



Hospital Accountability for Medical Malpractice within Civil Liability and Patient Safety Governance

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ABSTRACT

Hospital liability in medical malpractice has become an important issue because modern care is delivered through institutional systems that shape clinical decisions, patient safety, and legal responsibility. This study aims to examine the scope of hospital accountability when patient injury results from negligent medical services, unsafe governance, inadequate supervision, or breach of patient rights. The research applies a normative juridical method with descriptive analysis of legal doctrine, health law principles, civil liability, administrative responsibility, criminal responsibility, and patient safety scholarship. The findings show that hospitals may be liable through vicarious responsibility for negligent health workers, direct institutional negligence, civil compensation duties, regulatory sanctions, and limited criminal accountability in serious cases. Hospital responsibility is strengthened by failures in credentialing, staffing, informed consent, documentation, incident reporting, disclosure, and digital health governance. Effective liability should distinguish unavoidable medical risk from malpractice while ensuring patient compensation, institutional correction, and safer health service systems.



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INTRODUCTION

Hospital liability in medical malpractice develops from the legal relationship between the patient and the health care institution. Patients receive services through an organized system that includes doctors, nurses, pharmacists, laboratory officers, radiology units, emergency teams, administrators, and digital records. Harm may occur because of an individual professional error, but the hospital remains relevant because treatment is delivered through institutional arrangements. Civil responsibility becomes stronger when personnel act within hospital services, use hospital facilities, follow hospital schedules, and appear to patients as part of the same provider organization. Indonesian legal studies place hospital liability within civil law, statutory health obligations, and patient protection principles (Hutagaol et al., 2024).

Medical malpractice must be separated from an unsuccessful medical result. A patient may deteriorate despite proper care, and a serious complication may occur even when treatment follows professional standards. Legal liability requires more than disappointment, pain, or death after treatment. It requires a breach of a duty that should have been fulfilled and a causal connection between the breach and the injury. Medical risk, medical error, and malpractice have different legal meanings because unavoidable risk does not automatically prove negligence. Liability becomes justified when conduct departs from professional standards, accepted procedures, adequate consent, or reasonable institutional safeguards (Arimbi, 2025).

Hospital liability also reflects the modern character of health services. Hospitals do not only provide buildings and beds. Hospitals design service systems, appoint professionals, grant clinical privileges, operate emergency units, provide medical equipment, issue protocols, maintain records, and manage risk. These functions create direct institutional duties toward patients. A hospital may be liable when harm results from unsafe staffing, weak supervision, inadequate emergency readiness, defective

equipment, poor infection control, unreliable documentation, or failure to respond to patient deterioration. Corporate legal analysis in the Indonesian health law context treats hospitals as legal entities that carry independent responsibility for negligent service governance (Wicaksono, 2025).

Vicarious liability is significant because patients usually experience hospital services as a unified process. A patient may not know whether a physician is an employee, a contractor, a resident, an attending specialist, or an independent practitioner with clinical privileges. Internal legal arrangements should not automatically defeat patient protection when the hospital presents the service as its own and benefits from the treatment relationship. Vicarious liability assigns responsibility to the institution when health workers act under hospital authority or within hospital service activities. Recent Indonesian scholarship connects this doctrine with Article 1367 of the Civil Code and statutory hospital responsibility for worker negligence (Nobel et al., 2025).

Direct hospital negligence differs from vicarious liability because it focuses on the hospital's own conduct. The hospital may be responsible even when the immediate negligent professional is difficult to identify. Direct negligence may appear in negligent credentialing, inadequate staffing, poor clinical pathways, failure to maintain equipment, failure to supervise trainees, failure to ensure medication safety, or failure to maintain accurate patient records. Patient safety research shows that adverse hospital events are costly, harmful, and often avoidable, which supports legal attention to institutional systems rather than isolated professional fault (Pina-Sánchez & Gosling, 2020). Hospital liability therefore includes governance failure that creates foreseeable patient harm.

The development of digital health adds another layer to hospital responsibility. Electronic health records, clinical decision support systems, telemedicine platforms, artificial intelligence tools, and automated alerts can improve care, but they may also create new malpractice risks. Hospitals that adopt digital systems control procurement, configuration, training, access rights, audit logs, workflow integration, and response to system failures. Liability may arise when digital tools generate unsafe recommendations, obscure information, cause alert fatigue, or delay referral. The malpractice risk is not limited to the clinician who uses the tool because institutional choices determine how the technology enters patient care (Rowland et al., 2022).

Patient communication is closely connected to hospital liability. Medical records, informed consent, handoff communication, discharge instructions, test result reporting, and adverse event disclosure all shape patient safety and legal proof. Communication failures in malpractice claims show that harm can occur when information is incomplete, inaccurate, absent, delayed, or not directed to the right person (Humphrey et al., 2022). Hospitals therefore need standardized communication systems because patient care involves many professionals and units. Liability becomes stronger when a hospital lacks reliable handoff procedures, does not ensure informed consent, delays critical result notification, or fails to document important clinical decisions.

Disclosure after adverse events is part of institutional responsibility. Patients and families need factual information about unexpected harm, further treatment, investigation steps, and corrective action. Concealment increases mistrust and may worsen legal conflict. Communication and resolution programs show that transparent handling of adverse outcomes can be associated with improved liability outcomes when supported by structured investigation and fair response (LeCraw et al., 2025). Apology laws also show that disclosure, regret, and liability are connected in malpractice systems, although legal effects depend on jurisdiction and context (Ross & Newman, 2021). Hospitals should treat disclosure as an organized duty rather than an informal personal reaction.

RESEARCH METHODS

Normative juridical research is applied to examine hospital liability in medical malpractice through legal doctrine, statutory principles, civil responsibility, administrative supervision, criminal responsibility, patient rights, and institutional governance. The research uses a descriptive formal approach because the main issue concerns how hospitals are legally responsible when negligent health services cause patient injury. The analysis includes vicarious liability, direct institutional negligence, informed consent, documentation, supervision, patient safety, incident reporting, disclosure, digital health, and compensation. The legal materials consist of recent journal sources on Indonesian health law and international patient safety literature that address malpractice claims, institutional responsibility, and preventable adverse events.

Qualitative analysis is used to connect legal doctrine with health service practice. The discussion interprets hospital liability through the elements of duty, breach, causation, and damage, then relates those elements to institutional duties such as credentialing, staffing, supervision, record management, emergency readiness, and risk control. The approach does not calculate claim frequency as a statistical study. Empirical findings from patient safety and malpractice claim literature are used to describe how institutional systems influence legal responsibility. The method is suitable because malpractice liability depends on the relationship between legal norms, professional standards, hospital governance, evidence, patient harm, and remedial mechanisms.

RESULTS AND DISCUSSION

1. Institutional Duties and Bases of Liability

Hospital responsibility begins when the institution accepts a patient for examination, treatment, emergency care, surgery, hospitalization, or other health service. Acceptance creates duties to provide reasonable care through competent personnel, safe facilities, lawful procedures, and adequate supervision. The duty does not require guaranteed recovery, but it requires organized services that meet professional and regulatory standards. Liability may arise when those standards are breached and the breach causes damage. Civil liability is particularly relevant because patients usually seek compensation for physical injury, additional medical costs, disability, lost income, psychological harm, or death. Indonesian legal analysis after Law Number 17 of 2023 connects hospital negligence with civil accountability (Haryono et al., 2025).

Vicarious liability provides a practical basis for hospital accountability because health services are delivered by personnel acting within institutional structures. Doctors, nurses, pharmacists, and technicians may directly commit the negligent act, but the hospital may remain responsible when those persons act under hospital control, use hospital facilities, and provide services to hospital patients. The doctrine protects patients from the difficulty of proving internal employment status or hidden contractual arrangements. It also encourages hospitals to supervise personnel and enforce standards. Indonesian malpractice scholarship identifies vicarious liability as a legal mechanism for institutional responsibility when health workers cause patient loss during hospital services (Kadir, 2026b).

Direct institutional liability applies when the hospital itself breaches an organizational duty. Negligent credentialing, inadequate staffing, weak infection control, unavailable emergency equipment, defective medical devices, incomplete records, and unsafe clinical pathways can create direct responsibility. The hospital's liability is not dependent only on proving one negligent doctor. It may arise from management failure that makes patient injury foreseeable. A hospital that ignores repeated complaints, incident reports, audit findings, or known resource shortages may be treated as institutionally negligent. Patient safety literature supports this view because preventable adverse outcomes often arise from system weakness, limited infrastructure, and inconsistent implementation of standards (Padula & Pronovost, 2022).

Civil responsibility may be based on unlawful act, breach of obligation, or violation of patient rights. Patients enter hospitals with a legitimate expectation that services will be provided according to medical standards, professional ethics, and legal regulations. When negligence causes harm, compensation becomes a legal consequence. The hospital may be liable for losses caused by personnel or by institutional failures. Civil liability also performs a corrective function because compensation acknowledges the patient's injury and encourages the hospital to revise unsafe practices. Recent Indonesian studies describe hospital civil responsibility as connected to negligence by medical personnel, health law obligations, and the institution's role as health service provider (Permatasari & Musyafah, 2024).

Administrative liability concerns compliance with licensing, accreditation, service standards, patient safety duties, record keeping, reporting, and regulatory supervision. Administrative sanctions can require corrective action even when civil litigation has not been completed. Warnings, restrictions, supervision orders, and license related consequences may be imposed when hospitals fail to comply with mandatory standards. Administrative responsibility is preventive because it addresses unsafe conditions before additional injury occurs. Indonesian health law scholarship after the 2023 Health Law emphasizes that hospitals carry legal responsibility for malpractice through statutory duties and regulatory obligations, especially when institutional systems fail to protect patients during care (Vitrianingsih et al., 2025).

Criminal responsibility is narrower because criminal liability requires a higher level of fault and stricter proof. Ordinary medical error should not automatically become a criminal case because medicine involves uncertainty and unavoidable risk. Criminal responsibility may become relevant when gross negligence, intentional misconduct, abandonment, falsification, or reckless institutional conduct causes serious injury or death. Criminal qualification must still respect the difference between accepted medical risk and negligent malpractice. Legal scholarship on medical risk and negligence emphasizes that punishment must be based on clear proof of fault, especially when criminal sanctions are connected to serious injury or death in health services.

Hospital responsibility is shaped by the legal relationship between medical personnel and the institution. Employment, appointment, credentialing, clinical privilege, service contract, and supervision arrangements can influence liability. Formal labels do not always determine legal responsibility because courts and regulators may examine actual control, patient reliance, hospital representation, and integration of services. A hospital that advertises a specialist service, collects payment, provides equipment, schedules treatment, and manages patient records may be closely connected to the acts of the personnel who provide that service. Civil law analysis in Indonesia states that hospital liability depends strongly on the pattern of legal relations with medical personnel.

Proof remains essential in malpractice disputes. A patient must generally establish the existence of duty, breach of duty, causation, and damage. Expert opinion is often required because courts need to determine whether treatment departed from accepted medical standards. Hospital records, consent forms, nursing notes, medication charts, device logs, laboratory results, imaging reports, incident reports, and witness statements become important evidence. Incomplete documentation can weaken the hospital's defense and may support allegations of poor care. Legal certainty in malpractice resolution depends on clear procedures, evidentiary standards, and institutional accountability under the health law framework (Purwanto et al., 2025).

Causation is difficult when the patient already has severe illness, multiple professionals are involved, or the injury may arise from disease progression. Liability should not be imposed merely because treatment failed. The negligent act or institutional failure must materially contribute to the harm. The distinction between medical risk, medical error, and malpractice is therefore necessary. Medical risk may be unavoidable, medical error may occur without legal negligence, and malpractice involves a breach of professional or institutional standards. Clear classification prevents unfair criminalization of medical personnel while preserving the patient's right to compensation when preventable negligence causes injury.

2. Patient Safety, Professional Standards, and Evidence

Patient safety is a core basis for hospital responsibility because malpractice frequently arises from preventable adverse events. Hospitals must manage risks related to diagnosis, surgery, anesthesia, medication, infection control, emergency care, intensive care, obstetrics, discharge, and follow up. Adverse events increase morbidity, mortality, hospital costs, and legal exposure. Hospital accountability therefore requires proactive prevention rather than only defensive response after litigation. Research on adverse events describes them as expensive and avoidable hospital problems that require measurement, classification, and corrective action (Jose-Saras et al., 2022). The legal implication is that hospitals should maintain safety programs capable of identifying and reducing predictable risks.

Credentialing and privileging are preventive duties that determine which professionals may perform specific clinical activities. Hospitals must verify education, licensing, experience, competence, disciplinary history, and procedure specific authority. Liability may arise when a hospital permits an unqualified or unsafe practitioner to treat patients, ignores warning signs, or fails to review privileges after complaints. Clinical volume and claim risk research shows that practice patterns are relevant to malpractice risk management because exposure and experience affect claims analysis (Schafer et al., 2023). Hospitals should use credentialing not as an administrative formality, but as an evidence based mechanism for patient protection and legal risk reduction.

Supervision is necessary when hospitals involve residents, interns, trainees, advanced practice providers, and multidisciplinary teams. Patients may be treated by persons with different levels of competence and authority. The hospital must define which acts require direct supervision, which acts require consultation, and which conditions require immediate escalation. Malpractice claims involving

advanced practice providers show that hospitals and practices may be named in payment responsibility when team structures contribute to harm (Myers et al., 2021). Supervision failures can therefore create institutional liability. Effective governance requires written role definitions, accessible supervisors, documentation of oversight, and patient communication about provider roles.

Staffing affects the legal assessment of reasonable hospital care. Inadequate nurse coverage, excessive workload, unavailable specialists, fatigue, and lack of emergency personnel can make harm foreseeable. Even competent professionals may fail when the institutional environment prevents safe monitoring, timely medication, rapid escalation, or accurate documentation. Hospitals control staffing policy, budget allocation, scheduling, and contingency planning. Patient safety literature links adverse outcomes to institutional system failures and limited infrastructure. A hospital should not shift all blame to frontline workers when management decisions create conditions that make standard care impracticable. Staffing adequacy is therefore a legal governance issue.

Informed consent protects patient autonomy and reduces malpractice conflict. A valid consent process requires explanation of diagnosis, proposed treatment, benefits, material risks, alternatives, and consequences of refusal. A signed form is not enough when communication is incomplete or not understood. Hospitals should provide policies, translated materials, documentation standards, and professional training for high risk procedures. Communication failures in anesthesia malpractice claims show that incomplete, inaccurate, absent, or delayed information can contribute to patient injury (Douglas et al., 2021). Hospital liability may arise when consent procedures are reduced to paperwork and fail to ensure patient understanding of material treatment risks.

Medical documentation is a clinical duty and a legal safeguard. Accurate records show the patient's condition, diagnosis, treatment plan, consent, medication, monitoring, clinical changes, consultation, discharge instruction, and response to adverse events. In malpractice disputes, records establish what occurred and whether standards were met. Poor documentation can indicate weak care coordination and may make causation harder to assess. Electronic health records can support safety by capturing data, but they can also create copy errors, hidden results, and alert fatigue. Scholarship on mining electronic health records for malpractice risk management shows that digital record data can support patient safety improvement when properly used (Adler-Milstein et al., 2022).

Incident reporting connects legal accountability with organizational learning. A reporting system should capture near misses, adverse events, sentinel events, falls, medication errors, diagnostic delays, infection risks, equipment failures, and communication problems. Reports should lead to root cause analysis, corrective action, and feedback. Hospitals that collect reports but ignore repeated risks may increase their liability because they have notice of danger. Comparative research on malpractice claims and incident reporting shows that the two sources reveal different safety information and should both inform risk management (Vetrugno et al., 2022). Incident reporting therefore supports prevention, evidence preservation, and institutional correction.

Communication failures are frequent in malpractice disputes because hospital care depends on continuous information transfer. Handoffs, referrals, emergency escalation, test result communication, discharge instructions, and patient education must be reliable. Claims research found that communication and handoff failures appear in a substantial portion of medical malpractice claims, and structured tools may prevent many failures. Hospitals should implement standardized handoff protocols, closed loop communication, escalation chains, and critical result notification systems. Liability may arise when institutional communication systems are absent, unclear, or not enforced. Communication should be treated as a patient safety standard, not a personal habit.

Emergency care creates a specific liability setting because decisions must be made quickly and often with incomplete information. Hospitals must still provide reasonable triage, resuscitation, emergency equipment, specialist referral, and documentation (Kadir et al., 2026). Urgency may affect the scope of informed consent, but it does not remove the duty to act competently. Misclassification, delay, refusal of emergency treatment, lack of equipment, or premature discharge may create liability. Intensive care malpractice research also shows that complex settings involving multiple specialties require attention to procedures, risk disclosure, and accurate description of complications (Myers, 2021). Emergency and intensive care liability therefore involves clinical judgment and institutional readiness.

Diagnosis is an area where hospital responsibility is often substantial. Diagnostic safety depends on laboratory accuracy, imaging quality, specialist consultation, result tracking, medical records, and

follow up systems. A missed diagnosis may involve physician judgment, but it may also involve lost results, delayed radiology reports, unavailable tests, or poor communication between units. Hospitals should maintain systems for abnormal result alerts, critical value reporting, second review, and follow up after discharge. Artificial intelligence may assist diagnosis, but it also raises liability questions when algorithms contribute to error. Diagnostic AI scholarship places responsibility among clinicians, institutions, and developers when automated systems affect patient care (Cestonaro et al., 2023).

Medication safety requires institutional control from prescription to administration. Doctors prescribe, pharmacists review, nurses administer, and electronic systems may generate warnings. Errors can occur through wrong dose, wrong patient, wrong route, allergy oversight, duplication, interaction, look alike drug names, or poor reconciliation (Mappaselleng & Kadir, 2025). Hospitals control formularies, storage, labeling, barcode systems, pharmacy staffing, medication protocols, and high risk medication checks. Liability may arise when the medication process is unsafe or when known errors are not corrected. Patient safety studies show that preventable harm requires systematic measurement and improvement rather than reliance on individual vigilance alone.

Infection control is a direct hospital obligation because hospital acquired infection risk is created by the treatment environment. Sterilization, hand hygiene, environmental cleaning, isolation, antimicrobial stewardship, waste management, surveillance, and staff training are institutional duties. Liability may arise when infection occurs because the hospital fails to maintain accepted prevention standards. Proving causation can be complex because patients may have underlying risk factors, but hospital records, infection surveillance, sterilization logs, and audit findings can show whether prevention duties were fulfilled. Administrative responsibility may also arise when infection control failures violate regulatory or accreditation requirements. Hospital infection prevention is therefore both a clinical duty and a legal duty.

3. Compensation, Disclosure, and Preventive Governance

Compensation is the civil remedy that responds to patient loss after negligent harm. Malpractice injury may create medical expenses, rehabilitation costs, loss of income, disability, dependency, psychological suffering, and death related losses. Civil liability should provide proportionate recovery when negligence and causation are proven. Compensation also signals that patient rights have legal force and that institutional failure carries financial consequences. Indonesian civil liability research connects hospital responsibility with negligence by medical personnel and the hospital's duty to provide health services under the 2023 Health Law framework. Compensation therefore has remedial and preventive functions.

Disclosure after an adverse event should be structured, factual, and respectful. Patients need information about what happened, what immediate care is required, what review will occur, and what corrective steps will be taken. Hospitals should preserve evidence, support clinicians, involve risk management, and communicate consistently. Communication and resolution programs show that transparency after unexpected outcomes can improve liability outcomes when paired with investigation and appropriate resolution. Apology law scholarship also shows that apologies, disclosure, and evidentiary rules influence malpractice behavior. Disclosure should not be improvised during conflict because poor communication may worsen distrust and litigation (Kadir, 2026a).

Mediation and non judicial dispute resolution can reduce the burden of malpractice litigation when the facts are suitable for early settlement. Patients often seek explanation, acknowledgment, corrective action, and compensation. Hospitals often seek fair assessment, protection from unsupported claims, and preservation of professional reputation. Mediation can support both interests when supported by medical review and legal advice. Legal certainty remains essential because informal settlement should not remove patient rights or conceal systemic risk. Indonesian scholarship on malpractice resolution emphasizes the need for clearer procedures and certainty under the health law framework. Fair resolution requires transparency, evidence, and institutional follow up.

Hospital defenses remain legitimate in a balanced liability system. Hospitals may show that treatment followed professional standards, that the outcome was an unavoidable medical risk, that adequate consent was obtained, that causation was not proven, or that the injury resulted from the underlying disease. These defenses protect hospitals from liability based only on dissatisfaction or hindsight. A fair malpractice framework must avoid equating every bad outcome with negligence. Medical risk scholarship supports a careful distinction between unavoidable risk, error, and malpractice.

Patient protection and professional protection are both required because excessive blame may encourage defensive medicine and underreporting.

Digital health governance has become a necessary part of malpractice prevention. Hospitals that use electronic records, telemedicine, decision support, and artificial intelligence should define responsibility for system selection, validation, training, monitoring, and failure response. Digital health technologies create malpractice specific risks because clinicians may rely on outputs, alerts, recommendations, or incomplete information embedded in the workflow. Artificial intelligence also raises potential criminal and corporate responsibility issues when clinical decision systems contribute to serious harm. Hospitals should maintain human oversight, audit trails, algorithm performance review, data quality controls, and clear escalation procedures.

Corporate responsibility requires leadership commitment. Hospital directors and managers control budget, policy, staffing, supervision, accreditation readiness, safety audits, and patient complaint systems. Malpractice prevention cannot be delegated entirely to individual clinicians because many risks originate from institutional choices. Corporate analysis of Indonesian hospitals under the 2023 Health Law states that hospitals carry legal consequences as service providers and legal entities. Leadership should ensure that policies are not only written but implemented, monitored, and revised. A hospital may have protocols yet remain negligent when staff are not trained, resources are insufficient, or noncompliance is tolerated.

Risk management should integrate claims data, incident reports, patient complaints, mortality reviews, audit findings, and insurance feedback. Claims reveal serious disputes and compensation exposure, while incident reports reveal unsafe conditions that may not reach litigation. Electronic health records may also help identify risk patterns when data are analyzed ethically and accurately. Hospitals should classify malpractice risk by department, harm type, causation factor, preventability, cost, and recurrence. Corrective actions should be assigned to responsible units and evaluated for effectiveness. Risk management is ineffective when it produces reports without measurable change in clinical practice.

Professional standards remain the main benchmark for negligence. Courts and regulators examine whether the treatment was consistent with accepted medical knowledge, available resources, urgency, patient condition, and reasonable institutional procedures. Recent legal scholarship in medicine proposes a shift toward patient centered reasonable care rather than rigid reliance on customary practice (Aaron et al., 2025). That development is relevant because customary practice may not always represent safe or ethical care. Hospitals should therefore align clinical protocols with current evidence, patient rights, and safety goals. Liability prevention requires compliance with standards that are professionally sound and legally defensible.

Hospital accountability should include protection for health workers who report unsafe conditions. Professionals may become defendants in malpractice cases even when institutional failures contributed to the harm. Unsafe staffing, unavailable equipment, unclear protocols, and excessive workloads can expose clinicians to liability created by management decisions. A just accountability system distinguishes human error, risky behavior, reckless conduct, and institutional failure. Hospitals should encourage reporting without retaliation while maintaining discipline for serious misconduct. Claims involving advanced practice providers and intensive care settings show that team based care creates shared responsibility that requires clear oversight and institutional learning.

Patient rights provide the normative basis for hospital liability. Patients have rights to safe care, information, consent, confidentiality, complaint submission, and access to records according to applicable law. Hospital responsibility strengthens these rights by creating consequences when rights are violated and injury follows. Legal protection for patients must operate through civil remedies, administrative supervision, internal complaints, professional discipline, and judicial review. Indonesian scholarship on hospital responsibility under Law Number 17 of 2023 supports institutional accountability for malpractice committed by health workers during hospital services (Hidayat & Asyhadie, 2024). Patient rights become effective only when enforcement mechanisms are accessible and reliable.

The most effective hospital liability model combines prevention, proof, compensation, and correction. Prevention requires staffing, supervision, credentialing, protocols, communication systems, infection control, medication safety, and technology governance. Proof requires complete records, preserved evidence, expert review, and transparent investigation. Compensation requires fair civil remedies when negligence causes damage. Correction requires incident analysis, policy revision,

training, monitoring, and administrative compliance. This model recognizes that malpractice is not only an individual professional issue. It is also an institutional governance issue. Hospital responsibility is therefore justified when the hospital controls the conditions of care and those conditions contribute to preventable patient harm.

CONCLUSION

Hospital liability in medical malpractice includes vicarious responsibility for negligent health workers, direct institutional negligence, civil compensation, administrative sanctions, and limited criminal responsibility in serious cases. Hospitals are responsible because they control the organization of care through credentialing, staffing, supervision, facilities, records, policies, digital systems, and patient communication. Liability should be imposed when there is a duty, a breach of professional or institutional standard, a causal link, and legally recognized damage. Unavoidable medical risk must remain distinct from negligent malpractice so that accountability protects patients without unfairly punishing proper medical care. A balanced framework gives legal protection to patients and reasonable certainty to health providers.

Hospital responsibility should develop toward preventive governance. Effective accountability requires meaningful informed consent, accurate documentation, reliable handoff communication, incident reporting, disclosure after adverse events, mediation, clinical audit, and digital health oversight. Patient safety literature shows that many harmful events are connected to system weakness, and legal doctrine should therefore examine institutional control as well as individual conduct. Hospitals that respond transparently, compensate fairly, and correct unsafe systems can reduce future malpractice exposure and improve public trust. Legal responsibility functions best when it provides remedies for injured patients while requiring hospitals to improve service quality, patient safety, and professional supervision.

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