audits, review panels predominantly adopt a linear, person-centered approach to error analysis, focusing on which midwife failed to monitor vital signs or which junior resident delayed surgical notification.^{6,11} As articulated in James Reason's Swiss cheese model of organizational accidents and the concept of 'vulnerable system syndrome', serious clinical failures are almost never the result of isolated individual errors; rather, they arise from the alignment of latent organizational vulnerabilities across multiple system tiers. In the study setting, these latent conditions included chronic stockouts of parenteral oxytocin and magnesium sulfate in primary *Puskesmas*, absence of 24-hour dedicated emergency surgical staff in district hospitals, fragmented inter-facility radio communication, and lack of municipal budget allocations for fuel-subsidized ambulance boats.¹¹ When clinical audits focus exclusively on blaming frontline providers, these underlying conditions remain intact, ensuring that identical failure modes recur when the next high-risk parturient arrives. Transitioning to a restorative clinical governance paradigm requires replacing individual blame sheets with root cause analysis (RCA) and Healthcare Failure Mode and Effect Analysis (HFMEA) frameworks that systematically identify latent system failures and mandate institutional remediation.^{25,26}

4.9 Language, comprehension, and consent infrastructure

The sociolinguistic and bioethical disconnect observed in emergency informed consent calls for a restructuring of hospital communication bylaws and clinical translation infrastructure.^{20,21} In regional and rural Indonesian communities, clinical encounters frequently cross sharp linguistic and cultural boundaries, as parturients and their extended families communicate primarily in regional languages (such as Bugis, Makassarese, or Torajan) and have limited familiarity with modern surgical interventions.²¹ When clinicians present complex Indonesian-language consent forms under acute crisis conditions, the process violates the bioethical requirements of comprehension and voluntariness, reducing consent to a legally defensive rubber-stamping exercise.^{20,22} To bridge this divide, secondary and tertiary

hospitals in decentralized districts should implement standardized multimedia informed consent protocols and employ certified healthcare language interpreters.²¹ More fundamentally, hospital bylaws should establish clear, legally binding standard operating procedures that operationalize emergency consent waivers during acute maternal collapse, freeing clinicians from the fear of litigation when immediate life-saving surgery must precede administrative formalities.

4.10 Lessons from no-fault compensation systems

International comparative health law suggests that jurisdictions with sustained low maternal mortality have systematically decoupled clinical error analysis from punitive fault-based tort litigation.^{25,26} In countries with adversarial common law or fault-based civil liability systems, such as the United States and the United Kingdom, defensive medicine in obstetrics remains widespread, driving excessive cesarean section rates, clinical burnout, and reluctance to manage high-risk parturients. In contrast, countries that have enacted 'no-fault' compensation frameworks for obstetric birth injuries, most notably the Scandinavian patient injury compensation systems (Sweden, Denmark, and Norway) and New Zealand's Accident Compensation Corporation (ACC), have dismantled the adversarial incentive to conceal medical errors. Under these models, injured patients or bereaved families receive prompt, equitable, state-administered compensation without having to prove provider culpability or negligence in court, while clinical review committees operate in confidence under statutory non-discovery protections to analyze systemic failure modes. For Indonesia, while a complete transition to a no-fault compensation scheme would require long-term legislative restructuring, the immediate operationalization of mandatory ADR and specialized Health Dispute Resolution Boards under Law No. 17 of 2023 offers an indispensable bridge toward a restorative, patient-centered, and learning-oriented medicolegal system.

4.11 The role of professional societies

In terms of translational implementation, professional medical societies, most notably the Indonesian Society of Obstetrics and Gynecology (*Perkumpulan Obstetri dan Ginekologi Indonesia*, POGI) and the Indonesian Midwives Association (*Ikatan Bidan Indonesia*, IBI), should play a proactive role in codifying standardized clinical practice guidelines that resolve ethical ambiguities at the bedside. While national statutes articulate broad normative rights, frontline clinicians require unambiguous, institutionally endorsed clinical algorithms that specify protocols for executing emergency informed consent waivers, managing language barriers, and conducting inter-professional consultations. POGI and IBI should collaborate with the Ministry of Health to promulgate standardized, multilingual clinical consent protocols and to institute accredited training modules in healthcare law, clinical bioethics, and conflict de-escalation across obstetric residency and midwifery curricula. Furthermore, professional associations should establish dedicated medicolegal advocacy and peer-support committees to provide immediate psychological first aid and legal guidance to clinicians involved in serious intrapartum events, mitigating the moral injury and defensive clinical paralysis that currently compromise maternal healthcare delivery across Indonesia.

4.12 Strengths and limitations

This study has distinct methodological strengths, notably the multi-stakeholder triangulation of frontline clinicians, regulators, legal advocates, and bioethicists across multiple tiers of the Indonesian health system, paired with a doctrinal critique of national health statutes. Several limitations must nevertheless be acknowledged. First, the fieldwork was geographically concentrated in South Sulawesi Province and national health hubs; although South Sulawesi serves as an archipelagic referral microcosm with considerable demographic and geographical diversity, local health governance dynamics in other Indonesian provinces may differ. Second, qualitative interviews may be subject to social desirability bias, particularly when discussing sensitive medicolegal liability and defensive clinical practices; this was mitigated through member checking, data triangulation, and strict pseudonymization. Future studies should longitudinally evaluate the implementation of restorative dispute resolution mechanisms under the new Health Law and conduct spatial econometric modeling of emergency referral travel times across Indonesia's remote archipelagic regions.

5. Conclusion

This investigation elucidates the ethical dilemmas, medicolegal impediments, and clinical governance fractures that perpetuate preventable maternal and perinatal mortality across decentralized Indonesia. The findings indicate that maternal survival is systematically undermined by coercive emergency consent rituals, spousal gatekeeping, the absence of perinatal palliative care, and the paralysis of maternal death audits by punitive blame culture and fear of criminal prosecution under the KUHP. The widespread practice of defensive referral dumping shows how clinicians, working under unmitigated legal precarity, are incentivized to prioritize personal liability avoidance over urgent patient survival. Statutory guarantees under prevailing health legislation remain decoupled from clinical realities because of the absence of safe-harbor protection for clinical peer-review data and fragmented emergency referral infrastructure.

Eliminating preventable maternal and newborn deaths in Indonesia requires a decisive shift from punitive litigation to restorative clinical governance. Safeguarding patient autonomy through explicit statutory emergency consent waivers, enacting evidentiary privilege for AMP-SR proceedings, operationalizing specialized pre-litigation medical dispute mediation boards under Law No. 17 of 2023, and funding subsidized archipelagic emergency referral corridors are essential legal and systemic prerequisites. Only through such integrated structural, legal, and ethical reforms can Indonesia fulfill its constitutional mandate to guarantee dignified, safe, and equitable obstetric care for every mother and newborn across the archipelago.

Declarations

Use of generative artificial intelligence. The authors did not use generative artificial intelligence or AI-assisted technologies at any stage of this work, including study design, data collection and analysis, interpretation of findings, and the writing or editing of the manuscript. The authors take full responsibility for the integrity and accuracy of the content.

Author contributions. AA: Conceptualization, Methodology, Investigation, Formal analysis, Data curation, Project administration, Writing – original draft. JH: Methodology, Formal analysis, Validation, Writing – review and editing. Both authors

have read and approved the final version of the manuscript and agree to be accountable for all aspects of the work.

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Conflict of interest. None. The authors declare no competing financial, personal, or professional interests.

Ethical approval. The study protocol and interview procedures were reviewed and approved by the. All key informants provided written informed consent prior to enrollment.

Consent for publication. Not applicable. All qualitative data were anonymized using alphanumeric participant codes, and no personally identifiable information is presented.

Data availability. The qualitative codebooks, thematic extraction matrices, and documentary legal corpus analyzed during the current study are available from the corresponding author upon reasonable request.

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