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Relationship Between Hospitals and Doctors Based on the Principle of Justice

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Abstract

This research investigates the legal dynamics of hospital-physician partnerships, evaluating them against the principles of Commutative and Distributive Justice. While these relationships are normatively grounded in the principle of freedom of contract under the Indonesian Civil Code, a significant discrepancy exists between theory and practice. The study reveals that the "independent contractor" status often masks a subordinate employment relationship, creating structural injustice due to the unequal bargaining power between physicians and institutions. This imbalance is further complicated by a legal vacuum regarding contract standardization, which often shifts the burden of liability onto physicians through recourse rights while obscuring corporate accountability. To rectify these inequities, the study proposes the integration of legal regimes via legal analogy (analogia iuris) to ensure proportional justice and legal certainty. Moving forward, the research emphasizes the urgent need for government-issued regulations to standardize agreements and eliminate "take-it-or-leave-it" contracts. Furthermore, hospitals must refine their internal clauses to ensure fair risk distribution, while professional bodies like the Indonesian Medical Association (IDI) should provide standardized templates and advocacy. These collective measures are essential to safeguarding clinical autonomy, strengthening physician bargaining power, and ensuring a transparent, protected healthcare ecosystem for both medical professionals and patients.
Keywords: *Doctor; Hospital; Partnership Agreement; Principle of Justice*

1. INTRODUCTION

The legal landscape governing the relationship between healthcare institutions and medical practitioners has undergone a profound paradigm shift over the last decade, transitioning from a traditional "*master-servant*" hierarchy to a complex, multifaceted partnership often plagued by contractual ambiguity. Current empirical data suggest a sharp trajectory in medical malpractice litigation and administrative disputes, yet existing legal frameworks frequently fail to bridge the widening chasm between the corporate-profit interests of hospitals and the professional autonomy of doctors.

The legal landscape governing the relationship between healthcare institutions and medical practitioners has undergone a radical transformation over the last decade, particularly accelerated by the global health crisis and the subsequent digitalization of medical services. Data from recent legal audit indicates a significant 25% increase in "internal" legal disputes not between patients and doctors, but between doctors and hospital management regarding contractual imbalances and professional liability.[1]

The right to health is a human right guaranteed under Article 28H paragraph (1) and Article 34 paragraph (3) of the 1945 Constitution, which mandates that the state is

[1] Diah Ratu Sari Siti Nurlaelah, Mochammad Ali Asgar, Arisman, "Legal Position of the Professional Disciplinary Council: Central Authority for Disciplinary Enforcement of Medical and Healthcare Professionals in Hospitals," *SIGn Jurnal Hukum* 7, no. 2 (2026): 1325–40.

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responsible for providing decent healthcare facilities. This constitutional pillar is implemented through Law Number 17 of 2023 concerning Health (Health Law), which regulates the provision of comprehensive and integrated health services. The realization of these services begins with the legal relationship between medical personnel and the Hospital (RS) as a healthcare institution. Pursuant to Article 37 paragraph (2) and Article 198 paragraph (2) of the Health Law, doctors are positioned not only to provide curative services but also as medical personnel who exercise their competence within healthcare facilities.[2]

This legal relationship is generally governed by the labor framework under Law Number 13 of 2003 and Law Number 6 of 2023 (the Job Creation Law). However, the applicability of the Job Creation Law remains a subject of controversy, particularly following Constitutional Court Decision Number 168/PUU-XXI/2023, which partially granted a judicial review concerning the protection of workers' rights. In the context of the medical field, this legal uncertainty creates complexity in determining the status and legal protection of doctors, especially regarding the balance between professional autonomy and their obligations as workers within a hospital's management structure.[3]

In practice, the relationship between hospitals and doctors is based on agreements that must fulfill the legal requirements for a valid contract as regulated under Article 1320 of the Indonesian Civil Code (KUHPerdata). This relationship is generally categorized into permanent doctors (Civil Servants/PNS, Government Employees with Work Agreements/PPPK, TNI/POLRI, or private employees under Fixed-Term/Permanent Work Agreements) and non-permanent doctors, who are often structured through the concept of partnership.[4]

While foundational literature has long discussed the contractual nature of these engagements, most previous studies remain purely descriptive-normative, focusing only on the formal validity of employment under civil codes. There is a profound State of the Art deficit where existing research fails to analyze the "substantive equity" of these contracts within the context of modern healthcare industrialization.[5] The limitation of prior research lies in its preoccupation with the "doctrine of vicarious liability," which addresses external accountability to patients but systematically ignores the internal power dynamics. In practice, many Hospital Bylaws now function as contracts of

[2] Felicia Maya, Budi Sarwo, and Daniel Budi Wibowo, "Juridical Study of the Work Relations Between Doctors and Hospitals in the Implementation of Health Services," *Soepra* 9, no. 1 (2023): 116–36, https://doi.org/10.24167/sjhk.v9i1.5360.

[3] Humas Mahkamah Konstitusi Republik Indonesia, "Kabulkan Sebagian, MK Minta UU Ketenagakerjaan Dipisahkan Dari UU Cipta Kerja," Mahkamah Konstitusi Republik Indonesia, 2024, https://www.mkri.id/berita/kabulkan-sebagian,-mk-minta-uu-ketenagakerjaan-dipisahkan-dari-uu-cipta-kerja-21782.

[4] M. Zamroni, *Hukum Kesehatan: Tanggung Gugat Dokter Dan Rumah Sakit Dalam Praktik Pelayanan Medis* (Surabaya: Scopindo Media Pustaka, 2023).

[5] Lintang Zandra Camellia, "Aspek Keperdataan Dalam Upaya Penyelesaian Sengketa Medis Antara Pasien Dengan Tenaga Medis Berdasarkan Undang-Undang Kesehatan," *Jurnal Hukum & Pembangunan Volume* 54, no. 3 (2024), https://doi.org/10.21143/jhp.vol54.no3.1647.

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adhesion, take-it-or-leave-it agreements that prioritize institutional risk mitigation over the doctor's professional autonomy. Consequently, a research gap is explicitly identified: there is an absence of an analytical-comparative framework that evaluates whether these contracts satisfy the Principle of Justice, specifically Commutative Justice (equivalence of performance) and Distributive Justice (fair allocation of risks and rewards).

This study is critically urgent due to the enactment of recent regulations, such as the Indonesian Health Law No. 17 of 2023, which introduces a centralized disciplinary mechanism. Theoretically, this research challenges the stagnant "*master-servant*" interpretation of medical labor, proposing a "Justice-Based Partnership" model. Practically, the failure to address this legal gap has led to the rise of "defensive medicine" and high clinician burnout, which directly compromises the quality of national patient care. By analyzing the shift from traditional employment to professional partnership, this research seeks to provide a new legal construction that ensures equitable protection for both the institution and the physician.

Although Article 28D paragraph (2) of the 1945 Constitution and Article 38 of Law Number 39 of 1999 concerning Human Rights guarantee the right to work and the right to fair treatment, the fulfillment of these rights within such contractual clauses often encounters significant obstacles. Ambiguity arises when contractual clauses designed as partnerships inadvertently include fixed wage provisions, which are a defining characteristic of an employer-employee relationship. Consequently, an imbalance in bargaining power emerges through the use of adhesion contracts (standardized contracts), which restrict the doctor's ability to negotiate medical fees, on-call workloads, and compliance with the hospital's internal regulations, specifically the hospital bylaws. The status of "partner" often eliminates normative labor rights such as severance pay, social security, and leave due to a payment system based on *fee-for-service*.[6]

Furthermore, the issue of monoloyalty within Cooperation Agreements constitutes a form of substantive injustice that restricts a doctor's professional right to practice at other facilities. This not only undermines the freedom to choose employment but also hinders patient access to the expertise of specialist doctors.[7] Based on the aforementioned background, this research aims to conduct an in-depth study regarding the "Partnership Relationship Between Hospitals and Doctors Based on the Principle of Justice."

[6] Yudith Ilela, Adonia Ivonne Laturette, and Sarah Selfina Kuahaty, "Penerapan Sistem Perjanjian Kerja Waktu Tertentu Dalam Perspektif Hukum Positif Indonesia," *Pamali: Pattimura Magister Law Review* 4, no. 2 (2024): 226, https://doi.org/10.47268/pamali.v4i2.2144.

[7] Suhendro dan Yetti Dinni Indrayuni, "Itikad Baik Hubungan Hukum Perjanjian Kerjasama Tenaga Kesehtan di Rumah Sakit Pemerintah," *Jurnal Ilmu Pengetahuan Dan Riset Sosial* 1, (1) (2022), https://ejournal.uinmybatusangkar.ac.id/ojs/index.php/proceedings/article/view/7186.

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Previous research by Kinang (2024), concludes that these relationships are categorized either as employer-employee interactions or as hospital partnerships.[8] In contrast, this current study distinguishes itself by analyzing the substantive aspects of innominate partnership patterns, such as room rentals inclusive of medical personnel, which are widely practiced yet lack standardized regulation. This research proposes a solution through the integration of legal regimes via legal analogy (*analogia iuris*) to address the structural injustices inherent in these partnership contracts.

The research gap between studies, Kumalasari (2024), the focus of this research, which analyzes the partnership relationship between hospitals and physicians. Most current health law literature tends to emphasize external liability, namely, consumer protection and the fulfillment of patient rights regarding medical malpractice. However, a significant and often untouched gap remains concerning structural internal liability between hospitals and physicians within innominate partnership schemes.[9] This gap is evident in how the uncertain legal status of physicians as "partners" often obscures the parameters of justice in the distribution of legal risks. While previous research has largely dissected the doctrine of vicarious liability for the benefit of patients, this study aims to fill that void by analyzing how the principle of proportional justice should be applied in partnership contracts. This is to ensure that a physician's medical autonomy does not result in a unilateral and exploitative shift of liability from the hospital institution.

The State of the Art in this field reveals a significant analytical deficit. Previous research has primarily focused on the "doctrine of vicarious liability," which addresses external accountability to patients but neglects the internal "justice-based" dynamics between the hospital management and the physician. The limitation of earlier studies lies in their failure to address the power imbalance inherent in hospital bylaws, which often prioritize institutional risk management over the doctor's right to fair professional protection.

Consequently, a research gap exists: there is a lack of an analytical-comparative framework that evaluates hospital-doctor contracts through the lens of Distributive and Commutative Justice. This research is urgent because, theoretically, it challenges the stagnant interpretation of medical contracts that treat doctors as mere subordinates. Practically, the absence of a justice-based legal standard leads to "defensive medicine" and high turnover rates, which ultimately compromise the quality of patient care. By explicitly comparing current Indonesian regulations with global justice principles, this study seeks to provide a new legal construction that ensures equitable rights and

[8] Andi Kinang, "Analisis Yuridis Hubungan Kerja Tenaga Medis (Dokter) dengan Rumah Sakit (Studi Kasus Putusan Mahkamah Agung Republik Indonesia Nomor: 36 K/Pdt.Sus-PHI/2023)" (Universitas Nasional, 2024), https://repository.unas.ac.id/id/eprint/12326/.

[9] Ratna Kumalasari, "Analisis Hubungan Tanggung Jawab Hukum Antara Rumah Sakit dengan Pasien dalam Pelayanan Kesehatan" (Universitas Islam Sultan Agung, 2024), https://repository.unissula.ac.id/36983/1/Magister Ilmu Hukum_20302200284_fullpdf.pdf.

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obligations for both parties.

This research significantly enriches the discourse on health law in Indonesia by addressing the restructuring of the legal relationship between hospitals and physicians. Theoretically, it offers a novel approach using legal analogy (*analogia iuris*) to integrate civil law (leasing) with labor law to analyze innominate partnership patterns, effectively clarifying the often-distorted doctrine of corporate liability. Practically, the study provides strategic guidance for drafting transparent and balanced contract clauses, specifically regarding the mitigation of recourse rights (hak regres) to prevent the unilateral shifting of legal risks onto physicians. Finally, from a policy perspective, this thesis highlights the urgent need for government and professional organizations (IDI) to standardize regulations and fill the current legal vacuum *(rechtvacuüm),* fostering a healthcare ecosystem rooted in the principle of proportional justice for physicians, hospitals, and patients. The objectives of this research are to analyze the patterns of partnership relationships between hospitals and physicians and to evaluate the application of the principle of justice within these partnership relationships.

2. METHOD

The methodology of this research is strictly defined as normative legal research, focusing on the internal consistency of legal norms and their alignment with the philosophical foundations of equity. To address the complexities of the hospital-doctor relationship, the study employs a multifaceted approach, integrating the statute approach to scrutinize relevant regulations such as the the Indonesian Civil Code (KUHPerdata), the Labor Law, the Job Creation Law, the Health Law, and Government Regulation No. 28 of 2024, the conceptual approach to dissect the principles of Commutative and Distributive Justice, and a comparative approach to evaluate international legal standards against domestic practices. The data utilized are exclusively secondary, comprising primary legal materials such as national legislation and hospital bylaws, secondary legal materials including peer-reviewed journals and authoritative legal treatises from the last decade, and tertiary legal materials like legal dictionaries and encyclopedias for conceptual clarification. These data are gathered through a systematic literature study and a rigorous document review process, ensuring that the selection of materials is both current and highly relevant to the justice-based inquiry. Finally, the collected legal materials are processed using a qualitative-deductive analysis method, whereby legal principles are systematically applied to the specific contractual phenomenon of hospital-doctor engagements to derive a new, justice-oriented legal construction that resolves the identified research gaps.

3. RESULTS AND DISCUSSION

3.1 Cooperation Agreements

In accordance with Article 34, Paragraph (3) of the 1945 Constitution of the Republic of Indonesia, the state participates in the provision of decent healthcare

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facilities.[10] This is emphasized in Law Number 23 of 2014 concerning Regional Government, which stipulates that regional governments shall strive to provide optimal healthcare services for the welfare of the community.[11] The effort to enhance health-based welfare is carried out through healthcare personnel. Pursuant to Articles 5 and 6 of Law Number 13 of 2003 concerning Labor, every worker, whether general labor, medical personnel, or healthcare professionals, possesses equal rights and opportunities to obtain employment and a decent living without discrimination based on gender, ethnicity, race, religion, or political affiliation, in accordance with the interests and abilities of the respective worker.[12]

One form of protection for legal certainty regarding these workers is the execution and implementation of employment agreements. Every medical or healthcare professional recruited to assist in the operations of this hospital is a contract worker operating under a collective labor agreement based on an employment contract agreed upon by both parties, namely, the healthcare professionals themselves and the hospital, as the healthcare facility provider, led directly by the hospital director.[13]

A Cooperation Agreement is a written agreement between two or more parties who bind themselves to jointly execute an activity or venture to achieve specific mutually beneficial goals. Indonesian civil law, a PKS is derived from the Principle of Freedom of Contract as stipulated in Article 1338 of the Indonesian Civil Code, which grants parties the right to determine the content, form, and terms of the agreement, provided they do not conflict with the law. Unlike conventional employment contracts, which are often subordinate (employer-employee) in nature, a PKS ideally reflects a coordinative and equal relationship, where each party provides specific contributions, whether in the form of resources, expertise, or facilities, and shares risks and benefits according to the proportions mutually agreed upon within the contract clauses.[14]

According to Article 1313 of the Indonesian Civil Code, an agreement is an act whereby one or more persons or others, comprising essential elements such as parties, mutual consent, performance (prestasi), a lawful cause, and specific objectives. The legal framework of agreements is governed by an "open system" under Article 1338(1), which upholds the principle that all legally executed agreements serve as law for the parties

[10] Mahkamah Konstitusi Republik Indonesia, "UUD Negara Republik Indonesia Tahun 1945," 1945 Mahkamah Konstitusi Republik Indonesia § (2017), https://www.mkri.id/public/content/infoumum/regulation/pdf/UUD45 ASLI.pdf.

[11] Kementerian Perindustrian Republik Indonesia, "Undang-Undang Republik Indonesia Nomor 23 Tahun 2014 Tentang Pemerintah Daerah," Mahkamah Konstitusi Republik Indonesia (2014), https://www.kemenperin.go.id/kompetensi/UU_13_2003.pdf.

[12] Kementerian Perindustrian Republik Indonesia.

[13] Muhammad Chandra B.Simarmata, Degdy Saddam Kennedy and Lestari Voctoria Sinaga, "Analisis Hukum Tentang Perjanjian Terapeutik Antara Dokter Dengan Pasien Dalam Pelayanan Kesehatan," *Jurnal Rectum* 4, no. 1 (2022): 203–17, https://doi.org/http://dx.doi.org/10.46930/jurnalrectum.v4i1.1458.

[14] Budi Purnomo Sari Herda Putri, Paulus Windraji, "Tinjauan Hukum Perjanjian Kerjasama Antara Rumah Sakit Dan Perusahaan Asuransi Kesehatan," *JIIP - Jurnal Ilmiah Ilmu Pendidikan* 8, no. 10 (2025): 11558–64, https://doi.org/10.54371/jiip.v8i10.9346.

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involved. Furthermore, for an agreement to be legally binding, it must fulfill the four validity requirements stipulated in Article 1320: mutual consensus, legal capacity, a specific object, and a lawful cause. This framework is underpinned by fundamental legal principles, most notably *pacta sunt servanda* (binding force), good faith, consensualism, and freedom of contract, alongside broader values of equity, legal certainty, and moral protection.[15]

Pursuant to Article 1338 of the Indonesian Civil Code, there are three fundamental principles of civil law. First, the Principle of Freedom of Contract, which, according to Agus Yudha Hernoko, is implicitly contained within the article, granting parties the liberty to choose the cause of their agreement, determine its object and form, and decide whether to adopt or deviate from optional statutory provisions (*aanvullend*). Second, the principle of *Pacta sunt servanda* is derived from the mandate that all legally executed agreements serve as law for the parties involved. This principle dictates that an agreement has legally binding and compulsory force, requiring both parties to fulfill their obligations until the contract is completed. Finally, complementing the binding nature of contracts is the Principle of Good Faith, which is explicitly reflected in the requirement that all agreements must be executed in good faith.[16]

According to Article 1313 of the Indonesian Civil Code, an agreement is defined as a legal act whereby one or more parties bind themselves to one or more other parties, encompassing essential elements such as legal subjects, mutual consent, performance (*prestasi*), a lawful cause, and a specific object. The contractual framework under Indonesian civil law is governed by an "open system" pursuant to Article 1338 paragraph (1) of the Indonesian Civil Code, which embodies the principle of freedom of contract and stipulates that every legally executed agreement shall bind the parties as law (*pacta sunt servanda*). Furthermore, for an agreement to attain legal validity, it must satisfy the four fundamental requirements prescribed under Article 1320 of the Indonesian Civil Code, namely mutual consent, legal capacity, a specific object, and a lawful cause. These provisions collectively establish the normative foundation of contractual relationships, emphasizing legal certainty, good faith, proportionality, and the protection of the parties' rights and obligations.

Furthermore, for an agreement to be legally binding, it must fulfill the four validity requirements stipulated in Article 1320: mutual consensus, legal capacity, a specific object, and a lawful cause. This framework is underpinned by fundamental legal principles, most notably binding force, good faith, consensualism, and freedom of contract, alongside broader values of equity, legal certainty, and moral protection. An agreement is a derivative of general contract law, founded upon the principle of freedom of contract. Regulations concerning work agreements are explicitly outlined in Chapter

[15] Sari Herda Putri, Paulus Windraji.
[16] FJP Law Offices, "Asas-Asas Pasal 1338 Kitab Undang-Undang Hukum Perdata." Frederik J. Pinakunary, 2024, https://fjp-law.com/id/asas-asas-pasal-1338-kuhperdata/.

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VII A of the Indonesian Civil Code (KUHPerdata) regarding agreements to perform work. Pursuant to Articles 1601 through 1617, a work agreement is understood as a commitment wherein a worker expresses their willingness to perform tasks for an employer for a specific duration in exchange for wage compensation.[17]

Meanwhile, the Cooperation Agreement established between a hospital and a doctor is grounded in the general theory of obligations, as mandated by Article 1320 of the Indonesian Civil Code (KUHPerdata). Article 1320 of the Indonesian Civil Code (KUHPerdata) stipulates four requirements for a valid agreement to be legally binding: the consensus of the parties, the capacity to act, a specific subject matter, and a lawful cause. A violation of the subjective requirements (1 & 2) renders the contract voidable, whereas a violation of the objective requirements (3 & 4) renders the contract null and void by law.[18]

Several models have emerged regarding the patterns of work contracts between hospitals and doctors. Legally, a physician is categorized as an employee if their relationship with a hospital fulfills an employment relationship: work, orders, and wages. In this legal construction, the physician is positioned as a worker under the direction of hospital management (subordination), where working hours, standard operating procedures, and compensation are determined unilaterally by the institution. This status typically applies to permanent physicians or civil servants (ASN) doctors in government hospitals. Under the doctrine of vicarious liability, the juridical consequence of this employee status is that the hospital bears full responsibility for any medical actions performed by the physician within the scope of their duties. However, this position is often considered to limit a physician's clinical autonomy due to the strong administrative control exercised by the hospital as the employer.[19]

Broadly speaking, the legal relationship between medical personnel and hospitals consists of two distinct categories under the law. First is the employment relationship, which positions the physician as an employee of the hospital, establishing a "physician-in" model characterized by a *master-servant* dynamic between the employer and the worker. In this capacity, the physician must adhere to all labor regulations, with their reciprocal rights and obligations governed by both the Labor Law and the Indonesian Civil Code. Second is the relationship based on agreement, where the physician is not an employee but enters into an obligation with the hospital arising from a specific contract. In this pattern, the physician is granted the right to utilize the hospital's facilities, such as outpatient or inpatient services, at the time a legal relationship for healthcare services is established between the physician and the patient. This second

[17] Jaringan Dokumentasi dan Informasi Hukum Mahkamah Agung Republik Indonesia, "Kitab Undang-Undang Hukum Perdata" (n.d.), https://jdih.mahkamahagung.go.id/.
[18] Jaringan Dokumentasi dan Informasi Hukum Mahkamah Agung Republik Indonesia.
[19] Dimas Noor Ibrahim, "Tanggung Jawab Hukum Rumah Sakit Terhadap Dokter Dalam Perjanjian Medis Di Indonesia (Studi : Rumah Sakit Siaga Raya)," *Jurnal Ilmiah Publika* 10, no. 2 (2022): 275, https://doi.org/10.33603/publika.v10i2.7556.

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model is entirely governed by the provisions of the Indonesian Civil Code.[20]

The employment patterns at the hospital, the legal basis for agreements between the hospital and its physicians, can be categorized into two distinct frameworks. First, Permanent Physicians are classified as employees who provide medical services during official working hours for and on behalf of the hospital. They are bound by hospital regulations, subject to the supervision of management and owners, and appointed via a Director's Assignment Letter (SK), with working hours often exceeding 40 hours per week.[21] Second, Non-Permanent Physicians function as attending physicians (partners), where the relationship is based on a written contract that positions the doctor and the hospital as equals. In this partnership, the physician provides professional performance while the hospital serves primarily as a facility provider. Generally, these agreements are grounded in Article 1234 of the Indonesian Civil Code and Law No. 13 of 2003 concerning Labor for employee-based physicians, as well as Article 1338 paragraph (1) of the Indonesian Civil Code, which emphasizes the principle of freedom of contract for partnership-based arrangements.[22]

Article 1234 of the Indonesian Civil Code (KUHPerdata) serves as the primary foundation of the law of obligations in Indonesia, specifically outlining the forms of performance (prestasi) or the fulfillment of contractual duties.[23] According to this article, every obligation is aimed at giving something (memberikan sesuatu), doing something (berbuat sesuatu), or refraining from doing something (tidak berbuat sesuatu). The object of the obligation determines the nature of the duty that the debtor must fulfill for the creditor: "giving something" pertains to the transfer of ownership or possession of property, "doing something" refers to a specific service or active deed, while "refraining from doing something" constitutes a promise to abstain from certain actions for the benefit of the other party.

In this model, the hospital positions itself as the principal or authoritative party delegating medical service responsibilities to the doctor. Meanwhile, the doctor holds the status of an employee and a subordinate of the institution (the hospital), thus remaining bound by instructions and internal hospital regulations. This relationship is formalized through an Employment Agreement and is fully subject to the Labor Law regime. Juridically, should medical negligence occur, the hospital bears legal liability for patient losses based on the principle of vicarious liability.

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[20] Hulman Panjaitan Roselyn Hutagaol, Dhaniswara K. Harjono, "Pertanggungjawaban Rumah Sakit Terhadap Malpraktik yang Dilakukan Tenaga Medis dalam Perspektif Hukum Perdata", *Jurnal Hukum To-Ra: Hukum Untuk Mengatur Dan Melindungi Masyarakat* 10, no. 2 (2023): 359–71, https://doi.org/https://doi.org/10.55809/tora.v10i2.381.

[21] Andryawan Yohana, "Hubungan Hukum Antara Dokter dan Pasien dalam Penanganan Medis pada Situasi Kegawatdaruratan", *El-Iqtishady: Jurnal Hukum Ekonomi Syariah* 2 (2024): 306–12.

[22] Maya, Sarwo, and Wibowo, "Juridical Study of the Work Relations Between Doctors and Hospitals in the Implementation of Health Services."

[23] Jaringan Dokumentasi dan Informasi Hukum Mahkamah Agung Republik Indonesia, Kitab Undang-Undang Hukum Perdata.

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Furthermore, the standing of the physician and the hospital is equal. In this position, the physician is the party obligated to provide performance, while the hospital's function is merely as a provider of facilities (such as beds, catering, nursing or midwifery staff, and both medical and non-medical equipment). The concept is essentially as if the hospital is leasing its facilities. In this pattern, doctors provide medical services autonomously and independently. The hospital's function is limited to providing infrastructure, medical facilities, and administrative support for the doctor in managing their patients. This relationship is governed by a Cooperation Agreement. Because this is not a hierarchical employment relationship, the agreement is not subject to the Labor Law but rather to the principles of obligations under the Indonesian Civil Code (KUHPerdata). Specifically, it is governed by provisions regarding service agreements and obligations.[24]

The physician, as an Attending Physician (partner), is a legal subject who conducts medical practice within a hospital through a partnership scheme rather than an employment or labor relationship. In this arrangement, the relationship between the physician and the hospital is coordinative and equal, with the physician acting as an *independent contractor* who utilizes hospital facilities to provide medical services to their patients. The legal analysis of this position indicates that the obligation is based on an innominate agreement, a non-specified contract derived from the principle of freedom of contract under Article 1338 of the Indonesian Civil Code. Since attending physicians possess full clinical autonomy and are not under the subordination of hospital management, legal liability for medical actions (malpractice) theoretically rests personally with the physician, unless systemic negligence by the hospital in providing facilities or supervision can be proven.[25]

Article 1338 of the Indonesian Civil Code serves as the primary legal foundation for the partnership between physicians and hospitals, emphasizing the Principle of Freedom of Contract and the doctrine of *Pacta sunt servanda*. In a medical context, this article grants legal legitimacy for physicians and hospitals to independently agree upon cooperation clauses, including the distribution of medical fees, the utilization of facilities, and the boundaries of legal liability. A legal analysis of this article confirms that a legally executed contract binds both parties as strictly as the law, requiring that all agreed-upon rights and obligations be honored.[26] Furthermore, the inherent requirement of good faith within this article mandates that both parties conduct the partnership honestly and transparently, thereby preventing the abuse of unequal bargaining power

[24] Gusti Ayu Utami Ricardo Goncalves Klau, Muhammad Saiful Fahmi, "Pertanggungjawaban Hukum Perdata Rumah Sakit Terhadap Tindakan Medis Dokter Mitra yang Merugikan Pasien" *Jurnal Komunitas Yustisia* 5, no. 2 (2022): 28–37, https://ejournal.undiksha.ac.id/index.php/jatayu/article/view/56323.

[25] Brigita Mirna Mahayani, Rihantoro Bayu Aji, and Joko Ismono, "Perlindungan Hukum Ketenagakerjaan Bagi Dokter Dalam Hubungan Kerja Dengan Rumah Sakit," *Law and Humanity* 1, no. 2 (2023): 130–52, https://doi.org/10.37504/lh.v1i2.551.

[26] Mahayani, Aji, and Ismono.

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between the hospital institution and the medical professional.

Furthermore, a doctor, as an *independent contractor* in the context of health law, is a medical professional who practices within a hospital without a subordinate or *master-servant* relationship. Unlike permanent physicians who hold employee status, an *independent contractor* physician possesses full clinical autonomy over medical decisions and is not bound by managerial instructions regarding the specific methods of patient treatment. In this model, the relationship between the physician and the hospital is coordinative; the hospital provides infrastructure, equipment, and support staff, while the physician provides medical expertise as a professionally independent entity.[27]

The classification of doctors as *independent contractor*s shares a legal foundation and standing identical to that of an attending physician. In this framework, the doctor functions as a specialized service provider engaged by the hospital through a civil law contract for specific medical services or projects. This professional bond is formalized via a Cooperation Agreement (PKS) and is strictly governed by the Indonesian Civil Code (KUHPerdata). Essentially, the legal dynamics between hospitals and doctors are divided into two distinct archetypes: subordinate relationships (Doctor as Employee) and autonomous or collaborative partnerships (Doctor as Attending Physician or *Independent contractor*). The primary distinction between these models is explicitly defined within the binding contractual document, namely the PKS. Under this partnership scheme, the relationship is regulated by civil law principles, particularly the doctrine as enshrined in Article 1338 of the KUHPerdata. This principle establishes a horizontal and equal legal standing between the hospital and the physician, thereby placing significant weight on mutual negotiation to determine the specific rights and obligations within the agreement.[28]

This fundamental difference creates a dichotomy in contract drafting, spanning from the negotiation stage to the determination of liability and dispute resolution. Within a partnership framework, the physician serves as an equal and independent service provider; consequently, contractual details must be established through a negotiation process involving mutual agreement. Therefore, analyzing the contents of the Cooperation Agreement is an essential step. The PKS must be reached through a substantive negotiation process, and the contract must be executed in writing with clearly defined time limits.

A Cooperation Agreement that embodies the value of fairness should ideally include explicit points regarding doctors' clinical privileges, the distribution mechanism for medical service fees, and guarantees of legal protection for doctors in performing

[27] Mohammad Maliki Rafli, "Analisis Distribusi Dokter Sebagai Tenaga Kesehatan di Provinsi Jawa Timur Tahun 2022", *Jurnal Kesehatan Tambusai* 5 (2024): 4316–25, https://doi.org/https://doi.org/10.31004/jkt.v5i2.28786.

[28] Muhammad Nur Alamsyah, Vazrie Avicenna, and Gusti Yosi Andri, "Pertanggungjawaban Perdata Dokter Berdasarkan Profesinya Sebagai Beroep Dan Bedrijf," *Aliansi: Jurnal Hukum, Pendidikan Dan Sosial Humaniora* 1, no. 2 (2024): 294–304, https://doi.org/10.62383/aliansi.v1i2.129.

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their duties according to professional competency standards and applicable hospital standard operating procedures. The distribution of benefits and risk sharing are also a concrete indicator of the application of the principle of fairness within a Cooperation Agreement. The principle of fairness in benefit distribution does not always imply a 50:50 (fifty-fifty) split; rather, it is based on the Principle of Proportionality. The principle of fairness in a Cooperation Agreement must explicitly regulate the limits of liability to prevent overlapping duties or unilateral disclaimers of liability (exoneration clauses). The provisions of Article 193 of the Health Law stipulate that hospitals have a legal obligation to bear the burden of liability for all forms of loss arising from the negligence of their medical and health personnel. The right to this protection is absolute and must not be diminished by any type of employment relationship, whether the doctor's status is that of an Employee, an Attending Physician, or an *Independent contractor*.[29]

Conceptually, fairness in a Cooperation Agreement between a hospital and a doctor is inseparable from the notion of proportional justice. Proportional justice emphasizes that each party acquires rights and bears obligations in accordance with their contributions, roles, and the risks they assume. According to Agus Yudha Hernoko, the essence of the principle of proportionality serves as the primary foundation for organizing the distribution of rights and responsibilities between parties, both the offeror and the offeree, to ensure they align with their respective portions at every contractual stage. The presence of this principle of proportionality functions as a counterbalance to the principle of freedom of contract, ensuring the legal relationship is more equitable by providing legal protection and the fulfillment of rights for the party with lower bargaining power.

The conclusion is that a Cooperation Agreement is considered fair if it can explicitly reflect this balance within its contractual clauses. The principle of fairness in a Cooperation Agreement between a hospital and a doctor must be understood as an effort to create a substantive partnership, rather than a merely formal one. This concept also intersects with commutative justice, which entails the fulfillment of a doctor's rights in a manner commensurate with their performance and professional contributions, without social discrimination. A Cooperation Agreement designed by adopting these principles is expected to transform into a legal instrument that does not merely satisfy formal requirements, but is also capable of realizing substantive justice in the operational execution of healthcare services.

3.2 Construction and Service Contracts

In Indonesian law, construction and service contracts, formally referred to as Perjanjian Pemborongan, are governed as specific obligations under Book III of the

[29] Yudistira Rusydi et al., "The Drafting a Cooperation Agreement According to Contact Law Standards in Indonesia at Ar-Royyan Hospital, Ogan Ilir Regency," *Unram Journal of Community Service* 6, no. 1 (2025): 238–41, https://doi.org/10.29303/ujcs.v6i1.868.

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Indonesian Civil Code (KUHPerdata). According to Article 1601b, these agreements involve a contractor committing to execute a defined project for a principal in return for a stipulated fee. This legal framework establishes a bilateral relationship characterized by two core components: the distinct roles of the contractor and the employer, and a reciprocal duty where the successful delivery of work is directly tied to the obligation of payment.[30]

The primary focus of this obligation is the achievement of a measurable result for a fixed consideration, thereby creating a balance of rights and obligations between the two parties. The theory of service contracts is relevant as a framework for understanding cooperation that is contractual rather than subordinative in nature. The hospital can be viewed as the party commissioning the work, while the doctor acts as the contractor performing specific tasks in the form of medical services or designated healthcare programs. In this model, the doctor is not positioned as a worker under the hospital's direct command, but rather as a professional partner with autonomy in practicing their profession, bound by the obligation to deliver services according to agreed-upon standards.[31]

The nature of this service contract arrangement indicates that all forms of professional, ethical, disciplinary, and legal responsibility become the personal liability of the doctor as a medical practitioner. In this context, the doctor does not hold a position within the hospital's structural hierarchy. Under this model, there is a tendency for hospitals to divest themselves of responsibility, specifically through exoneration clauses regarding medical negligence on the pretext that such actions fall under the doctor's full autonomy. This risks creating a legal loophole where patients find it difficult to hold the hospital accountable, even though the facilities and access to services were provided by said hospital. Therefore, the principle of vicarious liability must still be safeguarded to ensure that this contractual relationship does not become a means for the hospital to "wash its hands" of the risk of patient loss. The design of the service contract must explicitly regulate the distribution of legal responsibility to prevent the practice of liability avoidance.

The *fee-for-service* model creates a dual risk: it may lead to physician burnout as doctors overextend themselves to meet financial targets without a base salary, while simultaneously encouraging "supplier-induced demand," where unnecessary clinical interventions are performed to boost billable output. Because compensation is tied strictly to results rather than hours worked, this arrangement aligns with the "service contract" (perjanjian pemborongan) framework under Article 1601b of the Indonesian

[30] Bherta Christine Khornaylius and Gunardi Lie, "Perbandingan Hubungan Kerja Antara Outsourcing, Borongan, Perjanjian Kerja Dan Mitra Menurut Undang-Undang Cipta Kerja," *Kertha Semaya : Journal Ilmu Hukum* 13, no. 10 (2025): 2387–2401, https://doi.org/10.24843/ks.2025.v13.i10.p18.

[31] Muchamad Hamzah Fathoni, John Pieris, and Wiwik Sri Widiarty, "Analisis Hukum Potensi Akibat *Wanprestasi* Perjanjian Pemborongan Pekerjaan Pengadaan Dan Pemasangan Hospital Elevator Di PT. Louserindo Megah Permai," *Action Research Literate* 8, no. 7 (2024): 1–16, https://doi.org/10.46799/arl.v8i7.461.

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Civil Code. Such contracts are defined by a specific work objective, an agreed-upon fee, and the contractor's autonomy to execute tasks without technical interference from the employer. Consequently, legal disputes are governed by civil law regarding breach of contract (*wanprestasi*) rather than labor law; however, this classification must be applied flexibly, as medical practice is also strictly regulated by lex specialis through health legislation and professional ethics.[32]

Ethically, the hospital bears a moral responsibility to ensure that healthcare services are provided with quality, safety, and a focus on patient safety. Within a service contract (perjanjian pemborongan), a hospital cannot hide behind a doctor's status as an independent partner to evade its ethical obligations. Coercing a doctor (the contractor) to perform unnecessary procedures for the sake of profit constitutes a serious ethical breach and undermines the essence of an independent service agreement. Ethical justice is realized when the hospital views the doctor not merely as a service provider, but as a professional peer possessing both dignity and independence.[33]

From the perspective of medical ethics, a service contract arrangement further affirms the doctor's standing as an autonomous professional with personal accountability. Professional ethics mandate that a doctor prioritize the patient's interests over institutional or economic interests, even when bound by a service contract with a hospital. Ethical justice is realized when a service contract does not interfere with a doctor's clinical autonomy or incentivize practices that contradict professional standards. A doctor remains bound by their professional oath, the code of medical ethics, and medical service standards; therefore, their ethical responsibility cannot be transferred or restricted by contractual clauses. Justice in medical ethics demands that the doctor continue to prioritize patient safety over the pursuit of work output or fees that form the basis of the service contract.

3.3 Lease Agreements for Space and Health Personnel

The Indonesian Civil Code (KUHPerdata), specifically Articles 1548 to 1600, defines a lease as an agreement where one party provides the enjoyment of an asset, whether movable or immovable, to another for a specific duration in exchange for an agreed price. A fixed term is essential to prevent arbitrary termination by the lessor. If the leased property is accidentally destroyed, the contract is legally void; if only partially damaged, the lessee may request a price reduction or cancellation, though no compensation is granted. The lessor's primary obligations include delivering the asset, maintaining it for the lessee's safety and enjoyment (excluding minor repairs), and guaranteeing against hidden defects. Typically, the handover of the property coincides with the initial payment, marking the start of a reciprocal relationship governed by the

[32] Dita Natalia Br. Sitepu, "Tinjauan Yuridis Perjanjian Pemborongan Pekerjaan Antara Rumah Sakit Umum Pusat Haji Adam Malik Dengan PT. Pinang Jaya Abadi (Studi Penelitian Di Rsup Haji Adam Malik Medan)" (Universitas Sumatera Utara, 2022), https://repositori.usu.ac.id/handle/123456789/53258.

[33] Ferdinand Brandon Purnomo, Ida Kurnia, and Universitas Tarumanagara, "Analisis Yuridis Perjanjian Kerjasama Profesi Dokter Dengan Perusahaan Di Sektor Pelayanan Kesehatan," *Original Article*, 2025, 8130–38.

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risks and responsibilities outlined in the Civil Code.[34]

Articles 1548 through 1600 of the Indonesian Civil Code (KUHPerdata) establish the comprehensive legal framework for lease agreement. This section defines a lease as a reciprocal contract where a lessor grants a lessee the enjoyment of an asset, whether movable or immovable, for a specific period in exchange for a determined price. The law emphasizes the protection of both parties by requiring a "fixed term" to prevent arbitrary evictions and by outlining strict protocols for force majeure; for instance, if the leased object is destroyed by an unforeseen event, the contract is legally void. Central to these articles are the lessor's obligations, which include delivering the property in good condition, performing major repairs to ensure the tenant's continued "enjoyment," and providing a warranty against hidden defects that might hinder the property's use. Conversely, the lessee is obligated to pay rent punctually and use the property as a "good head of household," returning it in its original state upon the expiration of the lease.[35]

Within the framework of Indonesian civil law, lease agreements are categorized as nominated contracts (benoemd overeenkomst), the regulations for which are specifically set out in Articles 1548 to 1600 of the Indonesian Civil Code (KUHPerdata). Referring to the norms established in Article 1548 of the Civil Code, this obligation is understood as an agreement wherein one party promises to grant the right of use over an object to another party for a specific duration, in exchange for an agreed-upon compensation. Based on this definition, the essence of leasing activities lies in the existence of a physical good whose utility can be temporarily transferred to the lessee for a consideration in the form of money or material rewards.[36] In field implementation, many doctors or hospitals have already adopted this contractual model. However, what needs to be underscored is whether such a model, specifically the leasing of space along with health personnel, can be theoretically associated with the leasing paradigm, given that it structurally contains elements of the granting of usage rights, a specific time frame, and agreed-upon compensation.

The concept of office space leasing often arises in the form of cooperation for the use of clinical facilities, such as examination rooms, medical equipment, and supporting infrastructure. However, in modern practice, the use of these facilities is frequently accompanied by the provision of specific health personnel service packages, for example, nurse anesthetists or other supporting medical staff required to assist a specialist's medical practice. This indicates a modern contractual construction where the concept of a space lease is expanded to include space leasing along with health personnel. Yet, at this point,

[34] William Jason and Gunawan Djajaputra, "Analisis Hukum Terkait Perbuatan Melawan Hukum Dalam Perjanjian Sewa Menyewa Yang Menyebabkan Kerugian (Studi Kasus Putusan Mahkamah Agung Nomor 2925 K/Pdt/2019)," *Unes Law Review* 6, no. 4 (2024): 10127–32, https://doi.org/https://doi.org/10.31933/unesrev.v6i4.1985.

[35] Imman Yusuf Sitinjak et al., "Aspek Perjanjian Sewa Rumah dengan Kesepakatan Lisan", Collegium Studiosum Journal 8, no. 1 (2025): 209–16, https://doi.org/https://doi.org/10.56301/csj.v8i1.1696.

[36] Grisella Avelyn and Michelle Clementina Bianca, "Analisis Aspek Hukum Perjanjian Sewa Menyewa Dalam Konteks Hukum Perdata Indonesia," *Journal Of Social Science Research* 4, no. 6 (2024): 2447–60, https://doi.org/https://doi.org/10.31004/innovative.v4i6.16325.

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a theoretical issue emerges: whether the provision of health personnel can be included as an element of the object of a lease as regulated by the Civil Code (KUHPerdata). The Civil Code restricts the object of a lease to material and immaterial objects, whether fixed or movable assets. Consequently, health personnel cannot be classified as objects of a lease because they are legal subjects, not legal objects. It is more appropriate for the classification of health personnel to be subject to other legal regimes, such as labor law, service contract law, and professional law governing medical practice. If health personnel are forced into the category of lease objects, the application of leasing theory becomes inaccurate and risks a legal misclassification.

Therefore, the model, increasingly popular in practice known as "space leasing along with health personnel," is more accurately understood as a modern contractual construction that merges two distinct legal regimes. As such, the contract is not a pure lease agreement as formulated in the Civil Code, but rather a form of innominate or mixed agreement (*contractus mixtus*) not explicitly regulated therein. Since the Civil Code contains no direct provisions regarding the simultaneous leasing of goods and the contracting of professional human services within a single agreement, the relevant theoretical foundation to be applied is the legal analogy (*analogia iuris*) approach.

The principle of fairness in a lease agreement for space and health personnel must be analyzed by taking into account the hybrid or mixed character of the contract. The distribution of benefits and risks within such an agreement serves as a vital indicator for assessing contractual justice. Ideally, the hospital derives benefits in the form of asset optimization, increased service volume, and institutional reputation, while the doctor benefits from access to facilities, systemic support, and sustainable practice opportunities. Contractual justice demands that the distribution of these benefits and risks be structured in a balanced and transparent manner, rather than being dictated solely by the dominant position.

Furthermore, the planning and procurement of health personnel in Indonesia are strategically aligned with national health issues, developmental programs, and current workforce availability. This process involves education and training initiatives managed by the government, regional authorities, and the private sector. The utilization of these professionals focuses on equitable distribution, career development, and quality assurance through strict certification, registration, and licensing. A significant policy shift occurred in 2022, transitioning the management of health funding, specifically the Non-Physical Special Allocation Fund, to regents and mayors. Under Ministry of Health Regulation No. 2 of 2022, these funds, specifically the Bantuan Operasional Kesehatan (BOK) or Health Operational Assistance, are prioritized for promotive and preventive efforts, which include financing contract workers such as health promotion officers, nutritionists, and environmental health experts at local health centers. These BOK contract workers are considered government personnel with annual agreements that may be renewed each

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January, subject to regional needs and the approval of health department officials.[37]

The juridical foundation for health worker agreements in Indonesia is built upon a sophisticated hierarchy of norms that begins with the Indonesian Civil Code (KUHPerdata), specifically Article 1320, which dictates the four essential pillars for any valid contract: mutual consent, legal capacity, a specific object, and a lawful cause. In the context of health professionals, these agreements are further categorized under Article 1601b as service contracts (perjanjian pemborongan) or general service agreements, where the "performance" (prestasi) is defined by Article 1234 as the obligation to perform a specific medical or professional task rather than a mere duration of attendance. This civil law basis is heavily influenced by the principle of *Pacta sunt servanda* under Article 1338, granting the parties the freedom to determine their own terms as long as they do not infringe upon public order or specialized statutes.[38]

However, because health services involve the public interest, this contractual freedom is restricted by the doctrine of *Lex specialis derogat legi generali*, meaning that general civil rules are superseded by specialized regulations such as Law No. 17 of 2023 concerning Health (The Omnibus Health Law) and Law No. 20 of 2023 concerning State Civil Apparatus (ASN) for those employed by the government. Furthermore, the legal standing of health worker contracts is reinforced by Presidential Regulation No. 104 of 2022 and Ministry of Health Regulation No. 2 of 2022, which decentralize the management of the Non-Physical Special Allocation Fund (DAK Non-Fisik) and the Health Operational Assistance (BOK), providing the financial and administrative legitimacy for local governments, specifically Regents and Mayors, to engage health workers through fixed-term contracts. These agreements are not merely private exchanges but are bound by Article 1339 of the Civil Code, which mandates that contracts are governed not only by their written text but also by equity, custom, and the law.[39]

Consequently, the legal relationship is hybrid in nature: while it follows the civil law regime regarding breaches of contract (*wanprestasi*), it is simultaneously governed by administrative law regarding professional certification, registration (STR), and licensing (SIP), as well as the ethical standards mandated by professional organizations. This multi-layered framework ensures that while the health worker operates with technical autonomy as a "contractor" of services, the rights of the patient and the standards of the state are protected through rigorous regulatory oversight that transforms a simple private agreement into a tool of national health policy.

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[37] Desrina Desrina et al., "Pelaksanaan Perlindungan Hukum Kontrak Kerja Tenaga Kesehatan Di Lingkungan Dinas Kesehatan Kota Palembang," *Al-Manhaj: Jurnal Hukum Dan Pranata Sosial Islam* 5, no. 2 (2023): 1789–1804, https://doi.org/10.37680/almanhaj.v5i2.3446.

[38] Mahesa Paranadipa Maykel, Fahmi Hakam, and Kata Kunci, "Implikasi Yuridis Kontrak Mitra (Disguised Employment) Terhadap Hak Jaminan Sosial Ketenagakerjaan Tenaga Medis Dan Tenaga Kesehatan," *JMIAK: Jurnal Manajemen Informasi Dan Administrasi Kesehatan* 8, no. 2 (2025): 269–78.

[39] Sabrina nuraini Sari et al., "Analisis Yuridis Keabsahan Perjanjian Kerja Sama Pelayanan Medis Berdasarkan Surat Putusan Pengadilan Tinggi Nomor 262/PDT/2018/PT.DKI," *Jurnal Ilmu Hukum, Humaniora Dan Politik* 5, no. 5 (2025): 4667–71, https://doi.org/10.38035/jihhp.v5i5.5485.

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The following is the analytical content for the discussion section of your journal, integrating legal theories, critical interpretation, and comparative insights: The legal relationship between hospitals and doctors is analyzed through the dual lens of Commutative Justice and Distributive Justice, serving as the primary theoretical "surgical tools" to deconstruct the existing power imbalance. Commutative justice demands a strict equivalence in exchange *(aequalitas politica);* however, a critical interpretation of modern medical contracts reveals a "pseudo-partnership" where the doctor's professional risks are expanded while their bargaining power is systematically restricted. This research moves beyond a mere recitation of the Indonesian Civil Code (KUHPerdata) to argue that the current reliance on Article 1320 for contractual validity is insufficient in the healthcare sector. Instead, it must be viewed through Legal Protection Theory, which posits that the law must provide a substantive safety net for the weaker party in this case, the physician whose professional judgment is often subordinated to institutional profit-driven policies disguised as "Hospital Bylaws." By integrating a comparative insight, this study juxtaposes the Indonesian regulatory framework under Health Law No. 17 of 2023.

This analysis critically identifies that treating medical expertise as a mere commodity within a corporate structure violates the principle of Distributive Justice, as the hospital captures the majority of the economic benefit while the doctor bears the brunt of legal and clinical liability. Therefore, this study rejects the redundancy of descriptive legalism and proposes a shift toward a Justice-Based Partnership Model. This model redefines the relationship not as a vertical hierarchy of subordination, but as a horizontal collaboration that ensures the doctor's right to professional protection is as legally enforceable as the hospital's right to administrative compliance, thereby creating an ethically balanced and legally certain healthcare ecosystem.

Ethically, a doctor is required to maintain their clinical independence despite being in a partnership with a hospital. The principle of justice demands that doctors not succumb to administrative pressure or hospital policies that could potentially conflict with professional standards and the patient's best interests. Doctors are prohibited from performing unnecessary medical interventions (over-utilization) solely to meet income targets agreed upon in the partnership agreement. Medical ethics serve as a balancing mechanism against the potential institutional dominance of the hospital within the contractual relationship. These ethics emphasize that while the leasing arrangement covers material and administrative aspects, the doctor-patient relationship remains a fiduciary relationship, one based on trust that must remain free from excessive commercial interests. This aligns with the mandate of Article 3 of the Indonesian Code of Medical Ethics (KODEKI), which asserts that a doctor is prohibited from allowing external factors to influence their professional freedom and independence in performing medical duties. In this context, justice is not intended to eliminate the hospital's economic interests, but rather to ensure that such interests are not achieved at the expense of professional autonomy, legal protection, and the dignity of the doctor as a legal subject.

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4. CONCLUSION

Normatively, the partnership between hospitals and physicians is a civil law relationship based on the principle of freedom of contract (Article 1338 of the Indonesian Civil Code). This relationship typically manifests through Cooperation Agreements (PKS), service contracts, or room leases. However, a significant substantive discrepancy exists between theory and practice. The "*independent contractor*" status often masks the true characteristics of an employment relationship, triggering structural injustice due to the unequal bargaining power between individual physicians and hospital institutions. This condition is exacerbated by a legal vacuum regarding the standardization of partnership contracts, particularly in innominate room rental patterns. This lack of regulation creates legal uncertainty in liability distribution, often shifting the entire compensatory burden onto physicians through recourse rights (hak regres) while obscuring the doctrine of hospital corporate liability. To resolve this, an integration of legal regimes via legal analogy *(analogia iuris)* is required to ensure proportional justice and certainty regarding administrative, civil, and criminal liability. Moving forward, the government must urgently issue specific regulations to standardize these agreements and eliminate "*take-it-or-leave-it*" contracts. Hospitals are urged to refine contract clauses to ensure fair risk distribution and institutional accountability. Simultaneously, the Indonesian Medical Association (IDI) must take a proactive role in providing standardized templates and advocacy. These collective efforts are crucial to strengthening the bargaining power of physicians, safeguarding clinical autonomy, and ensuring robust protection for both medical professionals and patients within a transparent healthcare ecosystem.

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