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## **Developing Equitable Policies for Task-Shifting from Supervisors to Resident Doctors in Indonesian Teaching Hospitals: A Legal and Ethical Framework**

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# Developing Equitable Policies for Task-Shifting from Supervisors to Resident Doctors in Indonesian Teaching Hospitals: A Legal and Ethical Framework

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**Abstract— Background:** Task-shifting from supervisors to resident doctors is critical to specialist medical education in Indonesia. While broadly regulated under Law No. 17 of 2023, the absence of specific derivative regulations creates significant challenges, including role ambiguity, increased risk of medical errors, and inequities in supervision.

**Aims:** This study aims to critically evaluate the proposed implementation of international best practices within Indonesia's unique healthcare system and formulate a legal and ethical framework for equitable task delegation.

**Methods:** Employing an empirical juridical approach, the study integrates in-depth interviews, document analysis, and legal doctrinal reviews across multiple teaching hospitals.

**Result:** Findings indicate that the absence of derivative regulations leads to ambiguity in authority, inconsistent supervision practices, and heightened medical risks. International models such as the ACGME and EU directives offer useful insights but require contextual adaptation. This study further highlights systemic barriers in Indonesia, including resource constraints, logistical challenges, and political inertia. The critical role of supervisors is emphasised, necessitating clear training, certification, and accountability standards.

**Conclusion:** There is an urgent need for a structured and localised task-shifting policy framework that integrates global standards while addressing Indonesia's practical realities. The proposed model outlines legal clarity, equitable delegation mechanisms, competency-based assignments, and institutional accountability.

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**Index Terms— Healthcare Regulations; Patient Safety; Resident Doctors; Specialist Medical Education; Supervisor Delegation; Task Shifting.**

## I. INTRODUCTION

The practice of medicine epitomises a profound human endeavour to serve others, rooted in a purity of intention and commitment to patient safety that make it a highly respected profession [1,2]. A doctor's actions, executed consciously and purposefully, are described as *actus humanus*, reflecting deliberate and responsible decision-making [3,4]. In Indonesia, "task-shifting" is embedded within the frameworks of public and private law. The term "authority," often interpreted from the Dutch term *bevoegdheid*, is understood as the legal right or power to perform specific actions and implement and enforce laws. According to Mochtar Kusumaatmadja, formal authority inherently grants an individual the power to act within the scope of legal provisions [5,6].

Task-shifting, defined as the delegation of clinical responsibilities from senior to junior medical staff, is increasingly relevant in Indonesia's healthcare system due to a significant shortage of specialist doctors. While Law No. 17 of 2023 on Health provides a general mandate for supervision in medical education, the absence of derivative regulations creates inconsistencies and gaps in implementation. This legal vacuum contributes to unclear accountability, increased risk of medical errors, and professional inequity [2,7-10].

For instance, a case involving a surgical resident doctor at a satellite teaching hospital in Purworejo underscores the risk of unclear delegation protocols. The death of a patient during a surgical procedure performed by the resident led to a dispute over accountability; the supervising doctor denied responsibility due to the lack of formal documentation. This incident highlights the need for transparent and standardised task delegation protocols to ensure accountability and patient safety [11,12].

Task-shifting is critical in addressing the workforce challenges in Indonesia's healthcare system, particularly given the country's low doctor-to-patient ratio of 0.7 doctors per 1,000 patients—one of the lowest in Southeast Asia [13]. In this context, efficient delegation mechanisms are essential to optimise limited resources while maintaining patient safety and quality care standards [14].

On a global level, task-shifting is strictly regulated within medical education frameworks [15]. Although Indonesia references global medical education standards, such as those of Accreditation Council for Graduate Medical Education (ACGME) in the United States or European Union directives, the application of these models must consider Indonesia's institutional capacity and socio-political landscape. This study investigates how international practices can be adapted to local realities and what legal frameworks are necessary to ensure safety, accountability, and equity in task delegation [10,16].

The enactment of Law No. 17 of 2023 on Health represents an important step in establishing guidelines for task-shifting in specialist medical education. It emphasises supervision based on the competence and qualifications of resident doctors. However, without standardised formats or derivative regulations, the implementation of task delegation remains inconsistent, leading to overlapping duties and potential legal conflicts. [17,18].

The objectives of this research are: (1) to identify regulatory gaps in the current legal system related to task-shifting; (2) to assess challenges in implementing international standards in Indonesia's healthcare settings; and (3) to propose a justice-based model of delegation, grounded in competency, transparency, and professional development.

## II. LITERATURE REVIEW

Task-shifting, the delegation of medical authority from senior to junior doctors, is an important aspect of specialist medical education programs, particularly in resource-limited settings such as seen in Indonesia [19,20]. This approach addresses the scarcity of healthcare professionals while fostering the professional development of junior doctors [12]. However, significant challenges arise from the absence of specific regulations under Indonesia's Law No. 17 of 2023, including heightened risks of medical errors and inequities in supervision. Without derivative regulations defining criteria, mechanisms, and standards for task-shifting, the practice

jeopardises patient safety and the quality of specialist medical education [7,8].

Task-shifting in the context of medical education refers to transferring clinical tasks from fully licensed physicians to supervised trainees, often to maximise limited human resources. In high-income countries, such practices are highly regulated, supported by frameworks like those of the ACGME and EU directives. These guidelines emphasise the importance of supervision protocols, written delegation procedures, and evaluation mechanisms based on performance metrics [22,23]. Similarly, the EU's directives on medical education establish structured frameworks that emphasise adequate supervision, patient safety, and quality training [24,25].

In contrast, Indonesia's regulatory framework remains incomplete, offering only broad guidelines under the Health Law and Ministry of Health regulations. This regulatory gap results in inconsistencies in implementation, leading to potential legal ambiguities and inefficiencies in task delegation [26,27].

A notable case from a teaching hospital in Purworejo Regency illustrates the very real dangers of inadequate task-shifting regulations. In this instance, a surgical procedure, conducted under remote supervision by a resident doctor, resulted in the death of a patient. The absence of formal documentation led to disputes over accountability between the supervising doctor and the resident [28]. This case underscores the urgent need for transparent and structured delegation protocols to mitigate risks and ensure accountability [27,29].

International literature highlights the benefits of structured task-shifting: enhanced workforce efficiency, improved training quality, and reduced clinician burnout. However, these benefits are contingent on robust institutional systems, including supervisor training, feedback loops, and legal protection for both parties. In Indonesia, where infrastructure disparities exist between teaching hospitals, the absence of uniform procedures exacerbates inequity [23,25,29].

Several measures are proposed to address the challenges of task-shifting in Indonesia. First, detailed derivative regulations should be developed to define the mechanisms, criteria, and processes for task delegation, including competency evaluations and structured supervision [27,32]. Standardised formats for delegation, such as clear documentation and reporting protocols, should be introduced to

enhance transparency, clarify responsibilities, and prevent legal ambiguities [30,33]. Finally, elements from international standards should be integrated to improve the quality of supervision and align Indonesia's medical education practices with global benchmarks [34].

Beyond regulatory frameworks, task-shifting raises critical legal and ethical questions [35]. Informal communication methods, such as telephone calls or text messages, are often used to delegate tasks, increasing the risk of miscommunication and medical errors [36]. Formalising such processes is essential to ensure accountability and safeguard patient safety [33,37].

Furthermore, ethical considerations require that delegation protocols respect the professional development of resident doctors while prioritising patient welfare [38]. Clear legal guidelines can help to balance these competing interests in an equitable manner [39,40].

Indonesia's incomplete regulatory framework for task-shifting underscores the need for comprehensive reforms. By adopting international best practices and addressing the unique challenges within its healthcare system, the country can enhance patient safety, improve the quality of specialist medical education, and ensure equitable task delegation [41,42].

Building supervisor capacity is essential. A recurring issue identified is the lack of dedicated training for supervisors, who often rely on ad-hoc experience rather than formal instruction. International models incorporate leadership development for supervisors to support residents while maintaining quality of care. Integrating such elements would strengthen Indonesia's approach [43,44]. This inquiry evaluates whether existing practices ensure equitable opportunities and responsibilities for resident doctors while fostering professional growth and maintaining patient safety [45,46]. In summary, although international models offer valuable guidance, their implementation must be recalibrated to Indonesia's context. Legal reform, resource investment, and supervisory training are prerequisites to effective, equitable task-shifting.

### III. RESEARCH METHODOLOGY

This study employs an empirical juridical approach, integrating normative legal analysis with qualitative field research to investigate the practice of task-shifting from supervising doctors to resident doctors in teaching hospitals in Indonesia.

This approach is chosen to critically examine how existing legal norms are implemented in practical, institutional contexts—particularly in regions where regulatory application remains inconsistent. Field research was conducted at several teaching hospitals in Central Java and the Special Region of Yogyakarta, selected purposively due to their strategic roles as referral centres and their affiliation with specialist medical education programs. These institutions also reflect varying levels of readiness and compliance in implementing supervisory structures and task delegation procedures.

Primary data were obtained through in-depth interviews, with participants including supervising physicians, resident doctors, hospital administrators and medical education coordinators. The interviews explored participants' experiences, challenges, and strategies related to clinical task delegation, especially in the absence of specific derivative regulations.

Direct field observations were also conducted in clinical settings, particularly in surgical and internal medicine departments. These observations aimed to document how supervision and delegation actually take place during daily clinical routines, revealing gaps between normative expectations and operational realities. Observed phenomena included informal delegation practices, lack of written documentation, and varying levels of supervisor presence.

Secondary data consisted of relevant statutory instruments such as Law No. 17 of 2023 on Health, Ministerial Regulation No. 2052/Menkes/Per/X/2011, hospital bylaws, and medical education policies. The study also reviewed professional codes of conduct issued by organisations such as the Indonesian Medical Association (IDI) and relevant collegia, as well as published academic literature and judicial case records involving disputes over the delegation of clinical authority.

Data analysis was performed thematically to identify patterns related to legal ambiguity, supervisory practices, patient safety risks, and institutional responses. Legal interpretation was carried out using doctrinal methods to evaluate the clarity, enforceability, and sufficiency of the current legal framework in regulating clinical delegation. Comparative insights from international models, including the ACGME and EU directives, were used to assess the feasibility of adapting global best practices to the Indonesian context.

This methodological framework is intended not

only to map legal and ethical shortcomings, but also to formulate evidence-based recommendations. Particular attention was given to real-world barriers such as limited supervisory training, administrative resistance, and the lack of standardized delegation protocols, which collectively impede consistent and just implementation of task-shifting in Indonesian teaching hospitals.

#### IV. RESULT AND DISCUSSION

This study first explores the gaps in the current regulations governing task-shifting from supervisors to resident doctors, identifying specific weaknesses in the legal framework that contribute to risks such as medical errors, unclear accountability, and inconsistencies in implementation. Justice in Indonesia must be interpreted through the lens of *Pancasila*, emphasising the principles of fairness, humanity, and legal certainty for all stakeholders involved in healthcare service delivery [47,48].

According to *Pancasila*, laws must protect citizens by preventing arbitrary actions and creating humane social conditions that allow individuals to reach their full potential. These philosophical principles must be integrated with practical regulation in the medical field [7,8,21].

Often equated with power, authority represents a form of formal power derived from law, while power encompasses a broader scope beyond formal structures [27]. Authority is legitimised by law and structured regulation, whereas this may not always be the case for power [39]. Theoretically, authority derived from legislation is obtained through attribution, delegation, and mandate [49,50]. Attribution involves granting new authority through legislation [33]; delegation refers to the transfer of existing authority to another party [40]; while a mandate entails the execution of authority by a subordinate on behalf of the principal authority holder [30,51].

Regulations governing task-shifting in Indonesia are intended to ensure that clinical tasks are performed by competent personnel [10]. While patient safety is prioritised, the lack of precise protocols for delegation and supervision often leads to uncertainty over accountability, a heightened risk of errors, and reduced quality of care [12,52]. The regulations aim to clarify the scope of delegable tasks and establish supervision standards [12,53].

In practice, however, field data from teaching hospitals in Central Java and Yogyakarta reveal that delegation is often carried out informally, without written guidelines, competency evaluations, or

structured supervision, thereby undermining legal certainty and patient safety. Supervision was inconsistent and frequently limited due to high workloads and lack of formalised policies. This misalignment between legal expectations and clinical practice elevates the risk of both medical error and legal disputes.

Although regulations governing task-shifting emphasise the requirement that medical actions be performed by competent individuals, the absence of derivative technical rules often causes uncertainty regarding accountability, which in turn can compromise patient safety and reduce the quality of care. Ideally, these regulations should clarify the scope of tasks that can be delegated, while also establishing enforceable standards of supervision. [54].

In the context of medical education, task-shifting should support residents' professional growth through structured delegation preceded by competency evaluation—an approach that is consistent with national and international standards. For instance, ACGME in the United States mandates detailed delegation guidelines and performance benchmarks for residents before they may undertake specific clinical tasks. In contrast, as revealed through interviews and observations, such competency frameworks have not yet been institutionalised in Indonesian teaching hospitals.

Indonesian legislation, and particularly Law No. 17 of 2023 on Health, provides a general framework for task-shifting. Relevant provisions address delegation between medical personnel and other health workers and call for more detailed derivative regulations. The Ministry of Health's Regulation No. 2052/Menkes/Per/X/2011 authorises written delegation to nurses or midwives, yet no equivalent procedural clarity exists for residents, causing confusion and legal vulnerability [2,6,44].

Article 290 of Law No. 17 of 2023 mandates that all delegation should be just and transparent, with proper documentation. Yet, according to on interviews, most hospitals have no formal records or SOPs for delegation. Such absence increases the likelihood of favouritism, discrimination, and inconsistent supervision outcomes. These findings support the need for detailed regulation that stipulates formats for written delegation, supervisory roles, and documentation retention requirements [9,10].

Countries such as Malaysia and Singapore provide

useful comparative insights. The Malaysian Medical Council defines general training and supervision standards, though it lacks detailed delegation mechanisms. In contrast, Singapore's Health Professions Act explicitly delineates supervisory boundaries and includes mandatory feedback mechanisms—an element that Indonesia may consider integrating. Similarly, the UK's General Medical Council (GMC) offers detailed guidance on supervision and clinical responsibility, especially within hospital training systems [25,56,57]. Furthermore, the findings demonstrate that current task-shifting practices are not yet aligned with the core principles of justice, equity, and professionalism. Internal hospital policies (hospital bylaws), governed under the Ministry of Health's Regulation No. 772 of 2002, outline broad relationships among physicians, hospital managers, and owners [49,59]. These relationships, known as the triad, require regulation to prevent conflicts that might otherwise arise due to the complexity of modern hospitals transitioning from social units to socio-economic entities [60,61].

The study also emphasises the importance of safeguarding medical confidentiality, as regulated under Law No. 17 of 2023. In the context of task-shifting, this includes ensuring that delegation does not lead to breaches of patient privacy or inappropriate access to sensitive information—a concern raised during observations in several hospital units [62].

Effective task-shifting must prioritise not only legal protection, but also professional development. Supervisors retain legal accountability, while residents are responsible for operational tasks within the scope of their certified competencies [63]. As endorsed by several hospital-based respondents, delegation should be formalised in writing and accompanied by competency certification from the academic department or the head of the study program [64]. This structured model would ensure clarity around roles and responsibilities, and mitigate legal risk for both parties [12,65].

Indonesia should develop derivative regulations within a standardised delegation framework to ensure that task-shifting aligns with international best practices [49]. These regulations should include criteria for competency evaluation of resident doctors, supervision standards for supervisors, and precise documentation protocols to enhance transparency and accountability [66].

By learning from international frameworks, Indonesia can build a contextually adapted model for clinical delegation. This would need to be adjusted for resource limitations and the fragmented governance structures inherent in Indonesia's healthcare system—a challenge repeatedly emphasised by the participants in this study.

Finally, the research aims to advocates for the design of a comprehensive and equitable model a comprehensive and equitable model for task-shifting that addresses legal, ethical, and practical challenges in teaching hospitals [67]. This model should integrate global best practices while accommodating Indonesia's unique healthcare and regulatory context, ensuring clarity, structured supervision, and fairness in task delegation [68].

Equitable task-shifting requires a transparent and structured system that provides equal opportunities for all resident doctors to develop professionally [39]. It involves clear delegation procedures, ongoing supervisor training, and mechanisms for feedback and complaints [45,69,70].

The theories of justice proposed by John Rawls and Aristotle provide foundational principles for equitable task-shifting. Rawls' *Justice as Fairness* emphasises equal access to opportunities and the equitable distribution of resources to benefit the least advantaged [32,71]. Aristotle's *Distributive Justice* advocates for proportional allocation based on individual needs and contributions [72].

As described in the *Republic*, Plato's concept of justice, centred on role-specific contribution, is applicable to clinical settings, supporting harmony within medical teams. Supervisors should guide and support resident doctors, fostering an environment where roles align with individual competencies [32].

Equitable task shifting should also consider the well-being of resident doctors. This includes mechanisms for psychological support, such as counselling programs and stress management training. By addressing these aspects, teaching hospitals can create a supportive environment prioritising both patient safety and professional development [45].

In summary, the study highlights the urgent need to address the regulatory gaps left by Law No. 17 of 2023 via derivative regulations that operationalise task-shifting practices. Educational institutions and healthcare providers must collaborate to implement these reforms through structured training, policy enforcement, and regular evaluations. By adopting international benchmarks while tailoring them to

local conditions, Indonesia can build a fair, safe, and high-quality system of task delegation that strengthens both medical education and patient care.

## V. CONCLUSION

The implementation of task-shifting from supervising doctors to resident doctors in Indonesian teaching hospitals, as regulated under Law No. 17 of 2023, remains substantively inadequate. Although the law provides a foundational framework, the absence of specific derivative regulations has led to significant legal and operational gaps—particularly in terms of authority structure, supervision procedures, and documentation requirements. Field data from teaching hospitals in Central Java and Yogyakarta further confirm that the delegation of clinical responsibilities is often informal, undocumented, and lacking in standardised competency-based mechanisms, thereby exposing both supervisors and residents to professional and legal risks.

The inconsistent application of delegation protocols across institutions has compromised not only patient safety, but also the fairness and quality of clinical education. Without a unified regulatory standard, disparities in supervision and learning opportunities continue to affect the professional development of resident doctors. These findings point to the urgent need for clear, enforceable, and context-sensitive derivative regulations that align delegation processes with clinical competencies and supervisory accountability.

To address these issues, the Ministry of Health must prioritise the formulation of detailed regulatory instruments that articulate the legal, ethical, and administrative requirements for task-shifting. These instruments should mandate written delegation protocols, periodic competency evaluations, clear lines of supervisory responsibility, and institutional oversight mechanisms such as audits and grievance procedures. Only through this level of clarity and structure can task delegation be carried out in a manner that is legally sound and ethically defensible.

Furthermore, Indonesia stands to benefit significantly by adopting and adapting key elements from international frameworks such as the ACGME in the United States and the EU directives on medical education. These models emphasise accountability, structured supervision, and performance-based delegation. However, their implementation in Indone-

sia must be accompanied by systemic support, including supervisory training, administrative coordination, and equitable distribution of clinical responsibilities.

Ultimately, task-shifting reforms that emphasise legal clarity, fairness, and transparency will not only enhance the quality and safety of healthcare services, but also strengthen the integrity of Indonesia's specialist medical education system. By building a just and structured delegation framework, Indonesia can serve as a model for other low- and middle-income countries grappling with similar regulatory and workforce challenges in the medical education sector.

## VI. RECOMMENDATIONS

In response to the persistent gaps identified in the implementation of task-shifting from supervisors to resident doctors, the Indonesian government—particularly the Ministry of Health—must urgently develop derivative regulations to operationalise the mandates of Law No. 17 of 2023. These regulations should provide a comprehensive and enforceable framework that defines the legal boundaries, procedural mechanisms, and clinical scope of delegation. By addressing current ambiguities, these regulatory instruments will promote legal certainty, strengthen institutional compliance, and uphold the principle of patient safety.

Clear competency evaluation criteria must be embedded within the regulatory structure to ensure that resident doctors only undertake delegated tasks after demonstrating adequate preparedness. Legal frameworks must explicitly delineate the roles and responsibilities of both supervisors and residents, reducing the potential for conflict and building a transparent, trust-based supervisory culture. These frameworks must also be adaptable to local resource constraints while maintaining fidelity to professional standards.

Effective and equitable implementation of task-shifting regulations requires multi-sectoral collaboration involving healthcare institutions, academic entities, professional associations, and regulatory bodies. To ensure consistency, all stakeholders must commit to conducting regular, mandatory training for both supervisors and resident doctors. Such training should emphasise ethical delegation, competency-based task allocation, documentation protocols, and dispute prevention strategies.

In addition, a national evaluation system should be

instituted to measure the effectiveness of delegation practices, with regular audits and supervisory performance reviews incorporated into hospital accreditation criteria. This will help enforce standardisation and continuous improvement in task-shifting governance. Raising awareness and building an institutional culture around equity, accountability, and patient-centred care is essential to embedding these practices in daily operations.

Policies must also prioritise fair and structured opportunities for all resident doctors to develop clinical competencies. Tasks should be assigned based on objectively assessed readiness, rather than seniority alone. Transparent documentation procedures—including written delegation, supervisor identification, and confirmation of resident competency—should be standardised across teaching hospitals. Structured mentorship systems and ongoing feedback mechanisms will further support residents' growth while reducing risks to patient care. Indonesia is encouraged to adopt and adapt best practices from global regulatory leaders, including ACGME in the United States and the European Union's directives on clinical training. These models offer established principles of structured supervision, accountability, and fairness in task delegation. International collaboration—whether through benchmarking, capacity building, or academic partnerships—can accelerate Indonesia's progress in building a credible, just, and high-quality framework.

To facilitate this transition, Indonesia should also leverage digital technologies in the fields of supervision, documentation, training, and monitoring. Electronic delegation records, e-supervision tools, and integrated feedback platforms will support transparency, real-time accountability, and national standardisation. By aligning its regulatory approach with global benchmarks while accommodating its national context, Indonesia can build a resilient, ethically grounded task-shifting model that protects patients, supports residents, and promotes excellence in medical education.

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#### IX. CONFLICT OF INTEREST DISCLOSURE

The authors declare no conflicts of interest associated with this research. The findings and recommendations presented are solely based on the research and analysis conducted.

#### X. ETHICS APPROVAL STATEMENT

Ethical approval for this study was obtained from the ethics committee of the teaching hospital where the research was conducted. All procedures were performed in compliance with institutional guidelines to ensure the protection and confidentiality of all participants involved.

#### XI. PATIENT CONSENT STATEMENT

As this study did not involve direct patient interaction or data collection from patients, a patient consent statement is not applicable.

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