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Legal Responsibility and Protection of Obstetrics and Gynecology Residents in Delegated Emergency Care Authority in Disadvantaged, Frontier, and Outermost Regions: An Analysis of Law No. 17 of 2023 on Health

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Abstract

Obstetric emergency services in Underdeveloped, Frontier, and Outermost (3T) regions face complex medicolegal challenges, particularly regarding the limited number of Obstetricians and Gynecologists (OBGYN). The presence of Residents (Specialist Doctor Education Program Participants/PPDS) assigned to 3T areas places them as emergency medical decision-makers through the mechanism of delegation of authority from the sole OBGYN as the Doctor in Charge of Services (DPJP). This study aims to analyze the boundaries of legal responsibility and protection for OBGYN Residents performing emergency obstetric procedures in 3T areas based on Law Number 17 of 2023 concerning Health. This study uses a normative juridical method with a statutory and conceptual approach. The results indicate that Law No. 17 of 2023 provides a framework for strengthening legal protection through medical personnel immunity in overmacht conditions within 3T regions. The study concludes that clear operational standardization of clinical delegation between educational institutions and regional hospitals is essential to ensure legal certainty and patient safety.

Keywords: Delegation of Authority, OBGYN Resident, Obstetric Emergency, 3T Areas, Health Law.

A. Introduction

Maternal health services, particularly in the field of obstetrics and gynecology, constitute one of the areas of medical practice with a very high medicolegal risk.[1] This risk increases significantly and exponentially when such services are provided in Disadvantaged, Frontier, and Outermost Regions, commonly referred to as 3T regions.[2] Unlike the healthcare ecosystem in urban areas, 3T regions especially those with archipelagic and coastal

[1] Nadia Tiara Syahredi Adnani, Syofirman Syofyan, and Yussy Adelina Mannas, "Perlindungan Hukum Dokter Program Pendidikan Dokter Spesialis (PPDS) Terhadap Pelimpahan Wewenang Dokter Spesialis Dalam Pelayanan Medis Di Rumah Sakit (Studi Kasus Di Rumah Sakit Umum Pusat Dr. M. Djamil Padang Bagian Obstetri Dan Ginekologi)," *UNES Law Review* 6, no. 1 (2023): 1209–16.

[2] Yuyut Prayuti, Yuda Kusumah, and Zaenal Abidin, "Perlindungan Hukum Bagi Tenaga Medis Dan Tenaga Kesehatan Dalam Undang-Undang Nomor 17 Tahun 2023 Tentang Kesehatan," *Legal Standing: Jurnal Ilmu Hukum* 9, no. 2 (2025): 503–13.

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topography face extreme geographical isolation, limited infrastructure, and the absence of referral transportation available on a 24 hour standby basis. Unpredictable weather conditions or the lack of adequate sea and air access often completely disrupt the standard referral chain. Amid these geographical realities, the availability ratio of Obstetrics and Gynecology Specialists is highly disproportionate to the fluctuating burden of maternal emergency cases.[3]

In an effort to fulfill the principle of equitable access to healthcare for communities in these isolated areas, participants in specialist medical education programs, known as residents, are often delegated to serve in regional general hospitals within educational networks or affiliations.[4] However, the shortage of human resources frequently results in the Obstetrics and Gynecology Specialist, as the sole Attending Physician or Physician in Charge of Care in the region, being unable to be physically present at the healthcare facility on a full 24-hour basis.

This condition places residents in a critical dilemma when confronted with life-saving obstetric emergencies. Cases such as massive postpartum hemorrhage, obstructed labor, eclampsia, or fetal distress require medical decision-making and operative intervention, such as cesarean section or laparotomy, within an extremely narrow golden period—often within minutes. Waiting for the physical presence of the Attending Physician or forcing a referral process to a regional hospital that may take hours would instead result in fatal consequences and lead to maternal and fetal mortality. This conflict between complying with the administrative rigidity of delegated authority and fulfilling the moral obligation to save lives is what gives rise to an absolute emergency condition or overmacht/force majeure for residents in the field.[5]

Theoretically, legal discourse on the delegation of medical authority generally focuses only on the ecosystem of main teaching hospitals, which possess an ideal tiered supervision system.[6] Previous regulations and competency standards for medical trainees were designed based on the assumption of direct physical supervision by consultants within the same building. In remote areas, however, this delegated mandate undergoes clinical distortion. Residents de facto transform into the highest medical decision-makers in the operating room, even though de jure the attribution of authority remains attached to the Attending Physician, who is compelled to provide instructions only through remote telemedical means.

Previous studies on the legal responsibility of residents have mostly relied on the old Medical Practice Law regime, which is no longer relevant, and have failed to capture the

[3] Nurul Ragilia Berdame, "Kebijakan Pemerintah Dalam Pelayanan Kesehatan Terhadap Masyarakat Yang Kurang Mampu Menurut Undang-Undang Nomor 17 Tahun 2023 Tentang Kesehatan," *LEX PRIVATUM* 13, no. 5 (2024); Republik Indonesia, "Undang-Undang Nomor 17 Tahun 2023 Tentang Kesehatan," *Lembaran Negara Republik Indonesia Tahun*, 2023.

[4] Zainal Abidin, "Perlindungan Hukum Peserta Pendidikan Dokter Spesialis Di Rumah Sakit= Legal Protection for Specialist Doctor Education Participants in Hospitals" (Universitas Hasanuddin, 2024).

[5] George Yared et al., "Uterine Sacrifice in Obstetric Emergencies Case Series: Complex Cases of Fetal Distress, Labor Challenges, and Life-Saving Interventions," *SAGE Open Medical Case Reports* 12 (2024): 2050313X241261487.

[6] Andrew Gray and Stephen Harrison, *Governing Medicine: Theory And Practice: Theory and Practice* (McGraw-Hill Education (UK), 2004).

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empirical reality of remote delegation in isolated regions.[7] There remains a significant legal gap in examining the limits of medical discretion and the strict responsibility of obstetrics and gynecology residents when carrying out emergency mandates in situations where the Attending Physician is physically unavailable.

The novelty of this study does not merely lie in its focus on legal protection for Obstetrics and Gynecology Residents serving in disadvantaged, frontier, and outermost (3T) regions. More importantly, this study develops a multi-layered accountability framework for emergency obstetric care in remote areas. Unlike previous studies that primarily examine residents' legal responsibility from an individual perspective, this research analyzes the interrelated responsibilities of multiple actors, including residents, attending physicians (DPJP), regional hospitals, educational institutions, and local governments. Through this framework, the study demonstrates that legal accountability in emergency delegated care cannot be imposed solely upon frontline residents, but must be understood as a shared responsibility arising from professional, institutional, educational, and governmental obligations. This approach offers a broader legal construction for ensuring patient safety and legal certainty within the healthcare system of 3T regions. This study specifically examines the shift in this protection paradigm, the limitations on the application of the doctrine of vicarious liability, and the legitimacy of medical immunity for residents acting under conditions of overmacht.[8]

This study aims to comprehensively analyze the limits of legal responsibility and protection for obstetrics and gynecology residents who perform emergency interventions in 3T regions. The findings of this study are intended to provide absolute legal certainty for specialist trainees and to serve as a strategic evaluation basis for educational institutions and local governments in formulating Standard Operating Procedures for adaptive emergency clinical delegation that ensure patient safety.

B. Research Method

This study employs a normative juridical research design, commonly referred to as legal research. This design focuses on a comprehensive examination of positive legal norms, legal principles, and legal doctrines governing medical practice and specialist medical education. The selection of the normative juridical method is based on the urgency of conducting vertical and horizontal synchronization among statutory regulations in order to identify legal gaps or blanket norms in the mechanism of delegated authority for residents in 3T regions.[9]

The research approaches used in this study include the statute approach and the conceptual approach. The statute approach is conducted by examining Law Number 17 of 2023 on Health, its implementing regulations such as Government Regulation Number 28 of

[7] Muhammad Rizaldy Hariansyah, Slamet Sampurno, and Nur Azisah, "Legal Responsibility for Negligence Performed by Doctors Specialist Education Doctors Programs," *Soepra Jurnal Hukum Kesehatan* 6, no. 2 (2020): 265–76.

[8] Muhammad Farsha Shihab, "Analisis Yuridis Doktrin Vicarious Liability Dalam Praktik Medis Studi Putusan MK No. 21/PUU-XXI/2023," *Arus Jurnal Sosial Dan Humaniora* 5, no. 2 (2025): 1925–36.

[9] Jonaedi Efendi, Jhonny Ibrahim, and Prasetijo Rijadi, "Metode Penelitian Hukum: Normatif Dan Empiris," 2016.

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2024, and Law Number 1 of 2023 on the Criminal Code. Meanwhile, the conceptual approach is applied to construct legal arguments by referring to the views of legal scholars and medical doctrines related to vicarious liability, *overmacht*, and standards of obstetric emergency care.[10]

The legal materials analyzed in this study consist of three levels. Primary legal materials comprise binding statutory regulations; secondary legal materials include literature, scientific journals on health law, and policy documents related to the placement of specialist medical education program participants; and tertiary legal materials include legal dictionaries and medical encyclopedias.[11]

Data collection is carried out through comprehensive library research. The researcher identifies specific medicolegal issues in 3T regions, inventories relevant primary and secondary legal materials, and classifies them based on the research problems.[12]

All collected data are then analyzed qualitatively using a descriptive-prescriptive method. The researcher not only describes the factual condition of legal limitations, or das sein, but also provides analytical arguments regarding what should be normatively regulated, or das sollen/what the law ought to be, in order to ensure firm legal certainty and protection for obstetrics and gynecology residents serving on the front line.[13],[14].

C. Results and Discussion

1. Juridical Analysis of the Mechanism for Delegating Clinical Authority under the Regime of Law Number 17 of 2023 on Health

Obstetric emergency services in Disadvantaged, Frontier, and Outermost regions, commonly referred to as 3T regions, such as Teluk Wondama Regency, have distinctive characteristics that distinguish them from main educational centers in major cities. Geographically and demographically, 3T regions are often confronted with challenges of territorial isolation, archipelagic transportation infrastructure that is highly dependent on weather conditions, and healthcare facilities that have not been standardized evenly. These conditions directly affect the extremely limited availability ratio of expert medical personnel. Normatively, the delegation of medical authority constitutes a crucial legal instrument to ensure healthcare continuity amid the limited availability of Obstetrics and Gynecology Specialists. Law Number 17 of 2023 on Health provides a new foundation for the implementation of specialist medical education and medical practice in a more integrative manner, seeking to bridge the gap between academic ideals and empirical realities in the field.[15]

From the perspective of medical administrative law, the delegation of authority from an

[10] S H I Jonaedi Efendi, *Rekonstruksi Dasar Pertimbangan Hukum Hakim* (Prenada Media, 2018).
[11] Mike McConville, *Research Methods for Law* (Edinburgh University Press, 2017).
[12] Terry Hutchinson and Nigel Duncan, "Defining and Describing What We Do: Doctrinal Legal Research.," *Deakin Law Review* 17, no. 1 (2012): 83–119.
[13] Edward L Rubin, "Law and and the Methodology of Law," *Wis. L. Rev.*, 1997, 521.
[14] Vicki C Jackson, "Law: Methodologies," *The Oxford Handbook of Comparative Constitutional Law*, 2012, 54.
[15] Adnani, Syofyan, and Mannas, "Perlindungan Hukum Dokter Program Pendidikan Dokter Spesialis (PPDS) Terhadap Pelimpahan Wewenang Dokter Spesialis Dalam Pelayanan Medis Di Rumah Sakit (Studi Kasus Di Rumah Sakit Umum Pusat Dr. M. Djamil Padang Bagian Obstetri Dan Ginekologi)."

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Obstetrics and Gynecology Specialist as the Attending Physician or Physician in Charge of Care to a resident in 3T regions generally takes the form of a mandate, rather than a delegation. The essential distinction between the two lies in the transfer of responsibility. In a mandate relationship, legal responsibility by attribution remains with the mandator, namely the Attending Physician, as long as the mandatary acts within the scope of the instructions given. The resident acts for and on behalf of the Attending Physician. However, the realities in 3T regions often obscure these boundaries in practice. When the Attending Physician is unable to be physically present due to geographical constraints or the limited number of specialists—where there may be only one Obstetrics and Gynecology Specialist serving an entire regency or several islands—the delegation must inevitably be carried out through oral instructions or telemedical means.[16]

The latest Health Law, through Article 1 point 22 in conjunction with Articles 558 and 561 of Government Regulation Number 28 of 2024, has begun to recognize the role of telemedicine technology in healthcare services. However, it has not specifically regulated the limits of residents' responsibility in executing such remote instructions. In fact, the juridical implications of conditional independent practice under the supervision of an educational institution depend heavily on the clarity of these limits of authority. Telephone instructions in a critical situation, for example when a stable signal is unavailable while a patient is experiencing hemorrhagic shock, transfer the cognitive and executive burden entirely to the resident. This is consistent with the view that legal protection is absolutely necessary for specialist medical education program participants assigned to network hospitals, given that they are entities undergoing education while simultaneously providing healthcare services.[17]

Furthermore, the clinical authority or clinical privilege of an obstetrics and gynecology resident in an assigned region is based on a progressive level of competence approved by the educational institution. A crucial problem arises when clinical needs in the field, such as an emergency cesarean section in a case of fetal distress or obstetric hysterectomy in refractory uterine atony, exceed the formal competency level of the resident on duty at that time. At this point, a shift occurs from structured delegation to unavoidable emergency delegation. Law Number 17 of 2023 on Health, through Article 273 in conjunction with Article 275, provides a legal basis for medical personnel to perform life-saving interventions in emergency conditions, setting aside administrative competency barriers in the interest of patient safety, in accordance with the principle *salus populi suprema lex esto*.

A further legal issue concerns the potential conflict between professional medical authority and the administrative authority of hospitals in determining clinical delegation. Professional authority is fundamentally derived from competence, certification, and professional standards established by medical education institutions and professional organizations. In contrast, hospitals exercise administrative authority through credentialing processes, clinical privileges, and hospital bylaws. In practice, particularly in 3T regions,

[16] Gunawan Widjaja, "Wewenang, Pelimpahan Wewenang Dan Akibat Hukumnya Dalam Konsepsi Hukum Perdata," *Jurnal Alwatzikhoebillah: Kajian Islam, Pendidikan, Ekonomi, Humaniora* 9, no. 2 (2023): 310–19.

[17] Peraturan Pemerintah Nomor 28 Tahun 2024 tentang Peraturan Pelaksanaan Undang-Undang Nomor 17 Tahun 2023 tentang Kesehatan.

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situations may arise where urgent clinical needs require residents to perform procedures beyond the scope of formally granted hospital privileges but still within the limits of professional competence and emergency necessity. This creates a normative tension between professional judgment and institutional administrative restrictions. Therefore, legal interpretation of delegated authority in emergency settings should seek to harmonize professional standards and hospital governance, ensuring that patient safety remains the primary consideration while maintaining legal certainty for healthcare personnel.

2. The Dilemma of Legal Responsibility: Between Vicarious Liability and Residents' Medical Discretion in Remote Areas

The core medicolegal issue for obstetrics and gynecology residents in 3T regions lies in determining the subject of legal responsibility when a medical risk or adverse event occurs. Doctrinally, health law recognizes the concept of **vicarious liability**, or substitute liability, which is similar to the principle of *respondeat superior*. Article 193 of Law Number 17 of 2023 on Health explicitly affirms that healthcare facilities are legally responsible for losses arising from the negligence of their medical personnel.[18]

The concept of vicarious liability is further strengthened by the enactment of the new National Criminal Code, namely Law Number 1 of 2023. Under this latest regulation, Articles 45 to 50 explicitly recognize corporations as subjects of criminal offenses. In the context of healthcare services in 3T regions, if systemic failure occurs—such as the unavailability of blood bags, malfunctioning anesthesia equipment, or the absence of sea transportation to refer patients—the hospital as a corporation cannot shift such fault onto frontline medical personnel. Negligence in providing standard life-saving facilities positions the corporation as a subject that may be held criminally liable. However, it should be noted that this doctrine does not automatically release residents from personal liability if the actions taken are purely categorized as gross negligence, regardless of the limitations of the available facilities.[19]

A more in-depth legal elaboration is required with regard to residents' medical discretion under conditions of *overmacht* or force majeure. In regional general hospitals located in 3T areas, an obstetrics and gynecology resident often stands as the only medical personnel with basic surgical competence available on site during an obstetric crisis. If the resident chooses not to act for the sake of personal legal safety, for instance by waiting for the Attending Physician who is outside the city or island, the resident may be blamed for omission that results in the patient's death. This dilemma becomes even more complex in remote areas when efforts to obtain informed consent from the patient's family in an emergency are obstructed by communal cultural practices or the absence of the family decision-maker under local tradition. Conversely, if the resident acts without direct physical supervision, the resident risks being accused of exceeding authority and may face criminal

[18] Hariansyah, Sampurno, and Azisah, "Legal Responsibility for Negligence Performed by Doctors Specialist Education Doctors Programs."

[19] Yusuf Daeng et al., "Pertanggungjawaban Pidana Rumah Sakit Dan Tenaga Medis Di Atas Tindakan Malpraktik Berdasarkan Undang-Undang Nomor 17 Tahun 2023 Tentang Kesehatan," *Innovative: Journal Of Social Science Research* 3, no. 6 (2023): 3453–61.

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charges.[20]

To mitigate the threat of criminalization that often overshadows medical personnel in such gray-area situations, Law Number 17 of 2023 on Health not only strengthens the concept of medical personnel immunity under Article 273 in conjunction with Article 275, but also introduces a procedural filter mechanism through Article 308. This article affirms that law enforcement authorities may not directly process criminal allegations against medical personnel suspected of committing violations, but must first obtain a written recommendation from the Professional Discipline Council. This council functions as an objective peer-review instrument to assess whether an emergency surgical procedure performed without the physical presence of the Attending Physician constitutes negligence or, instead, a lawful life-saving intervention under conditions of *overmacht*. The author argues that, in the context of 3T regions, this standard of competence must be interpreted contextually, namely as the standard of care applicable in remote areas, rather than the ideal standard of a type A hospital. A physician's civil liability in emergency care should be measured by the maximum rational effort made according to the facilities available, not merely by the final outcome.

In addition, the presence of a senior Obstetrics and Gynecology Specialist as the Attending Physician who provides remote guidance still positions the resident as a legal extension of that physician. Legal responsibility should therefore be proportional: the Attending Physician is responsible for the accuracy of the instructions given, while the resident is responsible for the accuracy of the technical execution in the field. If a medical incident leads to a claim by the patient's family, Article 327 of the Health Law requires that the dispute first be resolved through out-of-court dispute settlement, or alternative dispute resolution. This mechanism is aligned with the restorative justice approach, which is particularly relevant in remote areas with strong communal cultural characteristics. Resolution through mediation or customary deliberation is far more effective in restoring losses and maintaining long-term relationships between healthcare institutions and communities than formal litigation, which consumes considerable time and costs.[21]

To ensure comprehensive legal certainty, statutory-level protection must be translated into operational instruments. Hospitals in 3T regions must have specific hospital bylaws and clinical pathways that legalize the delegation of independent authority to residents under conditions of "absolute emergency" as a form of institutional protection for residents on duty. These documents serve as written legal legitimacy confirming that telemedical instructions and emergency surgical discretion are legally recognized by the institution. Standardization through clinical pathways specifically designed for hospitals in disadvantaged regions constitutes the most effective preventive legal instrument to ensure that residents are not left to struggle alone, either in the operating room or in the courtroom.

[20] Tamara Damayanti, Hendri Darma Putra, and Happy Yulia Anggraeni, "Informed Consent Pada Kasus Kegawatdaruratan Di Rumah Sakit Berdasarkan Undang-Undang No. 17 Tahun 2023," *UNES Law Review* 7, no. 1 (2024): 246–54.

[21] K Sari, P Prastopo, and S S Bungin, "Penyelesaian Sengketa Medis Pasca Disahkannya Undang-Undang Kesehatan Nomor 17 Tahun 2023," *Jurnal Cahaya Mandalika* 5, no. 2 (2024).

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3. The Problem of Informed Consent in Obstetric Emergencies in Archipelagic Regions

One of the fundamental legal instruments in medical services is informed consent, or consent to medical treatment. Normatively, every high-risk medical procedure must obtain written consent from the patient or the patient's closest family member after adequate explanation has been provided. However, the application of this doctrine in 3T regions, particularly those with archipelagic or coastal characteristics such as Teluk Wondama, West Papua, often conflicts with sociological and geographical realities.[22]

In obstetric emergency cases such as placental abruption or severe eclampsia, patients often arrive with decreased consciousness or are medically incompetent to provide consent. On the other hand, the husband or immediate family member as the next of kin who is entitled to provide representative consent may be at sea, on another island, or hindered by limited communication and transportation access. Waiting for the presence of the family decision-maker may exhaust the golden period for saving the patient's life. In addition, communal patriarchal culture in some remote areas sometimes causes accompanying family members to be reluctant to sign informed consent without the approval of customary elders or the head of the immediate family.[23]

In facing this impasse, the obstetrics and gynecology resident on duty must be protected by the doctrine of presumed consent. Under Law Number 17 of 2023 on Health, in a life-threatening emergency, life-saving medical interventions may and must be carried out immediately without waiting for written informed consent. The author emphasizes that the absence of written informed consent in 3T regions under conditions of absolute emergency cannot be construed as an unlawful act or administrative negligence subject to criminal prosecution. The resident's clinical decision in such a situation is absolutely protected by the principle of zaakwaarneming, namely the management of another person's interests without prior authorization, as recognized under civil law, whereby medical personnel are legally deemed to have assumed responsibility in order to protect the patient's right to life.

4. Legal Validity of Telemedicine and Tele-Mentoring as Instruments of Delegation

The physical absence of the Attending Physician or Physician in Charge of Care in regional general hospitals located in 3T regions compels the mechanism of delegated authority to transform through the use of information and communication technology, commonly referred to as tele-mentoring or emergency telemedical consultation. The Attending Physician may rely solely on voice calls, instant messaging applications, or video calls with fluctuating internet network quality to guide residents who are dealing with complications on the operating table.

Juridically, this situation gives rise to discourse concerning the validity of evidence and the transfer of responsibility. If the communication network is interrupted in the middle of

[22] Handrian Purawijaya et al., "Informed Consent Dan Sengketa Medis Dalam Instalasi Gawat Darurat (IGD): Tinjauan Etik Dan Hukum," *Syntax Literate; Jurnal Ilmiah Indonesia* 10, no. 7 (2025): 9148–54.

[23] Eri Puji Kumalasari, "Informed Consent Dalam Penanganan Pasien Gawat Darurat Di Puskesmas Kota Kediri Wilayah Selatan," *Sinar: Jurnal Kebidanan* 4, no. 1 (2022): 30–37.

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a critical procedure, the demarcation of responsibility between the Attending Physician as the provider of instructions and the resident as the executor becomes blurred. Under Government Regulation Number 28 of 2024 concerning the Implementation of the Health Law, the provision of telemedicine has obtained legal legitimacy. However, within the framework of emergency delegation, a sharper legal interpretation is required.[24]

The author argues that remote instructions from the Attending Physician have binding legal force equivalent to physical presence, provided that such instructions are recorded chronologically in the medical record. If an intervention fails due to the interruption of telecommunication access, responsibility for the medical risk or adverse event returns to the principle of vicarious liability in relation to corporate liability under the National Criminal Code. The absence of reliable communication infrastructure in the operating room of a 3T regional general hospital constitutes a systemic failure of hospital management and the local government as the provider of public facilities, rather than negligence on the part of the resident. Therefore, medical personnel cannot be made the sole subject of liability, or scapegoat, for a failed medical outcome whose root cause lies in the technological infrastructure gap in remote areas.[25]

5. Legal Position and Responsibility of the Main Educational Institution in the Assignment Scheme of Residents in 3T Regions

The discourse on legal protection for residents in 3T regions cannot be separated from the role of a third entity that is often overlooked in juridical accountability, namely the medical education institution or university, or the main teaching hospital from which the resident originates. Structurally, the presence of obstetrics and gynecology residents in regional general hospitals in 3T areas is not based on an independent personal initiative, but rather constitutes the implementation of an external rotation curriculum or regional clinical rotation required by their educational institution.

From the perspective of civil and administrative law, the relationship among the resident, the 3T regional general hospital, and the educational institution forms a complex tripartite legal relationship. The resident is positioned as a learner whose rights and obligations remain subject to the academic authority of the home institution. Therefore, the application of legal protection must not be imposed solely on the local hospital's mechanism of vicarious liability under Article 193 of the Health Law. The author argues that the main educational institution also bears proportional legal responsibility or joint liability if a medical dispute arises from the delegation of emergency authority in the assigned region.

Theoretically, the educational institution acts in loco parentis, namely as a substitute guardian or protector for its learners. The institution's legal obligation or duty of care does not cease when residents are deployed to remote areas. The educational institution has a pre-assignment obligation to conduct periodic feasibility audits of network hospitals in 3T regions. If the educational institution knowingly sends residents to a hospital that lacks

[24] Bob Wahyudin et al., "Legal Protection for Doctors in Telemedicine Services: A Human Rights and Comparative Law Perspective," *Jurnal Suara Hukum* 7, no. 1 (2025): 124–55.

[25] Kartika Kartika and Andika Andika, "The Legal Protection for Independent Practicing Doctors in Providing Telemedicine Services to Patients," *Soepra Jurnal Hukum Kesehatan* 10, no. 2 (2024): 335–50.

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blood availability, emergency anesthesia facilities, or an Obstetrics and Gynecology Attending Physician on standby, and allows the residents to bear clinical risks alone, the institution may be deemed to have committed systemic negligence or negligent placement.

In the context of dispute resolution, the educational institution must not disengage when law enforcement authorities begin summoning residents. The implementation of the mandate for the protection of medical personnel under Law Number 17 of 2023 on Health requires the restructuring of cooperation agreements or memoranda of understanding between the local government where the regional hospital is located and the sending university. Such agreements must contain an indemnification clause, explicitly stating that the university and the local government will assume civil liability and provide full legal assistance or advocacy if residents face legal claims arising from life-saving actions performed under conditions of *overmacht*. The existence of this binding clause would provide psychological and legal security for residents in carrying out their service and educational functions without the looming fear of medical criminalization.[26]

D. Conclusion and Recommendations

Based on the results of the comprehensive analysis and elaboration of the discussion, three main conclusions can be drawn. First, the mechanism for delegating medical authority from Obstetrics and Gynecology Specialists to residents in 3T regions under Law Number 17 of 2023 on Health constitutes a form of mandate-based delegation that is clinically and administratively valid in order to ensure patient safety. The latest Health Law provides flexibility through the recognition of remote instructions or tele-mentoring and the role of medical trainees in taking over emergency interventions, provided that such actions remain within the scope of institutional assignment. Life-saving interventions performed without written informed consent due to situational barriers in remote areas are justified by the doctrines of presumed consent and *zaakwaarneming* in order to prevent clinical deterioration. Second, the construction of legal responsibility in this delegation of authority has shifted significantly. Doctrinally, health law adopts the principle of **vicarious liability**, under which healthcare facilities bear strict responsibility for medical risks that arise. This is reinforced by the new National Criminal Code, namely Law Number 1 of 2023, which positions corporations, including hospitals and local governments, as primary subjects of criminal law for failures to meet safety infrastructure standards. On the other hand, obstetrics and gynecology residents in 3T regions are afforded special legal protection in the form of medical immunity under conditions of *overmacht* or force majeure when performing life-saving interventions without direct physical supervision. This protection is effective and valid as long as the action is based on rational medical discretion and the maximum attainable standard of medical science in accordance with the facilities available. Third, Law Number 17 of 2023 provides a dual legal shield for medical personnel against the threat of criminalization. Article 308 functions as an absolute filter, whereby criminal prosecution cannot be processed by law enforcement authorities without a recommendation from the

[26] Lisda Pradita Wardhany, M Khoirul Huda, and Mohammad Zamroni, "Tanggung Jawab Hukum Rumah Sakit Pendidikan Pada Peserta Program Pendidikan Dokter Spesialis Dari Tindakan Perundungan.," *Yustitiabelen* 10, no. 2 (2024): 131–51.

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Professional Discipline Council. Meanwhile, Article 327 encourages the application of restorative justice, requiring medical disputes to be resolved through non-litigation mechanisms or mediation, an approach that is highly consistent with the local wisdom of communities in frontier and archipelagic regions.

The principal contribution of this study is the development of a multi-layered accountability model for emergency obstetric care in 3T regions. Under this model, legal responsibility is distributed among residents, attending physicians, hospitals, educational institutions, and local governments according to their respective duties and capacities. Consequently, adverse outcomes arising from emergency delegated care should not automatically result in individual liability for residents, but must be assessed within the broader context of institutional, educational, and governmental responsibility.

In response to medicolegal gaps that may still potentially harm medical personnel, this study formulates several strategic recommendations. For regional hospitals in 3T regions, it is necessary to immediately formulate and ratify detailed internal regulations in the form of **hospital bylaws**, which should be further derived into emergency Standard Operating Procedures and clinical pathways. These legal documents must explicitly legalize emergency clinical privileges for residents and recognize the validity of telemedical instructions as a legitimate form of delegation, thereby strengthening legal certainty for residents on duty. For main educational institutions, namely universities, and local governments, it is mandatory to update cooperation agreements governing external regional clinical rotations. Such agreements must contain indemnification clauses and joint liability provisions that guarantee the availability of full legal advocacy for residents if they are confronted with legal disputes. Universities must not relinquish their institutional responsibility to protect residents when assigning their trainees to regions with limited facilities. For regional law enforcement authorities, it is recommended that legal perceptions be harmonized by prioritizing the principle of **ultimum remedium**, namely criminal law as a last resort, and by ensuring strict compliance with the peer-review mechanism through the Professional Discipline Council before undertaking legal intervention against medical personnel who are working on the front line.

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