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Institutionalizing Internal Mediation: Strengthening the Medical Committee in Indonesian Hospitals

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Abstract

Medical disputes in hospitals are frequently resolved through external channels, such as litigation or third-party mediation, imposing substantial burdens related to cost, time, and reputational risk on healthcare professionals and institutions. This study examines the critical urgency of strengthening the medical committee's role as an internal mediator in resolving such disputes, utilizing a juridical-normative approach and extensive literature analysis. The study emphasizes the medical committee's strategic position, which possesses technical clinical competence, professional ethical insight, and internal legitimacy necessary to mediate conflicts objectively, fairly, and transparently. Findings suggest that a stronger mediative role for the medical committee inversely correlates with the potential for disputes to escalate into litigation, thereby reducing administrative burdens and risks. Strengthening this function offers significant benefits, including risk mitigation, enhanced patient trust, reinforced ethical culture, accelerated restorative resolution, and a foundation for developing robust internal hospital regulations. The study recommends mandatory capacity building in mediation, communication, and health law for committee members, coupled with systematic monitoring mechanisms. This research expands the discourse on the committee's mediative function practically, it offers an effective internal dispute resolution model for Indonesian hospitals.

Keywords: Health Law, Internal Mediator, Medical Committee, Medical Dispute, Restorative Justice.

1. Introduction

Medical disputes represent a critical and growing challenge within the architecture of modern healthcare services, particularly in hospital settings. The confluence of rising patient awareness regarding their fundamental rights, the rapid evolution of complex legal regulations governing healthcare, and the inherent intricacies of medical practice creates an increasingly fertile ground for conflict between medical professionals and patients (Putra et al., 2024). Historically, the dominant mechanisms for resolving these conflicts in Indonesia have been directed towards external routes, primarily through formal litigation in courts or external third-party mediation (Irfan & Hidayat, 2018; Nasution et al., 2022). While these external pathways offer formal mechanisms for legal recourse and the enforcement of patient and professional rights, their practical application is fraught with significant drawbacks that undermine the therapeutic relationship and strain institutional resources.

Litigation, often deemed the *ultimum remedium* or last resort, typically imposes severe burdens that extend far beyond the legal outcome. It is notoriously protracted, often consuming months or even years, delaying resolution and prolonging psychological distress for all involved parties (Wang et al., 2020). The associated financial costs, covering legal fees, administrative charges, and potential compensation, are substantial. Crucially, litigation inherently adopts an adversarial framework, positioning the physician and the patient as defensive opponents, which fundamentally destroys the trust and communication essential for effective healthcare delivery and the continuity of care (Zaluchu & Syaharudin, 2022). This outcome runs counter to the objectives of a patient-centred healthcare system and erodes public confidence in hospital integrity.

The imperative, therefore, lies in urgently seeking Alternative Dispute Resolution (ADR) mechanisms that are more efficient, equitable, and restorative, with the capacity to preserve the delicate professional relationship between provider and recipient (Fadillah & Putri, 2021). The academic anxiety arising from the shortcomings of external resolution fuels the demand for reinforcing internal mediation efforts within the hospital environment, specifically through the optimization of the Medical Committee's role (Ummah et al., 2019). The establishment of the Medical Committee, defined by Indonesian law, is primarily centered on clinical governance, professional quality control, and the enforcement of medical discipline. However, this study posits that its internal legitimacy and deep understanding of both clinical standards and professional ethics grant it a unique and strategic advantage over external bodies (Widjaja, 2020).

The committee's intrinsic ability to assess the dispute's substance with technical accuracy, contextual understanding, and ethical impartiality makes it an ideal candidate for internal mediation. Such a mechanism promises quicker, cheaper, and more morally legitimate conflict resolution, as it is conducted by peers who are custodians of professional standards. Strengthening the medical committee's mediative role is not merely a technical adjustment; it represents a fundamental strategic shift towards building a medical dispute resolution system oriented around restorative justice and the repair of relationships (Baihaky & Isnawati, 2024).

Indarwati et al. (2018), Anailyka et al. (2025), and Lakoro et al. (2025) show that previous studies have focused primarily on formal legal channels, the involvement of external mediation agencies, and regulatory aspects of health law when discussing the need for ADR in medical settings. Critically, there remains a discernible gap analysis in the academic literature concerning how the internal structures of a hospital, particularly the medical committee, can proactively and effectively execute a formal mediation function to prevent the escalation of disputes into the legal sphere (Firdaus et al., 2024). External mediators, while impartial, lack the technical clinical

expertise and structural proximity necessary to understand the minute details of the medical practice leading to the conflict.

The novelty of this study lies in its emphasis on the transformation of the medical committee from a reactive professional disciplinary body into a proactive, strategic internal mediator. This dual function, preserving professional quality while facilitating dispute resolution, leverages the committee's existing authority to foster a constructive dialogue between disputing parties. This perspective offers a new paradigm for conflict management, positioning the hospital as an active, self-regulating entity responsible for conflict resolution, thereby reinforcing the principle of restorative justice which prioritizes relationship recovery over punitive measures. The central proposition driving this research is that the stronger the medical committee's role as an internal mediator, the lower the escalation of medical disputes into litigation. This proposition provides a vital discussion space on how hospitals can effectively manage conflicts internally, thereby avoiding protracted legal proceedings that damage institutional reputation and morale.

This study aims to achieve three interconnected objectives, to analyze the urgency of institutionalizing the medical committee's role as an internal mediator in medical disputes, to delineate the existing research gap concerning the committee's mediative function, and to propose a conceptual framework and practical strategies for optimizing the committee's internal dispute resolution function within the Indonesian healthcare context. The expected outcome is a robust theoretical basis that promotes regulatory and internal policy reforms, enabling the medical committee to assume a central role in resolving medical disputes swiftly, efficiently, and justly.

2. Methods

This research adopts a juridical-normative research methodology, focusing on the study of law as a system of binding norms, principles, and concepts governing the resolution of medical disputes. The core of the analysis involves interpreting relevant statutes and legal doctrines pertaining to patient rights, medical professional obligations, and the institutional mandate of the Medical Committee. The study is categorized as descriptive-analytical research. It first describes the existing legal and ethical conditions surrounding medical disputes and the institutional framework of the medical committee. Subsequently, it analyzes and synthesizes the normative and ethical issues to construct a comprehensive understanding of the urgency and strategic implementation of the committee's mediative role.

The research primarily relies on secondary legal materials, categorized as follows, Primary Legal Materials consist of national legislation, including the Health Law (Law Number 17 of 2023), the Hospital Law, and other relevant government regulations and official documents concerning medical disputes and professional bodies. secondary legal materials come from academic legal literature, such as scholarly journal articles, legal textbooks, and previous research reports focusing on medical dispute resolution, the functions of the medical committee, and internal mediation mechanisms. Tertiary legal materials, such as legal encyclopedias, law commentaries, and reference documents used to clarify legal concepts and terms (Snyder, 2019).

Data collection was executed through literature review (library research), involving systematic searches of online databases (Google Scholar, PubMed, DOAJ) using keywords related to medical dispute, medical committee, and internal mediation. The selection criteria prioritized publications from the last fifteen years, ensuring the data reflects contemporary legal and ethical debates. The data analysis employed qualitative-descriptive content analysis, where arguments and findings from the synthesized literature were presented in a narrative form, emphasizing the

relevance of concepts, regulations, and practices to establish the strategic position of the Medical Committee as a restorative internal mediator (Booth et al., 2016; Hart, 2018; Creswell & Creswell, 2018).

3. Results and Discussion

3.1. Urgency of Strengthening the Medical Committee as Internal Mediator

Medical disputes in Indonesian hospitals continue to rise along with greater public awareness of patient rights and the growing complexity of healthcare regulations. Most cases are still resolved through external channels, mainly litigation or third-party mediation, even though these paths create heavy burdens in terms of time, cost, and damage to the relationship between doctors and patients (Nasution et al., 2022; Putra et al., 2024). The adversarial nature of court proceedings directly contradicts the basic principle of healthcare, which depends on trust and open communication. Once a case enters the court, both parties become opponents, and even if the patient wins compensation, the trust is often broken forever (Zaluchu & Syaharudin, 2022). This situation frequently leads to defensive medical practices where doctors order unnecessary tests or avoid high-risk procedures just to protect themselves, finally lowering the overall quality of care.

Litigation also fails to meet the need for quick resolution. Cases can take years to finish, causing prolonged stress for patients who usually need immediate answers and closure (Wang et al., 2020). The financial burden is equally serious: legal fees, expert witnesses, and possible compensation create huge costs for hospitals and make justice difficult to reach for patients with limited income (Irfan & Hidayat, 2018). More importantly, external resolution rarely examines the root causes inside the hospital. Courts focus on who is liable and how much compensation should be paid, but they do not force the hospital to change its procedures, train staff better, or improve communication systems (Maikel et al., 2024). As a result, the same problems tend to happen again, turning hospitals into repeated litigants instead of learning organizations.

The theory of Internal Dispute Resolution (IDR) clearly shows that mechanisms located inside the organization are faster, cheaper, and better at keeping relationships intact (Wang et al., 2020; Setiaji et al., 2023). When disputes are handled internally by people who understand both clinical and ethical aspects, parties feel heard and solutions feel fairer. This approach follows the principle of litigation as the last resort (*ultimum remedium*) that has long been accepted in Indonesian law, especially in health matters (Hadjon, 1987; Susanti & Zurnetti, 2025). Internal resolution also reduces reputational damage because the process stays confidential and does not become public news that can scare away future patients.

Indarwati et al. (2018), Firdaus et al. (2024), and Nurvidyaning et al. (2025) explain that although existing studies recognize the need for alternative dispute resolution in healthcare, they predominantly focus on formal courts, external mediation bodies, or general health law regulations. Very few examine how hospital internal structures, especially the medical committee, can actively prevent disputes from reaching court. External mediators, although neutral, do not have the clinical knowledge or daily proximity to understand the real context of medical decisions and often operate under a specific health mediator jurisdiction that still directs cases outward (Mufrizal et al., 2024). Therefore, a visible research gap remains regarding the proactive use of the medical committee as a formal internal mediator.

This gap becomes more critical after the enactment of Law Number 17 of 2023 on Health, which emphasizes patient safety and professional accountability yet still leaves the internal mediation function of the medical committee underdeveloped in practice. Strengthening this internal role is not just an option; it has become an

urgent need to protect patients, doctors, and hospitals at the same time. By handling disputes early and restoratively inside the hospital, escalation to court can be significantly reduced, resources can be saved, and most importantly, the trust that forms the heart of healthcare can be preserved.

3.2. Legal Position of the Medical Committee and Existing Research Gap

The Medical Committee in Indonesian hospitals has a strong legal foundation that makes it suitable to act as an internal mediator. Under Indonesian law, the committee is required in every hospital, and its main duties are to oversee clinical governance, maintain professional quality, and enforce medical discipline (Widjaja, 2020). This authority comes directly from the Hospital Law and related regulations, giving the committee a high level of internal legitimacy that external bodies do not have (Lu et al., 2022). Because its members are experienced doctors and health professionals, the committee understands both the technical side of medical practice and the ethical standards that must be followed. This combination allows the Committee to look at a dispute not just as a legal problem, but as a clinical and ethical issue that needs fair handling.

The committee has three main strengths that support its role in mediation. First, it has technical clinical competence. Committee members are senior medical staff who know hospital protocols, standard operating procedures, and the risks that come with certain treatments (Firdaus et al., 2024). When a dispute happens, they can quickly decide if the problem came from an accepted medical risk, a small mistake, or a real deviation from standards (Lu et al., 2022). External mediators usually need extra expert reports, but the committee can give an accurate clinical explanation right away. This ability makes patients and doctors feel that the process is based on real medical facts, not just general opinions.

Second, the committee carries ethical professional legitimacy. Its primary job is to protect professional ethics and discipline, so it is seen as the guardian of medical standards inside the hospital (Sperling et al., 2025). In mediation, the committee does not only look for a quick agreement; it makes sure the outcome respects ethical responsibility. This means encouraging honest acknowledgment of mistakes, a sincere apology when needed, and real steps to prevent the same problem in the future (Susila, 2021). Patients often say that an honest explanation and apology mean more to them than money alone, and the committee is in the best position to make this happen.

Third, the committee has structural independence within the hospital. Even though it works inside the hospital, the law requires it to act independently on matters of quality and ethics (Tai & Chang, 2023). Hospital management cannot easily interfere when the committee handles professional issues. This independence helps build patient trust because families see that the hospital is willing to let its own doctors be reviewed by peers who know the work well. At the same time, being inside the hospital gives the committee access to medical records, staff statements, and the full context that outside mediators rarely get (Maikel et al., 2024).

The idea of restorative justice fits perfectly with the committee's role. Restorative justice focuses on repairing harm and rebuilding relationships instead of just punishing someone. In medical disputes, this means bringing the doctor and patient together for open talk, giving a clear explanation of what happened, accepting responsibility where needed, offering apology and fair compensation, and most importantly, changing hospital procedures so the same harm does not happen again (Windayani & Adipradana, 2020; Baihaky & Isnawati, 2024). The medical committee is already responsible for quality improvement, so turning a dispute into a learning moment comes naturally to it. External courts or mediators usually stop at deciding who pays; they do not force the hospital to improve safety systems.

Even with these strengths, a clear research gap exists. Most studies in Indonesia discuss external mediation, court cases, or general alternative dispute resolution in

healthcare (Indarwati et al., 2018; Irfan & Hidayat, 2018). Very few explore how the medical committee can formally take on mediation duties to stop disputes from going outside the hospital (Firdaus et al., 2024). Current hospital regulations mention the committee's role in discipline and quality, but they rarely spell out step-by-step mediation procedures. This gap leaves many committees unsure about their authority to mediate, causing hospitals to send cases straight to court or external bodies. Filling this gap by giving the committee a clear mediative function would make the most of its existing legal position and natural advantages.

3.3. Framework and Strategies for Strengthening the Medical Committee Role

To make the medical committee a strong and effective internal mediator, hospitals need a clear and practical framework. The main idea is simple, the stronger and more structured the mediation role, the fewer disputes will go to court. This framework must cover regulations, training, procedures, and monitoring so that mediation becomes the first and main choice for resolving medical disputes. Without these elements, the committee will stay mostly in its old disciplinary role and miss the chance to handle conflicts early and restoratively.

The first strategy is regulatory formalization. Many hospitals still lack detailed rules that clearly allow and guide the medical committee to act as a mediator (Juliandri et al., 2023). Hospital by-laws need to be updated or created with specific sections on internal mediation. These rules should explain the scope of cases the committee can handle, the steps from start to finish, timelines for resolution, confidentiality requirements, and most importantly, that a signed mediation agreement has the same legal power as a court-approved settlement (Setiaji et al., 2023). When everything is written clearly in the by-laws, committee members feel safe and confident to mediate because they have strong legal protection.

The second strategy focuses on capacity building. Clinical expertise alone is not enough for good mediation. Committee members need special training in health law mediation, restorative communication techniques, active listening, and handling emotional situations (Windayani & Adipradana, 2020; Ginanjar et al., 2025). Training should be mandatory and lead to certification so that members learn how to guide parties toward mutual understanding, encourage sincere apologies, and reach agreements that include not only compensation but also real changes in hospital procedures. Restorative justice principles must be the heart of this training: every mediation should aim to explain what happened, acknowledge harm where it exists, repair the relationship, and prevent future incidents (Susila, 2021; Baihaky & Isnawati, 2024).

The third strategy is systematic Monitoring and Evaluation (M&E). Without measuring results, hospitals cannot know if internal mediation really works. A simple but regular M&E system should record every mediated case, including time taken to resolve, costs saved compared to expected litigation, patient satisfaction scores, and concrete improvements made because of the mediation outcome. This data will show the real benefits and help convince hospital management to invest more in the committee's mediation function (Nasution et al., 2022; Juliandri et al., 2023). It also creates a feedback loop that keeps improving the process over time.

Cultural change is also necessary to support the framework. Some doctors may see the committee's involvement as punishment rather than help, while patients may worry that an internal process will favor the hospital (Wiguna et al., 2025). Hospitals can address this by openly sharing success stories of mediated cases (without revealing identities), explaining the process in patient information materials, and inviting patient representatives to observe general mediation training. When both sides see that the committee prioritizes fairness, safety, and relationship repair, trust grows quickly.

Putting all these strategies together creates a complete model. The medical committee becomes the first stop for any complaint, conducts mediation based on

restorative justice, reaches binding agreements when possible, and only sends unresolved cases outside if absolutely necessary. This model follows the *ultimum remedium* principle, saves money and time, protects reputations, and most importantly, turns every dispute into an opportunity to make the hospital safer and more patient-centered (Susanti & Zurnetti, 2025). Indonesian hospitals that adopt this framework will be better prepared for the growing number of medical disputes and can set an example for healthcare institutions across the country.

Practical implementation of this framework can be illustrated through hospitals that have begun adopting structured internal mediation units, where the medical committee collaborates with quality and patient safety teams to conduct early assessment meetings within 48–72 hours after a complaint is filed. In such settings, committees often use standardized mediation forms, harm-acknowledgment templates, and procedural checklists to ensure consistency and fairness. However, institutional challenges remain. Resistance from clinicians who may fear blame or legal exposure often delays the mediation process, while some hospital administrators hesitate to formalize mediation authority due to concerns about liability and reputational risks. Limited financial support for training and inconsistent documentation practices also weaken the effectiveness of internal mediation mechanisms.

To enhance relevance and contextual strength, international comparison provides valuable insight. Many countries, such as Japan and the Netherlands, have implemented hospital-based mediation or complaint resolution boards that operate on principles similar to restorative justice, offering rapid, confidential, and trust-oriented dispute handling. These models demonstrate that internal mediation can significantly reduce litigation rates and improve patient satisfaction when supported by clear regulations, mandatory mediator training, and transparent oversight structures. Drawing from these comparative experiences, Indonesian hospitals can further refine the proposed framework by developing standardized national guidelines and incorporating patient representatives or ombudspersons to strengthen neutrality perceptions.

4. Conclusion

This study confirms the critical need to strengthen the medical committee's role as the main internal mediator for medical disputes in Indonesian hospitals. The current dependence on external litigation and third-party mediation is costly, slow, and often damages the trust between patients and healthcare providers. The medical committee, with its clinical expertise, ethical authority, and position inside the hospital, is uniquely qualified to handle disputes quickly, fairly, and restoratively. By giving the committee clear mediation duties and proper support, hospitals can resolve most conflicts internally, avoid lengthy court battles, and turn every dispute into a chance to improve patient safety and service quality.

The practical implication is that hospitals can save time, money, and reputation while building stronger patient trust. Theoretically, this research adds a new perspective on how internal hospital bodies can support restorative justice in healthcare. However, the study is limited to normative legal analysis and has not yet tested the proposed framework in real hospital settings. Future research should examine actual implementation in several hospitals, measure success rates and patient satisfaction after internal mediation, and compare outcomes with hospitals that still rely on external resolution. Such empirical studies will provide stronger evidence and help refine the model for wider use across Indonesia.

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