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## The Noodtoestand Doctrine and the Limits of Physicians' Criminal Liability in Remote Emergency Medical Services

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**Abstract:** This article examines the limits of physicians' criminal liability when emergency medical services are provided in remote areas with limited facilities, personnel, referral access, and diagnostic support. It uses normative legal research with statutory, conceptual, and comparative approaches. The analysis connects Indonesian criminal law, health law, medical practice regulation, medical ethics, and recent literature on emergency care, patient safety, rural health services, and the necessity defense. The article argues that noodtoestand cannot operate as blanket immunity. It must be tested through imminent danger, absence of reasonable alternatives, proportionality, good faith, professional competence, and accountable documentation. The article proposes conditional legal protection through professional review before criminal prosecution. This model protects physicians who act reasonably under constrained emergency conditions while preserving patient rights and medical accountability.

**Abstrak:** Artikel ini mengkaji batas pertanggungjawaban pidana dokter ketika pelayanan medis gawat darurat dilakukan di daerah pedalaman dengan keterbatasan fasilitas, tenaga, akses rujukan, dan dukungan diagnostik. Penelitian ini menggunakan metode yuridis normatif dengan pendekatan perundang-undangan, konseptual, dan komparatif. Analisis menghubungkan hukum pidana Indonesia, hukum kesehatan, regulasi praktik kedokteran, etika medis, dan literatur terbaru tentang layanan darurat, keselamatan pasien, serta pembelaan keadaan darurat. Artikel ini menegaskan bahwa noodtoestand tidak dapat menjadi imunitas mutlak bagi dokter. Doktrin tersebut harus diuji melalui bahaya nyata, ketiadaan alternatif wajar, proporsionalitas, itikad baik, kompetensi profesional, dan dokumentasi yang akuntabel. Artikel ini menawarkan model perlindungan hukum bersyarat melalui penilaian profesional sebelum pemidanaan, agar dokter tetap terlindungi tanpa mengabaikan hak pasien dan akuntabilitas medis.

**Keyword:** criminal liability, emergency medical services, health law, noodtoestand, physicians.

## INTRODUCTION

Emergency medical services in remote areas create a specific criminal law problem because physicians must make urgent clinical decisions while facing limited infrastructure, limited specialist support, delayed referral, shortage of health workers, and incomplete diagnostic facilities. Recent rural emergency literature shows that rural patients rely heavily on emergency departments, tele-emergency care, primary care linkage, and local health resources when ordinary referral pathways are slow or unavailable (Castro-Delgado et al., 2025; Gettel et al., 2025; Mohr et al., 2023; Sreeram et al., 2024; Zhang, 2024). Criminal liability analysis cannot use an urban tertiary hospital standard without first examining the real resources available to the physician at the time of action.

The legal problem becomes sharper when the patient is in a life-threatening condition. A physician may face two legal risks at the same time. If the physician delays action, the delay may be read as omission, abandonment, or refusal to provide emergency help. If the physician acts quickly without complete consent, ideal facilities, or complete diagnostic confirmation, the same action may later be challenged as negligent, excessive, or outside professional standards. Recent studies on defensive medicine and Indonesian criminal policy show that unclear legal thresholds can push physicians toward excessive caution, unnecessary procedures, or avoidance of high-risk cases (Baungard et al., 2022; Ginting et al., 2025; Hely Ramadhini Harahap & Ahmad Ma'mun Fikri, 2025; Kakemam et al., 2022).

Patient safety must remain central. A remote setting does not reduce the patient's dignity, autonomy, and right to safe treatment. Patient safety literature distinguishes unavoidable adverse outcomes from preventable harm, professional negligence, and system failure (Brennan et al., 1991; Iong, 2024; Panagioti et al., 2019; Shojania & Dixon-Woods, 2017). This distinction is essential because criminal law should not punish a physician merely because the medical outcome is bad. Criminal law should intervene only when culpable conduct meets the threshold of fault, unlawfulness, causation, and blameworthiness.

The doctrine of *noodtoestand*, or necessity, provides a relevant conceptual entry point. Necessity is generally understood as a defense that permits an otherwise unlawful act when the act prevents a greater and imminent harm. Criminal law scholarship treats necessity as a difficult doctrine because it involves the ranking of harms, the relation between justification and excuse, and the risk of over-expanding exceptions to legal rules (Alexander, 2005; Arnolds & Garland, 1974; Colvin, 1990; Dennis, 2009; Gearty, 1989). For emergency medical services, the doctrine must be translated into a clinical legal test rather than used as a general slogan for exoneration.

In the Indonesian legal context, the problem is not merely whether physicians need protection. The more precise issue is how criminal law should evaluate emergency medical action when health service conditions are structurally unequal. Recent Indonesian literature after Law Number 17 of 2023 shows a strong concern with medical dispute resolution, professional discipline, emergency patient refusal, legal protection for doctors, and the relation between the new Health Law and the new Criminal Code (Abang Anton et al., 2024; Al Ghifari et al., 2026; Awangga, 2025; Dwi Atmoko, 2022; Gladys Haryanto et al., 2025; Nurchasanah et al., 2025; Tamon et al., 2025). This article responds to that issue by placing *noodtoestand* within a balanced criminal and health law framework.

The novelty of this article lies in the construction of a strict *noodtoestand* test for physicians in remote emergency medical services. Previous discussions often frame doctors as subjects who need legal protection or patients as subjects who need protection from malpractice. This article integrates both positions. It argues that criminal law protection should be conditional. Protection is justified when the physician acts in good faith, faces imminent danger to the patient, has no reasonable safer alternative, uses proportional medical action,

respects professional standards, and documents the decision-making process. This model prevents both over-criminalization of doctors and erosion of patient rights.

The impact expected from this article is a practical doctrinal framework for physicians, hospitals, professional boards, investigators, and courts. The framework helps distinguish medical tragedy, system failure, professional negligence, and criminal fault. It also prevents emergency conditions from becoming a blanket excuse for reckless conduct, poor documentation, forged consent, or concealment of medical facts (Keristian & Triana, 2025; Ritonga et al., 2025; Sakinatunnisa & Alawiya, 2025; Viranda & Zulfiko, 2026).

The problem formulation of this article is: 1. How should the *noodtoestand* doctrine be used to determine the limits of physicians' criminal liability in remote emergency medical services? 2. What legal protection model can protect physicians acting under emergency constraints without weakening patient rights and medical accountability?.

## LITERATURE REVIEW

*Noodtoestand* is commonly positioned within the broader doctrine of necessity. The doctrine operates when a person faces a conflict of duties or interests and chooses an act that prevents greater harm. Classic criminal law literature explains that necessity must remain exceptional because it justifies or excuses conduct that would otherwise be unlawful (Alexander, 2005; Arnolds & Garland, 1974; Colvin, 1990; Dennis, 2009; Gearty, 1989). In medical emergency cases, this doctrine cannot become an automatic defense. It must be tied to imminent danger, lack of reasonable alternatives, proportionality, and accountable conduct.

Physicians' criminal liability requires more than an undesirable medical outcome. Malpractice and defensive medicine literature shows that clinical practice contains uncertainty, but liability analysis must still distinguish inherent risk, ordinary negligence, gross negligence, and reckless conduct (Baungaard et al., 2022; Ginting et al., 2025; Kakemam et al., 2022; Schaffer et al., 2017; Studdert, 2005). Indonesian criminal policy literature adds that the new Criminal Code and Health Law must be read together so that medical risk is not automatically equated with criminal fault (Abang Anton et al., 2024; Hely Ramadhini Harahap & Ahmad Ma'mun Fikri, 2025).

Patient safety literature provides another analytical layer. Adverse events may arise from individual error, communication failure, limited resources, lack of institutional support, or unavoidable treatment risk. Older patient safety studies remain useful for conceptual distinctions, but recent literature on public health emergency ethics and medical responsibility strengthens the need for system-sensitive accountability (Brennan et al., 1991; Iong, 2024; Keristian & Triana, 2025; Panagioti et al., 2019; Shojania & Dixon-Woods, 2017). The law must identify whether harm resulted from culpable physician conduct or from structural scarcity beyond the physician's control.

Remote emergency medical services have distinct structural characteristics. Distance, lack of specialists, limited diagnostic equipment, unstable communication, and delayed transport can limit the options available to the physician. Recent studies show that telehealth, rural emergency department use, emergency readiness, primary care linkage, and local resource distribution strongly influence emergency outcomes in remote or rural settings (Castro-Delgado et al., 2025; Gettel et al., 2025; Mohr et al., 2023; Sreeram et al., 2024; Tsou et al., 2021; Zhang, 2024). These constraints do not remove the duty of care, but they shape the legal assessment of reasonableness.

Informed consent remains central to patient autonomy. A competent patient ordinarily has the right to receive adequate information and to decide whether to accept or refuse medical intervention (Appelbaum, 2007). Emergency care creates an exception when the patient is unconscious, family is absent, and delay would create serious harm. Recent Indonesian studies after Law Number 17 of 2023 confirm that emergency consent, forged consent, professional

documentation, and emergency facility responsibility must be regulated carefully so that physicians can act quickly without weakening patient rights (Damayanti et al., 2024; Putri et al., 2025; Ritonga et al., 2025; Sakinatunnisa & Alawiya, 2025; Viranda & Zulfiko, 2026).

## **METHOD**

This study uses normative legal research. The research object is the legal construction of physicians' criminal liability in remote emergency medical services when the noodtoestand doctrine is invoked. The primary legal materials consist of the Indonesian Criminal Code, Law Number 1 of 2023 concerning the Criminal Code, Law Number 17 of 2023 concerning Health, Law Number 29 of 2004 concerning Medical Practice, Government Regulation Number 28 of 2024, informed consent regulation, professional standards, and the Indonesian Code of Medical Ethics. Secondary legal materials consist of recent journal articles, books, and comparative literature on necessity, medical liability, patient safety, emergency consent, telehealth, and rural emergency care.

The study applies three approaches. First, the statutory approach examines the relationship between criminal liability, emergency medical duties, health service obligations, informed consent, medical practice standards, and professional discipline. Second, the conceptual approach clarifies the meaning of noodtoestand, overmacht, fault, unlawfulness, proportionality, professional competence, medical risk, and patient autonomy. Third, the comparative literature approach uses international and Indonesian scholarship to identify how necessity, emergency care, patient safety, medical liability, and rural health service constraints are discussed in broader legal and health literature.

The legal materials were collected through library research and document analysis. The analysis proceeds through grammatical, systematic, and teleological interpretation. It first maps the structure of criminal liability in emergency medical decisions. It then distinguishes medical risk, medical accident, ordinary negligence, gross negligence, and justified emergency action. Finally, it formulates a conditional protection model that can be used as an argumentative framework in policy drafting, professional assessment, and legal analysis before criminal prosecution.

## **RESULTS AND DISCUSSION**

### **Remote Emergency Medical Services as a Distinct Legal Context**

Remote medical services cannot be treated as a mere geographical variation of ordinary urban hospital practice. Distance, facility gaps, limited personnel, unstable communication, limited ambulance capacity, and referral delays shape the physician's real choices. Recent studies show that rural and remote emergency systems depend on local emergency department capacity, tele-emergency support, primary care linkage, and readiness of rural health professionals (Castro-Delgado et al., 2025; Gettel et al., 2025; Mohr et al., 2023; Sreeram et al., 2024; Tsou et al., 2021). This means that the standard of criminal assessment must identify what alternatives were realistically available at the time of action.

This does not mean that remote physicians have a lower duty of care. The better formulation is contextual accountability. The physician remains bound by professional competence, patient safety, clinical reasoning, and documentation. However, criminal law should not compare a remote emergency setting to a tertiary hospital if the physician did not have the same specialists, devices, medicines, referral speed, and diagnostic options. The relevant question is whether the physician acted reasonably and proportionally within the constraints that actually existed.

**Table 1. Remote Constraints and Criminal Law Implications**

Remote Constraint	Legal Relevance	Criminal Law Implication
Limited diagnostic tools	The physician may be unable to confirm diagnosis with ideal certainty.	Fault should not be inferred only from diagnostic uncertainty.
Limited personnel	Clinical judgment may be made without specialist assistance.	Reasonableness must consider available human resources.
Delayed referral	Waiting for transfer may increase risk of death or disability.	Immediate action may be justified if delay creates greater harm.
Limited informed consent opportunity	The patient may be unconscious and family unavailable.	Presumed consent or necessity may justify urgent action if strictly limited.
Incomplete documentation during crisis	Documentation may occur after stabilization.	Post-action documentation remains essential for accountability.

Source: Author's normative synthesis based on recent rural emergency care and criminal liability literature.

**Noodtoestand, Overmacht, and the Boundary of Emergency Justification**

Noodtoestand should be understood as a strict legal test. It is not a general exemption from responsibility. It is an exceptional doctrine that requires immediate danger, a choice between harms, proportional action, and no reasonable lawful alternative (Alexander, 2005; Arnolds & Garland, 1974; Colvin, 1990; Dennis, 2009; Gearty, 1989). For physicians in remote emergency care, the doctrine may be relevant when the physician must perform an urgent action to prevent death, permanent disability, or serious deterioration, even though the action cannot fully satisfy ordinary procedural requirements.

The concept must also be distinguished from related criminal law doctrines. Overmacht refers broadly to compulsion or force that can remove criminal responsibility when the actor has no meaningful freedom of choice. Noodtoestand is more specific. It refers to a necessity situation where the actor chooses the lesser harm to prevent a greater harm. Noodweer concerns necessary defense against unlawful attack. This article does not discuss self-defense. It discusses emergency medical action under clinical danger and resource scarcity.

The key point is the distinction between justified emergency action and punishable negligence. If a physician acts hastily without adequate assessment when safer alternatives exist, noodtoestand should not apply. If a physician ignores professional standards, acts beyond competence without urgency, forges documentation, or fails to record essential decisions after stabilization, criminal law protection becomes weak (Ritonga et al., 2025; Viranda & Zulfiko, 2026). However, when the physician faces immediate danger, has no viable alternative, acts within the best available professional judgment, and chooses the lesser harm, criminal liability should be restricted.

**Table 2. Elements of the Noodtoestand Test in Remote Emergency Medical Services**

Element	Meaning in Emergency Medical Services	Evidence Needed
Imminent danger	The patient faces death, serious injury, disability, or rapid deterioration.	Triage note, vital signs, clinical record, witness statement.
No reasonable alternative	Referral, delay, or waiting for consent would create greater danger.	Referral availability, distance, facility limitation, communication record.
Proportional action	The medical action is limited to preventing greater harm.	Clinical reasoning, procedure note, risk-benefit explanation.
Good faith	The physician acts to save the patient, not for convenience or concealment.	Decision chronology, team note, professional consultation when possible.

Element	Meaning in Emergency Medical Services	Evidence Needed
Professional competence	The action is within competence or necessary due to emergency conditions.	License, practice authority, clinical standard, peer assessment.
Accountable documentation	The emergency decision is recorded after patient stabilization.	Medical record, informed explanation to family, incident report.

Source: Author's formulation based on necessity doctrine and emergency medical accountability literature.

### The Boundary between Medical Risk, Negligence, and Criminal Liability

Medical risk is not identical to criminal negligence. A bad outcome can occur even when a physician follows reasonable clinical judgment. Patient safety literature recognizes that adverse events may arise from system limits, clinical uncertainty, communication failure, or unavoidable treatment risk (Brennan et al., 1991; Iong, 2024; Panagioti et al., 2019; Shojania & Dixon-Woods, 2017). Criminal liability should therefore require more than harm. It should require proof that the physician breached a relevant duty with culpable mental state or grossly unreasonable conduct.

The remote emergency context requires a structured causation analysis. The law must ask whether the harm resulted from the physician's culpable act, the patient's prior condition, system scarcity, referral delay beyond the physician's control, or an unavoidable medical complication. This distinction matters because criminal punishment should not replace health system responsibility. If the state or facility fails to provide equipment, personnel, ambulance access, or referral capacity, individual criminalization of the physician may be normatively unfair unless the physician also committed a culpable breach.

Litigation and liability studies also show that patients and families may sue doctors for reasons related not only to the final injury but also to poor communication, dissatisfaction with explanation, perceived concealment, or weak accountability. Defensive medicine research adds that fear of litigation may cause excessive testing, referral avoidance, and delayed decision-making (Baungaard et al., 2022; Ginting et al., 2025; Kakemam et al., 2022; Schaffer et al., 2017; Studdert, 2005; Studdert et al., 2006). A strict *noodtoestand* test can discipline this analysis by protecting reasonable emergency decisions while keeping room for liability when there is gross negligence, recklessness, or intentional concealment.

### Presumed Consent, Patient Autonomy, and Emergency Action

Informed consent remains a central expression of patient autonomy. Competent patients ordinarily have the right to receive information and approve or refuse medical intervention (Appelbaum, 2007). Emergency care is different when the patient is unconscious, family is absent, time is critical, and delaying treatment would create serious harm. In such cases, presumed consent and necessity may support urgent medical action, but only as limited exceptions (Chiong et al., 2014; Kompanje et al., 2020).

Indonesian discussion after Law Number 17 of 2023 places informed consent within the broader protection of patient rights and medical personnel accountability. In emergency conditions, the legal issue is not whether consent can be ignored. The real issue is whether the physician can prove that delay would endanger life or cause serious disability, that the action was medically necessary, and that the reason for acting without ordinary consent was documented (Damayanti et al., 2024; Putri et al., 2025; Ritonga et al., 2025; Sakinatunnisa & Alawiya, 2025; Viranda & Zulfiko, 2026).

This article does not place patient autonomy below physician protection. The better position is sequential accountability. Before action, the physician may rely on emergency necessity if consent cannot be obtained and delay would create greater harm. During action,

the physician must limit the intervention to what is clinically necessary. After stabilization, the physician must explain the action, risks, and reasons to the patient or family and record the decision. This sequence prevents emergency exceptions from becoming routine shortcuts.

### Indonesian Criminal and Health Law Framework

In Indonesian law, *noodtoestand* must be placed within the broader architecture of criminal responsibility, health service obligations, medical practice standards, and professional ethics. Article 48 of the old Criminal Code provides the doctrinal basis for compulsion or necessity. Law Number 1 of 2023 concerning the Criminal Code must also be read because it updates the architecture of criminal responsibility. Recent criminal policy scholarship stresses that medical personnel protection under the new Criminal Code must be harmonized with health law and professional discipline (Abang Anton et al., 2024; Hely Ramadhini Harahap & Ahmad Ma'mun Fikri, 2025).

Law Number 17 of 2023 concerning Health and Government Regulation Number 28 of 2024 strengthen the governance framework for health services, medical personnel, discipline, and dispute resolution. These instruments also support a more structured distinction between medical disputes, disciplinary violations, civil negligence, administrative responsibility, and criminal wrongdoing (Al Ghifari et al., 2026; Awangga, 2025; Gladys Haryanto et al., 2025; Nurchasanah et al., 2025; Sakinatunnisa & Alawiya, 2025; Tamon et al., 2025). This distinction is important because criminal prosecution should be the last and strictest response, not the first reaction to every adverse medical outcome.

Law Number 29 of 2004 concerning Medical Practice remains relevant because it regulates professional practice, competence, registration, licensing, discipline, and medical accountability. Medical dispute literature also indicates the importance of professional assessment before criminalization because expert review can identify whether the conduct breached professional standards or reflected a justified emergency decision (Dwi Atmoko, 2022; Keristian & Triana, 2025; Ritonga et al., 2025). The legal framework should therefore support a pre-prosecution professional review mechanism for emergency medical cases.

**Table 3. Indonesian Legal Framework for Emergency Medical Liability**

Legal Source	Relevance	Use in the Proposed Model
Old Criminal Code, Article 48	Basis for force majeure or necessity doctrine.	Used to frame <i>noodtoestand</i> as a strict exception.
Law Number 1 of 2023 concerning Criminal Code	Updates the structure of criminal responsibility and fault.	Used to align medical liability with current criminal law policy.
Law Number 17 of 2023 concerning Health	Regulates health services, patient rights, duties, protection, discipline, and dispute resolution.	Used to connect emergency duties with conditional legal protection.
Government Regulation Number 28 of 2024	Implements health law governance, including service and dispute mechanisms.	Used to support mediation, professional review, and proportional accountability.
Law Number 29 of 2004 concerning Medical Practice	Regulates professional practice, competence, registration, and discipline.	Used to assess professional basis and competence.
Informed consent regulation and KODEKI	Regulates patient autonomy, emergency explanation, ethics, and records.	Used to evaluate consent exceptions and post-action accountability.

Source: Author's normative synthesis based on Indonesian criminal law, health law, medical practice regulation, and medical ethics.

### Conditional Protection Model for Physicians in Remote Emergency Services

A conditional protection model is needed because the two extreme approaches are both problematic. Absolute immunity for physicians can weaken patient rights and reduce accountability. Unrestricted criminalization can produce defensive medicine, delay emergency action, and discourage physicians from serving remote areas (Baungaard et al., 2022; Ginting et al., 2025; Marzuki et al., 2023; Ni Luh Gede Astariyani & Julio de Araujo da Silva, 2025; Silva et al., 2026). The legal model must therefore protect good-faith emergency decisions while still allowing liability for gross negligence, reckless conduct, intentional harm, forged documentation, or concealment.

The proposed model contains five safeguards. First, criminal investigation should distinguish medical dispute, disciplinary violation, civil negligence, administrative violation, and criminal negligence. Second, emergency medical cases should receive professional review before criminal prosecution. Third, the review must consider the remote setting, available facilities, referral feasibility, time pressure, and actual clinical risk. Fourth, medical records and post-action explanation must be treated as central evidence. Fifth, sanctions should be proportionate to the quality of fault, not merely to the severity of the outcome.

Professional review should not be understood as a shield against law enforcement. It functions as an evidentiary filter. The review may involve a hospital medical committee, medical disciplinary body, professional organization, or independent medical expert. The review should answer whether the physician acted within professional competence, whether emergency action was necessary, whether safer alternatives existed, and whether the record supports good faith and proportionality. This mechanism protects both parties. It prevents arbitrary criminalization of physicians and prevents emergency conditions from becoming a device to hide negligence.

**Table 4. Conditional Protection Model for Remote Emergency Medical Services**

Assessment Stage	Question	Protection Effect
Stage 1: Emergency status	Was there immediate risk of death, serious injury, or severe deterioration?	If yes, noodtoestand analysis becomes relevant.
Stage 2: Available alternatives	Was referral, delay, or family consent realistically possible without increasing danger?	If no, urgent action may be legally justified.
Stage 3: Proportionality	Was the medical action limited to preventing greater harm?	If yes, criminal blame is reduced or excluded.
Stage 4: Professional basis	Did the physician act according to competence and the best available standard?	If yes, bad outcome alone should not create criminal liability.
Stage 5: Accountability	Was the decision documented and explained after stabilization?	If yes, evidence of good faith and reasonableness is strengthened.

Source: Author's conditional protection model for remote emergency medical services.

### Impact for Doctors, Patients, Investigators, and Policy Makers

The theoretical impact of this article is the refinement of noodtoestand into a clinical legal test for remote emergency medical services. The doctrine is not left at the level of abstract criminal law. It is converted into operational elements: imminent danger, no reasonable alternative, proportional action, good faith, professional competence, and accountable documentation.

The practical impact for physicians is a decision-making and documentation framework. Physicians who act in emergency conditions can use the test to record why immediate action

was necessary, what alternatives were unavailable, what risks were considered, what action was chosen, and how the action was explained after stabilization. For patients, the model keeps autonomy, safety, documentation, and explanation as essential conditions of accountability (Damayanti et al., 2024; Putri et al., 2025; Viranda & Zulfiko, 2026).

For investigators and courts, the model offers a structured threshold to distinguish medical tragedy, system failure, professional negligence, and criminal fault. For hospitals and professional boards, it supports the drafting of emergency SOPs, documentation standards, referral protocols, and expert review procedures. For policy makers, it supports legal harmonization between criminal law, health law, medical practice regulation, telemedicine, and rural emergency care (Naurah et al., 2025; Sakinatunnisa & Alawiya, 2025; Setiadi et al., 2023; Situngkir et al., 2024; Suwadi et al., 2024).

## CONCLUSION

The noodtoestand doctrine can be used to determine the limits of physicians' criminal liability in remote emergency medical services, but only through a strict legal test. The doctrine should apply when a physician faces an imminent threat to the patient, has no reasonable safer alternative, acts proportionally, acts in good faith, works within the best available professional competence, and records the decision after stabilization. It should not apply to reckless conduct, intentional harm, gross negligence, forged consent, or concealment of medical facts.

The legal protection model proposed in this article is conditional protection. Physicians in remote emergency services should not be criminalized merely because a patient suffers a bad outcome under constrained conditions. At the same time, patient rights remain protected through professional standards, documentation, post-action explanation, and professional review. This model gives a balanced basis for Indonesian health law and criminal law because it protects emergency medical action without weakening accountability.

The impact of this article is a conditional protection framework that can guide physicians, hospitals, professional boards, investigators, and courts in assessing emergency medical cases in remote areas. The framework prevents two errors at once: the over-criminalization of reasonable emergency medical action and the misuse of emergency conditions to excuse gross negligence or concealment. It also reinforces patient protection by making documentation, proportionality, professional competence, and post-action explanation essential elements of legal accountability.

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