pISSN 2798-2106 eISSN 2808-4470

Studi Ilmu Sosial Indonesia
Vol. 3, No. 1, 293-320

Medical Treatment Consent and Patient Autonomy Rights in Clinical Practice

Fayola Issalillah, Titik Ustani, Desak Gede Sri Baktiasih, Lina Wahyu Indayanti, Ayu Indah Wuryani

Universitas Sunan Giri Surabaya

correspondence: fayolaissalillah@gmail.com

Abstract

This article develops a normative account of *informed consent* as a legal and ethical requirement for medical interventions. It explains valid consent through four elements: relevant disclosure, functional decision capacity, voluntary choice, and accountable documentation. Patient autonomy is presented as deliberative self determination shaped by personal values, while professional duties set justified limits when requests contradict accepted clinical standards or when capacity is impaired. Emergency care is examined as a narrow justification for immediate action to prevent serious harm, with a continuing duty to explain and record reasons once communication becomes feasible. The paper also addresses vulnerable patients, including children, persons with cognitive impairment, language barriers, and those exposed to dependency pressure, where consent may appear present yet remain unfree or misunderstood. A procedural justice lens is used to stress clarity, respectful communication, and opportunities for questions and clarification. The central claim is that lawful consent requires substantive understanding rather than a signature ritual, and that institutions share responsibility for creating conditions where autonomy can be exercised with dignity and trust.

Keywords: informed consent, patient autonomy, medical law, procedural justice, emergency care, vulnerable patients, clinical communication.

Issalillah, F., T. Ustani, D. G. S. Baktiasih, L. W. Indayanti, & A. I. Wuryani. 2023. Medical Treatment Consent and Patient Autonomy Rights in Clinical Practice, Studi Ilmu Sosial Indonesia, 3(1), 293-320.

Introduction

Modern medical practice is built upon a professional relationship that links clinical knowledge with respect for human dignity. In the service space, medical decisions touch the body, pain, life expectancy, and the patient's identity as a subject entitled to determine their own life's direction. Therefore, informed consent cannot be understood as an administrative formality, but rather as a communicative event that tests the quality of the doctor-patient relationship. Consent demands an honest explanation regarding the purpose of the action, alternatives, risks, and possible outcomes, accompanied by an opportunity for the patient to ask questions and deliberate. This becomes crucial because every citizen, without exception, has the right to receive justice in every health service they obtain (Issalillah, 2021). At the same time, doctors bear the obligation to act according to professional standards and weigh benefits and risks proportionally. Tensions between professional obligations and patient choices often arise when complex information must be translated into understandable language without reducing accuracy. At this point, *informed consent* becomes an ethical and legal bridge that ensures medical actions remain within legitimate and humane boundaries. If this bridge collapses and a misdiagnosis occurs, serious legal consequences will arise for the medical personnel involved (Setiyadi et al., 2023). Failure to maintain this bridge has the potential to transform an action intended to help into one perceived as coercion (Grady, 2015).

In daily practice, informed consent often takes place under time pressure, limited facilities, and high emotional stress. In emergency units or procedure rooms, decisions must be made quickly, while patients and families are in a state of anxiety. These circumstances can narrow the space for conversation, even though conversation is the core of meaningful consent. Furthermore, the doctor-patient relationship involves a clear knowledge imbalance. Therefore, our national legal system must be truly prepared and fair in facing various health crises that may occur in society (Vitrianingsih & Issalillah, 2021). Knowledge imbalance can drive patients to surrender decisions entirely to the doctor, or conversely, to refuse medical advice due to misunderstanding. In both conditions, patient autonomy is easily misinterpreted. Autonomy is not merely the freedom to choose, but the ability to choose after understanding relevant

information and being free from undue pressure (Stanley, 1998). Thus, healthcare organizations need to realize that *informed consent* operates within a complex social space, where language, status, and trust determine whether a patient truly understands. Moreover, the living environment and social conditions of the community often influence their level of understanding regarding health itself (Warin, 2023). If consent is limited to a signature, then the right to autonomy is reduced to a symbol that fails to protect the patient when difficult decisions must be made.

The legal framework regarding informed consent contains the idea that intervention on another person's body requires a valid basis. This valid basis generally takes the form of consent given after an explanation, except in certain justified circumstances. In a normative understanding, the law functions in two ways: it protects the patient from actions without consent, and it protects the doctor who acts according to procedures and standards. This kind of protection is crucial, especially for communities seeking treatment at public health centers or *puskesmas* (Tampil et al., 2023). However, such protection only works if rules are translated into real communicative practices. In clinical settings, legal language often feels distant from the patient's experience, while clinical language often feels foreign. When this linguistic gap is wide, consent becomes vulnerable to subtle manipulation for instance, a patient may feel they must agree for fear of being considered difficult (Hall et al., 2012). This condition is even more difficult for those living in suburban areas or near waste disposal sites, whose health rights are often neglected (Issalillah & Mardikaningsih, 2022). Consent born of fear cannot be considered free consent. Therefore, legal regulations need to be read alongside communicative ethics, as the right to autonomy requires social conditions that enable freedom of choice. Thus, the study of informed consent must link legal norms with the way the doctor-patient relationship is built, including how risks are explained and how uncertainty is acknowledged.

Patient autonomy is often praised as a primary principle; however, autonomy has limits determined by safety, mental capacity, and professional obligations to prevent foreseeable harm. In medical practice, these limits appear in various forms. Patients may refuse certain actions, but such refusal needs to be understood as an informed decision, not merely a reaction to fear. On the other hand, the national health insurance

must also ensure that every patient receives their full rights without discrimination (Tamaka et al., 2023). Conversely, doctors are not obligated to perform actions that conflict with professional standards or lack an adequate basis of benefit. When a patient's request conflicts with medical considerations, a negotiation occurs that tests the quality of communication and the clarity of roles. Furthermore, autonomy is also linked to privacy, confidentiality, and the patient's control over their personal information (Eyal, 2014). Informed consent touches all these aspects, as explaining a procedure often involves discussing sensitive personal conditions. Therefore, social support from the surrounding environment is greatly needed to aid the healing process, especially for the elderly (Khayru, 2022). The practice of consent must place the patient as the owner of their information, while ensuring that clinical decisions remain grounded in responsible medical reasoning. The limit of autonomy is not a denial of rights, but rather a tool to maintain the balance between freedom of choice and the obligation to protect life.

Emergency situations present the sharpest tension between the need for rapid action and the demand for full consent. In life-threatening situations or those threatening vital functions, delaying action for formal procedures can increase harm. Yet, rapid action also carries the risk of ignoring patient preferences, including religious values or life values they hold. This is where law and ethics provide certain exceptions; however, those exceptions must be strictly understood so they do not turn into a habit. Additionally, the government bears a great responsibility to guarantee the rights of patients with mental disorders within the social security system (Wuryani et al., 2023). Beyond emergencies, vulnerable patient groups add complexity for example, pediatric patients, patients with impaired decision-making capacity, patients with language barriers, or patients in relationships of dependency. Groups of people with disabilities also require special attention to ensure they still receive equal access to health services (Subiakso et al., 2023). Vulnerability can make consent appear to exist, when in fact it is not free or not understood. Vulnerability can also lead families or other parties to take over decisions under the guise of protection, even when the patient's preferences have not been confirmed. Therefore, informed consent demands special attention to the way understanding is tested, the way conversations are documented, and

the way it is ensured that decisions reflect the patient's most authentic will according to their capacity (Manson, 2012).

The description of the problem in this topic relates to the tension between the legal regulation of informed consent and the reality of clinical communication practices. Many regulations demand explanation, consent, and documentation; however, practice often moves in a fast rhythm, technical language, and organizational pressure. When explanations are given briefly and uniformly, patients may feel they are receiving information without truly understanding it. On the other hand, if explanations are too detailed without structure, patients can become overwhelmed and choose to surrender to the doctor's authority. Both conditions equally undermine autonomy. Problems also arise when the definition of consent is narrowed down to a form, so that the quality of the process is not assessed. In essence, every patient has the right to feel safe and protected when dealing with complex medical procedures (Tampil et al., 2023). Within a normative framework, this issue indicates a gap between legal norms and the communication norms required to form a rational choice. This gap creates a risk that consent is used merely as a shield for the institution rather than as a protection for the patient (Krumholz, 2010). This description focuses on the problem of process management, including how information standards are formulated, how the ability to understand is tested, and how conversations are maintained to respect the patient's dignity.

The next description of the problem concerns the limits of patient autonomy and how those limits are applied in emergency situations and to vulnerable patients. Autonomy is often stated as an absolute right, yet in practice, it faces the concepts of capacity, best interests, and the obligation to save lives. When a patient is unable to make a decision, the organization must determine who is legally authorized to represent them and how that decision reflects the patient's values. The government also needs to continuously ensure that existing policies truly favor the welfare of the broader community (Issalillah, 2021). When a patient is capable but under intense pressure, the organization must assess whether the consent is truly free. In emergency situations, exceptions to consent can be justified, but the limits of these exceptions must be understood so they do not expand into a justification for action without dialogue. In vulnerable

patients, there is a risk that decisions are made by other parties under the pretext of kindness, causing the patient's voice to disappear (Appelbaum, 2007). This includes providing legal certainty for those in need of medical assistance in very urgent conditions (Vitrianingsih & Issalillah, 2021). This issue shows that the main challenge is not merely the absence of rules, but rather the difficulty of translating principles into procedures that can be executed consistently and accountably. This description refrains from offering solutions and focuses on the normative complexity of balancing protection, freedom, and professional obligation.

Informed consent determines the legitimacy of medical actions and determines the quality of patient protection, especially when decisions involve significant risks and uncertainty. This writing is important to affirm that patient autonomy demands more than formal consent—it requires a communication process that ensures understanding, freedom, and respect. This is because the ultimate goal of all these rules is to improve the quality of life for the community in a fair and equitable manner (Issalillah, 2021). Urgency also arises because emergency situations and vulnerable groups reveal the limits of a uniform consent model. In such conditions, legal regulations and institutional procedures need to be read through a lens of ethical caution so that exceptions do not undermine principles. Furthermore, this writing is necessary to clarify the relationship between the professional obligations of doctors, the rights of patients, and the responsibilities of healthcare organizations in providing conditions that enable meaningful consent. We all hope that the relationship between healthcare providers and the community remains well-maintained for the common good (Setiyadi et al., 2023; Tampil et al., 2023). With a strong normative framework, this discussion can serve as a basis for clinical education, the drafting of hospital guidelines, and the improvement of consent governance (Aulisio et al., 2000).

The objective of this writing is to formulate a normative conceptual framework regarding *informed consent* and the right to patient autonomy in medical practice. The description is directed toward explaining the legal structure of medical action consent, the limits of patient autonomy, and the ethical reasoning that justifies exceptions in emergency situations and for vulnerable patients. This writing also aims to organize normative criteria for valid consent, namely understandable explanation, proper decision-making

capacity, and freedom of choice. Its theoretical contribution is to clarify the relationship between the legitimacy of medical actions and the quality of clinical communication. Its practical contribution is to provide a conceptual reference for the formulation of institutional guidelines and professional learning regarding respect for patient dignity.

Method

This study utilizes a qualitative literature study to develop a conceptual synthesis regarding informed consent, patient autonomy, and the limits of its justification in medical practice. The focus of the study is directed toward legal and ethical norms, as well as how both guide medical consent procedures in routine situations, emergencies, and for vulnerable patients. Baronov (2015) emphasizes the importance of conceptual foundations in social research methods; thus, this writing organizes working definitions of valid consent, decisional capacity, and freedom of choice. Bailey (2008) asserts the need for procedural order in social research, including clarity of scope and consistency of terminology, so that the synthesis does not devolve into loose moral discourse. Reading materials are grouped by theme, such as elements of consent, the duty of disclosure, power relations in clinical communication, and the justification of actions in urgent conditions.

The processing of sources was conducted through repeated reading, recording of normative propositions, and comparisons between ideas to find coherence and points of tension. Crano et al. (2014) emphasize that social research methods need to separate claims, reasons, and consequences; therefore, the discussion in this study distinguishes between descriptions of norms, ethical reasoning, and procedural implications. Kalof and Dan (2008) stress the importance of selecting relevant sources and evaluating the suitability of concepts with the research questions, so sources were chosen based on their ability to explain the legitimacy of medical actions and the protection of patient rights. Comparisons are used to organize the boundaries of autonomy for example, when the right to refuse meets professional obligations, or when decisional capacity is questioned in patients with specific vulnerabilities.

The synthesis is structured as an argumentative framework that addresses the research problem without presenting field data. Singleton and Straits (2018) emphasize that social research approaches need to

maintain coherence between questions, concepts, and conclusions; thus, the structure of this writing follows a path from basic norms and exceptions to application in special situations. The reliability of reasoning is maintained by checking the consistency of definitions, restraining overgeneralization, and linking every normative claim to a clear conceptual structure. The results are presented as an analysis centered on the elements of valid consent, the limits of patient autonomy, and the principles justifying actions in emergencies and for vulnerable patients, with an emphasis on procedural justice and respect for dignity.

Result and Discussion

Informed consent can be understood as a normative standard that transforms medical action from a mere technical intervention into an action that is morally legitimate and legally accountable. At the core of this concept lies the recognition that the patient's body is not an object of service, but a private domain that can only be touched through valid reasons and free consent. This aligns with the view that consent for medical action is a basic right of every patient that must be protected from both legal and medical ethical perspectives (Chairul et al., 2023). Free consent is not merely an uttered agreement, but a consent born after the patient receives relevant information and can internalize the meaning of that information. Within this framework, *informed consent* functions as a mechanism to limit professional power, as well as a trust-building mechanism. Trust is formed when patients feel they are not being led manipulatively, not intimidated, and not persuaded through language that closes off options. Furthermore, honesty in providing information is crucial to prevent the falsification of health documents, which can violate professional ethics and criminal law (Hartika et al., 2023). Therefore, *informed consent* demands quality of communication, not just the existence of information. Quality of communication includes understandable language, space for questions, and the acknowledgment of uncertainty. Uncertainty must be acknowledged so that patients do not receive false promises. In medical practice, acknowledging uncertainty is part of professional honesty. This honesty is a prerequisite for patient autonomy to be meaningful, as choosing without knowing the existence of uncertainty is choosing in the shadow of an illusion (Simpkin & Schwartzstein, 2016).

The right to patient autonomy stems from the idea that humans possess the capacity to determine their own life values. In healthcare, these life values are reflected in preferences regarding quality of life, risk tolerance, views on suffering, and moral beliefs. Awareness of the importance of this quality of life is also closely related to the healthy lifestyle and mental health of today's younger generation (Aisyah & Issalillah, 2022). Consequently, patient autonomy cannot be treated as a narrow choice between agreeing or refusing. Autonomy is a space for deliberation about what is considered good for the patient according to the patient's own judgment. However, this space always exists within the limits of human ability to understand information. This is where the doctor's obligation to provide an explanation gains ethical significance. A good explanation does not force a conclusion, but rather helps the patient assess the consequences. However, there are often differences in perspective between the patient's wishes and the attitude of medical personnel who may be overly protective or paternalistic, which can ultimately lead to legal issues (Feriadi et al., 2023). Within a normative framework, autonomy does not negate the need for professional guidance. Legitimate professional guidance is guidance that is transparent about its reasoning and respects the patient's final decision (Entwistle et al., 2010). Guidance turns into coercion when a doctor conceals alternatives or selectively emphasizes risks to direct a choice. Therefore, *informed consent* regulations need to emphasize the ethics of information presentation, including balance, readability, and relevance. Thus, patient autonomy and the doctor's obligation strengthen each other when both are understood as a partnership in decision-making, rather than a competition of authority.

Legal regulations for medical action consent generally include the elements of valid consent, such as explanation, understanding, capacity, and voluntariness. These elements can be understood as the minimum requirements that protect patients from actions without a basis. Patient comfort and satisfaction with services, such as those experienced by BPJS patients at public health centers, also depend heavily on how their rights are respected during the medical process (Darmawan et al., 2022). However, within a normative framework, minimum requirements should not be treated as a maximum limit. If organizations stop at minimal fulfillment, consent becomes a ritual devoid of meaning. Therefore, the discussion needs to distinguish between formal compliance and

substantive legitimacy. Formal compliance relates to the existence of documents, whereas substantive legitimacy relates to the existence of understanding and freedom. Substantive legitimacy demands attention to the patient's social situation, such as family pressure, economic dependency, or fear of clinical authority. Nevertheless, in life-threatening emergency situations, doctors must sometimes take swift action without consent for the sake of patient safety based on the principle of urgent necessity (Abdullah et al., 2023). Such pressures can make patients agree without truly choosing. Therefore, strong legality requires communication procedures that account for power relations (Stiggelbout et al., 2015). Furthermore, the law also affirms the professional obligation of doctors to act according to standards. This obligation creates a boundary for autonomy, as a doctor cannot legally perform actions that conflict with standards even if the patient requests them. Within this framework, the boundary of autonomy is not a reduction of rights, but rather a limitation of action to ensure medical decisions remain within the corridor of professional responsibility.

The concept of decision-making capacity is central to the discussion because informed consent requires that the patient is able to understand, weigh, and communicate choices. Capacity is not identical to intelligence or education, but rather a functional ability at the time the decision is made. Therefore, every health facility must ensure that every individual receives the same legal protection for their choices (Chairul et al., 2023; Feriadi et al., 2023). Consequently, capacity is situational. A person may have the capacity for simple decisions but struggle with complex ones. In a normative framework, the assessment of capacity must be conducted with caution so as not to turn paternalistic. Paternalism arises when capacity is deemed low simply because the patient chooses an option that differs from the doctor's preference. A difference in choice is not evidence of a lack of capacity. Conversely, capacity can be impaired by pain, fear, delirium, or pressure. It is important for hospitals to maintain service quality so that patients feel respected and satisfied with the decisions they make themselves (Darmawan et al., 2022). Therefore, consent procedures need to include steps to maximize capacity, such as managing pain, allowing time, or using simpler language. The principle that must be upheld is that a patient's disagreement must be respected as long as their capacity is adequate, even if the decision

is considered unwise by the doctor. However, this respect does not erase the doctor's obligation to ensure the patient understands the consequences. This is where dialogue becomes essential, as dialogue allows for the correction of misunderstandings without erasing choice (Appelbaum & Grisso, 1988). Finally, good understanding between the patient and the doctor will create a harmonious relationship and prevent future legal problems (Hartika et al., 2023; Abdullah et al., 2023).

Voluntariness or freedom of choice is often the most difficult element to maintain within clinical spaces. Clinical settings possess hierarchies, symbols of authority, and dependency. Patients frequently feel they are in a weak position, making it easy to follow recommendations without questioning. Freedom of choice can also be compromised by family pressure, especially when the family acts as the information liaison. This indicates that the protection of patient rights must always be viewed through the lens of law and medical ethics so that they do not feel pressured (Herisasono et al., 2023). In a normative framework, freedom of choice demands that patients be given the opportunity to state their preferences without intimidation. This opportunity may require private conversations between the doctor and the patient, particularly when pressure is suspected. Freedom of choice also demands that the patient understands that refusing a procedure does not mean being abandoned. If a patient fears abandonment, consent becomes a transaction of fear. Therefore, informed consent procedures need to state clearly that basic care will still be provided and that the patient's decision will not be met with a demeaning attitude. Furthermore, a person's social environment and mental condition significantly influence their ability to courageously make decisions without fear (Issalillah & Khayru, 2021). A demeaning attitude is a subtle form of coercion. Within this framework, healthcare organizations bear a cultural responsibility to uphold respect for choice. Without such a culture, legal norms have no real power. Thus, voluntariness is an institutional issue, not merely an issue of an individual doctor's character (Nelson et al., 2011).

The obligation of explanation in informed consent demands relevant standards of information. Relevance means that the information provided is related to the decision to be made. Relevant information includes the purpose of the action, a general outline of how it works,

expected benefits, significant risks, available alternatives, and the possibilities if the action is not taken. In a normative framework, explanations need to be structured as a narrative that helps the patient compare options. If an explanation is delivered as a list of technical terms, it is difficult for the patient to understand. However, if an explanation is delivered as persuasion, the patient loses their freedom. The delivery of this information must be done very carefully, especially in today's era where social media often influences mental health and how people perceive medical information (Khayru & Issalillah, 2022). Therefore, explanations must be balanced. Balance means mentioning advantages and disadvantages with reasonable weight and without being selective. Explanations also need to include relevant uncertainties, as the outcomes of many medical decisions cannot be guaranteed. Erasing uncertainty is a form of deception. Furthermore, explanations must consider the patient's values. Patient values determine what is considered an acceptable risk. For example, some patients fear a loss of function more than other risks. Therefore, explanations need to open a space to ask about the patient's priorities. Thus, meaningful informed consent is a two-way dialogue process that incorporates patient values into clinical reasoning without sacrificing professional standards (Spatz et al., 2016).

Documentation of consent is often understood as the core, whereas it is merely a trace of the process. In a normative framework, a document is a tool of accountability, not a substitute for communication. If an organization emphasizes the document as the goal, then the process may be accelerated to chase a signature. A signature obtained without understanding creates an illusion of legitimacy. Therefore, documentation needs to be understood as part of a governance structure that motivates quality communication. Currently, the use of electronic medical records is also an important part that must be considered from a legal standpoint to ensure patient data remains secure (Kholis et al., 2023). Good documentation reflects the main points of the conversation, including the patient's questions and the doctor's answers. However, documentation must also maintain privacy. Privacy is a part of autonomy because patients have the right to control their personal information. Legally and ethically, the completion of medical records by doctors must be done correctly to protect these patient rights (Mubarak et al., 2023). In a digital situation,

documentation is increasingly easy to copy and access. Therefore, document governance needs to emphasize access restrictions and purpose of use. The principle of purpose limitation ensures that information is not used outside the interests of service and legitimate accountability. Within this framework, informed consent relates to the patient's right to their own information. Explaining an action often involves the disclosure of sensitive data. We must also be vigilant so that patients' personal information, especially accident victims, is not disseminated indiscriminately in digital media (Muhammad et al., 2023). If patients feel their data is not secure, they may withhold information, and service becomes less accurate. Therefore, patient autonomy demands information security as a prerequisite (Spector-Bagdady & Lombardo, 2019).

The limits of patient autonomy also emerge in situations where a patient demands actions that do not conform to standards or that are professionally unjustifiable. Within a normative framework, physicians have an obligation to refuse actions that lack an adequate basis for benefit or that carry disproportionate risks. This refusal must be conveyed with a respectful explanation so that the patient does not feel insulted. Maintaining patient dignity through good ethics is the best way to provide legal protection for all parties (Herisasono et al., 2023). Insulting a patient means stripping away their dignity and turning the relationship into a power struggle. However, the refusal must also be clear so that the patient does not conclude that the physician is neglecting them. At the same time, patients have the right to seek a second opinion or look for alternative services. This right is a part of autonomy and serves as a corrective mechanism for potential bias. This is crucial because a patient's psychological condition can be heavily affected if they feel they have no other options in their treatment (Issalillah & Khayru, 2021). Within this framework, the limit of autonomy does not mean the patient must follow the physician, but rather that clinical decisions must remain within the corridor of responsibility. This distinction is important so that autonomy is not misunderstood as a right to command the physician. A physician is not an executor of the patient's will, but a professional working in collaboration with the patient. Collaboration requires honesty from both sides. The patient is honest about preferences, and the physician is honest about professional boundaries. Thus, the limit of autonomy is a space for

ethical negotiation that requires mature communication and fair procedures (Quill & Brody, 1996).

Emergency situations demand a special discussion regarding the justification of actions when full consent is impossible to obtain. Within a normative framework, emergency justification rests on the principle of protecting life and preventing serious harm that cannot be delayed. However, this justification is narrow in scope and must be used proportionally. Therefore, every medical action in an urgent condition must still be neatly documented in accordance with applicable medical record regulations (Mubarak et al., 2023). Proportionality means that the actions taken are truly necessary for stabilization or to avoid immediate damage. Actions that can be delayed should wait for consent. Furthermore, emergency justification does not erase the obligation to provide an explanation as soon as circumstances permit. An explanation after the action remains important so that the patient understands what happened to their body. This is vital to prevent misunderstandings when such information spreads to the public or family through digital media (Muhammad et al., 2023). This understanding maintains dignity and prevents the feeling of being treated as an object. In emergencies, the family often becomes the source of information regarding the patient's values. However, the family can also be in a state of panic. Therefore, emergency communication must be brief yet clear, and must separate essential information from details that can wait. The normative framework demands that an emergency is not used as an excuse to eliminate documentation, but rather to adjust its form. Adjusting the form means records that reflect the reasons for the action and the reasons why consent could not be obtained at that time. All these steps are taken to ensure that the patient's rights remain protected even in difficult circumstances (Kholis et al., 2023; Herisasono et al., 2023). Consequently, emergencies remain under the umbrella of accountability (Iserson et al., 1995).

Vulnerable patients raise questions about who becomes the subject of consent and how autonomy is respected when capacity is limited. In pediatric patients, autonomy develops gradually. At this stage, the influence of technology and social media on the mental health of children and adolescents also needs to be a concern in the medical assistance process (Khayru & Issalillah, 2022). Within a normative framework, children need

to be involved according to their level of understanding, so that decisions do not become entirely an affair of adults. This involvement builds respect and reduces trauma. In patients with cognitive impairments or certain mental disorders, capacity needs to be assessed functionally. However, capacity assessments must avoid stigma, as stigma can cause patients to be automatically sidelined. Social support and understanding of the patient's traumatic conditions greatly assist their mental recovery process (Issalillah & Khayru, 2021). In patients with language barriers, consent may appear to exist but is actually not understood. Within a normative framework, language barriers demand communication aids, including competent interpreters. An incompetent interpreter can alter meaning, and a change in meaning can change choices. Furthermore, vulnerable patients often depend on institutions for basic needs. This dependency can suppress freedom of choice. Therefore, consent procedures for vulnerable patients demand attention to power relations and protection from pressure. The security of their personal data in electronic systems must also be a top priority for hospitals (Kholis et al., 2023). This protection is procedural, such as providing safe speaking spaces and offering opportunities for deliberation. Thus, vulnerable patients demand more careful and structured informed consent (Hall et al., 2012).

Family relationships in medical decision-making often strengthen support, but they can also obscure the patient's voice. In many cultures, families play a significant role in caring and decision-making. Within a normative framework, the family's role needs to be acknowledged without erasing the patient's rights. Acknowledgment means the family can help in understanding the patient's values and assist in deliberation, but the decision must still reflect the patient's will if the patient possesses capacity. This is very important to note because differences in social status within society often influence how the quality of healthcare is provided to patients and their families (Nalin et al., 2022). Tension arises when a family asks a doctor to hide a diagnosis or prognosis to protect the patient. Such a request tests the principles of honesty and autonomy. Hiding information can prevent a patient from organizing their life and arranging end-of-life decisions. However, delivering information without sensitivity can be hurtful. Therefore, the normative framework demands respectful communication, namely conveying the truth in a humane manner and

according to the patient's readiness. Patient readiness should not be used as a permanent excuse to withhold information, but rather as a consideration for the method and timing. Additionally, families may have their own interests, such as economic or reputational interests. Thus, the doctor needs to maintain focus on the patient's interests. However, maintaining focus does not mean being hostile toward the family. What is required is a procedure that places the patient at the center, while still managing family relations ethically (Hardwig, 1990).

The right to refuse medical action is a powerful expression of autonomy. Within a normative framework, refusal must be respected as long as the patient has capacity and understands the consequences. This respect is often difficult when the doctor judges that the action is life-saving or highly beneficial. However, forcing an action undermines the basic principle of consent. Our own country already has clear legal regulations to protect patient rights, including those who are underprivileged, so they still receive justice in service (Noor et al., 2023). On the other hand, refusal also triggers the doctor's obligation to ensure that the refusal is not the result of a misunderstanding. If a refusal stems from erroneous information, the doctor needs to correct it through patient explanation. Correction is not the same as coercion. Correction is part of the professional responsibility to ensure that decisions are based on understanding. Furthermore, refusal may be related to religious beliefs or moral values. In a normative framework, these values need to be respected, yet the doctor still needs to assess the consequences for safety. If a refusal carries serious risks, the doctor can suggest alternatives that align with the patient's values. However, alternative suggestions must be honest about their limitations. This framework demands that refusal also needs to be clearly documented, including the explanations provided and the patient's understanding. Documentation here serves as protection for both the patient and the doctor. Thus, refusal is a legitimate part of decision-making, not a failure of service (Appelbaum, 2007).

The concept of implied consent is often discussed in the context of routine actions, such as procedures that are socially considered normal during an examination. However, within a normative framework, implied consent has its limits. Implied consent cannot be applied to invasive procedures or high-risk actions. Implied consent is also inapplicable when a

patient is in doubt or shows signs of refusal. Therefore, organizations need to distinguish between types of actions and arrange consent standards according to the level of risk and invasiveness. In addition to medical actions, protection for patients as consumers also includes the responsibility of pharmacists in providing safe medication (Setiawan et al., 2023). This distinction ensures that procedures do not burden minor actions while still protecting patients during major ones. However, such a distinction must be accompanied by communication. Implied consent does not mean an absence of explanation. A brief explanation is still necessary so that the patient understands what is being done. Furthermore, implied consent must not be used to avoid conversations about choices. If alternatives exist, the patient needs to be informed. Within a normative framework, the goal of consent is choice, not merely permission. Choice requires information about alternatives. Therefore, implied consent must be understood as a minimal form applicable to specific actions, not as a shortcut. Thus, the governance of informed consent requires a classification of actions and proportional communication guidelines (Manson & O'Neill, 2007).

Procedural justice becomes an essential element in informed consent because it determines whether a patient feels treated as a respected subject. Procedural justice in service means the decision process is clear, reasons are explained, and the patient is given the opportunity to express preferences (Entwistle et al., 2010). When the process is unclear, patients tend to view medical actions as unilateral acts. A unilateral perception erodes trust, and without trust, communication becomes defensive. Defensive communication reduces the quality of consent, as patients tend to withhold questions or refuse without listening. The government also needs to continuously monitor for fraud in health insurance that could disadvantage the public and damage our health protection system (Setiawan et al., 2023). Within a normative framework, procedural justice is also related to time. Patients need time to deliberate, especially regarding elective procedures. If time is always constricted by schedules, autonomy is pressured. However, time is also linked to access. Patients from certain social groups may feel reluctant to ask questions or feel unworthy of requesting an explanation. Therefore, procedural justice demands that physicians actively invite questions. Inviting questions is a form of respect. Furthermore, procedures must ensure that information is provided in an

understandable form, for example, with the help of visual aids or summaries. Thus, procedural justice bridges legal norms and the patient's experience within the clinical space.

Medical confidentiality is closely linked to informed consent because consent often involves the use and disclosure of health information. Within a normative framework, patients have the right to know how data is used, who can access it, and for what purpose. If patients do not understand the use of their data, consent for action may lose its meaning because medical actions often involve laboratory tests, imaging, and referrals involving multiple parties. In modern situations, data is frequently stored in digital systems. Digital systems facilitate access but also increase the risk of misuse. The primary goal is that every health policy taken can be truly fair and help improve the quality of life for the broader community (Nalin et al., 2022). Therefore, consent governance needs to include explanations regarding confidentiality and its limits (Grande et al., 2013). Limits to confidentiality may arise when the law requires specific reporting or when there is a serious risk to others. Within a normative framework, these limits must be explained honestly, as honesty is the foundation of trust. Additionally, vulnerable patients may fear that information will be used for discrimination. This is particularly important for patients from low-income groups who are entitled to the same guarantee of legal protection in every hospital (Noor et al., 2023). Such fear can lead patients to withhold important information. Withholding information can jeopardize clinical decisions. Therefore, the protection of confidentiality is a part of protecting autonomy. Thus, informed consent does not end with the procedure but extends to the management of information accompanying that procedure.

Consent for high-risk actions demands attention to the way risks are conveyed. Risks can be presented in various forms, such as probability, severity, and long-term impact. Within a normative framework, the communication of risk must avoid two extremes: fear-mongering or excessive reassurance. Fear-mongering undermines freedom, while excessive reassurance undermines understanding. Balance can be achieved by explaining risks that are material to the decision, namely risks that could reasonably influence a patient's choice. However, what is material can differ between patients. Therefore, the doctor needs to ask what the patient

considers most important. In this framework, *informed consent* becomes personalized not by following mere whims, but by respecting the patient's values (Spatz et al., 2016). We all hope that health professionals, including pharmacists, always prioritize safety and protection for patients as consumers (Setiawan et al., 2023). The communication of risk also needs to consider health literacy. Patients with low literacy require simpler language, yet simple language must not sacrifice truth. This demands professional communication skills. Furthermore, risk explanations must be accompanied by alternatives, including the alternative of not performing the action. It is also very important to ensure that all these medical processes are free from any form of fraud or document falsification that could harm many parties (Setiawan et al., 2023). The alternative of not performing an action is a part of autonomy, as choosing means weighing all possibilities. Thus, *informed consent* for high-risk actions is a test of communication integrity and a test of commitment to patient respect.

Emergency situations involving vulnerable patients reveal the highest complexity. When a patient is unconscious or unable to speak, and when action must be taken immediately, doctors often act based on the principle of rescue. However, within a normative framework, rescue actions still need to consider the patient's potential preferences, for example, through medical records, family information, or previous statements. Ignoring known preferences undermines dignity. Yet, delaying action to search for preferences can also be dangerous. Therefore, emergency reasoning demands a proportional balance. Proportionality means taking the actions necessary to preserve life and delaying choice-based decisions until consent can be obtained. In an emergency, documenting the reasons is also important, so that actions can be ethically audited. An ethical audit is not for punishment, but to ensure that exceptions are used narrowly. Furthermore, after the patient is stable, a recovery conversation is needed—namely, an explanation of what was done and why. The recovery conversation restores the autonomy that was temporarily suspended. For vulnerable patients, the recovery conversation also needs to involve a legal guardian, while still ensuring that the patient's voice is sought (Iserson et al., 1995). Thus, an emergency does not erase autonomy, but rather delays part of its expression within justifiable limits.

The relationship between *informed consent* and a doctor's legal responsibility often creates the misperception that consent is a shield against lawsuits. Within a normative framework, consent is not a shield, but rather evidence that the doctor respects the patient and that the decision was made through the correct procedure. If an action is performed with negligence or violates standards, consent does not erase responsibility. Conversely, if a doctor acts according to standards and performs proper communication, consent strengthens the legitimacy of the action. Therefore, *informed consent* must be understood as part of good professional practice, not as a defensive technique. When consent is used as a defensive technique, the language used tends to be legalistic and frightening. Frightening language undermines freedom. Additionally, defensive techniques often drive doctors to provide excessive information without structure, just to appear thorough. Excessive information without structure can confuse the patient and reduce understanding. Within a normative framework, what is required is relevant information organized clearly. Clarity is a form of respect. Thus, healthcare institutions need to foster a culture that values communication as a core competency. This culture is more protective than a mere stack of documents. Therefore, the relationship between consent and accountability must be understood as a relationship that strengthens ethics, not one that triggers defensiveness (Katz, 1984).

The involvement of the healthcare team in consent raises questions about the division of responsibility. In practice, many actions involve doctors, nurses, and other personnel. Patients often receive information from various people. Within a normative framework, the division of responsibility must be clear so that information is consistent and the patient does not receive conflicting messages. Conflicting messages reduce trust and interfere with decision-making. Therefore, institutions need to organize team communication standards for example, who explains a specific part, who ensures understanding, and who documents the process. However, standards must not make the conversation mechanical. The conversation must remain responsive to the patient's questions. Furthermore, institutions need to recognize that nurses are often the ones closest to the patient and often act as interpreters of clinical language. This role is important, but it must not exempt the doctor from the responsibility of explaining the primary action. Within a normative framework, the

primary responsibility lies with the party performing or deciding on the action. However, the collective responsibility of the team remains to maintain consistency and respect. Thus, *informed consent* is an organizational process, not just a process between two individuals. Organizational processes demand coordination, communication training, and a uniform culture of respect (Aulisio et al., 2003).

Informed consent is also related to the issues of sedation use and pain management. In certain procedures, sedation can affect decision-making capacity. Within a normative framework, consent for procedures involving sedation must be obtained before the sedation affects consciousness. If consent is requested after sedation, the consent loses its quality of voluntariness. Furthermore, severe pain can impair attention and understanding. Therefore, managing pain can be part of maximizing capacity. However, managing pain can also alter consciousness. This balance demands clinical judgment and ethical reasoning. It is evident here that *informed consent* cannot be separated from the patient's physiological condition. Thus, consent procedures must be flexible without losing their principles. Flexibility means adjusting the sequence, for example, providing certain analgesia that does not impair understanding before the discussion. Additionally, communication needs to acknowledge that a patient in pain might agree only to end their suffering, rather than because they understand. Therefore, the doctor needs to assess understanding with simple questions that examine the core of the decision. Checking for understanding is an ethical tool that prevents pseudo-consent. Consequently, *informed consent* demands intertwined clinical and communication skills (Silvestri et al., 2001).

In patients with social vulnerabilities, such as economic dependency or low social status, consent can be distorted by the fear of losing access to services. Within a normative framework, such fear reduces freedom of choice. Therefore, *informed consent* requires guarantees that basic services are not withheld as a tool of pressure. This guarantee must become the institutional culture, not just a statement. Culture is visible in the way staff respond to questions, how they respond to refusals, and how they explain consequences. Furthermore, vulnerable patients often have limited legal and health literacy. The normative framework demands that explanations do not rely on exclusionary terms. Explanations need to use relevant

examples and check for understanding. Checking for understanding is not a test, but a way to ensure the patient truly understands. Additionally, if a patient requires a companion, the companion must be chosen with regard to the patient's interests. A companion with their own interests can steer the choice. Therefore, institutions need to have procedures to identify conflicts of interest. All these steps demonstrate that *informed consent* is a mechanism of justice, as it protects the vulnerable from subtle dominance. Thus, patient autonomy demands protection mechanisms that are sensitive to social inequality (O'Neill, 2003).

Medical consent at the end of life has a strong moral dimension because decisions touch on values regarding suffering and dignity. Within a normative framework, consent in this situation demands honesty about the prognosis and the goals of care. The goal of care may shift from curing toward palliative care. This shift must be explained so that the patient can assess what most aligns with their life values. However, honesty must also be conveyed with empathy, so that information does not become verbal violence. It is seen there that *informed consent* combines truth and the method of delivery. Furthermore, patient comfort is also influenced by fundamental things such as cleanliness and the safety of the drinking water they consume while in the hospital (Issalillah et al., 2022). Families may push for aggressive actions out of hope, or refuse actions out of fear. Within a normative framework, decisions must center on the patient's will if that will can be known. If the will cannot be known, then decisions must follow the best interests interpreted carefully. The interpretation of best interests must avoid the interests of the institution or the mere convenience of the family. Thus, *informed consent* at the end of life demands a framework that places the patient's dignity at the center, accompanied by communication procedures that provide space for time and questions. This affirms that consent is not a one-time event, but a repeating process that follows changing conditions (Bernat & Peterson, 2006).

The relationship between *informed consent* and professional communication competence creates a demand that medical education must place communication as a core skill. Within a normative framework, communication is not a talent, but a competence that can be trained. This competence includes the ability to organize information, the ability to listen to patient values, and the ability to manage the emotions of the

patient and family. If education emphasizes technical skills without communication, doctors will struggle to implement meaningful *informed consent*. The quality of this communication significantly determines patient satisfaction with the services they receive as a whole (Khayru & Issalillah, 2022). This difficulty is then replaced by the ritual of forms. Therefore, institutions need to organize communication learning as part of professional ethics. Professional ethics demand respect for autonomy and respect for dignity. Respect does not occur if the patient is not understood. Furthermore, good communication also protects doctors from unnecessary conflict, as many conflicts arise from a sense of not being explained to. In major medical procedures such as C-sections, a good relationship between the doctor and patient is highly necessary so that each party understands their responsibilities (Kaseger et al., 2023). Within this framework, *informed consent* is a tool for conflict prevention through honesty and clarity. However, conflict prevention is not the primary goal, but a consequence of respect. Thus, legal regulations need to be linked to institutional education and training policies, so that norms turn into habits. Habit is where ethics live within an organization. Without habit, norms remain mere text (Levinson et al., 1997).

Legal regulations provide the basic framework and certain exceptions, especially in emergencies, but exceptions must be interpreted narrowly and proportionally. The limits of patient autonomy arise from the professional obligation to act according to standards, from the need to protect patients when capacity is inadequate, and from the demand to maintain public safety in certain circumstances. Hospitals must also always guarantee that every action taken is in accordance with applicable legal rules for everyone's safety (Kaseger et al., 2023; Khayru & Issalillah, 2022). In emergency situations, actions can be justified to prevent serious harm, with the obligation of explanation and records as soon as circumstances permit. In vulnerable patients, procedures need to emphasize involvement according to capacity, protection from family or institutional dominance, and communication support such as interpreters. All basic needs of patients, including small things that support their physical health, must remain prioritized by service providers (Issalillah et al., 2022). This framework centers on patient dignity as the primary reason, while maintaining the doctor's professional responsibility (Grady, 2015). Thus,

informed consent becomes a space for ethical cooperation between the law, the profession, and the patient experience.

Conclusion

Informed consent is a normative mechanism that links the legitimacy of medical actions with respect for the patient's right to autonomy. Valid medical consent demands a communication process that conveys relevant information in a balanced manner, verifies understanding, assesses decisional capacity functionally, and protects freedom of choice from undue pressure. The limits of patient autonomy are understood as a corridor of professional responsibility and the protection of dignity, particularly when patient requests conflict with professional standards or when decisional capacity is impaired. Emergency situations reinforce the need for narrow and proportional justifications for swift action, accompanied by the duty of disclosure and documentation once the situation allows. For vulnerable patients, consent requires more structured procedures to prevent pseudo-consent arising from language barriers, dependency, or the dominance of other parties. Thus, the core of the discussion lies in the shift from formal compliance toward substantive legitimacy consent as a process that genuinely protects the patient while simultaneously maintaining the accountability of the profession and healthcare institutions.

The implications and recommendations emphasize the need for healthcare institutions to organize informed consent as a standardized organizational process that remains responsive to patient needs. Consent procedures should focus on the quality of communication, including the use of understandable language, an explanation structure that emphasizes the comparison of options, and comprehension check steps that are not demeaning. The governance of consent documents must be established as a trace of the process, with an emphasis on information security and access restrictions. In emergency situations, institutions need to reinforce guidelines on the proportionality of actions and the obligation for post-stabilization disclosure, ensuring that exceptions do not expand into habits. For vulnerable patients, institutions must ensure engagement according to capacity, the use of competent interpreters when necessary, and procedures to identify pressure and conflicts of interest. Clinical

communication education and training must be positioned as a core professional competence, so that respect for autonomy becomes a consistent work habit that is ethically and legally accountable.

References

Abdullah, I. S. T., Hardyansah, R., & Khayru, R. K. 2023. Presumed Consent and the Doctrine of Necessity as the Basis for Emergency Medical Treatment Without Informed Consent. *Journal of Social Science Studies*, *3*(1), 343-354.

Aisyah, N., & Issalillah, F. 2022. Healthy Eating, Mental Health, and Environmental Awareness: Implications for the Health of Young Generations. *Journal of Social Science Studies*, *2*(2), 157-162.

Appelbaum, P. S. 2007. Assessment of Patients' Competence to Consent to Treatment. *New England Journal of Medicine*, 357(18), 1834-1840.

Appelbaum, P. S., & Grisso, T. 1988. Assessing Patients' Capacities to Consent to Treatment. *New England Journal of Medicine*, 319(25), 1635-1638.

Aulisio, M. P., Arnold, R. M., & Youngner, S. J. 2000. Health Care Ethics Consultation: Nature, Goals, and Competencies. *Annals of Internal Medicine*, 133(1), 59-69.

Aulisio, M. P., May, T., & Bayley, C. 2003. Ethics consultation: services, structures, and roles. *Journal of Clinical Ethics*, 14(3), 143-156.

Bailey, K. 2008. *Methods of Social Research*. Simon and Schuster, New York.

Baronov, D. 2015. *Conceptual Foundations of Social Research Methods*. Routledge, New York.

Bernat, J. L., & Peterson, L. M. 2006. Patient-centered informed consent in surgical practice. *Archives of Surgery*, 141(1), 86-92.

Chairul, Z., Hardyansah, R., Waskito, S., & Khayru, R. K. 2023. Informed Consent as a Fundamental Right of Patients: The Law and Medical Ethics Perspective. *Journal of Social Science Studies*, *3*(2), 209-214.

Crano, W. D., M. B. Brewer & A. Lac. 2014. *Principles and Methods of Social Research*. Routledge, New York.

Darmawan, D., Issalillah, F., Khayru, R. K., Herdiyana, A. R. A., Putra, A. R., Mardikaningsih, R., & Sinambela, E. A. 2022. BPJS patients satisfaction analysis towards service quality of public health center in Surabaya. *Media Kesehatan Masyarakat Indonesia*, *18*(4), 124-131.

Entwistle, V. A., Carter, S. M., Cribb, A., & McCaffery, K. 2010. Supporting Patient Autonomy: The Importance of Clinician-patient Relationships. *Journal of General Internal Medicine*, 25(7), 741-745.

Eyal, N. 2014. Using informed consent to save trust. *Journal of medical ethics*, *40*(7), 437-444.

Feriadi, E. H., Khayru, R. K., Issalillah, F., Vitrianingsih, Y., & Mardikaningsih, R. 2023. Patient Autonomy, Paternalistic Healthcare Providers, and Criminal Liability in Therapeutic Contracts. *Journal of Social Science Studies*, *3*(1), 307-318.

Grady, C. 2015. Enduring and emerging challenges of informed consent. *New England Journal of Medicine*, *372*(9), 855-862.

Grande, D., Mitra, N., Shah, A., Wan, F., & Asch, D. A. (2013). Public attitudes about personal health information as a shared resource. *JAMA Internal Medicine*, 173(1), 37-43.

Hall, D. E., Prochazka, A. V., & Fink, A. S. 2012. Informed consent for clinical treatment. *Cmaj*, *184*(5), 533-540.

Hardwig, J. 1990. "What About the Family?. *The Hastings Center Report*, 20(2), 5-10.

Hartika, Y., Saputra, R., Pakpahan, N. H., Darmawan, D., & Putra, A. R. 2023. A Study on the Falsification of Health Certificates: Perspective of Criminal Law and Professional Ethics. *Journal of Social Science Studies*, 3(2), 175-180.

Herisasono, A., Darmawan, D., Gautama, E. C., & Issalillah, F. 2023. Protection of Patient Rights in the Perspective of Law and Medical Ethics in Indonesia. *Journal of Social Science Studies*, *3*(2), 195-202.

Iserson, K. V., Sanders, A. B., & Mathieu, D. 1995. Ethics in Emergency Medicine. *The American Journal of Emergency Medicine*, 13(2), 241-243.

Issalillah, F. 2021. Advancing Quality of Life Through Sustainability Policies That Prioritize Health and Equality. *Studi Ilmu Sosial Indonesia*, 1(2), 65-74.

Issalillah, F., & Khayru, R. K. 2021. Social Perceptions of Domestic Violence and its Implications forthe Mental Health and Recovery Process of Victims. *Journal of Social Science Studies*, *1*(2), 125-130.

Issalillah, F., & Mardikaningsih, R. 2022. Environmental Justice and Health Burdens in Marginalized Communities Near Waste Sites. *Studi Ilmu Sosial Indonesia*, 2(1), 145-168.

Issalillah, F., Khayru, R. K., & Aisyah, N. 2022. Parameters of Mineral Water that is Safe for Health. *Bulletin of Science, Technology and Society*, *1*(1), 4-6.

Kalof, L., & A. Dan. 2008. *Essentials of Social Research*. McGraw Hill Education (UK), Maidenhead.

Kaseger, H., Baktiasih, D. G. S., Harianto, A. V., Indaryanti, N., & Issalillah, F. 2023. The Interplay of Legal Responsibilities in Cesarean Operations: A Study of Doctor-Patient Relationships within Hospital Settings. *Legalis et Socialis Studiis (L355)*, *1*(3), 26-34.

Katz, J. 1984. The silent world of doctor and patient. *Free Press*. (Cit. *The Yale Law Journal*, 94(7), 1731-1759, 1985).

Khayru, R. K. 2022. Social Support Systems and its Implication for Healthcare Provision for the Elderly Population, *Studi Ilmu Sosial Indonesia*, 2(2), 333-360.

Khayru, R. K., & Issalillah, F. 2022. Service quality and patient satisfaction of public health care. *International Journal of Service Science, Management, Engineering, and Technology*, *1*(1), 20-23.

Khayru, R. K., & Issalillah, F. 2022. The Impact of Social Media on Mental Health: An Analysis of the Effects on Anxiety, Depression, and Sleep Disorders in Adolescents and Young Adults. *Journal of Social Science Studies*, *2*(1), 95-102.

Kholis, K. N., Chamim, N., Susanto, J. A., Darmawan, D., & Mubarak, M. 2023. Analyzing Electronic Medical Records: A Comprehensive Exploration of Legal Dimensions within the Framework of Health Law. *International Journal of Service Science, Management, Engineering, and Technology*, *4*(1), 36-42.

Krumholz, H. M. 2010. Informed Consent to Promote Patient-Centered Care. *JAMA*, 303(12), 1190-1191.

Levinson, W., Roter, D. L., Mullooly, J. P., Dull, V. T., & Frankel, R. M. 1997. Physician-patient communication: the relationship with malpractice claims among primary care physicians and surgeons. *JAMA*, 277(7), 553-559.

Manson, N. C. 2012. Informed Consent: Autonomy and Self-Ownership. *Journal of Medical Ethics*, 38(11), 643-644.

Manson, N. C., & O'neill, O. 2007. *Rethinking informed consent in bioethics*. Cambridge University Press.

Mubarak, M., Darmawan, D., & Saputra, R. 2023. Legal and Ethical Arrangements for Medical Record Filling by Doctors: A Normative Study. *Bulletin of Science, Technology and Society*, *2*(1), 33-38.

Muhammad, A. I., Saputra, R., Pakpahan, N. H., Darmawan, D., & Khayru, R. K. 2023. Ethics and Legality in the Dissemination of Information on Traffic Accident Victims Through Digital Media. *Journal of Social Science Studies*, *3*(2), 235-244.

Nalin, C., Saidi, S. A. B., Hariani, M., Mendrika, V., & Issalillah, F. 2022. The Impact of Social Disparities on Public Health: An Analysis of Service Access, Quality of Life, and Policy Solutions. *Journal of Social Science Studies*, *2*(1), 39-46.

Nelson, R. M., Beauchamp, T., Miller, V. A., Reynolds, W., Ittenbach, R. F., & Luce, M. F. 2011. The concept of voluntary consent. *The American Journal of Bioethics*, *11*(8), 6-16.

Noor, A., Herisasono, A., Hardyansah, R., Darmawan, D., & Saktiawan, P. 2023. Juridical Review of the Rights of Indigent Patients in Health Services in Indonesia. *Journal of Social Science Studies*, *3*(2), 253-258.

O'Neill, O. (2003). Some limits of informed consent. *Journal of Medical Ethics*, 29(1), 4-7.

Quill, T. E., & Brody, H. 1996. Physician Recommendations and Patient Autonomy: Finding a Balance between Physician Power and Patient Choice. *Annals of Internal Medicine*, 125(9), 763-769.

Setiawan, R. A., Khayru, R. K., Mardikaningsih, R., Issalillah, F., & Halizah, S. N. 2023. Implementation of Indonesian Positive Law in Combating Fraud and Forgery in Health Insurance and Protection against Industrial Losses. *Journal of Social Science Studies*, *3*(1), 271-280.

Setiawan, S., Hardyansah, R., Khayru, R. K., & Putra, A. R. 2023. Consumer Protection in the Health Sector: The Legal Responsibilities of Pharmacists. *Journal of Social Science Studies*, *3*(2), 131-138.

Setiyadi, G. B., Negara, D. S., Khayru, R. K., Darmawan, D., & Saputra, R. 2023. Misdiagnosis and Legal Liability of Doctors: A Normative Juridical Study in the Indonesian Health System. *Journal of Social Science Studies*, *3*(2), 215-220.

Silvestri, G., Pritchard, R., & Welch, H. G. 2001. Preferences for chemotherapy in patients with advanced non-small cell lung cancer: descriptive study based on real life situations. *BMJ*, 317(7161), 771-775.

Simpkin, A. L., & Schwartzstein, R. M. 2016. Tolerating Uncertainty — The Next Medical Revolution?. *New England Journal of Medicine*, 375(18), 1713-1715.

Singleton, R., & B. C. Straits. 2018. *Approaches to Social Research*. Oxford University Press, Oxford.

Spatz, E. S., Krumholz, H. M., & Moulton, B. W. 2016. The new era of informed consent: getting to a reasonable-patient standard through shared decision making. *Jama*, *315*(19), 2063-2064.

Spector-Bagdady, K., & Lombardo, P. A. 2019. Something Old, Something New: Informed Consent in the Era of Next-Generation Sequencing. *Journal of Law, Medicine & Ethics*, 47(1), 172-177.

Stanley, B. M., Walters, D. J., & Maddern, G. J. 1998. Informed consent: how much information is enough?. *Australian and New Zealand journal of surgery*, *68*(11), 788-791.

Stiggelbout, A. M., Pieterse, A. H., & De Haes, J. C. 2015. Shared Decision Making: Concepts, Evidence, and Perspectives. *Patient Education and Counseling*, 98(10), 1172-1179.

Subiakso, A., Juliarto, T. S., Darmawan, D., Sisminarnohadi, S., & Romli, R. I. A. 2023. Legal rights in access to health services for persons with disabilities. *Bulletin of Science, Technology and Society*, *2*(3), 15-20.

Tamaka, R. S., Wuryani, A. I., Lethy, Y. N., Issalillah, F., & Hardyansah, R. 2023. Legal Review of Patients' Rights in the Health Insurance System. *Studi Ilmu Sosial Indonesia*, 3(2), 69-84.

Tampil, V. C., Mubasyiroh, A. A., Khayru, R. K., Darmawan, D., & Prasetyo, B. A. 2023. Legal Protection for Patients in Health Services at Community Health Centers. *Studi Ilmu Sosial Indonesia*, 3(2), 85-100.

Vitrianingsih, Y., & Issalillah, F. 2021. The National Legal System's Effectiveness in Handling Public Health Crises Responsively and Fairly. *Journal of Social Science Studies*, *1*(2), 203-208.

Warin, A. K. 2023. Social Relationship Between Urban Living Characteristics and Social Determinants of Population Health, *Studi Ilmu Sosial Indonesia,* 2(2), 307-332.

Wuryani, A. I., Kaseger, H., Tamaka, R. S., Tampil, V. C., & Issalillah, F. 2023. Juridical Review of Government Legal Measures for Ensuring Rights of Patients with Mental Disorders in Social Security Administration. *Bulletin of Science, Technology and Society*, *2*(3), 28-36.