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Standardization of Hospital Bylaws for the Legal Protection of Medical Professionals, Health Professionals, and Patients

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Abstract

This study examines the implementation of hospital bylaws across three hospitals affiliated with the Association of Nahdlatul Ulama Islamic Hospitals to develop a standardization model ensuring balanced legal protection for health workers, patients, and institutions. This normative legal research uses statutory, conceptual, and comparative approaches. Primary legal materials include Law Number 17 of 2023, Government Regulation Number 28 of 2024, Minister of Health Regulation Number 6 of 2026, and internal regulatory documents from Unipdu Medika Hospital, Surabaya Jemursari Islamic Hospital, and Sakinah Mojokerto Islamic Hospital. The analytical framework utilizes legal mapping, substantive coding, document comparison, and prescriptive synthesis. Findings indicate that all three hospitals have regulatory frameworks that vary significantly in procedural depth. Identified institutional gaps primarily involve legal updates, professional credentialing, patient rights, complaint mechanisms, legal assistance, risk management, and audit indicators. The recent promulgation of Minister of Health Regulation Number 6 of 2026 fundamentally strengthens these bylaws as the absolute basis for all internal clinical and corporate policies. Addressing these regulatory disparities, the research proposes a seven-layer Integrative HBL-ARSINU Model. This comprehensive framework integrates legal compliance, corporate governance, clinical governance, professional governance, patient rights and safety, legal risk and dispute resolution, and continuous improvement. Implementing this standardization model establishes auditable

minimum operational requirements while preserving each hospital's unique institutional identity.

Keywords: Hospital Bylaws; Legal Protection; Hospital Governance; Patient Safety; ARSINU.

INTRODUCTION

A hospital is a highly complex organization combining public service, professional, corporate, technological, financial, and social responsibility functions. A single episode of patient care routinely involves multiple stakeholders encompassing the institutional owner, the board of directors, professional committees, internal audit units, medical personnel, allied healthcare workers, and patients. Unclearly detailed authority at any point within this vast ecosystem may both trigger administrative disputes and actively create a profound criminogenic atmosphere. Ambiguous operational boundaries directly expose medical personnel to severe medical criminal liability for systemic failures and trigger corporate criminal responsibility following adverse patient safety incidents (McBride & Richman, 2025).

Navigating these severe operational hazards requires hospitals to establish internal rules with absolute formal validity, functioning as robust penal protection instruments. The Indonesian statutory framework, including Law Number 17 of 2023 and Minister of Health Regulation Number 6 of 2026, serves as a critical empirical case study demonstrating how domestic mandates intersect with global healthcare compliance. This monumental regulatory shift forces hospitals to consolidate fragmented bylaws to support sound corporate and clinical governance. Internal documents continuing to rely on repealed statutes may lead to severe interpretive uncertainty and structural ambiguity. This institutional negligence actively criminalizes frontline practitioners by leaving them legally defenseless against prosecution during unpredictable clinical outcomes (Martin et al., 2023).

Analyzed from the dual perspectives of criminal law and enterprise risk management, these internal bylaws should provide protection against the arbitrary criminalization of medical errors. The regulatory text systematically identifies competent governing bodies and dictates professional governance frameworks covering credentialing, clinical appointments, and explicit clinical privileges (Blanks and Wright, 2024). Securing penal protection for all involved stakeholders requires the bylaws to perform proactive preventive functions. By establishing precise standards of care and rigorous credentialing protocols aligned with World Health Organization and patient safety benchmarks, the bylaws eliminate the structural ambiguities prosecutors often exploit. This approach proves gross negligence or *culpa lata* in modern medical practice (Jalilvand et al., 2025).

The corrective function is applicable post-incident through objective clinical audits and multidisciplinary peer reviews to provide unassailable forensic evidence of professional compliance. Securing legal protection must never be misconstrued as absolute immunity from criminal accountability (Sermhattakit & Sae-Lim, 2025). Juridical protection against medical criminal liability remains warranted exclusively when professional conduct fully complies with proven competence, authorized privileges, established professional standards, and fundamental medical ethics. Patient protection can be provided symmetrically by mandating seamless access to medical information, transparent complaint channels, objective institutional review, and demonstrably fair conflict resolution pathways. This symmetrical structure successfully prevents medical disputes from immediately escalating into destructive criminal litigation.

Sae-Lim examined the historical evolution of hospital risk management through a comprehensive bibliometric analysis spanning four decades (Sae-Lim et al., 2024). Their systematic review reveals a profound paradigm shift from traditional clinical risk management to enterprise risk management. Relying exclusively on localized patient safety protocols leaves healthcare organizations highly vulnerable to corporate criminal responsibility arising from systemic operational hazards. This issue includes strategic planning failures and severe financial instability. Modern healthcare institutions operate within highly volatile environments, requiring solid mitigation strategies that go beyond basic clinical care to address the severe legal liabilities of organizational failure. Integrating comprehensive enterprise risk inventories directly into formal governance structures guarantees successful navigation of complex external disruptions in hospitals while establishing absolute evidentiary defenses against corporate negligence charges. Establishing a proactive enterprise risk structure prevents recurrent institutional failures by eliminating the root causes of systemic inefficiencies that prosecutors often identify as institutional gross negligence.

Complementing this institutional risk perspective, Alabdullah and Karwowski evaluated the global implementation of patient safety culture across diverse intercontinental hospital settings (H. Alabdullah & Karwowski, 2024). Their systematic synthesis reveals a critical dichotomy: healthcare institutions successfully cultivate unit teamwork but fail to eliminate highly punitive error-reporting environments. The persistent presence of blame-oriented cultures and chronic clinical understaffing severely undermines proactive safety management and actively positions medical professionals under the criminal concealment of adverse events. Punitive administrative responses inherently suppress transparent incident reporting, creating fear of criminal prosecution among frontline medical staff. Cultivating a robust patient safety culture requires transforming abstract organizational values into actionable normative standards that guarantee a structurally just culture capable of

protecting practitioners from arbitrary criminalization. Protecting healthcare workers from retaliatory punitive measures is absolutely essential for fostering open communication channels and preventing avoidable adverse medical events from escalating into severe medical malpractice litigation.

Establishing these protective cultures and comprehensive risk mitigation strategies depends entirely upon the structure of hospital governance accountability mechanisms. Jalilvand conducted a scoping review identifying inclusive governance and multidimensional accountability commitments as the fundamental pillars of functional hospital administration (Jalilvand et al., 2024). Effective institutional governance mandates the active integration of medical professionals into strategic decision-making boards to prevent deep accountability tensions that often obscure the precise attribution of criminal liability during adverse clinical outcomes. Translating these diverse accountability mechanisms into explicit regulatory obligations prevents administrative ambiguity and secures verifiable reporting lines across all organizational hierarchies. A definitive accountability plan helps stakeholders understand their operational boundaries, reducing the structural ambiguities that can create reasonable grounds for *culpa lata* accusations. Decentralizing administrative control through hybrid governance models further empowers clinical leaders to respond effectively to localized quality concerns before they materialize into fatal criminal negligence incidents.

Existing scholarly literature largely treats enterprise risk management and patient safety culture as distinct managerial phenomena rather than interconnected penal imperatives for mitigating medical criminal liability. Prior empirical studies consistently evaluate these administrative elements from descriptive operational perspectives without identifying how unstandardized clinical boundaries create criminogenic environments for healthcare institutions. Investigations addressing the rigorous standardization of governance principles as a proactive criminal defense mechanism across affiliated hospitals remain profoundly scarce. This critical scholarly deficit becomes glaringly apparent following the structural transformations mandated by Minister of Health Regulation Number 6 of 2026. This recent statutory enactment explicitly repeals numerous guidelines and forces the immediate recalibration of all existing hospital internal regulations to reflect modernized clinical architectures. Retaining obsolete internal bylaws relying on revoked legal instruments creates severe interpretive uncertainty. These structural ambiguities create reasonable grounds for *culpa lata* accusations and expose medical professionals to severe criminal prosecution following adverse clinical outcomes.

Addressing these complex regulatory anomalies requires a rigorous normative examination of the internal bylaws of Unipdu Medika Hospital, Surabaya Jemursari Islamic Hospital, and Sakinah Mojokerto Islamic Hospital. This study primarily aims

to analyze how standardizing these internal regulations functions as an essential penal protection instrument to mitigate medical criminal liability and corporate criminal responsibility. This research seeks to identify critical evidentiary strengths and structural omissions across the three foundational documents to develop an advanced standardization model intended to protect practitioners from arbitrary criminalization. Constructing the seven-layer Integrative HBL ARSINU Model will systematically harmonize absolute legal compliance, clinical oversight, and legal risk management into a unified forensic defense structure. Implementing this robust framework establishes highly auditable minimum operational requirements that reconcile domestic regulatory mandates with global safety benchmarks while preserving each participating institution's unique historical identity. Finally, this prescriptive synthesis guarantees balanced penal protection for medical personnel and vulnerable patients while ensuring that systemic administrative failures will not further lead to destructive criminal litigation.

METHODS

This study is normative juridical legal research with a prescriptive orientation to formulate an advanced penal protection model within hospital internal regulations. The analytical framework applies statutory, conceptual, and comparative approaches to evaluate the current regulatory instruments governing medical criminal liability. The statutory approach assesses how well existing hospital bylaws align with national legislation, including Law Number 17 of 2023, Government Regulation Number 28 of 2024, and the recently enacted Minister of Health Regulation Number 6 of 2026 (Marzuki, 2019). The conceptual approach systematically examines the theoretical foundations of corporate criminal responsibility, clinical oversight, professional accountability, *culpa lata* prevention, and forensic risk mitigation. The comparative approach identifies critical similarities, structural differences, evidentiary strengths, and regulatory gaps across the three selected hospital bylaw documents to synthesize a unified penal defense standard (Tahir et al., 2023).

The research relies upon a robust compilation of primary and secondary legal materials to construct a comprehensive criminal law analytical foundation. Primary legal materials comprise binding national legislation alongside the specific internal regulatory documents governing Unipdu Medika Hospital, Surabaya Jemursari Islamic Hospital, and Sakinah Mojokerto Islamic Hospital. The foundational articles of association and organizational bylaws of the Association of Nahdlatul Ulama Islamic Hospitals provide the necessary institutional context to integrate core ethical values into the proposed forensic governance model. Secondary legal materials consist of contemporary academic publications issued between 2021 and 2025 addressing medical criminal liability, global patient safety protocols, penal protection for medical personnel, enterprise risk management, and medical malpractice litigation

mechanisms. Regulations promulgated before this period were intentionally excluded from operative legal authority because Minister of Health Regulation Number 6 of 2026 explicitly repealed them.

The systematic analysis of these legal materials was conducted in four rigorously defined sequential stages for analytical precision. The initial stage of legal mapping explicitly identified the legal basis, current validity status, competent governing bodies, institutional powers, operational procedures, and protected interests embedded within each document (Widiarty, 2024). Substantive coding then classified the extracted texts into precise thematic categories: corporate criminal liability, clinical governance, professional oversight, patient rights advocacy, forensic risk management, malpractice dispute resolution, and continuous evaluation. Cross-document comparison then revealed recurring institutional strengths and highlighted critical regulatory omissions across the diverse hospital environments that could trigger criminal investigations. Prescriptive synthesis ultimately utilized these comparative findings to construct the standardized integrative penal model complete with minimum operational clauses, verifiable forensic implementation indicators, and a structured audit cycle (Rijadi, 2022).

This study's analytical scope focuses strictly on the normative legal design of the institutional documents, rather than attempting to quantify empirical operational compliance. The research design does not statistically measure individual staff perceptions, adherence to internal protocols, the frequency of clinical incidents, or the practical effectiveness of complaint resolution mechanisms on the hospital floor. Conclusions regarding institutional implementation remain strictly limited to assessing the normative readiness of the written regulations and validating the structural connection between these documents and the overarching penal governance system. Future empirical testing remains essential to comprehensively evaluate the practical effect of the proposed standardization model on daily organizational conduct, active patient safety metrics, and the measurable reduction of medical criminal prosecutions.

RESULT AND DISCUSSION

Juridical Transformation and Legal Certainty in Hospital Governance

The enactment of Minister of Health Regulation Number 6 of 2026 marks a profound juridical transformation that responds directly to global trends in corporate criminal responsibility within healthcare institutions. This statutory milestone systematically eradicates decades of fragmented administrative frameworks by consolidating disparate operational directives into a cohesive penal defense structure. Before this legislative reform, hospital governance relied on a convoluted matrix of sector-specific instruments, including outdated hospital bylaw guidelines and

separate decrees governing medical committees and supervisory boards. The persistence of these fragmented legal authorities frequently generated dangerous interpretive ambiguities, creating severe criminogenic vulnerabilities across different administrative units within a single institution. Consolidating these regulatory frameworks fundamentally redefines hospital internal regulations from mere administrative formalities into absolute legal protection for the healthcare corporation. Hospitals must now execute a comprehensive forensic audit to purge their internal operational documents of any reliance on repealed statutory instruments. Maintaining organizational bylaws anchored in revoked legislation directly threatens institutional legitimacy and creates severe legal vulnerabilities during criminal investigations or medical malpractice prosecutions (Mourajid et al., 2024).

Article 61 of the newly promulgated regulation explicitly mandates a streamlined binary structure functioning as the primary determinant of medical criminal liability. This mandatory model divides the institutional constitution into organizational regulations and regulations governing medical staff alongside other allied healthcare professionals. The organizational regulations form the core pillars of corporate governance by clearly defining the strategic relationship among the hospital owner, the supervisory board, and executive leadership. These corporate bylaws must explicitly embed fundamental principles of institutional transparency to prevent executive criminal liability arising from systemic negligence (Turato et al., 2024). The parallel mandate for professional staff regulations represents a monumental shift toward an inclusive clinical governance model that intentionally dismantles outdated physician-centered paradigms. By structurally unifying medical staff and other healthcare professionals under a single overarching governance framework, the regulation acknowledges the multidisciplinary reality of modern clinical interventions. These professional bylaws set rigorous parameters for clinical credentialing and clearly define clinical appointments. This unified regulatory umbrella ensures every healthcare provider works within a clearly defined scope of authorized practice. This precise allocation of clinical authority directly serves as the absolute legal test in criminal courts, distinguishing legitimate medical acts governed by *lex artis* from criminal unauthorized practice and severe malpractice (Hamdan & Jaafar, 2024).

Hospital internal regulations operating within this modern juridical paradigm must function exclusively as overarching umbrella norms that set definitive boundaries of criminal liability rather than exhaustive technical manuals. They are designed to establish the fundamental governing bodies, clearly delineate the limits of administrative authority, and mandate essential operational processes to prevent structural ambiguity. Subordinate organizational policies, including detailed standard operating procedures for clinical credentialing, medical record management,

informed consent acquisition, and incident reporting, must subsequently align perfectly with these constitutional principles (Ruddy et al., 2022). Drafting internal regulations with excessive technical granularity paradoxically creates organizational rigidity and exposes clinical departments to unfair criminal prosecution when rapidly evolving evidence-based medical protocols outpace rigid bureaucratic texts. The symbiotic relationship between the foundational bylaws and subordinate technical guidelines ensures the hospital maintains legal certainty while preserving operational agility to mitigate penal risks.

The juridical transformation of hospital governance extends beyond structural reorganization, requiring deep integration with parallel regulatory developments, including Minister of Health Regulation Number 24 of 2022 on electronic medical records. Modern hospital bylaws must explicitly govern digital data access controls, mandate verifiable electronic audit trails, secure patient confidentiality, and ensure accurate clinical documentation. These digital governance mandates carry substantial forensic value during criminal inquiries or fatal medical dispute resolutions by providing immutable records of clinical interventions (Naidoo & Suthiram, 2025). Embedding these technological compliance requirements directly into the internal regulations transforms routine quality measurement from optional administrative tasks into mandatory institutional duties designed to prevent the criminal concealment of evidence. Falsifying medical data or obscuring clinical errors during severe adverse events immediately triggers criminal prosecution. Cultivating a robust organizational safety culture demands rigorous digital tracking to expose deliberate data manipulation, foster continuous institutional learning, and prevent malicious individual blame.

Securing genuine legal certainty in this complex healthcare ecosystem requires systematically eliminating three distinct forms of operational unpredictability that often precipitate corporate criminal liability. The first systemic vulnerability is uncertainty of competence, which arises when a healthcare institution fails to maintain a transparent, measurable list of authorized clinical privileges, inviting accusations of gross negligence or *culpa lata*. The second vulnerability is organizational uncertainty, which arises when hierarchical relationships among hospital owners, executive directors, and frontline service units lack clear boundaries of authority, exposing hospital executives to criminal omission charges (Namasaba et al., 2024). The third major vulnerability is procedural uncertainty, which paralyzes institutional responses when patient complaints and disciplinary proceedings lack clear timelines. Standardizing hospital bylaws explicitly targets and eliminates these interacting uncertainties, drastically reducing the organizational risk of protracted medical criminal prosecutions.

The architecture of these standardized internal regulations must balance ex ante preventive safeguards with ex post forensic remedies. Ex ante protection operates proactively before any clinical harm materializes by enforcing stringent recruitment standards, conducting exhaustive license verifications, executing rigorous professional credentialing, and mandating comprehensive informed consent protocols (Kobayashi et al., 2025). These preventive mechanisms establish a highly fortified operational environment that actively detects and neutralizes latent clinical risks, eliminating the structural intent required for criminal liability. Ex post protection activates exclusively after an adverse incident or patient complaint occurs. This ensures the immediate preservation of clinical evidence, initiates objective multidisciplinary peer reviews, and facilitates good-faith mediation. Healthcare institutions that rely disproportionately on ex post mechanisms inevitably foster a reactive, chaotic organizational culture highly susceptible to criminal negligence investigations.

Governing both the preventive and corrective dimensions of legal protection requires administrative proportionality. Any institutional decision to restrict, suspend, or permanently revoke a practitioner's clinical privileges must rely on verifiable forensic evidence, an objective assessment of patient risk, and a scrupulously fair procedural hearing. Punitive sanctions must never be imposed arbitrarily simply because a clinical outcome is not what patients have expected when the practitioner adheres strictly to established medical standards and ethical guidelines (Pragosa et al., 2026). Administrative procedural compliance cannot shield a practitioner from substantive disciplinary review when credible allegations of severe intentional misconduct or deliberate criminal negligence arise. Embedding this principle of proportionality directly into the hospital bylaws protects vulnerable patients from substandard care shields and medical professionals from reactionary administrative punishments, while defending the broader institution from liability claims stemming from hasty governance decisions.

Within the specific operational context of the participating faith-based hospital network, the pursuit of absolute legal certainty must seamlessly intertwine with core organizational values to establish a comprehensive penal defense framework. The foundational ethical principles of trustworthiness, absolute justice, public interest, and collaborative deliberation have strong potential to negate criminal intent or mens rea during medical interventions (Pai et al., 2026). These abstract philosophical concepts must be rigorously translated into enforceable, reviewable forensic clauses within standardized bylaws. The principle of trustworthiness must be made explicit as a binding legal duty for all hospital executives and clinicians to exercise their delegated authority with absolute honesty and to meticulously document every consequential decision to prevent allegations of criminal fraud.

The fundamental value of justice must be reflected procedurally through the guaranteed institutional right of every accused practitioner or aggrieved patient to an impartial hearing free from undisclosed conflicts of interest. The principle of public interest must guide operational priorities for universal patient safety aligned with global standards, equitable access to specialized care, and the continuous improvement of healthcare delivery systems. The cultural mandate for collaborative deliberation must translate into mandatory institutional protocols requiring transparent clinical communication and a genuine commitment to good-faith dispute resolution. Integrating these defining values directly into the juridical structure of the hospital's internal regulations ensures that the institutional identity remains legally enforceable, serving as a shield against malicious prosecution (Krasuska et al., 2021).

This synthesis of modernized legal mandates and enforceable ethical values directly supports the global imperatives articulated by the World Health Organization regarding the absolute necessity of patient safety rights. Securing these rights extends far beyond passively displaying a printed charter of patient entitlements within a hospital lobby. Authentic penal protection requires internal bylaws to structurally link patient rights to clinical credentialing requirements, transparent data governance protocols, highly accessible complaint pathways, and mandatory corrective institutional follow-ups. Standardized internal regulations serve as the critical transmission mechanism, converting theoretical patient rights into guaranteed organizational actions that actively prevent medical harm. By systematically aligning national statutory reforms with core institutional values and international safety standards, the juridical transformation of hospital governance establishes reliable legal protection capable of preventing adverse events from escalating into destructive criminal litigation.

Comparative Analysis of Internal Regulations in the ARSINU Network

A comparative doctrinal analysis of internal regulations across the Association of Nahdlatul Ulama Islamic Hospitals network turns these institutions into empirical laboratories that reflect varying degrees of criminogenic vulnerability. Examining the foundational documents of Unipdu Medika Hospital, Surabaya Jemursari Islamic Hospital, and Sakinah Mojokerto Islamic Hospital reveals distinct administrative philosophies heavily influenced by their respective organizational classifications (Huang et al., 2025). Recognizing structural variations across these diverse healthcare institutions does not inherently signal administrative weakness; rather, it highlights distinct exposures to criminal liability within a unified faith-based network. Structural variation becomes a critical systemic liability only when it creates severe inconsistencies across mandatory governance components, including legal validity, professional credentialing, strict limits on clinical authority, patient rights advocacy, and transparent audit mechanisms. Analyzing these three distinct regulatory

environments provides the empirical foundation needed to build a resilient, network-wide penal protection model that bridges localized practices with modern national statutory mandates (Martin et al., 2022).

Unipdu Medika Hospital sets a strong benchmark for clinical and professional governance by explicitly positioning its internal regulations as a robust penal defense mechanism to protect medical personnel from malpractice allegations. The institution's principal strength lies in its comprehensive integration of corporate bylaws with detailed medical and nursing staff regulations. This framework sets out meticulous procedures for initial credentialing, periodic recredentialing, precise allocations of clinical privileges, formal clinical appointments, and rigorous informed consent protocols (Øyri et al., 2020). Strict credentialing and clinical appointment procedures guarantee a strong forensic defense. Medical practitioners have legal certainty about which clinical interventions they remain authorized to perform, effectively neutralizing accusations of unauthorized practice. Patients also receive assurance that their care comes only from personnel with verified competence. The institution also generates immutable documentary evidence that all clinical authority was granted through a highly objective, formalized peer-review process. This regulatory document also reveals critical vulnerabilities that require urgent remediation, including the need for broader normative provisions governing allied healthcare professions and measurable audit indicators to prevent isolated legal risks.

Surabaya Jemursari Islamic Hospital distinguishes itself through an exceptionally elaborate corporate governance architecture designed to support continuous institutional improvement. The internal regulations meticulously map the complex hierarchical relationships interconnecting the hospital owner, supervisory board, executive directors, internal audit units, and specialized risk management divisions. Embedding these exhaustive features directly into the foundational bylaws theoretically guarantees robust checks and balances. However, the principal vulnerability in this institutional framework is a severe lack of procedural depth that may create a dangerous loophole triggering executive criminal liability (McMullan et al., 2024). Securing genuine legal protection requires the bylaws to explicitly link each governing body's broad theoretical responsibilities to specific meeting frequencies, standardized reporting formats, and clear compliance indicators. Maintaining a sprawling corporate structure without these vital technical procedures means that hospital directors and executives can face direct criminal prosecution if their administrative system fails to prevent severe medical negligence. This deficit transforms a decorative organizational chart into a profound criminogenic vulnerability, leaving executives legally exposed to charges of systemic omission (Tanrıverdi et al., 2022).

Sakinah Mojokerto Islamic Hospital projects a distinctive administrative identity by anchoring its internal regulations in a values-based institutional

accountability framework. The organizational document prioritizes ethical relationships while explicitly embedding Islamic institutional values into the core of daily hospital services. Integrating these spiritual and ethical principles remains absolutely vital for sustaining institutional legitimacy and fostering moral accountability. Transforming these foundational values into functional legal protections requires explicit use of these values as binding legal instruments to negate criminal intent, including mens rea and dolus, in medical communications and clinical interventions (O'dowd et al., 2022). The institution must strengthen its normative frameworks governing professional credentialing, objective professional audits, and fair disciplinary processes to operationalize these ethical safeguards. The core institutional values of trustworthiness and public interest must actively mutate into binding legal duties that compel transparent clinical communication, rigorous documentation practices, and demonstrably fair dispute resolution to prove the absence of malicious intent in adverse clinical outcomes (Chen et al., 2023).

Synthesizing these comparative findings underscores that effective legal protection in modern healthcare operates as a deeply interconnected systemic phenomenon rather than an isolated individual responsibility. Medical risk and subsequent criminal liability rarely originate solely from isolated individual negligence. Severe institutional crises often incubate in systemic administrative failures, including unavailable clinical equipment, assignments that blatantly exceed verified professional competence, chronically incomplete medical records, degraded interprofessional communication, and executive oversight lacking measurable performance indicators (Van Dael et al., 2022). Standardizing internal regulations across the hospital network must go beyond superficial harmonization of legal vocabulary to engineer a unified operational ecosystem capable of anticipating and neutralizing these multifaceted systemic hazards. Moving beyond descriptive institutional observations allows this doctrinal analysis to consistently isolate the Four Root Causes of Medical Criminalization recurring across the entire hospital network (Rafati et al., 2024).

The first root cause of medical criminalization demands absolute regulatory harmonization and legal updating across all participating institutions. The three examined hospital bylaws collectively show a dangerous normative reliance on repealed national regulations that no longer have binding legal authority (Hayati et al., 2025). This widespread regulatory obsolescence requires an immediate and comprehensive legal remapping of all internal constitutions against the updated mandates. Eradicating outdated legal references prevents severe interpretive collisions and eliminates the structural ambiguities that prosecutors often exploit to establish illegal practice charges against frontline practitioners.

The second root cause exposes a profound deficit in equitable professional governance across the healthcare workforce. The comparative evaluation reveals an entrenched historical bias where institutional provisions governing physicians and nurses appear substantially more mature and legally fortified than those regulating allied healthcare professions. Modern clinical interventions rely heavily on seamless collaboration involving pharmacists, radiographers, and laboratory technologists (Wang et al., 2022). Ensuring balanced penal protection requires subjecting these vital allied professions to the same rigorous frameworks governing scopes of authority and delegation protocols to prevent arbitrary criminal negligence charges during complex delegated tasks.

The third root cause involves the chronic underdevelopment of operational pathways for patient rights, triggering destructive police reports rather than constructive institutional mediation. While the institutional bylaws frequently articulate patient rights as noble guiding principles, the concrete implementation pathways and verifiable evidence of administrative compliance remain distressingly abstract. Bridging this operational chasm requires translating abstract charters into highly accessible daily procedures encompassing non-discriminatory triage, linguistically comprehensible medical information, and robust privacy protections to rapidly deescalate patient dissatisfaction (Zhang et al., 2024).

The fourth and final root cause highlights the dangerous persistence of fragmented legal risk management mechanisms, letting adverse events escalate into criminal litigation. The evaluated internal regulations consistently fail to integrate complaint handling, factual clarification, good faith mediation, professional legal assistance, and post-dispute organizational learning into a single cohesive penal defense continuum. Fractured risk management systems force hospitals to remain entirely reactive, responding to legal crises only after immense reputational and financial damage has occurred (Lindsey et al., 2024). Consolidating these fragmented processes ensures that every patient complaint triggers a systematic institutional response prioritizing rapid de-escalation, objective truth-seeking, and immediate systemic remediation to prevent catastrophic criminal prosecutions.

Seven-Layer Integrative Standardization Model for Balanced Penal Protection

Synthesizing the normative mapping and comparative document evaluations directly requires the structural formulation of the Seven-Layer Integrative Model. This advanced framework serves as a comprehensive network-wide minimum standard that bridges mandatory national regulations with practical hospital operations and global penal defense strategies. The model does not attempt to replace the structural mandates established by Minister of Health Regulation Number 6 of 2026. Instead, it serves as a sophisticated instrument that connects core organizational bylaws and professional regulations with patient rights, legal risk management, dispute

resolution, and continuous institutional auditing to prevent criminal prosecutions. Permeating all structural layers are foundational Islamic ethical values encompassing trustworthiness, absolute justice, public interest, professional integrity, and respect for human dignity (Özaydın et al., 2024). Translating these moral principles into reviewable legal clauses ensures that institutional values become operational realities capable of negating malicious intent or mens rea in criminal investigations, similar to the stringent ethical defenses recognized in European medical jurisprudence (Birkeland et al., 2021).

The model's structure begins with the legal compliance layer, which ensures full conformity with the formal hierarchy of national legislation and includes automated review schedules for future statutory changes. Building directly upon this foundational compliance, the corporate governance layer meticulously regulates the strategic relationships linking institutional owners, supervisory boards, executive directors, and internal control units (August et al., 2025). Achieving robust institutional accountability within this sphere requires transparent reporting hierarchies and clearly defined boundaries of authority to systematically prevent executive criminal liability arising from systemic negligence. Advancing into clinical governance, the model establishes rigorous mechanisms for clinical leadership, structured professional committees, mandatory credentialing, precise clinical privilege allocations, evidence-based clinical audits, and peer reviews. This specific layer protects patients from unauthorized clinical procedures while safeguarding practitioners from arbitrary *culpa lata* accusations by providing immutable forensic proof of authorized practice (Kawu et al., 2023).

Beyond traditional physician-centered frameworks, the professional governance layer guarantees equitable protections and clear operational scopes for nurses, midwives, pharmacists, laboratory technologists, radiographers, and health information personnel. This professional layer explicitly regulates complex delegation tasks by establishing strict conditions, supervision protocols, and shared responsibilities to eliminate illegal task shifting that often invites criminal negligence charges in developing jurisdictions. Complementing professional protection, the patient rights and safety layer translates abstract statutory entitlements into accessible operational procedures covering non-discriminatory access, informed consent, privacy safeguards, and secure access to medical records (Hansen et al., 2026). Managing potential breakdowns in this delicate ecosystem, the legal risk and dispute resolution layer establishes a proactive risk register, early warning mechanisms, multidisciplinary review panels, and structured pre-litigation mediation pathways. This layer functions comparably to restorative justice mechanisms in North American healthcare systems, effectively preventing adverse events from escalating into destructive criminal police reports. Closing the structural loop, the continuous

improvement layer mandates annual internal audits and biennial evaluations, transforming every clinical incident or patient complaint into sustainable organizational learning and verifiable forensic audit trails rather than exposing staff to punitive individual blame (Y. Y. Alabdullah et al., 2023).

Operationalizing this seven-layer model requires embedding mandatory minimum clauses and executing a structured implementation roadmap across all participating network hospitals. The core contractual clauses require strict internal hierarchy, dynamic legal-update protocols, clear scopes of professional authority, balanced legal-assistance frameworks, and graduated dispute-resolution procedures (Zheng et al., 2025). Implementing these standards follows a four-phase progression, beginning with a comprehensive legal and organizational diagnosis across all member institutions. The next phase involves participatory document redesign and rigorous case simulations that test complex scenarios, including credentialing disputes and informed consent challenges. The third phase focuses on digital system integration, risk register deployment, and practical role-based training. The final phase establishes a cooperative, network-wide audit mechanism designed to share best practices and collectively elevate institutional standards without stigmatizing individual hospitals, aligning domestic healthcare operations with global criminal risk mitigation benchmarks (Tertulino et al., 2024).

This integrative standardization model ultimately secures balanced, harmonious, and equitable penal protection for all institutional stakeholders. For medical personnel, the framework provides absolute certainty regarding professional autonomy, clinical privileges, and institutional legal assistance when operating within authorized boundaries, offering a strong defense against malpractice criminalization. For allied healthcare professionals, the model successfully eliminates historical protection gaps by establishing transparent supervision and explicit delegation rules that prevent unfair transfers of criminal liability (Drummond et al., 2023). For patients, protection extends beyond a written charter to guaranteed access to competent care, transparent communication, secure medical records, and fair dispute-resolution pathways. For institutional owners and hospital administrators, structured authority and rigorous documentation provide clear evidence of legal compliance and due process to defend against corporate negligence claims. Systemic equilibrium is successfully achieved by combining rigorous competence standards, transparent administrative procedures, proportional disciplinary responses, and continuous organizational learning. While completely eradicating medical disputes from clinical practice is impossible, this standardization model drastically reduces their likelihood, accelerates factual clarification, and permanently replaces arbitrary administrative decisions with predictable justice protected from unwarranted criminal litigation

CONCLUSION

Evaluating the internal regulations across Unipdu Medika Hospital, Surabaya Jemursari Islamic Hospital, and Sakinah Mojokerto Islamic Hospital reveals profound criminogenic vulnerabilities and varying procedural depths within the network. The recent enactment of Minister of Health Regulation Number 6 of 2026 mandates a critical structural reorganization requiring institutions to eliminate obsolete legacy instruments and bifurcate their governing documents into distinct organizational regulations and professional staff bylaws. Addressing these pervasive regulatory gaps involves resolving widespread reliance on repealed legal provisions, closing professional governance deficits for allied health workers, operationalizing patient rights pathways, and unifying fragmented legal risk management systems to eliminate the structural ambiguities that prosecutors often make use of to criminalize medical personnel.

Synthesizing these comparative findings yields the Seven-Layer Integrative Model designed to bridge macro-level national statutory mandates with micro-level institutional practices and global penal defense strategies. This comprehensive framework systematically integrates legal compliance, corporate governance, clinical governance, professional governance, patient rights and safety, legal risk and dispute resolution, and continuous improvement into an auditable forensic continuum. Foundational Islamic ethical values permeate every layer, transforming abstract moral principles such as trustworthiness, justice, and public interest into enforceable, reviewable normative duties that specifically negate malicious intent, or mens rea, during medical criminal investigations.

Implementing this standardized architectural model establishes auditable minimum forensic requirements that preserve each faith-based institution's unique historical identity while creating systemic equilibrium against arbitrary criminalization. The resulting framework provides genuine penal protection and procedural due process for medical and allied healthcare personnel, while safeguarding patient rights and ensuring corporate criminal accountability. Replacing arbitrary administrative decisions with predictable justice permanently minimizes exposure to malpractice litigation and establishes a robust forensic benchmark for modern healthcare governance across increasingly litigious environments that seek to prevent adverse clinical events from escalating into destructive criminal prosecutions.

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