Research Horizon

ISSN: 2808-0696 (p), 2807-9531 (e)

Legal and Humanistic Approaches to Medical Procedure Refusal

Research Horizon
Volume: 05
Issue: 06
Year: 2025
Page: 2889-2898

Citation:
Susilo, D. H., & Jamaludin, A. (2025). Legal and humanistic approaches to medical procedure refusal. *Research Horizon*, *5*(6), 2889-2898.

Article History:
Received: October 3, 2025
Revised: November 7, 2025
Accepted: December 5, 2025
Online since: December 31, 2025

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Abstract

The refusal of medical treatment by patients, grounded in deeply held personal or religious beliefs, presents a profound legal and ethical dilemma, colliding with the healthcare professional's fundamental duty to preserve life. This study analyzes this dilemma from both normative and humanistic perspectives. This study employs a qualitative, doctrinal methodology, synthesizing a literature review of national and international legal regulations, bioethics, health law, and academic sources published between 2013 and 2024. The analysis reveals three core findings: Patients possess a robust, legally protected right to autonomy and religious freedom; Healthcare professionals are bound by an equally compelling legal and professional obligation to provide care, particularly in emergencies; and a significant tension exists where rigid legal-formalistic solutions (normative) fail to address the underlying humanistic considerations of patient dignity. The study argues for an integrative normative-humanistic framework. This model reconciles the conflict by moving beyond legal formalism to emphasize therapeutic communication and participatory-dialogic solutions. This integration minimizes disputes by ensuring legal certainty for physicians while respecting patient dignity. This research concludes that this integrated approach is essential for providing just, ethical, and humane resolutions in multicultural societies.

Keywords

Bioethics, Humanistic-Normative Approach, Medical Refusal, Patient Rights, Physician Obligations.

1. Introduction

The modern medical environment is a theater of profound ethical and legal complexity. At the heart of its most intractable dilemmas lies a foundational conflict, the collision between the patient's right to self-determination and the physician's duty to preserve life. This tension is never more acute than in the case of a patient's refusal of a life-sustaining medical procedure based on deeply held religious or personal beliefs (Bachri & Nurnaeni, 2022). This scenario creates an immediate and profound "academic anxiety" for legal scholars, ethicists, and medical practitioners alike, as it forces a direct confrontation between two cornerstone values of a liberal society, the sanctity of individual autonomy and the state's interest in protecting the lives of its citizens.

This dilemma manifests in critical, time-sensitive clinical situations. A patient adhering to a specific faith may refuse a life-saving blood transfusion, citing religious doctrine (Nurjanah et al., 2024; Prajany et al., 2025). A parent may refuse a standard vaccination for their child, grounding their objection in a complex matrix of spiritual and personal convictions (Enyinnaya et al., 2024). In other instances, a patient may reject a necessary surgical intervention or the use of specific pharmaceuticals, viewing them as a violation of their body's integrity or a contravention of divine will (Firmansyah & Wijaya, 2024). These are not acts of irrationality but are, from the patient's perspective, expressions of fundamental identity and conscience.

This expression of belief immediately runs parallel to the physician's *raison d'être*. The medical profession is anchored in the Hippocratic oath and the ethical principles of beneficence (to do good) and non-maleficence (to do no harm) (Ginghină, 2023). Legally, this ethical duty is codified into a professional standard of care, compelling a physician to take all necessary actions to save a life or prevent grievous bodily harm (Syarief, 2023). This obligation is particularly pronounced in emergency situations, where the law often presumes consent to act in the patient's best interest (Al-Shatnawi et al., 2021). The result is a legal paradox is the physician is legally obligated to act, while the patient is legally empowered to refuse.

This conflict raises a foundational question of jurisprudence: to what extent can and should the state, acting through its medical professionals, intervene and override a patient's autonomous decision in the name of life preservation? This is where the core problem of this research lies, a problem of both law and humanity (Jauhani et al., 2022). The "problem" is not simply that the conflict exists, but how it is resolved. A resolution that relies purely on a rigid, legal-formalistic (normative) approach for example, a court order compelling treatment may secure a legal "victory" for the physician but result in a profound humanistic "failure." Such an approach can be perceived as an act of violence by the state, irrevocably shattering the sacred trust that forms the bedrock of the physician-patient relationship (Herlina et al., 2020). It ignores the patient's dignity, reducing a human being with deep convictions to a mere object of medical intervention (Mustika & Soemantri, 2020).

Conversely, a purely humanistic approach that defaults to the patient's refusal in all circumstances, while respecting autonomy, may ignore the state's legitimate *parens patriae* interest in protecting vulnerable individuals from irreversible harm (Dwyer, 2025). It may also fail to provide the necessary legal certainty for physicians, leaving them exposed to potential litigation from family members who believe a life-saving action was wrongfully withheld. The law must provide a shield for the physician who, in good faith, honors a patient's informed refusal.

Previous scholarship has extensively navigated this difficult terrain. Studies in bioethics and health law have clearly delineated the legal boundaries of informed consent and its corollary, informed refusal (Umam, 2022). Research has highlighted the ethical conflicts in specific cases like transfusions and end-of-life care (Herlina et al., 2020; Nurjanah et al., 2024). In other jurisdictions, scholars have analyzed the efficacy of mediation and alternative dispute resolution mechanisms in mitigating these conflicts, demonstrating that dialogic approaches can often de-escalate legal conflict (Lee et al., 2020).

However, a significant research gap persists. There is a scarcity of scholarship that attempts to integrate the normative and humanistic approaches into a single, cohesive analytical framework. Much of the literature presents these two as opposing forces: "the law" versus "the patient's belief." This paper rejects that binary. The novelty of this research lies in its specific conceptual combination. It posits that the humanistic approach defined by therapeutic communication, respect for dignity, and shared decision-making is not an alternative to the normative legal framework, but rather the essential method by which the normative framework should be executed. The "humanistic" element is the process that gives true meaning and legitimacy to the "normative" outcome.

This study argues that the complex dilemmas arising from belief-based medical refusal cannot be adequately resolved by rigid legal statutes alone. Such dilemmas demand a dialogic process that respects the patient's dignity while simultaneously fulfilling the physician's legal and ethical duties. The thesis of this article is that an effective and just resolution is found only at the intersection of these two paradigms. Therefore, this study has three primary objectives. First, this paper will analyze the legal dilemma of medical refusal by deconstructing its distinct normative (legal rules) and humanistic (patient values) components. Second, it will identify the point of convergence where the patient's right to autonomy and the physician's duty of care can be reconciled within a single, coherent framework. Third, it will provide a substantive conceptual contribution that can inform hospital policy and ethical medical practice, offering a model for resolving these disputes in a manner that is legally sound, ethically robust, and profoundly human. This integrative approach is not only academically novel but practically essential for navigating the complex realities of healthcare in a pluralistic and multicultural society like Indonesia.

2. Methods

This study employs a qualitative, doctrinal research methodology. This approach is primarily normative-juridical, focusing on the analysis of legal norms, principles, and regulations (*das sollen*, or the law as it is written) (Creswell & Creswell, 2018). It is supplemented by a conceptual and philosophical approach to synthesize these legal norms with the principles of bioethics and humanistic philosophy. The research design is a systematic literature review (Booth et al., 2016). This method was chosen because the research question is conceptual and theoretical, aiming to synthesize existing legal and ethical frameworks rather than collect new empirical data. The objective is to build a new conceptual model from the existing body of high-quality academic and legal literature.

Data collection involved a systematic search of legal and academic databases, including Google Scholar, Scopus, DOAJ, and national legal repositories (e.g., Legal Documentation and Information Network). The search was limited to literature published in Indonesian and English between 2013 and 2024 to ensure contemporary relevance. Search keywords included: "medical refusal" (*penolakan tindakan medis*), "patient rights" (*hak pasien*), "bioethics" (*bioetika*), "religious beliefs" (*keyakinan agama*), "physician's duty" (*kewajiban dokter*), "informed refusal," and "health law" (*hukum kesehatan*). Only peer-reviewed articles, official legal documents, and scholarly monographs directly related to patient autonomy, bioethics, and medical refusal were included. Publications not addressing these topics or lacking academic rigor were excluded.

Data sources were categorized into primary and secondary legal material. Primary legal materials is the 1945 Constitution of the Republic of Indonesia (UUD 1945), Law Number 17 of 2023 concerning Health, and relevant international human rights treaties. Secondary legal materials include peer-reviewed academic journals, legal textbooks, and scholarly monographs on health law, bioethics, and human rights, while tertiary legal materials consist of legal dictionaries and encyclopedias used to ensure terminological precision. Legal norms and principles were first codified, followed by thematic coding of ethical and humanistic concepts. These were then integrated through iterative comparison to construct the final normative-humanistic framework.

Data analysis was conducted using a qualitative content analysis with a thematic synthesis approach. This involved a multi-stage process that began with codifying all legal norms and principles related to patient autonomy, religious freedom, and the physician's duty of care, followed by identifying and clustering key concepts from the bioethics and humanistic literature, such as therapeutic communication, shared decision-making, and patient dignity and concluding with the synthesis of these legal and humanistic themes to construct the integrative normative-humanistic framework that forms the core argument of this paper.

3. Results and Discussion

3.1. The Normative Fortress: Patient Autonomy and Religious Freedom

The doctrine of patient autonomy forms the primary legal pillar of this study. Rooted in the liberal tradition, autonomy is the principle that individuals have the right to self-determination, including the right to make decisions about their own bodies, free from coercion (Umam, 2022). In bioethics, this is arguably the preeminent principle, articulated by scholars like Beauchamp and Childress (2019) as one of the four foundational tenets of medical ethics. Legally, this principle is operationalized through the doctrine of informed consent (Arellano et al., 2023). This doctrine posits that medical treatment without the patient's consent constitutes battery (a civil and criminal violation). Logically and legally, the right to consent necessarily implies the right to refuse. This right of refusal stands even when the refusal seems, from a medical perspective, to be irrational or detrimental to the patient's health. The law protects the right to decide, not the rightness of the decision.

The first and most formidable pillar in this legal dilemma is the patient's right to self-determination. This is not a "soft" or "aspirational" concept; it is a robust, legally enforceable right, a normative fortress built upon constitutional and international law. The Indonesian legal framework firmly establishes this right. The *fons et origo* is the 1945 Constitution (UUD 1945). Article 28E(1) guarantees every person the freedom of religion and worship, and Article 28E 2) guarantees the right to "be free from... discriminatory treatment." Article 28G (1) protects the right to "personal self, dignity, and conscience." This constitutional protection is echoed in international law, which Indonesia has ratified. The Universal Declaration of Human Rights (UDHR) and the International Covenant on Civil and Political Rights (ICCPR) both enshrine freedom of thought, conscience, and religion as fundamental and, in the case of the ICCPR, non-derogable rights. The refusal of a medical treatment because it violates a core religious tenet is thus not merely a medical choice; it is an act of religious expression protected by the highest laws (Vieytez, 2024).

This general right is given specific force in healthcare law. The new Law Number 17 of 2023 concerning Health explicitly codifies the patient's right to "accept or refuse a part or all of medical assistance to be received" after receiving comprehensive information. This establishes the legal doctrine of informed refusal as the necessary corollary to informed consent (Umam, 2022). The law does not grant physicians the authority to treat; it grants patients the right to authorize treatment. Without that authorization, a physician who performs a procedure, even one that is life-saving, commits a battery. The patient is the sovereign of their own body.

The legal implications of this are profound. It means that the patient's belief system, however "medically irrational" it may appear to the physician, is legally protected. The law does not empower the physician or the state to judge the validity of a patient's belief; it only empowers them to verify its sincerity and the patient's capacity to make the decision. When a competent adult patient refuses a blood transfusion, they are operating squarely within their constitutional rights. A legal-formalistic approach that seeks to override this right faces an incredibly high legal and constitutional barrier. The normative framework, therefore, begins with a strong presumption in favor of patient autonomy. Any intervention that contravenes this right is, *prima facie*, unlawful.

3.2. Point of Convergence Between Patient Autonomy and Physician Duty

Juxtaposed against this is the doctrine of medical beneficence, which encompasses the physician's non-negotiable duty to act in the patient's best interest (Ginghină, 2023). This principle is paired with non-maleficence (do no harm). When a patient refuses life-saving treatment, the physician is trapped on honoring the refusal (autonomy) could be seen as violating beneficence (failing to act) and non-maleficence (allowing harm to occur). This duty is not merely ethical; it is a legally enforceable standard of care (Sakinatunnisa & Alawiya, 2025). This doctrine is further reinforced by the state's interest as *parens patriae* (parent of the nation), which grants it a limited power to intervene to protect those who cannot protect themselves, such as minors or in specific public health crises (Dwyer, 2025). The core legal dilemma, therefore, is a direct conflict between two competing legal rights and duties.

Juxtaposed against the patient's right to refuse is the physician's powerful, countervailing duty to act. This duty is not merely a professional aspiration; it is a legal imperative backed by the state, creating the central normative conflict of this study. The physician's duty is codified in multiple legal instruments. Law Number 17 of 2023 mandates that all healthcare personnel must provide "safe, high-quality, and humane health services" and are obligated to "provide health services according to their professional standards and code of ethics." This code of ethics, including the physician's path, centers on the preservation of life. The principle of beneficence the duty to act for the patient's good- is the core of this legal mandate (Ginghină, 2023; Gutimigo et al., 2025).

The law anticipates conflicts with autonomy and provides a specific, narrow exception: the emergency doctrine. Under Law of Health, in a medical emergency where a patient is unconscious and has no guardian, a physician is legally empowered (and obligated) to take immediate medical action to save the patient's life or prevent severe disability. This is a form of legally implied consent (*zaakwaarneming*), where the law presumes a reasonable person would consent to being saved. This principle is internationally recognized, forming a crucial exception to standard informed consent protocols (Al-Shatnawi et al., 2021).

This is where the legal dilemma crystallizes. The emergency exception is clear when the patient is incapacitated (e.g., unconscious). But what happens when the patient is capacitated (conscious and lucid) and actively refuses the emergency treatment? The physician is now trapped in a "catch-22." If the physician honors the refusal and the patient dies, the physician could face a malpractice lawsuit from grieving family members, who will argue that the physician "did nothing" and failed their duty of care (Jauhani et al., 2022). If the physician ignores the refusal and forces the treatment, they have committed battery and violated the patient's constitutional rights, exposing themselves to a different lawsuit.

Herlina et al. (2020) identifie this situation as a fundamental "tension. The legal framework, as currently constructed, imposes two mutually exclusive normative demands. A strictly formalistic reading offers no resolution; it merely exposes the contradiction. Such ambiguity generates significant psychological and legal pressure on physicians, who are forced to make urgent decisions under impossible conditions. The analysis therefore shows that the normative structure alone cannot resolve the dilemma. The normative framework can articulate the conflict, but it cannot provide a pathway out of it.

This analysis shows that the point of convergence between patient autonomy and the physician's duty of care cannot be located within the normative framework alone, because the law simultaneously imposes two conflicting mandates: the obligation to respect a competent patient's refusal as a matter of constitutional and statutory right and the imperative to preserve life as embedded in professional ethics and health legislation (Umam, 2022; Ginghină, 2023; Vieytez, 2024; Gutimigo et al., 2025). This tension, widely noted in the literature, demonstrates that legal norms can describe the conflict but cannot resolve it (Herlina et al., 2020). The genuine convergence point emerges only when the physician's duty to provide comprehensive, comprehensible, and ethically grounded information has been fulfilled, thereby enabling the patient to make a fully capacitated and value-consistent decision. At this threshold, the physician has discharged their normative obligations, and the patient's autonomy remains intact, creating a shared space where both parties align toward an ethically and clinically defensible course of action. This juncture, supported by transparent communication and mutual understanding constitutes the true intersection of autonomy and duty, forming the foundation upon which the integrative, humanistic resolution developed in the next section can operate.

3.3. The Integrative Solution: Reconciling Law and Humanity

This conflict, this paper argues, cannot be resolved by law alone. This introduces the third field: humanistic medicine. This approach is a response to the perceived "dehumanization" of modern, technology-driven healthcare (Doukas et al., 2013). It recenters the patient as a whole person, not just a biological entity, emphasizing that effective care requires understanding the patient's values, beliefs, and lived experience (Mustika & Soemantri, 2020). Its primary methods are therapeutic communication and Shared Decision-Making (SDM) (Bodegård et al., 2021; Mersha et al., 2023). Within this framework, a "dilemma" like a treatment refusal is not a legal battle to be won, but a communicational gap to be bridged. This literature suggests that when patients feel heard and their values are respected, conflicts are often resolved without resorting to legal coercion (Zhang et al., 2021). This study will synthesize these three fields, arguing that the humanistic approach is the process needed to successfully navigate the normative conflict between autonomy and beneficence.

The failure of a purely normative solution forces us to seek a resolution elsewhere. This study finds that the resolution is not a new law, but a new process. The "common ground" is an integrative framework where the humanistic process becomes the method for fulfilling the normative requirements. The literature review found that the primary driver of legal conflict in medical refusal cases is not the belief itself, but a breakdown in communication and trust (Herlina et al., 2020; Cantú-Quintanilla et al., 2024). Patients who feel disrespected, unheard, or "processed" by a cold, formalistic system are more likely to entrench themselves in opposition. Conversely, humanistic approaches are shown to de-escalate conflict and lead to collaborative solutions (Lee et al., 2020). This finding is the key. The humanistic model is the bridge across the normative divide.

An integrative normative-humanistic framework this paper proposes a framework built on three pillars, which moves the dilemma away from a "courtroom battle" and into a "counseling process." Once the patient has been adequately informed, the physician's normative duty to disclose material information is fulfilled, and the clinical interaction must shift from authority to partnership. At this stage, the physician engages in SDM, which, as Bodegård et al. (2021) emphasize, requires an active effort to understand the values underlying the patient's refusal. This involves listening for the fears, beliefs, and spiritual priorities that shape the patient's position (Vincensi, 2019). Through this dialogic process, common ground often emerges for example, when a patient who refuses a blood transfusion is willing to consider blood-conservation strategies or alternative pharmaceutical options (Shahar, 2021). This humanistic commitment to "hearing the patient" does not deviate from professional standards. It represents the highest expression of patient-centered clinical care (Mustika & Soemantri, 2020).

Yet resolving high-stakes refusals cannot rest on the physician alone. Such cases require an institutional mechanism capable of supporting both ethical deliberation and legal accountability. This study's primary policy recommendation is therefore the activation of a structured institutional response whenever a clinician encounters a critical refusal. Following a dialogic-participatory model (Bombard et al., 2011). The hospital should urgently convene a "dilemma team" composed of the patient and their family, the primary physician, a hospital ethicist or ethics committee representative, a social worker or psychologist, and a spiritual counselor aligned with the patient's faith tradition. Bringing these voices together ensures that the final course of action is not only clinically and legally sound but also aligned with the patient's values, thereby grounding the resolution in both normative and humanistic integrity.

This team's goal is not to "convince" the patient but to ensure a truly informed and compassionate decision is made. If, after this robust, documented, and good-faith process, the capacitated adult patient still refuses, the institutional decision must be to honor the refusal. This is where the framework provides the crucial legal certainty (*kepastian hukum*) for the physician (Syarief, 2023). By having followed this documented, multi-disciplinary, humanistic process, the physician and the hospital are shielded from liability. The physician and the hospital have not "done nothing", they have actively engaged in a complex ethical and legal process. The physician and the hospital have fulfilled their duty of care by providing all information and options, and they have fulfilled their duty to respect autonomy by honoring the patient's final, informed, and capacitated decision (Habibi et al., 2025). The legal documentation of this process becomes the physician's legal shield.

This integrative model shifts the entire paradigm. It moves the conflict from "law vs. belief" to "collaboration and respect." It reframes the physician's duty from "saving a life at all costs" to "caring for the patient as a whole person, within the bounds of the law." It ensures the patient's dignity is the central focus while simultaneously providing the clear, defensible legal process that the normative framework demands (Zhang et al., 2021).

4. Conclusion

The refusal of medical treatment on the grounds of patient belief encapsulates one of the most profound dilemmas in modern health law. It creates a direct collision between two fundamental legal and ethical principles are the patient's right to autonomy and the physician's duty of beneficence. This research concludes that a purely normative, legal-formalistic approach is insufficient to resolve this dilemma. Such an approach either results in the coercive violation of patient dignity or traps the physician in a state of legal uncertainty, exposed to liability for either acting or failing to act.

This study posits that the only tenable solution is an integrative normative-humanistic framework. This model does not abandon the law, it fulfills it through a more compassionate and robust process. The model re-conceptualizes "informed consent" as a continuous, empathetic dialogue rather than a single event. By institutionalizing this humanistic process, through therapeutic communication, shared decision-making, and participatory-dialogic mechanisms like ethics committees, a point of convergence is found. This framework provides legal certainty for physicians, not by empowering them to override the patient, but by creating a legally defensible process for respecting the patient's informed and capacitated refusal. Moreover, this framework can inform hospital policy, professional guidelines, and legal standards, offering practical guidance for healthcare practitioners navigating belief-based treatment refusals. This integrated approach is essential for achieving resolutions that are not only legal, but also just, ethical, and profoundly humane.

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Acknowledgment
We gratefully acknowledge the contributions of individuals who supported the completion of this article.

Funding Information
This research did not receive any funding.

Conflict of Interest Statement
The authors declare that there is no conflict of interest.

Ethical Approval and Originality Statement
Ethical approval was obtained for this study. The manuscript represents original work and has not been previously published, nor is it under consideration by another journal.

Data Disclosure Statement
The data that support the findings of this study are available from the corresponding author upon reasonable request.