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The Validity of Informed Refusal With Elements of Forced Discharge of COVID-19 Patients From Hospitals, as Reviewed in Accordance With Law No. 29 of 2004 on Medical Practices, in Conjunction With Law No. 4 of 1984 on the Prevention of Infectious Diseases (Case Study at Hospital X)

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ABSTRACT: Health is a vital aspect of human life. Covid-19 has had a significant impact on the Indonesian population, particularly on their health. During this period, the healthcare profession has come under intense scrutiny due to its direct involvement in healthcare. In the management of the Covid-19 pandemic, challenges have arisen, notably the high number of patients or their families requesting forced discharge before recovery. The research problem and objectives revolve around the validity of informed refusal with elements of forced discharge at the request of Covid-19 patients from hospitals and the legal consequences for both patients and doctors. The research methodology employed is empirical juridical, with primary data collected through questionnaires at a private hospital in West Jakarta, complemented by references from various sources, including books, journals, and legal regulations. Data analysis was conducted using a qualitative normative approach. The research findings indicate that cases of forced discharge following a Covid-19 diagnosis persist despite the existence of regulations such as the Health Law and the Law on the Prevention of Infectious Diseases. In conclusion, informed refusal does not constitute an agreement but rather a unilateral statement by the patient to the hospital and/or doctor. Consequently, full responsibility lies with the patient, as there are currently no regulatory provisions or prohibitions allowing patients to voluntarily leave the hospital, even if the patient's condition has not been assessed as fully recovered by the hospital or doctor.

Keywords: COVID-19, Doctor, Patient, Hospital, Forced Discharge

INTRODUCTION

In the history of human existence, the year 2019 will always be remembered as a dark period in the world's history. It marked the beginning of the long journey of the Coronavirus Disease 2019 (COVID-19), a deadly pandemic that rapidly and massively spread across the globe in early 2020,

claiming countless lives in various parts of the world, including Indonesia. COVID-19 is a type of disease that had never been identified in humans before, making it a novel and yet-to-be-detailed classified disease. Another name for this virus is Sars-CoV-2. Sars-CoV-2 is categorized as a zoonosis, which means it is a disease that is transmitted from animal vectors to humans. However, the exact animal source of the initial transmission of COVID-19 remains uncertain.

One of the reasons why this disease spreads quickly is because, apart from the virus's ability to transmit from animals to humans, it also spreads very rapidly from one human to another through respiratory droplets. The individuals most at risk of contracting this disease are those who have a history of close contact with COVID-19 patients, including healthcare workers and family members caring for COVID-19 patients. However, it's important to note that even individuals who inadvertently come into contact with asymptomatic COVID-19 patients can be at significant risk of infection if they do not maintain social distancing.

Common signs and symptoms of a COVID-19 infection include acute respiratory disturbances such as fever, sore throat, cough, and shortness of breath (dyspnea). The average incubation period is 5 - 6 days, with symptoms of fever, cough, and dyspnea during the fever incubation period. In severe cases, COVID-19 can lead to pneumonia, acute respiratory syndrome, kidney failure, and even death.

The scale of the virus's spread has had a profoundly significant impact on countries worldwide, with them mobilizing their available resources to address this new virus. One of the key efforts in tackling one of the most severe pandemics of the 20th century has been the strict record-keeping, with a focus on the World Health Organization (WHO) to create epidemiological reports. According to the WHO epidemiological report dated November 1, 2020, within the first three weeks, approximately 3.3 million new cases emerged globally, and the death toll increased by around 46% compared to the previous week, indicating a widening of the disease.

Although there has been a downward trend, based on WHO's daily data, there have been 85 new cases in the last 24 hours, bringing the total global cases to 527,211,631 with a total of 6,289,371 deaths. WHO statistics as of March 31, 2022, show that in Europe, there were a total of 220,823,286 confirmed cases, in the United States, there were a total of 157,213,193 confirmed cases, in the Western Pacific, there were a total of 60,272,398 confirmed cases, in Southeast Asia, there were a total of 58,135,604 confirmed cases, in the Eastern Mediterranean, there were a total of 21,774,407 confirmed cases, and in Africa, there were 8,991,979 confirmed cases. Specifically in Indonesia, there were a total of 6,054,973 confirmed cases, with 5,895,423 recoveries and 156,591 deaths. From these numbers, it's evident that the global impact of this pandemic is not a disease to be taken lightly by anyone.

As one aspect that will always remain vital in human life, the law becomes increasingly important when a country is faced with a crisis, such as a global pandemic that significantly impacts all other crucial aspects related to nationhood and governance. In such times, there is a need for clear and robust legal frameworks to provide certainty amidst the crisis. This certainty is required

by various institutions within a country, and given that this text specifically pertains to the fields of law and healthcare, the institutions in focus are all healthcare stakeholders, particularly hospitals. Hospitals are institutions that are susceptible to legal issues that may have lasting implications because they have a close connection to sensitive matters, namely healthcare efforts. Through healthcare efforts, those within hospitals, especially healthcare professionals such as doctors, nurses, midwives, and other healthcare workers, serve as the frontline in the battle against the Covid-19 pandemic.

By the end of 2019, hospitals became increasingly sought after by some members of the community, while simultaneously being avoided and even feared by others. This situation can be attributed, in part, to the role of various media outlets that spread hoaxes, leading to heightened fear among the public, to the point where they were afraid to visit hospitals. However, new cases continue to emerge in hospital settings, albeit those that are definitively detected. In reality, the numbers could be higher when considering the many Covid-19 patients who are unwilling to go to the hospital, possibly due to various reasons such as not wanting to be isolated or fearing that their condition will worsen. This infectious disease, Covid-19, has claimed numerous lives in various parts of the world and continues to pose a challenge for healthcare professionals in controlling its spread. Besides being caused by a novel virus, this challenge is also influenced by the behavior and choices of Covid-19 patients themselves. People have employed various methods to avoid medical efforts related to Covid-19, including refusing isolation by presenting non-reactive test results, which further complicates the situation.

Furthermore, the fatal consequence of public hesitation to seek healthcare at hospitals is that it leads patients to be less than honest about their condition when interacting with healthcare professionals. This, of course, becomes a double-edged sword for the pandemic situation, as Covid-19 patients who are not promptly treated by healthcare workers can become vectors for disease transmission. This lack of honesty also has a severe impact on healthcare workers who are already in a high-risk position for infection. With limited healthcare staff, the risk of contracting Covid-19 has only increased. It is essential to understand that such factors significantly complicate a country's efforts to manage the pandemic. Notably, even patients who are already in the hospital and undergoing healthcare procedures sometimes attempt to leave prematurely, despite being confirmed Covid-19 cases. This highlights the challenges faced in managing the pandemic, as some individuals may resist necessary medical interventions or isolation measures.

Doctors, nurses, midwives, and other healthcare professionals, as one of the professions within a hospital, interact with the public as part of their daily activities. The relationships that develop when someone comes to a hospital and interacts with doctors, nurses, midwives, and other healthcare professionals involved in healthcare give rise to an agreement known as a therapeutic transaction or therapeutic agreement. A therapeutic agreement is essentially an effort made by healthcare professionals towards patients as an obligation aimed at seeking the recovery of the patient's illness. In a therapeutic transaction, the focus is not on the outcome (resultant) but

rather on the effort (ins paining) made to the best of their abilities, in line with their competence and legal regulations.

This is because no healthcare professional can guarantee with certainty the recovery of the patient they are treating. Unfortunately, in practice, society often expects that a doctor, nurse, midwife, or other healthcare professional should be able to cure their illness and should not make any mistakes, no matter how small. As a result, healthcare professionals practicing in Indonesia frequently face various issues due to the doubts that arise from the uncertainty of legal aspects. The law, which should provide peace of mind and certainty in carrying out their duties, can lead to fatal consequences when not well understood by the public. This dilemma poses challenges for doctors, nurses, midwives, and other healthcare professionals in Indonesia who must make quick decisions under pressure, ultimately leading to defensive medicine practices.

A decision regarding the type of healthcare service to be provided by a doctor is primarily based on medical considerations by the doctor. However, fundamentally, a doctor can only provide education and explanations to the patient to the best of their ability. The final decision on whether to accept or reject the medical advice lies with the patient, in accordance with Law Number 39 of 1999 on Human Rights. Therefore, a doctor's role is primarily that of a guide and a source of information in the decision-making process. The issue that arises from this is conflicts or disagreements that occur due to differences in values or perspectives between the doctor and the patient, both of whom must make decisions in the context of the therapeutic transaction or agreement.

A therapeutic agreement can be considered a form of agreement between a doctor and a patient, and like any agreement, it is subject to the subjective and objective requirements for a valid agreement as stipulated in Article 1320 of the Indonesian Civil Code. If the conditions for a valid agreement are not met, the agreement can be invalidated by a court or deemed void, depending on which conditions were not met. The first condition states that an agreement must be based on mutual consent, so in this case, when a patient approaches a doctor and the doctor agrees to provide treatment, it indicates that there has been verbal consent. The second condition is that the parties must have legal capacity. According to Article 1330 of the Civil Code, those who lack legal capacity include minors, individuals under guardianship, married women in certain circumstances as specified by the law, and generally, individuals prohibited by law from entering into specific agreements. Therefore, if the patient does not fall into any of these categories, they are considered to have legal capacity. The third condition is that an agreement must involve a specific subject matter, which in this case is health. The fourth condition is that an agreement must concern a lawful cause, which should not be prohibited by existing regulations.

In every therapeutic transaction or agreement, both the hospital and the patient have rights and responsibilities. However, the primary goal when a patient comes to a hospital is to seek overall well-being, including physical, mental, spiritual, and social health, which enables individuals to lead productive social and economic lives. Hospitals are obligated to provide accurate information about the patient's condition and seek the patient's medical consent if further

healthcare interventions are needed. This consent must come from the patient, as stipulated in the Hospital Law Number 44 of 2009, in conjunction with the Health Omnibus Law (UU 17 of 2023). It has also been emphasized that hospitals must respect and protect the rights of patients, as outlined in PKM Regulation Number 4 of 2008 regarding Patient Rights and Obligations.

However, the complexity arises from another obligation of hospitals, which is to refuse patient requests that contradict professional standards, ethics, and legal regulations. On one hand, hospitals are required to respect and protect patient rights, but on the other hand, they may need to reject certain patient requests. This can be challenging, considering that, according to the constitution, everyone has the right to self-protection and security. Medical consent or informed consent is a process that involves communication within the therapeutic transaction. This communication occurs between the hospital, typically a doctor, and the patient. During this exchange of ideas, the hospital, usually a doctor, explains the details of the medical procedures that will or will not be performed on the patient. The purpose of informed consent is to provide comprehensive information and protection to the patient, as well as to offer legal protection to the hospital against potential negative outcomes and failures.

Certainly, a patient has rights, and one of those rights is the ability to consent to or refuse medical procedures after receiving an explanation of the procedure, which is known as informed refusal. One common form of informed refusal is in the form of a patient's request for discharge against medical advice (AMA) or what is often referred to as forced discharge. In essence, this occurs when a patient, of their own volition, goes against the recommendations or instructions of a doctor or other medical professionals who are providing healthcare services to the patient.

Regarding consent for medical procedures (informed consent), it is based on Law Number 29 of 2004 concerning Medical Practice and Minister of Health Regulation Number 290 of 2008 concerning Medical Consent. However, when considering the specific context of a pandemic, it should refer back to more specific regulations (*Lex Specialis*), such as Law Number 4 of 1984 concerning Infectious Disease Outbreaks, which states that a patient's right to refuse treatment is essentially lost when it concerns a contagious disease outbreak. However, forced discharges still occur, and there have been many reported instances in the media. For example, patients may choose to leave against medical advice for seemingly minor reasons, such as feeling uncomfortable or dissatisfied with their stay.

Additionally, there have been cases where patients did not trust the laboratory results from the hospital, leading them to discharge themselves against medical advice, which tragically resulted in their death. There are also cases where patients choose to discharge themselves against medical advice with reasons such as wanting to transfer or switch to another hospital. This situation is further exacerbated by instances where certain individuals forcibly remove patients from hospitals, as seen in the case of Banyuwangi. Unbeknownst to many, if not addressed with awareness and intervention, this could become a disturbing trend. Ironically, it's a situation that should receive special attention because it not only affects living COVID-19 patients but also extends to forcibly retrieving the bodies of the deceased.

Considering that even though the above-mentioned patients choose to leave against the advice or medical institutions' recommendations provided by doctors and are willing to bear all the risks, the hospital, especially the doctor, will always be faced with a dilemma if the patient requesting forced discharge is at high risk of transmitting the disease to others, as is the case with COVID-19 patients. In every healthcare facility, before a patient is discharged, they must obtain permission from the attending physician at the hospital. However, if not allowed by the doctor due to medical reasons, a patient can also exercise their right to leave against medical advice, provided they sign a Discharge Against Medical Advice (DAMA) form. Before signing this form, the medical staff will provide an explanation or request informed refusal as one form of evidence in case there are issues related to the patient's forced discharge in the future.

However, whether informed refusal is actually justified or not is the goal of this journal, because on the one hand, hospitals, in this case, a doctor, understand that there are certain patients who, if not treated further, such as COVID-19 patients requesting forced discharge, even though they have been confirmed to have COVID-19, are likely to transmit the disease to others or even end up dying. However, on the other hand, the hospital, in this case, the doctor, must respect the patient's rights, and this is a dilemma that should actually be resolved.

Many COVID-19 patients have requested forced discharge, with some claiming they want to self-isolate, even though the medical assessment by the hospital indicates that self-isolation is not feasible for their condition. This has led to unfortunate outcomes, including deaths, as seen in the case in Cilegon. Furthermore, in Demak, a patient who made the decision to leave against medical advice ultimately lost their life, and ironically, this occurred while they were on their way home.

The obligation to implement informed consent is clearly stipulated in Law Number 29 of 2004 concerning Medical Practice and also in Law Number 36 of 2009 jo Minister of Health Regulation Number 290 of 2008 concerning medical consent. However, the right to refuse is lost in certain conditions, and these specific conditions are related to infectious disease outbreaks such as Covid-19. Law Number 44 of 2009 states that hospitals must provide complete information to patients, and one of the patient's rights is to give consent or refusal to medical efforts by the hospital. Law Number 4 of 1984 concerning infectious disease outbreaks explicitly imposes criminal sanctions on those who obstruct the handling of infectious disease outbreaks. This is because, fundamentally, Law Number 44 of 2009 has emphasized that hospitals cannot be held accountable for any efforts to save human lives. Therefore, it is not justified for a Covid-19 patient to leave against medical advice.

Based on the background information provided above, the author feels the need to conduct a research with the title "The Legitimacy of Informed Refusal with the Element of Patients Leaving Against Medical Advice for Covid-19 Patients from Hospitals Reviewed in Law No. 29 of 2004 Concerning Medical Practice Jo Law No. 4 of 1984 Concerning Infectious Disease Outbreaks" with the hope of increasing awareness among all elements of society, both healthcare professionals and the general public, especially regarding informed refusal.

METHOD

The type of research used by the author in this study is empirical legal research, which aims to examine legal certainty based on secondary data obtained from literature and empirical facts gathered from human behavior. This includes verbal behavior obtained through interviews and actual behavior observed during the distribution of questionnaires to the target location to collect primary data. Social research on law, also known as socio-legal research, is indeed a part of legal research itself, even though some argue that social research is not strictly legal research. However, fundamentally, their research objects are the same, which is the law.

The research with issues like those mentioned above typically begins with a hypothesis. To test this hypothesis, data is collected. In this paper, the data is collected through direct engagement with the community, involving observations, interviews, and the use of questionnaires to gather data for analysis. The steps in this research are carried out as follows: 1). Formulating research questions and determining the survey objectives; 2). Developing concepts and hypotheses and conducting literature reviews; 3). Sampling; 4). Designing questionnaires; 5). Fieldwork; 6). Editing and coding; and 7). Analysis and reporting.

This research is a Descriptive Analytical study, which is a technique that uses field studies and literature reviews to describe or present facts or realities comprehensively and systematically. It is descriptive in nature because it aims to provide a comprehensive, complete, and systematic overview of informed refusal as an agreement and the public's understanding of informed refusal. It is analytical in the sense that this research not only presents what has been studied but also analyzes it from the perspective of applicable law. Given that this legal research is juridical-empirical, the data used in this study consist of primary data, which includes the responses obtained from questionnaires distributed to the respondents.

The research location is primarily focused on one of the private hospitals in West Jakarta (the hospital's name is not mentioned upon the hospital's request), with the target respondents for interviews being the patients currently visiting the hospital.

In relation to this research, the method used for data collection involves processing interview data qualitatively, resulting in a descriptive-analytical study. This research also employs various approaches, including a legislative approach. Since this research operates at the doctrinal level of law or for legal practice purposes, it cannot be divorced from legal regulations. The legislative approach doesn't just focus on the form of legal regulations but also examines the content, the analogous basis for the law's creation, the philosophical foundation of the law, and the logical reasoning behind legal provisions.

Therefore, in this research, the author essentially collects data through with questionnaires, interviews and, observations For the questionnaires, the author will directly engage with and interact with the public, distributing the prepared questionnaires to the selected sample. The questions in the questionnaire are closed-ended to facilitate data analysis once the data collection

is completed. Closed-ended questions mean that for each question, the author has provided answer choices, so respondents only need to select one of the options provided by the author.

The researcher employs a qualitative data analysis method in this study. Given the nature of this research using a descriptive analytical research methodology, the data analysis involves a qualitative approach to both primary and secondary data. The descriptive aspect encompasses the content and structure of positive law, which is an activity undertaken by the author to determine the content or meaning of legal rules used as references in addressing legal issues that are the subject of the study. This method aims to make an effort to understand the meaning behind actions or facts about the findings, particularly regarding the giving of informed consent, which ultimately leads to informed refusal in cases of patients being discharged against their will during the COVID-19 pandemic.

RESULT AND DISCUSSION

1. The Legitimacy of Informed Refusal with Elements of COVID-19 Patients Discharged Against Their Will from Hospitals

Informed refusal is a form of patient rejection, which is the opposite of informed consent. This rejection is based on an individual's right, protected by the state, to determine their own fate. When a patient comes to a hospital, meets with a doctor, and receives healthcare services, an agreement is made, known as the therapeutic agreement, between the Doctor and the Patient, with the hospital serving as the location where this agreement takes place. The subjects of the agreement are the Doctor and the Patient, while the object of the agreement is healthcare services, and these healthcare services are provided in the hospital, where there is also a contractual relationship between the doctor and the hospital, the doctor and the patient, and the patient and the hospital.

When a patient arrives at the hospital, they are usually asked to register at the Admission department of the hospital for registration purposes and administrative matters such as room allocation, financing, and so on. During this registration process, patients are typically required to provide certain documents such as identification cards, insurance cards, and others as part of the hospital's paperwork. Subsequently, patients will receive explanations from the registration staff regarding hospital regulations, which conclude with the patient signing a specific form after feeling adequately informed and agreeing to the terms presented by the hospital through the registration staff.

When a patient signs this form, an agreement is reached between the patient and the hospital. This agreement entails that the hospital will provide services in accordance with Standard Operating Procedures (SOPs), and the patient will comply with the hospital's regulations and provide compensation for the services as agreed upon, in line with what is stipulated in Article 31, Paragraph (1) of Law No. 44 of 2009 concerning Hospitals, which states that "Every patient

has an obligation to the Hospital for the services received." Thus, the hospital's performance involves providing accommodation and facilities, and the patient's performance entails providing compensation for the services rendered, as stated in Article 31, Paragraph (1) of the explanation section of Law No. 44 of 2009 concerning Hospitals.

The second relationship is between the doctor and the patient, where an agreement known as the therapeutic agreement is established when the patient arrives. In this context, each party has specific obligations. The doctor is obligated to provide services in accordance with medical professional standards, while the patient is required to follow the doctor's instructions and guidance.

The third relationship is between the doctor and the hospital, and it involves an employment agreement between the doctor and the hospital. Under this agreement, the doctor must work in accordance with the Standard Operating Procedures and agreed-upon working hours. In return, the hospital is obligated to provide the necessary facilities to the doctor and compensate them according to the employment agreement. This aligns with Article 13, Paragraph (3) of Law No. 44 of 2009, which states that every healthcare professional working in a hospital must adhere to professional standards, hospital service standards, applicable standard operating procedures, professional ethics, respect patients' rights, and prioritize patient safety.

Based on the above explanation, when viewed based on Article 1320 of the Indonesian Civil Code (KUHPerdata), the requirements of an agreement are met because each party has obligations, and failure to fulfill these obligations can be subject to a breach of contract lawsuit (*wanprestasi*) under Article 1234, as they are required to provide something based on their expertise or profession. Looking at this from a legal perspective, it is evident that in the relationships described above, between the hospital and the doctor, the doctor and the hospital, and the patient and the hospital, there are mutual agreements.

Secondly, each party is legally capable (*cakap hukum*). Even if a patient is unconscious, usually there are family members who represent the patient. Thirdly, there is something promised or the object of the agreement, and lastly, what is promised is lawful and not contrary to the law. Therefore, it is clear and legally binding under the law that each party is bound by a valid agreement. However, upon closer examination and considering the overall context, an informed refusal is not an agreement; rather, it is a unilateral statement by the patient to the doctor and the hospital in the form of a written refusal of medical advice or procedures to be performed on them.

However, each party has rights, as reflected in Law Number 44 of 2009 concerning Hospitals, Article 32 letter (k) which clearly states that one of the patient's rights is to accept or reject any medical actions to be taken by healthcare professionals for their illness. This gives rise to the concepts of informed consent and informed refusal, where informed consent is when the patient accepts or agrees to undergo medical procedures by healthcare professionals, and informed refusal is the patient's rejection of any medical procedures to be performed on them.

This is also emphasized in the Minister of Health Regulation Number 290 of 2008 concerning Medical Procedure Approval, Article 2 Paragraph (1), which states that all medical procedures to be performed on patients must be based on consent. Subsequently, in the same article, Paragraph (2) states that consent can be given in written or oral form, and Paragraph (3) states that the patient's consent should, in principle, be given after the patient has been explained about the medical procedure.

In the case of Covid-19 patients, the procedure involves isolation and close monitoring of the patient's condition. Unlike patients with mild conditions who can undergo self-isolation, the logic applied here is that when a doctor advises a Covid-19 patient to be hospitalized, it means the patient's condition is not suitable for self-isolation. The challenge arises when the patient insists on leaving against medical advice, believing that the right to leave voluntarily cannot be interfered with by the healthcare provider.

To complement this research, the researcher conducted interviews and surveys with 100 respondents to understand their understanding of Coronavirus Disease (Covid-19). Among the 100 respondents, it was found that 100% of them understand that Coronavirus Disease (Covid-19) is a dangerous and deadly disease. Furthermore, 90% of the respondents have a good understanding of the basic symptoms of Coronavirus Disease (Covid-19), such as fever, cough, runny nose, shortness of breath, hoarse voice, and sore throat. Among these 100 respondents, 100% correctly answered questions related to preventing Coronavirus Disease (Covid-19), such as wearing masks, avoiding crowds, washing hands, maintaining distance from others, and limiting mobility. Additionally, 83% of the respondents have a very good understanding of the screening tests that can be used to detect Coronavirus Disease (Covid-19), such as Rapid Antibody tests, Rapid Antigen tests, or Polymerase Chain Reaction (PCR) tests.

After assessing the respondents' knowledge about Coronavirus Disease (Covid-19), the author further evaluated their understanding by presenting several statements related to Coronavirus Disease (Covid-19) and analyzing the respondents' answers. From the interviews and questionnaires, it was found that 37% of the respondents agreed that individuals experiencing symptoms of Coronavirus Disease (Covid-19) do not need to seek medical attention, while 63% of the respondents felt that such individuals should seek medical care. Moreover, 52% of the respondents believed that doctors and/or hospitals are allowed to compel individuals presenting symptoms such as cough, runny nose, shortness of breath, fever, or sore throat to undergo Covid-19 screening, while 48% of the respondents disagreed with this.

Furthermore, 86% of the respondents believed that Covid-19 patients have the right to choose self-isolation (home isolation) even if the doctor has recommended in-patient treatment at the hospital. Respondents felt that this right should not be interfered with by doctors and hospitals. However, only 14% of the respondents believed that patients do not have the right to self-isolate if the doctor and the hospital have recommended in-patient treatment or isolation at the hospital.

In the next question, 82% of the respondents believed that Covid-19 patients have the right to accept or refuse all medical treatments offered by doctors and hospitals, while only 18% of the respondents believed that Covid-19 patients do not have the right to refuse all medical treatments offered by doctors and hospitals.

From these results, it can be concluded that there are still individuals in the community who believe that Covid-19 patients have rights similar to non-Covid-19 patients. This misunderstanding is also evident from the interview and questionnaire results, where 71% of the respondents believed that there are Human Rights and applicable rules that give Covid-19 patients the right to leave the hospital at their own request when they feel that their condition has improved. The remaining 29% disagreed with this.

The author also posed a question to assess the respondents' answers in relation to informed refusal, specifically whether patients must create and sign a written form that can serve as evidence when refusing medical treatment. Surprisingly, 86% of the respondents believed that conscious patients have the right to refuse medical treatment, but this decreased to 73% when the patient was unconscious or the decision was made by the family. Furthermore, 83% of the respondents believed that Covid-19 patients have the right to refuse isolation while conscious, but this decreased to 73% when the patient was unconscious or the patient's decision was made by the family.

Additionally, even with informed refusal, 85% of the respondents still believed that if a conscious patient wishes to leave in-patient care or isolation at the hospital, they have the right to do so, and this decreased slightly to 74% when the patient was unconscious or when informed refusal was made by the family on behalf of the patient. From this data, it can be concluded that there is still a tendency in society to consider that Covid-19 patients have rights similar to non-Covid-19 patients.

After assessing the respondents' knowledge and understanding, the author also evaluated their attitudes and behaviors related to Covid-19. From the interviews and questionnaires, the author found that 81% of the respondents had experienced Covid-19 symptoms such as fever, cough, runny nose, shortness of breath, or sore throat. Regarding Covid-19 screening, 65% of the respondents reported having received positive Covid-19 test results. In terms of the healthcare facilities most frequently visited during the Covid-19 pandemic, 68% of the respondents chose hospitals, 9% chose clinics, 12% chose community health centers (Puskesmas), 3% chose private doctor practices, and 8% chose not to seek healthcare at a healthcare facility and purchased medication on their own.

Regarding the refusal of medical procedures, 83% of the respondents were offered Covid-19 screening, and 19% of the respondents refused to proceed with the screening. The questionnaire also revealed that 22% of the respondents had been asked to fill out and/or sign a specific form related to refusing in-patient treatment or isolation after receiving medical explanations from the hospital. Additionally, 12% of the respondents had been hospitalized with Covid-19, 9% had

refused treatment after being diagnosed as Covid-19 patients by medical professionals, and 7% had been discharged against their will from the hospital as Covid-19 patients. From this data, it can be observed that even in a small population, cases of patients being discharged against their will are still present in the community.

From the data gathered by the author through interviews and questionnaires, the results indicate that almost the majority of respondents believe that certain actions, such as refusing to undergo Covid-19 screening, refusing in-patient treatment after being advised by a doctor, and choosing to leave the hospital against their will or to isolate at home, are fundamentally the rights of patients that cannot be intervened upon by doctors or hospitals. This is because respondents consider these actions as fundamental human rights inherent in every individual.

The results of the interviews and questionnaires also reveal that the majority of the population, while small in percentage, have at some point refused Covid-19 screening when they initially showed symptoms suggestive of Covid-19. Additionally, although the percentage is small, there are still respondents who have reported being discharged against their will from the hospital and engaging in informed refusal.

Here, the author wishes to emphasize to the readers that, unlike other research analyses that rely on the percentage of variables taken, for this research, even if some percentages are small, it doesn't mean that the results are not valid or not important. On the contrary, considering that the topic discussed in this paper is an infectious disease that can spread rapidly and cause death very quickly, even one patient who is at risk of transmitting the disease without proper treatment can have an enormous impact (Multiple Domino Effect). One patient who does not receive adequate treatment or therapy can lead to two others being infected, and so on, as Covid-19 transmission is exponential. Therefore, it is worth questioning whether there are indeed no limitations regulating the rights of patients in such situations.

If we carefully examine the Health Law No. 36 of 2009 Article 56 paragraph (1), it is explicitly stated that "Every person has the right to accept or refuse in part or all of the assistance to be provided to him after receiving and understanding complete information about the action." Furthermore, in Medical Practice Law No. 29 of 2004 Article 52 letter (d), it is stated that patients have the right to refuse medical treatment. This provides an understanding that patients have an absolute right to govern themselves. However, if we observe carefully and attentively, in the same article at paragraph (2), it is stated that the right to accept or refuse as referred to in paragraph (1) does not apply to patients suffering from diseases that can quickly spread into the wider community, individuals who are unconscious, and patients with severe mental disorders. This is also supported by Law No. 44 of 2009 Article 29 letter (k), which states that hospitals are obligated to reject the wishes of patients that contradict professional standards and ethics as well as legal regulations.

In this regard, Covid-19 patients are patients who have diseases classified as those that can spread widely and rapidly, so essentially, individuals suspected or suspected of having Covid-19

lose their right to refuse. Therefore, they essentially have no right to engage in informed refusal. And considering that informed refusal is not an agreement but a unilateral statement from the patient to the hospital, it is not bound by the conditions for a valid agreement as outlined in Article 1320 of the Civil Code.

2. Legal Consequences for Doctors and Patients Regarding the Discharge of Covid-19 Patients from the Hospital Against Their Will

Based on the above explanation, we can conclude that informed refusal is essentially the right of every patient seeking treatment or visiting a hospital. The law also explicitly addresses and regulates that patients with diseases that could potentially spread widely to the community do not have the right to exercise informed refusal. So, the question arises: what are the legal consequences if someone is discharged against their will?

Essentially, by allowing a patient to leave the hospital, it means that the doctor and the hospital are letting a patient with a high risk of spreading their disease to the community go without completing their treatment until they are fully recovered. This ultimately depends on the hospital's authority over the patient within the agreement that has been approved by both the hospital and the patient. Thus, the doctor, in this case, who provides information and the risks if the patient decides to leave against medical advice, has fulfilled their rights and obligations. A doctor's duty is to provide comprehensive information regarding medical procedures and the subsequent treatment plan, as well as the associated risks if the patient chooses to leave against medical advice.

This is because the doctor and the patient are bound by a therapeutic agreement, and when it comes to leaving against medical advice, it directly concerns the patient's relationship with the hospital. The doctor has already fulfilled their responsibility, which is to provide information and medical care to the patient, and the hospital's role is to provide accommodation and handle administrative matters. If a patient decides to leave against medical advice, this decision should have been educated and informed, and the hospital should have personnel in charge (PIC) responsible for this education.

The rights and obligations of the patient should ideally have been provided and communicated when the patient first arrived at the hospital. Therefore, concerning informed refusal, the final screening should be done by the admission or registration staff because a patient cannot leave if the administrative process is not completed. So, if a patient successfully leaves against medical advice, it is likely due to insufficient screening and education by the hospital.

However, legally speaking, this matter can still be debated because, in principle, every person should already be aware of the law due to the presumption of knowledge of the law (*persumptio iures de iure*), where it is assumed that everyone understands the law. Therefore, if informed refusal has indeed occurred with a COVID-19 patient, the party at fault here is either the patient or the patient's request to leave against medical advice, which may be an abuse of their right to

informed refusal. In this case, the patient is exerting their right, which is not recognized by the legal regulations, to the hospital, and the hospital, in turn, would not want to be blamed and allows the COVID-19 patient to leave against medical advice with the condition that they have been fully educated and are willing to bear all the associated risks.

In terms of criminal provisions, there are no specific regulations regarding informed refusal in Law Number 36 of 2009 concerning Health or Law Number 44 of 2009 concerning Hospitals. It is only mentioned that there may be an administrative fine that can be imposed by the Minister, as seen in Article 188, Paragraph (1), which states that the Minister can take administrative actions against healthcare providers and healthcare facilities that violate the provisions as stipulated in the Health Law. These actions can include written warnings or temporary or permanent revocation of licenses. However, in essence, doctors and hospitals have already fulfilled their duties, which include providing information and healthcare services. Typically, informed refusal contains a clause in which the patient agrees to bear all the risks that may result from leaving against medical advice, whether directly or indirectly.

When considering this from a simple logical perspective, doctors and hospitals cannot be held at fault because there are usually many considerations that form the basis for the decision to allow a patient to leave against medical advice, provided they sign an informed refusal. One of the most reasonable considerations is that doctors and hospitals are aware that patients or their representatives are legally competent individuals. Therefore, when a patient has decided not to be hospitalized, various challenges may arise, such as how healthcare providers can ensure that the patient does not remove their own IV line, how to administer injections to a patient who no longer wishes to be hospitalized, and how to prevent the patient from causing disruptions or disturbances in the hospital when they no longer wish to be hospitalized.

Therefore, ultimately, our attention should shift to who should actually be responsible if unwanted events occur. The responsibility in this case should lie with the patient or the patient's family who refuse to comply with the rules and regulations in the hospital, as well as those established in national regulations. In this regard, there are legal consequences that can be imposed on the patient or their family.

This is outlined in Law Number 4 of 1984 concerning the Eradication of Infectious Diseases, Article 14, Paragraph (1), which states that anyone who intentionally obstructs the implementation of infectious disease control as regulated by this law is subject to imprisonment for a maximum of 1 (one) year and/or a fine of up to Rp 1,000,000 (one million Rupiah). In this context, the patient is considered to be causing hindrance by obstructing the efforts of hospitals and healthcare providers in the control of infectious diseases, including examinations, treatment, care, and isolation of patients, as well as quarantine measures as specified in Law Number 4 of 1984 concerning the Eradication of Infectious Diseases, Article 5, Paragraph (1), letter (b).

CONCLUSION

Based on the data analysis conducted throughout the research titled "The Validity of Informed Refusal with Elements of Patients with COVID-19 Leaving the Hospital Against Their Will, Reviewed in Light of Law No. 29 of 2004 on Medical Practice Jo Law No. 4 of 1984 on Infectious Diseases Outbreaks," the author has reached the following conclusions:

First, the validity of informed refusal does not rely on the legal requirements for a valid contract as stipulated in the Civil Code Article 1230. This is because informed refusal is not a contract; it is essentially a unilateral statement made by the patient to the hospital. Informed refusal does not involve mutual agreement, and it represents the patient's written declaration to the hospital, indicating their willingness to accept all associated risks. Informed refusal, as a patient's right, is indeed regulated by laws such as Law No. 29 of 2004, Law No. 36 of 2009, and Law No. 44 of 2009. However, according to Law No. 36 of 2009 on Health, the exercise of informed refusal as a right does not apply to COVID-19 patients.

Secondly, the legal consequences for hospitals and patients resulting from informed refusal are essentially nonexistent. This is because the full responsibility for the decision to leave against medical advice, along with all associated consequences, lies with the patient who chooses to do so, even after being educated by the doctor and the hospital. In this regard, the doctor and the hospital have fulfilled their obligations. The legal consequences that may arise are directed towards the individual who declares such refusal, as outlined in Law No. 4 of 1984 on Infectious Disease Outbreaks, which imposes a maximum penalty of 1 (one) year of imprisonment and/or a fine of up to IDR 1,000,000.

Thirdly, the presence of the State, particularly in the context of implementing informed refusal during a public health emergency, requires the State to provide legal certainty and clear regulations. The State should ensure that all members of society comply with and adhere to the provisions of the law regarding requests for discharge from medical care at the patient's own request, especially when the patient is diagnosed with or suspected of having a contagious disease or during a contagious disease outbreak.

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