



NORMATIVE FACTORS BEHIND LOW MALPRACTICE CLAIMS FOR PATIENTS HARMED BY ERRORS

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Abstract

This article explains why malpractice lawsuits are rarely initiated by patients harmed by medical errors through a normative framework focused on rights awareness, proof structure, procedural design, and care relationships. Patients often struggle to distinguish acceptable medical risk from negligent conduct and to translate adverse outcomes into legal claims. Technical requirements for causation and standard of care, reliance on expert opinion, and limited understanding of medical records intensify perceived uncertainty. Multiple dispute channels with different aims create confusion about sequence, consequences, and attainable remedies. Trust in clinicians, social stigma against claimants, and continued dependence on healthcare services add psychological and relational costs that discourage litigation. Economic strain after injury, trauma, and lack of guidance reduce the practical capacity to pursue lengthy proceedings. By organizing these elements into coherent clusters, the article clarifies how normative conditions shape patient decision making and how procedural legitimacy affects willingness to seek judicial accountability. The framework supports clearer reasoning about access to justice in medical disputes and about patient protection within professional responsibility systems.

Keywords: medical negligence, malpractice claims, patient rights, burden of proof, expert evidence, dispute resolution, access to justice.

Introduction

The relationship between patients and medical personnel is a relationship that integrates the dimensions of trust, professional obligation, and legal certainty. Patients surrender personal information, their bodies, and critical decisions to medical personnel with the expectation of obtaining care that complies with professional standards. Within that relation lies an obligation to provide care that is careful, executed in good faith, and aligned with ethical principles as well as applicable legal provisions. At the same time, healthcare services possess a highly complex technical character, involving clinical action choices, resource limitations, and an inherent uncertainty of outcomes native to medical science. This complexity causes the distinction between acceptable medical risks and medical errors that generate liability to frequently require systematic explanation (Kurniawan, 2013). Within the legal sphere, the necessity for that explanation relates to proof, the evaluation of professional standards, and the determination of a causal link between actions and damages. This need for explanation demands clarity regarding fair legal protection for patients against negligence by medical personnel (Lethy et al., 2023). Consequently, the discussion of malpractice lawsuits cannot be separated from how society understands healthcare standards, structures of liability, and the position of the patient as a subject of rights.

The development of modern health services drives an increase in expectations toward service quality, information transparency, and patient safety (Marković, 2021). Patients are increasingly familiar with health information through mass media and digital platforms, thereby providing them with reference points to evaluate service quality. However, access to information is not always directly proportional to the ability to comprehend the boundary between complications that can reasonably occur and medical errors that can be held accountable. This divergence in understanding can influence how patients interpret clinical experiences, particularly when treatment outcomes fail to meet expectations. Ideally, these service quality expectations should align with sustainability policies that prioritize public health and equity (Issalillah, 2021). On the other hand, medical personnel work within a framework of professional obligations that demand caution, yet they continue to face diverse and not always predictable patient conditions. The tension between outcome expectations and the reality of

clinical uncertainty frequently generates questions as to whether a medical error has occurred. Those questions subsequently enter the legal arena when patients evaluate that a compensable loss has been sustained. From a normative standpoint, this situation demands clear parameters of liability, as well as clear dispute resolution pathways that guarantee the protection of patient rights and certainty for medical personnel.

A malpractice lawsuit is one of the mechanisms theoretically available to enforce accountability and provide remedies to aggrieved patients (Hafizah & Fitriasih, 2022). This mechanism resides within a broader spectrum that encompasses ethical complaints, administrative resolutions, as well as civil and criminal pathways according to the character of the act. At the level of principles, a lawsuit functions as a means to evaluate whether an action falls below appropriate professional standards, whether negligence or intent is present, and whether the harm possesses a causal link to the action. This evaluation of action also applies to cases of misdiagnosis and the legal liability of physicians within the Indonesian healthcare system (Setiyadi et al., 2023). However, the existence of a mechanism does not automatically mean that the mechanism is utilized by patients. A patient's decision to file a lawsuit is influenced by many considerations concerning legal understanding, evidentiary readiness, cost burdens, and social consequences. Furthermore, the patient's relationship with the health facility and medical personnel frequently continues after the event in question, causing the patient to consider the need for ongoing care. Within the normative sphere, this ongoing relationship can generate a dilemma between the need for remedy and the need to maintain service access. Therefore, the low frequency of malpractice lawsuits becomes an issue that demands a careful reading of its causal factors.

In the healthcare service system, the information imbalance between patients and medical personnel is a character that is difficult to avoid. Medical personnel possess clinical knowledge and access to care records, whereas patients are frequently in a vulnerable position due to illness, stress, or a limited understanding of medical terms. This imbalance influences the patient's ability to evaluate whether a medical error has genuinely occurred. Even when patients experience harm, they may find it difficult to formulate the event precisely in legal language (Khalid, 2023). This information disparity underscores the importance of the obligation

for transparency regarding medical costs and risks by private healthcare providers within legal constructions (Rachim et al., 2024). Moreover, medical records, examination results, and standard procedures are often central to proof, yet patients do not always master how to obtain, read, and evaluate these documents. Within a normative framework, the information imbalance creates a necessity for guarantees of the patient's right to obtain information and access documents. However, formal rights still require the practical capability to utilize them. Consequently, the low frequency of lawsuits can be related to the patient's limitations in evaluating their legal position. This situation also connects to the patient's perception regarding the probability of success, because without an understanding of proof, a lawsuit can be viewed as an uncertain process.

The culture of trust in healthcare services also shapes the way patients interpret medical errors. Many patients place medical personnel as authority figures working for the patient's well-being, so that criticism of medical actions feels like a socially inappropriate act (Litan et al., 2021). In a highly personal relationship, patients may feel indebted for the help that has been provided, despite the accompanying bad experiences. This feeling can inhibit the intention to demand accountability through legal channels. Furthermore, patients may view errors as part of an unavoidable risk, especially when the initial communication from the service provider emphasizes the uncertainty of outcomes. Within a normative framework, risk communication is an essential obligation, yet imbalanced communication can forge a passive acceptance of losses that ought to be evaluated objectively. This acceptance of risk also encompasses an understanding of patient rights within the applicable health insurance system (Tamaka et al., 2023). Therefore, it is necessary to distinguish between the legitimate acceptance of risk through informed medical consent and acceptance that occurs due to ignorance. The low frequency of lawsuits may reflect the dominance of social norms that emphasize resignation, rather than a critical examination of service standards. This situation invites a discussion on how patient rights are understood and internalized.

The institutional design of health dispute resolution can also influence a patient's choices (Pope, 2008). There are various pathways that can be pursued, ranging from internal complaints within health facilities, professional ethical mechanisms, to litigation processes. This diversity of

pathways can cause confusion for patients regarding the sequence, consequences, and functional differences of each avenue. Patients may assume that an ethical complaint is equivalent to a civil lawsuit, or assume that an internal settlement has closed the opportunity to demand compensation. This confusion relates to legal literacy and access to procedural information. In the normative realm, clear procedures should provide certainty and protection, but when procedures are not understood, they become psychological barriers that lead patients to choose silence. This procedural barrier is also visible in the law enforcement against midwife malpractice in midwifery services in Indonesia (Safitri et al., 2023). Moreover, resolution mechanisms that emphasize confidentiality can reduce the space for patients to test their claims openly. In such a position, patients may feel they have no control over the process. The low number of lawsuits can then be understood as the result of an interaction between procedural systems and the patient's experience in navigating those systems. The focus of this study becomes relevant to evaluate the causal factors that are normative and structural in nature.

The prominent problem lies in the public's ambiguous interpretation regarding the boundary between medical errors, complications, and risks that have been explained in the treatment consent (Mazor et al., 2024). This ambiguity causes many complaints to stop at the level of dissatisfaction without turning into structured legal claims. In normative language, a claim requires a description of the breached obligation, the unfulfilled standard, and the recoverable loss. Patients often lack the conceptual tools to construct such a description, especially when technical information is delivered in clinical terms. This ambiguity also extends to the aspect of health personnel's negligence in the use of herbal medicines and its legal implications for patients (Mansyur et al., 2024). At the same time, justifying statements can emerge from various directions for instance, explanations that an adverse outcome is a consequence of the illness causing the patient to hesitate in distinguishing between natural causes and causes due to negligence. This hesitation is also related to proof, as patients realize that proof requires expert opinions and medical documents. When the initial interpretation is already blurred, patients tend to evaluate a lawsuit as a process that is not commensurate with the energy and cost. Consequently,

the low frequency of lawsuits is related to an inadequate knowledge structure regarding the elements of liability in medical errors.

Another problem relates to the socioeconomic position of patients and its effect on access to justice. Malpractice lawsuits are frequently associated with court costs, legal fees, and the need for expert expenses, which normatively form part of the burden of proof. Although there are legal aid schemes and various forms of support, the perception of an expensive process can become a hindering factor. This economic disparity is similar to the health burdens and environmental injustices often experienced by marginalized communities around waste disposal sites (Issalillah & Mardikaningsih, 2022). Furthermore, patients who are victims of medical errors are frequently in a weak physical and psychological state, so their ability to endure a lengthy process becomes limited. This condition can amplify the patient's dependency on health facilities, especially if the patient still requires ongoing treatment or referrals. This dependency is increasingly evident in social support systems and their implications for healthcare provision for the elderly population (Khayru, 2022). Such dependency can generate anxieties regarding a decline in service quality or service refusal, even if those anxieties are not always legally justified. In the normative realm, this fear demonstrates the fragility of the patient's sense of security when exercising rights. The low number of lawsuits can then be understood as a reflection of an unequal bargaining position. This issue does not require quantitative data to be understood, as it can be explained through the concepts of access to justice, the burden of proof, and dependency relationships in healthcare services.

The urgency of this writing lies in the need to construct a normative framework that explains why malpractice lawsuits are relatively rarely filed by patients who are victims of medical errors. Without a clear framework, discussions frequently get trapped in moral judgments that simplify patients as passive or medical personnel as immune to the law (Chiarello, 2019). Normative writing based on written sources can unravel factors related to patient legal literacy, evidentiary structures, procedural designs, and trust relationships in healthcare services. This framework is essential to clarify the points that influence a patient's decision, without having to depend on case stories or surveys. Furthermore, an orderly explanation can help distinguish problems at the normative level, the procedural level, and

the social relations level. The results are expected to enrich academic understanding regarding access to justice in medical disputes and provide direction for the improvement of patient information service guidelines. Thus, the urgency of this study relates to legal certainty, the protection of patient rights, and the legitimacy of the medical profession's liability system within a constitutional state.

The objective of this writing is to formulate a conceptual explanation regarding the factors causing the low frequency of malpractice lawsuits by patients who are victims of medical errors within the framework of healthcare service liability. The discussion is directed toward identifying factors at the level of understanding rights, the structure of proof, the procedural design of dispute resolution, and the trust relationship between patients and medical personnel. Theoretically, this writing strengthens the understanding of access to justice in medical disputes and organizes the relationship between professional standards, errors, and evidentiary requirements. Practically, this writing provides an argumentative basis for the formulation of risk communication guidelines, information disclosure, and the strengthening of the patient's position in exercising their rights. This objective keeps the discussion focused on the causes of low litigation rates as a normative construction that can be explained systematically, rather than as a personal assessment of patient behavior.

Method

This study uses a qualitative literature study to construct a normative synthesis regarding the factors causing the low frequency of malpractice lawsuits by patients who are victims of medical errors. The materials used consist of social research methodology books, conceptual works on methods, and relevant legal and medical ethics sources for understanding accountability and access to justice. The initial step was carried out by establishing conceptual boundaries, including the definition of malpractice as an issue of liability and the low frequency of lawsuits as a choice of legal action. Kalof and Dan (2008) are used to emphasize the importance of formulating clear research questions, selecting relevant materials, and constructing coherent arguments in social research. The selection of materials was conducted through thematic tracing, assessing the consistency of definitions, the sharpness of propositions, and the direct

relevance to the research problem. This approach ensures that the description does not turn into a compilation of opinions, but rather a synthesis resting on an accountable conceptual structure.

The processing of materials was carried out through systematic reading and thematic coding to group causal factors into several clusters, such as rights-understanding factors, evidentiary factors, procedural factors, and service-relationship factors. Baronov (2015) serves as a reference to maintain conceptual order, particularly in distinguishing the explanatory frameworks, assumptions, and normative implications of each theme. For citation variation, methodological explanations are presented in narrative forms such as Henn et al. (2005), as well as parenthetical forms such as (Baronov, 2015). The synthesis process emphasizes the interconnections between themes, such as how the burden of proof interacts with legal literacy, or how patient trust interacts with the choice of dispute resolution pathways. Because the research is normative in nature, the strength of the study is placed on the consistency of reasoning and clarity of definitions, rather than on measuring the rate of occurrence. With this design, the results of the study are expected to provide a causal map that can serve as a basis for further academic discussion.

Although Gagnon (2010) is known for the case study framework, his principles regarding the regularity of the unit of study and the discipline of material collection remain relevant for organizing the discussion in a focused manner. These principles are used to establish the unit of discussion in the form of the structure of causal factors rather than empirical occurrences. Furthermore, Henn et al. (2005) is used to emphasize that good social research demands an argumentative flow that can be logically tested through the interconnection between questions, materials, and conclusions. Validity is maintained by checking the consistency of terms, avoiding claims that require field data, and binding every part of the discussion to the problem formulation. Thus, this method is sufficient to elaborate on the factors causing the low frequency of lawsuits as a normative construction that can be understood through the theory of liability, the theory of access to justice, and the principles of healthcare service ethics, without presenting statistics, interviews, or field observations.

Result and Discussion

Within the Indonesian legal system, regulations regarding medical errors which in academic literature are frequently referred to as medical malpractice are not formulated under a single specific term in statutory legislation. Indonesian positive law does not explicitly utilize the terminology of “malpractice,” but instead constructs liability through the concepts of fault and negligence of medical or health personnel in conducting their professional practice. Therefore, every form of legal liability within the health services sector must be analyzed based on the presence or absence of elements of fault, negligence, and the causal relationship between the medical action and the harm experienced by the patient.

The primary regulation concerning this matter can be found in Law Number 17 of 2023 concerning Health, which asserts that medical and health personnel are obligated to conduct their practice in accordance with professional standards, service standards, and applicable operational procedures. This law also provides protection to patients by emphasizing the right to obtain safe, quality, and accountable health services. The juridical study regarding this medical malpractice also applies specifically to the enforcement of regulations against midwives under the new Health Law (Vitriarningsih et al., 2023). Furthermore, patients possess the right to file complaints or claims if they suffer losses due to the actions of medical or health personnel. Nevertheless, this statute does not provide an explicit definition of malpractice, so the approach utilized remains based on the concept of professional error.

In the context of dispute resolution, health law in Indonesia encourages the use of alternative dispute resolution mechanisms, such as mediation or other forms of non-litigation settlement. This approach is intended to create a faster, more efficient, and proportional resolution, as well as to maintain the relationship between medical personnel and patients. However, such mechanisms are not absolute as a prerequisite before pursuing judicial pathways, meaning patients still retain the right to directly file a civil lawsuit or a criminal report in accordance with applicable legal provisions. This legal remedy constitutes an important part of fulfilling legal protection for patients in health services, including at the Community Health Center (Tampil et al., 2023).

Beyond the individual liability of medical personnel, the Indonesian legal system also recognizes institutional liability inherent to health service facilities. Hospitals or other health facilities can be held liable for losses experienced by patients resulting from the actions of medical personnel operating within their scope of employment. This principle aligns with the doctrine of employer liability or *vicarious liability*, which in Indonesian legal practice is also reflected in the provisions of Law Number 44 of 2009 concerning Hospitals. Within the hospital environment, mapping this institutional liability must run hand-in-hand with guarantees of legal protection for nurses in conducting their medical practice (Yulius et al., 2023). Consequently, legal liability in cases of medical error is not only personal in nature but can also be institutional.

From a criminal law perspective, medical errors that fulfill the elements of negligence can be subjected to provisions within the Indonesian Criminal Code (KUHP), specifically Article 359 and Article 360 which regulate negligence causing death or injury. Similar provisions are also accommodated in Law Number 1 of 2023 concerning the Criminal Code as a reform of national criminal law. In this context, medical personnel can only be held criminally liable if there is proven negligence that is legally blameworthy, along with a causal relationship between that action and the resulting harm. Establishing these criminal elements also serves as the foundation for examining the liability of medical personnel in relation to abortion malpractice (Hamzanwadi et al., 2024).

Meanwhile, within the realm of civil law, patients possess a legal basis to claim compensation through the mechanism of an unlawful act as regulated in the Indonesian Civil Code (Burgerlijk Wetboek), specifically Article 1365 and Article 1367. Through these provisions, patients can demand both material and immaterial damages by proving the existence of an unlawful act, fault, harm, and a causal relationship. Article 1367 also reinforces the possibility of hospital liability as the party responsible for the actions of medical personnel operating under its supervision.

Furthermore, from a consumer protection perspective, patients can be positioned as consumers of health services under Law Number 8 of 1999 concerning Consumer Protection. Within this framework, patients possess rights to security, safety, truthful information, as well as the right to obtain compensation or damages if the services received do not comply

with promised standards. Claims for these health consumer rights are basically influenced by urban environmental characteristics and social determinants that shape public health in general (Warin, 2023). This approach is complementary and, in practice, is frequently utilized simultaneously alongside health, civil, and criminal legal bases.

Thus, both factually and normatively, the regulation of medical errors within Indonesian law does not reside within a single, unified regime, but is instead scattered across various mutually complementary legal instruments. The approach utilized prioritizes the proof of elements of fault and negligence, and permits administrative, civil, and criminal liability against both individual medical personnel and health service institutions as a whole. This model of dividing normative protection and responsibility is generally equivalent to the challenges of protecting workers' constitutional rights in the implementation of labor regulations (Suyuti et al., 2023).

The low frequency of malpractice lawsuits by patients who are victims of medical errors can be understood as the result of a decision-making structure influenced by norms, procedures, and health service relationships. Within the framework of liability, a patient needs to evaluate whether a violation of professional standards has occurred, whether there is legally blameworthy fault, and whether the harm can be causally linked to the medical action. This evaluation process demands knowledge and access to information that patients do not always possess. At the same time, patients often enter health services in a vulnerable state, making safety and recovery the primary priority rather than the formulation of legal claims. The decision to sue typically emerges after the clinical phase has passed, when the patient attempts to comprehend what occurred and seeks an explanation (Wulandari, 2023). If the explanation received is deemed sufficient, or if the patient considers medical uncertainty to be the primary cause, the inclination to sue may weaken. Consequently, the low number of lawsuits does not necessarily indicate an absence of error, but rather demonstrates that the liability system is not yet easily accessible to patients. Therefore, normative discussions need to map the causal factors at the level of rights comprehension, the burden of proof, the design of dispute resolution pathways, and the social norms surrounding the medical profession.

The factor of patient rights comprehension constitutes the initial element that shapes the decision to sue. Patient rights encompass the

right to adequate information, the right to provide informed consent for procedures, the right to obtain medical records in accordance with regulations, and the right to file objections (Rusyd et al., 2018). However, rights written on paper do not automatically become rights that are exercised, because exercising rights requires practical understanding. Patients need to know what constitutes adequate information, when consent is deemed valid, and the procedures for obtaining documents. In fast-paced service situations, explanations are frequently delivered briefly, making it difficult for patients to ensure whether the explanation has met the standard. When a procedure yields a poor outcome, a patient may doubt whether the failure is a medical risk or the result of negligence. This doubt often stems from a lack of understanding regarding professional standards and elements of fault. Within a normative framework, uncertainty in understanding leads to restraint, as suing is viewed as an arduous step that requires initial certainty. Patients who are uncertain will tend to seek informal explanations and subsequently halt any further legal steps. Therefore, the low rate of lawsuits can be explained as a consequence of ambiguous understanding of rights and standards within the patient experience.

The burden of proof in malpractice cases constitutes a potent causal factor at the normative level. A lawsuit requires the patient to prove the existence of a breach of the duty of care, the existence of harm, and a causal relationship. Proving these elements frequently requires technical knowledge and the support of expert opinions, as professional standards cannot always be evaluated through lay logic. When patients anticipate the necessity of experts and medical documents, they may judge that a lawsuit is excessively difficult. Even if a patient possesses a moral conviction that an error has occurred, that conviction is insufficient to serve as proof. Furthermore, medical records frequently serve as the epicenter of evaluation, yet patients may feel that those records remain in the hands of the health facility. This feeling engenders a perception of power asymmetry that diminishes the courage to sue. Within the framework of access to justice, the perceived difficulty of the burden of proof can generate a deterrent effect, as patients evaluate the probability of success as low. This concept of the burdensome nature of proof is fundamentally closely related to the enforcement of legal provisions and the effectiveness of

sanctions regarding malpractice in traditional medicine clinics (Sirenden et al., 2024). This effect is also tied to the potential stigma of being a party that attacks medical personnel. Consequently, the low number of lawsuits can be understood as procedural rationality from the patient's perspective namely, an assessment that the burden of proof is disproportionate to their possessed capacity.

Information asymmetry between the patient and medical personnel reinforces the effect of the burden of proof. Medical personnel comprehend the diagnosis, therapeutic options, and the clinical rationale behind decisions, whereas the patient often only observes the sequence of actions and the outcome (Khalid, 2023b). Without adequate explanations, patients evaluate events retrospectively based on pain, cost, and changes in quality of life. This evaluation is humanly reasonable, yet it does not necessarily correspond with the element of fault in law. Information asymmetry also affects the patient's capability to identify relevant clinical decision points. In malpractice cases, it is crucial to know when a standard should have been followed and how a deviation occurred. If patients do not know that specific point, they are unable to formulate a claim in a structured manner. As a result, patients tend to delay, wait for additional information, or accept the situation as part of the risk. At the normative level, information asymmetry demands guarantees of clear communication and document access mechanisms. However, without the competence to interpret documents, formal access can still feel futile. Thus, the low rate of lawsuits is the result of two layers: information limitation and a limitation in deriving meaning from that information. These two layers forge an uncertainty that leads to the decision not to sue.

The factor of clinical communication also influences a patient's decision when evaluating a medical error. Communication encompasses explanations of the diagnosis, treatment options, risks, and potential complications. Normatively, communication is an integral part of fulfilling patient rights and a component of good service standards. When communication is conducted in a one-way or overly technical manner, patients may sign consent forms without adequate understanding. Following an adverse event, the patient might feel that they had consented to all risks, even though that consent actually required a sufficient understanding. This feeling of having consented can

diminish the drive to sue, as the patient assesses that they no longer have the right to complain. This limitation in communication also triggers vulnerability in medical negligence cases involving medication administration, viewed from the perspective of law and medical ethics (Alex et al., 2023). On the other hand, empathetic and transparent communication can lead patients to choose non-litigious resolutions because they feel acknowledged. In normative discussions, it is essential to distinguish between communication that meets information standards and communication that merely diffuses emotion. Communication that defuses without providing information can cause a patient to cease pursuing claims without understanding their legal standing. Therefore, the low number of lawsuits can be linked to communication patterns that forge passive acceptance. This acceptance is not always the result of a fair agreement, but can instead be born out of dependency and ignorance. Thus, clinical communication becomes a causal factor operating through the shaping of rights perception and claim legitimacy.

The relationship of a patient's trust toward medical personnel is a social factor that exerts a normative effect on the exercise of rights. Trust is built through professional reputation, personal experience, and cultural norms that position doctors as authorities (Yassa & Peter, 2018). This trust is vital for smooth service delivery, yet it can transform into an impediment when the patient evaluates that suing is an inappropriate action. Patients may view a lawsuit as an attack against someone who has strived to help them. Within the realm of values, the impulse to show gratitude can suppress the drive to demand accountability. When harm occurs, patients may also choose to avoid conflict so that their relationship with the health facility remains sound, particularly if they still require follow-up care. Normatively, this choice indicates the presence of a structural dependency. Dependency creates a calculation of social and clinical risks that reduces the utilization of litigation pathways. Furthermore, trust can lead patients to accept minimal explanations without requesting clarification. As a consequence, patients do not gather the information necessary to evaluate errors objectively. Consequently, the low frequency of lawsuits can be understood as a consequence of trust that is not accompanied by easily accessible accountability mechanisms. Trust serves as a potent social bond, yet it can also diminish the corrective function of the law.

Social stigma toward plaintiffs is a factor that frequently manifests in medical disputes. Patients may worry about being perceived as seeking profit, viewed as failing to understand risks, or regarded as damaging the honor of the profession. This stigma can originate from family, the community, or even from other healthcare personnel. Within a normative framework, stigma creates social costs that are invisible in legal procedures yet entirely real within the patient's experience. These social costs can be more burdensome than litigation expenses. Patients who have already endured physical and psychological harm may choose to avoid additional pressures (Filho et al., 2022). Furthermore, stigma can cause patients to hesitate in disclosing their experiences, preventing them from seeking legal assistance or a second opinion. When social support is absent, patients more easily accept harm as fate or bad luck. This type of acceptance can extinguish the possibility of a lawsuit from the very beginning. From an access to justice perspective, stigma reduces public participation in enforcing accountability. If a lawsuit is perceived as a reprehensible act, the legal mechanism becomes rarely utilized despite being available. Consequently, the low number of lawsuits can be explained as the result of social norms that obstruct the articulation of claims. Those social norms operate through shame, fear, and a sense of impropriety, all of which diminish the exercise of rights.

Uncertainty regarding the definition of malpractice also influences a patient's decision. In everyday conversation, the term malpractice is frequently used to describe any poor outcome, whereas normatively it demands specific criteria. This definitional uncertainty reinforces the vital importance of protecting patient rights from a comprehensive legal and medical ethics perspective in Indonesia (Herisasono et al., 2023). Patients holding a loose definition may experience frustration when explained that a poor outcome does not automatically denote an error. This frustration can lead in two different directions: some patients become aggressive, while others become apathetic. Apathy emerges when patients feel that the law cannot reach the harm they have experienced. Within a normative framework, the issue is not that the law fails to reach, but rather lies in the divergence between a subjective sense of justice and the elements of objective liability. If patients do not receive assistance to comprehend this distinction, they will judge a lawsuit as a dead end. Moreover, a vague

definition makes it difficult for patients to determine the proper resolution pathway. They may select the wrong channel and subsequently feel disappointed because the outcome does not meet expectations. This disappointment can close the opportunity to pursue other pathways that are actually relevant. Thus, the low frequency of lawsuits can be understood as a consequence of vague definitions and classifications, which affect how patients structure their claims and select mechanisms.

The procedural design of health dispute resolution influences patient behavior through the complexity and ambiguity of its stages (Kusuma & Isworo, 2022). Within many systems, there exist ethical mechanisms, disciplinary mechanisms, administrative mechanisms, and civil or criminal mechanisms. Each mechanism possesses a distinct objective, such as professional development, the imposition of sanctions, or the recovery of damages. Patients who do not comprehend these distinctions may assume that a single mechanism is sufficient, or believe that pursuing one mechanism will foreclose another. This uncertainty gives rise to the risk of missteps, leading patients to choose not to initiate any action at all. Normatively, procedures ought to be easily understood, yet in the practical reading of regulations, terminology and requirements are frequently highly technical. Furthermore, procedures may demand specific deadlines, complaint formats, and initial evidence. When patients lack legal accompaniment, they can easily feel defeated before they even begin. This deterrent effect does not require numerical proof to be understood, as it can be explained through rational behavior theory when confronting legal transaction costs. Consequently, the low number of lawsuits can be understood as a consequence of high procedural transaction costs, manifested in the complexity and ambiguity of the available pathways.

Financial costs and time commitments constitute factors that operate as practical considerations in the utilization of lawsuits (Kusuma & Isworo, 2022). A lawsuit requires registration fees, legal counsel fees, and supporting expenses such as expert witnesses. The process also consumes considerable time and energy, as patients must attend hearings, gather documentation, and face cross-examinations. Within a normative framework, these costs intersect with access to justice, because access does not merely signify that the courtroom doors are open, but rather implies a realistic capability to endure the process. Patients who are recovering or

bearing ongoing medical expenses may judge that a lawsuit merely compounds their burdens. Moreover, patients do not always pursue financial remuneration alone; they also seek the acknowledgment of error and guarantees of systemic improvement. However, if a lawsuit is perceived as yielding only an uncertain outcome, patients will avoid it. This uncertainty stems from the technical nature of the evidence required and the possibility of a judgment that does not meet expectations. Thus, the low frequency of lawsuits can be understood as the result of a cost-benefit calculation from the patient's perspective. This calculation is also heavily influenced by the information available regarding the process, meaning that legal literacy remains a factor that either reinforces or mitigates the deterrent effect of these costs.

A patient's dependency on health service facilities following a medical error event can create psychological barriers to suing (Dijkstra et al., 2022). Patients may still require follow-up care, medical record access, or referral letters. Although normatively health service facilities are prohibited from discriminating against patients for exercising their rights, patient anxieties may still persist (Cohen & Ezer, 2006). These anxieties can be anticipatory, as patients imagine the relationship becoming uncomfortable or communication turning sour. In healthcare services, comfortable communication is vital because it influences treatment compliance and the patient's sense of security. If patients evaluate that a lawsuit will ruin communication, they may choose to remain silent. Furthermore, patients may worry that other medical personnel will be reluctant to treat them to avoid becoming involved in a dispute. Such worries can narrow service options. Within a normative framework, dependency demonstrates an inequality in bargaining positions. This inequality causes patients to prioritize service access over recovery through a lawsuit. Consequently, the low number of lawsuits can be explained as a consequence of ongoing service relationships. That relationship creates a necessity to maintain rapport, which ultimately suppresses the utilization of adversarial legal mechanisms.

The role of the family in patient decision-making can also influence the low frequency of lawsuits. In many experiences of illness, the family acts as the decision-maker, companion, and financial backer. The family may encourage the patient to accept the situation and focus on recovery,

or they may drive legal action. However, the family frequently considers the social and emotional burdens that will arise from a dispute. If the family evaluates that a lawsuit will prolong stress, they may choose to avoid it. This emotional burden is similar to the impact of psychological stress that influences a patient's cardiovascular risk across various clinical settings (Issalillah, 2022). Normatively, this choice demonstrates that the exercise of rights is influenced by social support structures. When social support is weak, it becomes more difficult for patients to endure a lengthy process. Conversely, when social support is strong but leans toward conflict avoidance, the number of lawsuits remains low. Furthermore, the family may hold the view that medical errors are difficult to prove, thereby rendering a lawsuit irrational. This perspective strengthens when the family is unaware of available accompaniment or assistance channels. Consequently, the low number of lawsuits can be understood as the result of collective rationality within the household, rather than merely an individual decision. This factor reinforces that access to justice does not stand alone, but instead interacts with family structures and social norms.

A patient's legal awareness regarding the types of remedies that can be obtained through a lawsuit also influences their decision. If patients assume that a lawsuit only yields monetary compensation, whereas what they actually require is an explanation and an apology, they may opt for alternative pathways (Delduque et al., 2022). However, if these alternative pathways fail to provide a remedy that is deemed fair, patients may revert to passivity because they do not see an appropriate option. Normatively, remedies can take the form of financial damages, declarations of liability, or specific orders in accordance with the law. Patients who do not comprehend the variations in available remedies will find it difficult to formulate the objectives of a lawsuit. Without a clear objective, a lawsuit feels like an aimless gamble. Furthermore, patients may desire preventive measures to ensure that the error does not recur, yet they do not know how legal mechanisms can drive systemic improvements. This ignorance diminishes the motivation to sue. Consequently, the low frequency of lawsuits can be explained as a limitation in understanding the function of a lawsuit. Lawsuits are narrowly perceived as personal conflicts, rather than as accountability mechanisms capable of providing remedies and signaling

institutional improvement. Therefore, normative discussions need to position lawsuits within a broader spectrum of remedial objectives.

The availability of non-litigation dispute resolution mechanisms can also reduce the inclination to sue, though it is not an automatic solution. Mediation, internal complaints, or ethical forums can provide space for communication and clarification. When patients receive adequate clarification and feel treated fairly, they might not proceed with a lawsuit. However, within a normative framework, it is essential to evaluate whether non-litigation mechanisms provide remedies commensurate with the harm suffered. If not, such mechanisms can function as barriers that delay or halt a lawsuit without delivering a substantive resolution. This handling model must also take into account the challenges of national health development from the perspectives of law, service access, and disease governance in general (Harianto et al., 2024). Furthermore, non-litigation mechanisms can be confidential, meaning patients do not see an objective evaluation of service standards. This lack of transparency can diminish trust, but it can also reduce the energy required to prolong a dispute. Under such circumstances, patients may stop simply due to exhaustion. Consequently, the low frequency of lawsuits can be linked to the existence of alternative pathways that influence patient perceptions regarding the adequacy of a resolution. Normative discussions demand a distinction between a resolution that satisfies a sense of justice and one that merely terminates conflict. This factor demonstrates that a low number of lawsuits does not always mean patients are satisfied; it can also signify that patients have run out of options deemed meaningful.

The position of medical personnel and health facilities within the authority structure can forge patient anxieties regarding symbolic retaliation. Symbolic retaliation can manifest as cold communication, difficulty obtaining documents, or negative perceptions from the surrounding environment. Although such retaliation is unjustifiable, patient perceptions regarding its possibility can be powerful enough to deter a lawsuit. The vulnerability of a patient's physical condition in this situation resembles the link between periodontal tissue health and the progression of systemic diseases under chronic conditions (Issalillah, 2022). Within a normative framework, this perception relates to the sense of security when exercising rights. If the sense of security is low, patients

will exercise restraint. Moreover, patients may worry that a complaint will be met with a counter-report or accusations of defamation, particularly if the patient discloses their experience in the public sphere. This worry leads patients to choose silence or to convey complaints in a limited manner. Consequently, the process of gathering evidence and consolidating support becomes weak. Thus, the low frequency of lawsuits can be understood as the result of a power imbalance and uncertainty regarding protection for complainants. Normative discussions do not need to prove actual instances of retaliation to explain its deterrent effect, because that effect operates through the perception of risk. Risk perception becomes a rational psychological factor within situations of service dependency.

The ambiguity of professional standards for the public also influences the low frequency of lawsuits. Professional standards are typically formulated in clinical guidelines, ethics, and disciplinary provisions, which are not always easily accessible to patients. Patients require a point of reference to evaluate whether the care received complies with appropriate standards. If such references are unavailable, patients become dependent on the narrative of the service provider or stories from others. This dependency on narratives renders evaluations unstable. Sociologically, this condition perpetuates the power asymmetry and monopoly of knowledge historically inherent to the medical profession (Freidson, 1970). Within a normative framework, professional standards ought to be explainable in a manner understandable to patients, at least at the level of principles, such as the duty of care, the duty of documentation, and the duty of communication. When these principles are not understood, patients assume that evaluation belongs exclusively to the profession. This assumption diminishes the courage to demand accountability. Furthermore, patients may feel that confronting the profession will always result in defeat because the profession is perceived to possess strong internal solidarity, often referred to as the "medical wall of silence" (Berlinger, 2005). This feeling reinforces the perception of power asymmetry. Consequently, the low number of lawsuits can be explained as an impact of the lack of transparency in standards for the public, which weakens a patient's capability to test actions objectively.

The duty of documentation in health services is supposed to support accountability, yet for patients, medical documents can feel unwelcoming.

Medical records contain technical terms, abbreviations, and structures that are difficult to comprehend. Patients might obtain a copy, yet remain unable to interpret it. In malpractice cases, documents serve as the primary evidence to evaluate clinical actions and decisions. When patients feel that documents are unhelpful, they revert to memories and impressions. These impressions are emotionally powerful, yet legally weak in terms of proof. A patient's inability to interpret medical records creates an epistemic injustice, wherein patients lose their legal capacity merely due to the barrier of technical language (Fricker, 2007). Within a normative framework, this condition demonstrates the necessity for explanations understandable to patients regarding the contents of the records and the meaning of actions. However, this writing centers on the causes of the low frequency of lawsuits, so the focus is on the effect of difficult-to-understand documents. The effect manifests as an assessment that suing is impossible because the evidence cannot be comprehended. Moreover, patients may assume that documents always side with the health facility a suspicion that is rational given that these documents are fully produced and controlled by the service provider (Annas, 2012). This distrust leads to an attitude of resignation. Thus, the low frequency of lawsuits can be understood as the result of a comprehension gap over documents, rather than the mere absence of documents. This gap is a normative factor because it relates to access to meaningful information.

The role of professional organizations and ethical mechanisms can influence a patient's decision by framing a dispute as a disciplinary matter rather than a remedy for harm. Patients who are directed toward ethical mechanisms may feel that it is the proper pathway because it appears official. However, ethical mechanisms possess the objective of maintaining professional dignity and compliance with ethics, which is not always identical to providing compensation. If patients do not comprehend this difference in objectives, they might assume that the ethical process is sufficient and subsequently refrain from filing a lawsuit. Within a normative framework, this demonstrates that institutional designs can shape patient expectations. When expectations are formed incorrectly, patients may stop after obtaining an outcome that fails to satisfy their sense of substantive justice. This diversion from formal legal pathways to the profession's internal channels frequently functions as a safety valve for

medical institutions to diffuse broader legal conflicts (Relman, 2007). Some patients may feel that the ethical process is slow or closed, causing them to lose the energy to proceed. As a result, the frequency of lawsuits remains low. In normative discussions, the crucial point is the necessity for clarity regarding the function of each mechanism for the patient. However, as a causal factor, that functional ambiguity can be regarded as a pre-litigation filter that reduces litigation. Thus, the low frequency of lawsuits can occur because the ethical pathway is understood as a substitute for a lawsuit, rather than as a distinct mechanism with a distinct objective.

Psychological factors following a medical event also influence the decision to sue. Patients who are victims of medical errors can experience trauma, anxiety, or a loss of trust toward healthcare services. This condition causes patients to avoid interactions that recall the event, including legal processes that mandate repeating the story and facing examination. This phenomenon aligns with the symptoms of post-traumatic stress disorder and litigation-induced stress, where adversarial judicial processes frequently induce secondary traumatization for vulnerable victims (Vincent et al., 1994). Within a normative framework, psychological conditions affect the capacity to exercise rights. The lawsuit process is adversarial and demands narrative consistency, making it difficult for psychologically vulnerable patients. Furthermore, families may also encourage patients to close the experience to achieve a faster recovery. This encouragement suppresses the utilization of litigation pathways. Patients may also experience self-blame for instance, blaming themselves for delaying treatment or for consenting to the procedure. This guilt obscures an objective evaluation regarding the obligations of medical personnel. Consequently, the low frequency of lawsuits can be understood as a consequence of the psychological burden inherent to the victim's experience. This factor does not require data to be explained, as it accords with the principle that an agent's capacity is influenced by psychological conditions. In medical disputes, this capacity determines whether a patient is capable of enduring a lengthy process that demands mental resilience.

Household economic factors following the event can also suppress lawsuits (Halizah & Nuraini, 2021). Patients who are victims of medical errors may lose income, bear medical costs, or shoulder ongoing treatment expenses. Under such circumstances, the household's priority

is stability, causing a lawsuit to be viewed as an additional risk. Even if specific financing schemes are available, patients still require energy to manage them. Furthermore, a lawsuit can demand substantial initial costs. Within a normative framework, this condition demonstrates that access to justice is directly linked to economic capacity. This financial disparity triggers the "justice gap" phenomenon, where litigation costs and lost wages force economically vulnerable groups to accept losses without legal resistance (Galanter, 1974). Economic capacity influences the ability to secure legal representation, obtain expert opinions, and endure a lengthy process. When capacity is low, patients are more likely to choose a swift resolution, even if it is unsatisfactory. On the other hand, patients may choose to avoid conflict in order to continue working and earning an income. Consequently, the low number of lawsuits can be understood as an adaptive choice in a distressed economic situation. This factor operates as a powerful filter, because it works before the patient even understands legal details. In normative language, this is an issue of procedural justice, as costly procedures tend to reduce the participation of vulnerable groups (Rhode, 2004).

The absence of adequate accompaniment can also serve as a causal factor. Accompaniment encompasses assistance in understanding rights, constructing a chronology, evaluating evidence, and choosing a resolution pathway. Without accompaniment, patients confront a complex system and technical terminology. Within a normative framework, accompaniment strengthens the patient's capacity as a legal subject. When capacity is low, patients tend to accept information from authoritative parties, meaning critical evaluation does not occur. Studies in the sociology of law demonstrate that the presence of paralegals or legal aid institutions is highly crucial in bridging the gap between the reality of the victim's suffering and the formal language of the court (Felstiner et al., 1980). Moreover, patients may fear taking a wrong step and fear being humiliated in official forums. This fear diminishes initiative. Accompaniment is also essential for transforming grievances into structured claims. Without accompaniment, emotions can drive ineffective actions, such as venting on social media, which subsequently creates other legal risks and frightens the patient further. Ultimately, the patient chooses to stop. Thus, the low frequency of lawsuits can be explained as a consequence of the absence of

a bridge between the victim's experience and legal language. That bridge is typically built by companions, legal counsel, or aid institutions. When the bridge is unavailable, lawsuits rarely occur despite the harm experienced.

The existence of informed medical consent is frequently understood by patients as an absolute barrier to suing. Even though normatively consent regulates the acceptance of explained risks rather than clearing negligence, many patients assume that a signature means accepting all consequences. This assumption can be born because the consent process is conducted quickly, or because patients are not given an opportunity to ask questions. Following an adverse event, the patient views the consent document as proof that they themselves agreed, causing them to feel that they have no right to sue. Within international health law doctrine, a consent form is not an absolute exculpatory contract that can erase liability for clinical negligence (Meisel & Kuczewski, 1996). In normative discussions, this constitutes a misinterpretation regarding the function of consent. The function of consent is to ensure that a procedure is performed with understanding, not to eradicate professional obligations. When this interpretation is incorrect, the decision to sue weakens. Furthermore, service providers may explain consent defensively, making the patient even more convinced that legal pathways are closed. Consequently, the low frequency of lawsuits can be explained as an impact of the erroneous interpretation of consent. This interpretation operates at the level of basic legal knowledge. If basic knowledge is absent, patients cannot distinguish between accepted risks and actionable errors. This demonstrates the importance of patient rights literacy as a causal factor (Faden & Beauchamp, 1986).

Perceptions regarding the independence of experts also influence a patient's courage to sue. In malpractice cases, expert opinions frequently determine the evaluation of professional standards. If patients assume that experts will always defend the profession, they evaluate that a lawsuit stands no chance. This perception can be formed from common narratives about professional solidarity or from difficult experiences in obtaining a second opinion. This barrier is often exacerbated by the phenomenon of the conspiracy of silence, wherein fellow medical peers are reluctant to provide testimony that incriminates a colleague in court (Localio et al., 1993). Within a normative framework, the evaluation of professional

standards indeed requires expert competence, yet the system needs to ensure an objective evaluation. When patients do not trust that objectivity, they are reluctant to enter the process. Moreover, patients may worry that supporting experts are difficult to find or expensive. This worry reinforces perceptions of cost and uncertainty. Thus, the low number of lawsuits can be understood as the result of a crisis of trust toward the evidentiary mechanism. The evidentiary mechanism is deemed non-neutral, leading patients to choose not to utilize it. This factor is normative because it relates to the legitimacy of the evaluation process. If legitimacy is low, participation is low. In medical disputes, legitimacy is vital because technical evaluations demand public trust in the process, rather than in intuition. Therefore, the perception regarding experts is one of the factors that can explain the low frequency of lawsuits.

The unpredictability of lawsuit outcomes also operates as a deterrent factor. Patients may evaluate that court judgments are difficult to predict due to complex evidentiary elements and diverse interpretations of professional standards. This uncertainty causes a lawsuit to be viewed as an emotional and financial gamble. Within a normative framework, uncertainty is indeed a part of the judicial system, yet it can be minimized through consistent guidelines and practices. From the patient's perspective, uncertainty amplifies the risk of double loss the medical harm has already occurred, and then the legal lawsuit fails. This risk feels immensely heavy. In malpractice claims theory, unpredictability of outcome constitutes one of the largest disincentives that dampens a victim's intent to seek formal justice (Danzon, 2000). Furthermore, the lawsuit process can expose the patient's personal information, leading them to worry that their privacy will be compromised. This worry diminishes motivation. Patients may also judge that even if they win, the remedy will not restore their original state. This feeling leads to the conclusion that a lawsuit is meaningless. In normative discussions, it is necessary to distinguish between remedy as financial compensation and remedy as moral acknowledgment (restorative justice). However, patients who do not comprehend the function of a remedy will judge a lawsuit as futile. Consequently, the low number of lawsuits can be explained as a result of perceptions of uncertainty and perceptions of meaninglessness,

both of which are rooted in the interpretation of the objectives and outcomes of the legal process.

The comparison among criminal, civil, and ethical pathways within a patient's interpretation also exerts an influence. Some patients assume that a medical error must be prosecuted criminally to be taken seriously. When they discover that criminal elements are difficult to prove, they feel that no avenue exists. They might not comprehend that the civil pathway possesses a different standard of proof (balance of probabilities) and is oriented toward the recovery of damages (remedy). Selecting the wrong pathway can result in disappointment, causing the patient to stop. The public misunderstanding that conflates criminal sanctions with civil damages is a common phenomenon that frequently halts a patient's legal steps prematurely (Saks & Landsman, 2020). Within a normative framework, each pathway possesses a function. However, without proper interpretation, patients measure all pathways with a single metric, namely retribution. If that metric is not achieved, they feel they have failed. As a result, even civil lawsuits are not filed. This factor demonstrates that the low frequency of civil lawsuits can occur due to a misunderstanding of objectives. The tendency to focus on retribution can also be influenced by public narratives. In normative discussions, it is vital to emphasize that accountability can be pursued through remedies and improvements, not just punishment. Yet as a causal factor, the retributive narrative causes patients to overlook alternative pathways.

The factor of time is also important because malpractice claims frequently arise after a specific period. Patients require time to recover physically, gather documentation, and seek a second opinion. The more time that passes, the more difficult it becomes to construct a chronology and recall the details of clinical communication. Within a normative framework, the accuracy of the chronology is vital for proof. If the chronology becomes blurred, the patient's hesitation increases. Furthermore, patients may confront a specific deadline (statute of limitations) to pursue legal pathways. When patients are unaware of that boundary, the opportunity can be lost without them realizing it. Although this writing does not discuss the specific deadlines of particular legislation, normatively it can be asserted that ignorance of temporal procedures diminishes the exercise of rights. The time factor also operates through

emotional exhaustion. Patients who were initially angry can experience a decline in psychological energy over time, a process of claim degradation that commonly occurs in long-term disputes (Sloane, 2011). Patients choose to close the bad experience for the sake of inner peace. This closure of the experience reduces the likelihood of a lawsuit.

The quality of a health facility's initial response to a patient's complaint can also influence the litigation decision. When patients convey complaints and receive responses that are dismissive, defensive, or ambiguous, they can feel marginalized. This sense of marginalization can drive a lawsuit, but it can also lead to despair if the patient evaluates that it is impossible to fight the institution's power. Despair is more likely to occur when patients judge themselves to have no support. Within a normative framework, the initial response should be oriented toward clarification and the fulfillment of the right to information through honest and open communication (open disclosure). Unfortunately, a defensive culture of denial from the household or hospital management frequently severs the patient's access to information regarding what actually occurred in the operating room (Gallagher et al., 2007). If the initial response does not provide an explanation, patients lose the foundation to build a claim. They do not know what needs to be proven. Moreover, an initial response that threatens or blames the patient can generate fear that reduces initiative. Thus, the low number of lawsuits can be explained as a consequence of initial interaction experiences that fail to empower the patient. Empowerment here does not mean taking the patient's side, but rather providing the space to comprehend the event objectively.

The causal factors for the low frequency of lawsuits can be mapped into the clusters of knowledge, evidence, procedures, social relations, and psychological-economic capacity. The knowledge cluster encompasses the interpretation of patient rights, the interpretation of informed consent, and the interpretation of professional standards. The evidence cluster includes information asymmetry, the requirement for experts, access to documents, and perceptions of independent evaluation. The procedural cluster comprises the complexity of resolution pathways, the uncertainty of stages, and the dynamics of time. The social relations cluster covers trust, stigma, service dependency, as well as anxieties regarding symbolic retaliation. The capacity cluster consists of psychological burdens,

economic burdens, and the absence of accompaniment. This comprehensive mapping reinforces that the decision not to file a lawsuit is not a random decision, but rather a rational choice constrained (bounded rationality) by various structural and institutional limitations (Studdert et al., 2006). Within a normative framework, these factors operate to reinforce one another. A lack of understanding of rights amplifies the perception that proof is difficult, the perception that proof is difficult increases the unpredictability of outcomes, and the unpredictability of outcomes strengthens the choice to avoid conflict. Consequently, the low number of lawsuits can be explained systematically without field data, as it is the result of normative and procedural structures that shape the rational behavior of patients. This explanation answers the research problem by demonstrating the normative factors that forge the low utilization of malpractice lawsuits.

Conclusion

The conclusion of this writing affirms that the low frequency of malpractice lawsuits by patients who are victims of medical errors can be understood as a consequence of a normative construction involving the understanding of rights, the structure of proof, procedural design, trust relationships, as well as the psychological and economic capacities of the patient. Patients often face ambiguity in distinguishing between reasonable medical risks and errors for which accountability can be demanded, such that claims do not form in a structured manner. The technical burden of proof, the need for expert opinions, and medical documents that are difficult to understand reinforce the perception that a lawsuit has a low probability of success. The complexity of dispute resolution pathways and the uncertainty of the stages create high procedural transaction costs, which encourage patients to avoid litigation. Trust relationships with medical personnel, stigma toward plaintiffs, and dependence on follow-up services form social and clinical costs that are not visible in legal texts but influence decisions. The patient's capacity, which is strained by loss, trauma, and economic burdens, diminishes the ability to undergo a lengthy process. Thus, the low frequency of lawsuits is the result of an interaction of factors that can be explained normatively within the framework of access to justice and healthcare service liability.

The implications and suggestions that can be drawn involve the need for arrangements that strengthen a patient's ability to exercise their rights safely and purposefully, without diminishing the protection of medical personnel working according to standards. Clarity in understanding patient rights needs to be promoted through clinical communication that meets information standards, particularly regarding risks, alternative actions, and the meaning of consent. Patients must understand the structure of proof through concise procedural information concerning documentation, chronology, and the function of expert opinions, so that perceptions of impossibility can be corrected. The design of dispute resolution pathways needs to be clearly presented to the public, including the distinction in objectives between ethical mechanisms and loss recovery mechanisms. Protection for reporters and guaranteed access to services must be affirmed so that dependency does not turn into a fear of exercising rights. Advocacy support should be positioned as a bolster for access to justice for vulnerable patients, as advocacy helps translate clinical experiences into orderly legal language. Academically, this framework of factors can serve as a basis for further discussion regarding legitimacy, transparency, and procedural justice in medical disputes.

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**Normative Factors Behind Low Malpractice Claims for Patients Harmed by Errors
(Rapy Kurniawan, Rio Saputra, Rafadi Khan Khayru)**

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