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HEALTH FACILITY ACCOUNTABILITY FOR TERMINAL PATIENT PALLIATIVE CARE SERVICES UNDER HEALTH LAW

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Abstract- *This article examines the construction of obligations and accountability standards for health facilities in providing palliative care for terminal patients based on national health law. A normative legal study was used to assess the relationship between patients' rights to quality services, the obligations of the implementing institutions, and the accountability mechanisms arising from medical consent, medical records, and pain management. The analysis shows that palliative obligations are rooted in the guarantee of the right to health, as reinforced by the Health Law, the Hospital Law, and the Minister of Health Regulation on palliative care. Institutional accountability standards are realized through informed consent procedures that ensure patient understanding and consent, complete and verifiable medical record documentation, and pain management that prioritizes safety and the availability of analgesics, including opioids, in accordance with narcotics regulations. Consumer protection regimes, human rights, and medical practice discipline expand the scope of compliance and open the door to administrative, civil, and professional disciplinary sanctions in the event of system negligence. This article offers operational parameters for quality audits and risk mitigation, in the form of standard procedures, documentation indicators, and pharmaceutical governance, so that end-of-life services are carried out humanely and accountably. This approach emphasizes the obligation of hospitals and primary health facilities to establish referral networks, staff training, and complaint handling mechanisms. Compliance can be assessed by tracing written evidence on consent forms, progress notes, pain assessments, and medication records. These findings are relevant for policymakers, facility managers, and health workers. The measure of palliative care quality is determined by the consistency of procedures, transparency of information, and availability of appropriate therapies.*

Keywords: palliative care; terminal patients; quality of service; informed consent; medical records; pain management; facility accountability.

INTRODUCTION

Advances in medical science have extended life expectancy through more precise diagnostics, increasingly diverse curative therapies, and supporting technologies that expand the capacity of hospital services. The increase in life expectancy is accompanied by a rise in the number of patients living with progressive chronic diseases that at a certain stage no longer respond to curative therapies. In the terminal phase, the goal of care shifts from attempting to cure to maintaining dignity, reducing suffering, and preserving the quality of life of patients and their families. A fundamental aspect of preserving dignity and quality of life is ensuring that healthcare services are responsive to patient needs and uphold their rights, a principle deeply embedded in the intersection of law and medical ethics (Herisason et al., 2023). This shift in goals requires health facilities to have clear, measurable, and accountable palliative care management. In practice, palliative care includes pain control, management of non-pain symptoms, psychological support, spiritual support according to patient choice, and good clinical communication regarding care plans (Mollaoğlu et al., 2019). Because palliative care intersects with clinical decisions and patient values, the need for certainty in law increases, especially when decisions concern limiting futile medical interventions, continuing life-sustaining therapy, and setting realistic treatment goals.

The obligation of health facilities to provide palliative care does not stand alone as an ethical obligation. It is intertwined with administrative obligations, professional obligations, and obligations to protect patient rights. Healthcare facilities are required to establish a safe, high-quality, and patient-safety-oriented service system. The overall quality of service is a key determinant of patient satisfaction, as demonstrated in analyses of public health center services (Darmawan et al., 2022). In palliative care, quality is not only measured by the sophistication of the treatment, but also by the accuracy of the indications, the thoroughness of symptom assessment, the continuity of care, and patient involvement in decision-making. Many common actions in the terminal phase, such as opioid titration, palliative sedation in certain conditions, or discontinuation of therapy that no longer provides clinical benefits, require strong procedural standards and neat medical documentation (Keles, 2019). Without a clear normative framework, healthcare facilities are prone to placing patients at two risks simultaneously: undertreatment, which causes patients to endure pain that could actually be controlled, or overtreatment, which prolongs suffering due to disproportionate interventions. Both risks can give rise to disputes, including allegations of negligence, violation of patient rights, or violation of professional standards.

The clinical dimension aside, palliative care is a service that is greatly influenced by interprofessional coordination. Physicians, nurses, pharmacists, clinical psychologists, medical social workers, hospital chaplains, and other personnel are often needed to ensure that patients receive care that is tailored to their needs (Titko et al., 2020). This coordination requires a clear division of authority, effective internal referral processes, and adequate communication mechanisms between service units, especially when patients move from inpatient to outpatient care or to home care. In reality, healthcare facilities vary in terms of human resource capacity, availability of essential medicines, and access to palliative care teams. This variation raises normative questions: to what extent is the obligation to provide palliative care inherent to each facility, what are the minimum standards, and how can it be proven that a facility has fulfilled this obligation? Because palliative care targets vulnerable terminal patients, clarity regarding obligations and limits of responsibility is important to ensure patient protection, while healthcare workers obtain operational guidelines.

From a health law perspective, palliative care is related to the right to health services, the right to information, consent to medical treatment, and protection from substandard treatment. Palliative care requires honest, clear, and empathetic communication about prognosis, intervention options, and the consequences of each option. Such communication is directly related to the validity of consent to medical treatment and the quality of medical records as evidence. In terminal patients, the consent process often involves family members, guardians, or caregivers, adding to the complexity of determining who is authorized to represent the patient, how to ensure that the patient's wishes are respected, and how to avoid undue pressure. Similar complexities regarding service access, representation, and rights also arise in other institutional settings, such as in ensuring the right to visiting services for inmates, highlighting the universal importance of procedural clarity (Kurniawan et al., 2025). The obligations of healthcare facilities extend beyond the availability of medical personnel to include internal policies, standard operating procedures, and clinical communication training. Without these tools, critical decisions are often made on an ad hoc basis, weakening institutional accountability and jeopardizing patient safety.

The theme of healthcare facilities' obligation to provide palliative care for terminal patients has become increasingly relevant in line with the changing paradigm of healthcare quality, which is now measured through accreditation standards, patient safety indicators, and clinical and ethical risk control (World Health Organization [WHO], 2014). Palliative care is no longer understood as an additional intervention at the end of life, but rather as an integral part of health services that focus on the quality of life of patients with life-threatening illnesses. Various research studies show that palliative care needs exist in almost all service units, including internal medicine, oncology, neurology, pulmonology, geriatrics, and intensive care units, because terminal patients experience complex physical, psychological, social, and spiritual symptoms that cannot be optimally addressed by a curative approach alone (Kelley & Morrison, 2015).

When palliative care services are not systematically organized, the impact is felt not only by patients, but also by healthcare workers and families. Healthcare workers face increased moral and emotional burdens due to unclear treatment goals, decision-making conflicts, and tensions between aggressive interventions and the best interests of patients (Ferrell et al., 2013). Families, on the other hand, often feel abandoned in clinical and emotional uncertainty, especially when communication about prognosis, treatment goals, and end-of-life choices is not well structured. This underscores the critical link between service quality and patient satisfaction, a relationship that is foundational to the credibility and trust in public healthcare systems (Khayru & Issalillah, 2022). This situation contributes to a significant increase in treatment costs without accompanying improvements in patients' quality of life, mainly due to the disproportionate use of intensive medical interventions in the terminal phase (Meier, 2011). The integration of palliative care services into the healthcare system is therefore an institutional obligation that is directly related to service quality, patient safety, and fairness in the use of healthcare resources. Normative analysis is therefore necessary to map out the obligations of healthcare facilities, formulate minimum requirements that must be met, and explain the legal consequences of neglecting these obligations. This type of analysis aims to produce a map of norms that can be used as a reference for internal health facility policies, risk management considerations, and a basis for accountability in the event of service disputes in the terminal phase.

The obligation to provide palliative care is often vaguely understood as falling between professional ethical obligations and institutional legal obligations. This ambiguity raises questions about what standards healthcare facilities should meet when dealing with terminal patients, especially in facilities with limited resources. In terminal care, patient needs often involve intensive pain management, assessment of rapidly changing symptoms, and decisions about discontinuing interventions that are no longer beneficial. Ensuring the safety and appropriateness of all interventions, even basic ones like hydration, requires clear parameters, as emphasized in health safety standards for essentials like mineral water (Issalillah et al., 2022). If a healthcare facility does not have adequate internal policies, decisions may depend on the individual preferences of healthcare workers rather than institutional standards. When conflicts arise with families or undesirable events occur, facilities face difficulties in demonstrating that the actions taken were in accordance with accountable standards. This situation increases the potential for disputes, whether in the form of negligence claims, patient rights violations, or allegations of inhumane treatment due to unmanaged pain.

The next issue arises in the realm of medical consent and communication regarding prognosis. In terminal patients, communication about treatment goals determines the direction of care: whether the focus is on comfort, whether there are restrictions on resuscitation, whether there are options for home care, and how the patient's priorities are respected. The process of communication is often hampered by differences in understanding, family expectations that are not aligned with clinical reality, or healthcare providers' concerns about the legal consequences of discontinuing treatment. Without clear guidelines, the consent process risks becoming an administrative formality rather than a process that ensures patients understand their options and the consequences. As a result, medical records may not reflect the actual decision-making process. When disputes arise, incomplete documentation weakens the position of healthcare facilities and closes the opportunity for quality evaluation. This problem is structural because it concerns the system, documentation culture, and the capacity of facilities to provide communication training and clinical supervision.

Another issue relates to service availability and accessibility. Not all health facilities have palliative care teams or well-functioning referral networks. Access gaps lead to variations in the quality of terminal care between facilities and between regions. Terminal patients may experience repeated transfers, prolonged hospital stays, or excessive interventions due to the lack of a clear care plan. Innovative solutions are crucial to bridge this gap, such as leveraging technology to ensure equitable distribution of access to health services through telemedicine, despite its inherent challenges (Khayru & Issalillah, 2022). In such circumstances, normative questions arise: is it the direct obligation of health facilities to provide comprehensive palliative care, or is it sufficient to ensure effective referral and coordination mechanisms? When referrals are not available, are facilities required to build a certain minimum capacity, and how is that minimum determined? In addition, financing and service management aspects also affect the ability of facilities to provide pain control medication, counseling services, and family support. The lack of certainty regarding the limits of obligations and performance measures slows down system improvements and makes monitoring difficult.

This topic is important to examine at this time because modern healthcare increasingly emphasizes patient safety, risk control, and institutional accountability. In terminal patients, clinical decisions often fall within an area that requires strong professional reasoning and careful documentation. The ongoing transformation of healthcare, offers new potentials for enhancing palliative care delivery and patient-centered outcomes (Khayru, 2022). Normative analysis can explain what healthcare facilities should do to ensure that terminal care focuses on patient comfort and dignity, rather than simply prolonging biological processes without commensurate benefits. Clarity of obligations can help healthcare facilities design standard procedures, consultation flows, and training that reduce variations in practice between doctors or between units. In addition, a normative framework strengthens patient protection by ensuring that the right to information, the right to choose services, and the right to pain control are implemented consistently. Clarity of norms also provides a basis for hospital management to allocate resources appropriately, including the formation of palliative teams, the organization of pharmaceutical services, and the establishment of coordination mechanisms with social services and family support.

Normative discussions are also relevant because healthcare disputes often relate to communication, consent, and documentation, three areas that are particularly prominent in terminal care. When healthcare facilities do not have clear palliative policies, healthcare workers may take defensive measures, such as maintaining interventions that are no longer beneficial in order to avoid accusations of withholding care. This defensive approach has the potential to increase patient suffering and the burden on families. Discontinuing treatment without proper procedures can also raise legal and ethical issues. Normative review helps define the limits of justifiable actions, including clinical assessment procedures, communication processes, and the obligation to periodically review care plans. Health facilities thus obtain guidelines to ensure that decisions made can be tested professionally and administratively, while patients gain certainty that the services they receive are oriented toward their real needs and chosen values.

This research aims to compile a normative legal analysis of the obligation of health facilities to provide palliative care for terminal patients and to explain the extent of institutional accountability for the quality of such services. The output will be a map of norms that can be used to develop internal policies, standard operating procedures, and a risk management framework that is in line with patient rights protection, patient safety, and service accountability.

RESEARCH METHODS

This research uses a normative juridical method with a qualitative literature study design. The focus is to examine the law norms that regulate the obligations of health facilities in providing palliative care for terminal patients, then organize the relationship between norms to obtain a coherent formulation. Primary law materials include relevant laws and regulations regarding health services, hospitals, medical practice, consumer protection, and derivative provisions that regulate service standards and patient rights. Secondary law materials include academic literature on health law and clinical ethics used to assist in the systematic interpretation of norms and to assess the legal consequences of fulfilling or neglecting obligations. Nonnormal law materials may be used selectively as supporting information, as long as they do not replace the position of law materials and are not treated as sources of norms. The units of analysis in this research are normative provisions related to: (a) the obligations of health care facilities, (b) the rights of patients and families in end-of-life care, (c) professional and service standards, (d) consent to medical treatment and documentation, and (e) accountability mechanisms.

Inclusion criteria were established to select sources relevant to law research: (a) discussing norms, standards, or accountability of health services in terminal care; (b) having clear authorship, publisher, and year of publication; (c) being bibliographically identifiable for verification purposes. Exclusion criteria include sources without clear publisher identification, popular opinions without an academic basis, and sources whose validity cannot be verified. For primary law materials, selection was carried out by ensuring the validity of regulations and ensuring that the wording of the articles used was consistent with the official text. The search results were then compiled in a matrix that mapped each norm to a research issue, such as the obligation to provide information, the obligation to provide standard services, the obligation to refer, and the obligation to record.

The analysis technique uses thematic synthesis through the coding stage. First, open coding is carried out to mark relevant normative statements, including command norms, prohibition norms, permission norms, and norms that regulate procedures. Second, axial coding is carried out to connect themes, for example, the relationship between the patient's right to information and the conditions for valid consent, or the relationship between service standards and measures of institutional accountability. Third, selective coding is performed to compile normative propositions that answer the problem formulation. Quality assurance is carried out through the following steps: (a) checking the consistency of interpretations between sections of the manuscript, (b) retracing each normative claim to the underlying regulatory provisions, and (c) clearly separating the description of norms, interpretations, and argumentative assessments.

RESULTS AND DISCUSSIONS

Construction of Health Facility Obligations in Providing Palliative Care for Terminal Patients

The first basis for the construction of health facility obligations for palliative care services for terminal patients stems from the norm of the right to health in the 1945 Constitution of the Republic of Indonesia, specifically Article 28H paragraph (1), which affirms the right of every person to obtain health services, and Article 34 paragraph (3), which mandates that the state is responsible for providing health service facilities. This constitutional guarantee is particularly crucial for protecting vulnerable groups, such as indigent patients, whose rights to health services require continuous juridical oversight to ensure equitable access and dignified treatment (Noor et al., 2023). These two norms form the state's obligation to build a system, while health facilities are part of the instruments for its implementation through the provision of tangible services. In terminal care, this constitutional mandate works through the obligation to provide services that preserve human dignity, because respect for dignity is inherent in the fulfillment of basic rights. The constitution also places health services within the framework of social protection, which demands adequate access and fair treatment (Suanjaya et al., 2023). Palliative care can therefore be understood as a form of fulfilling the right to health when the curative goal has shifted towards reducing suffering and maintaining quality of life. With this construction, health facilities cannot place palliative care as an optional service that depends solely on the initiative of certain units, because the obligation arises from the highest hierarchical norm that binds legislators, health sector regulators, and service providers.

The next obligation was established by Law No. 36 of 2009 on Health, which places the rights of patients and the obligations of service providers in a single framework. Article 5 affirms the right of every person to obtain safe, quality, and affordable health services, so that the criteria of “safe” and “quality” must be applied to terminal patients, including pain management, symptom management, psychological support, and spiritual support in accordance with the patient's beliefs. Palliative care is included in the scope of health services because it aims to prevent avoidable suffering and disproportionate actions. Article 32 emphasizes that services must comply with professional and service standards, so that the obligations of health facilities include the development and implementation of operational standards for pain assessment, care plans, communication of care goals, and internal referrals to palliative care teams where available. The imperative for accurate diagnosis and adherence to standards is paramount, as misdiagnosis can directly undermine these objectives and form the basis of legal liability for doctors, reflecting a critical intersection between clinical practice and legal accountability (Setiyadi et al., 2023). The Health Law also contains provisions on the responsibilities of the central and local governments in the implementation of health services, which affect the obligations of facilities through licensing, guidance, and supervision (Arisanti et al., 2019). Palliative care obligations can thus be defined as institutional obligations to provide safe and high-quality services in the terminal phase, including ensuring continuity of care and symptom control as part of fulfilling patients' rights.

At the hospital institutional level, Law No. 44 of 2009 on Hospitals emphasizes the service obligations that must be fulfilled organizationally. This construction is important because hospitals are entities that have governance, resources, and more detailed service obligations than individual service providers. Article 29 contains the obligation of hospitals to provide safe, quality, non-discriminatory, and effective services, as well as other obligations such as maintaining medical records, providing infrastructure, and performing social functions. For terminal patients, the principle of non-discrimination means that hospitals cannot refuse patients because of a poor prognosis or because services are more oriented towards comfort than aggressive treatment. The principle of effectiveness must be interpreted as clinical effectiveness relevant to the goals of palliative care, so that actions that add burden without commensurate benefits have the potential to conflict with quality obligations. This obligation of integrity and accuracy extends to all medical documentation, where falsification of health certificates represents a serious breach of both criminal law and professional ethics, undermining the entire healthcare system's credibility (Hartika et al., 2023). Within this collaborative framework, each professional's role is crucial and carries distinct legal responsibilities, as seen in the context of consumer protection laws that define the legal accountability of pharmacists in the health sector (Setiawan et al., 2023). The Hospital Law also regulates patients' rights and hospitals' obligations to respect those rights, including the right to information and the right to privacy, which are very important in end-of-life decision-making. From this arises the normative consequence that hospitals are obliged to establish palliative care systems through clinical policies, consultation protocols, availability of essential medications, and interprofessional coordination to ensure that the obligations of Article 29 are fulfilled in a measurable manner.

More specific obligations related to palliative care are stipulated in Minister of Health Regulation No. 37 of 2014 concerning Palliative Care Services. This regulation defines palliative care as efforts to improve the quality of life of patients and families facing life-threatening illnesses through the prevention and alleviation of suffering, early identification, appropriate assessment, and management of pain and other physical, psychosocial, and spiritual problems. Based on this definition, the obligations of health facilities are structural in nature because they require a service system capable of early identification of palliative care needs, rather than waiting for conditions to worsen. This Minister of Health Regulation also directs the provision of palliative care at various levels of facilities, from primary care to referral, so that minimum obligations are attached to all facilities in the form of ongoing assessment, communication, and referral. Provisions regarding a multidisciplinary approach mean that health facilities are required to organize collaboration between doctors, nurses, pharmacists, psychologists, medical social workers, and spiritual workers in accordance with the availability of services. The institution's obligations do not stop at providing space or units, but also include clinical management, consultation mechanisms, family education, and support for home care if facility policy allows. This Minister of Health Regulation reinforces the argument that palliative care is part of the standard of care that must be available, so that failure to provide service mechanisms can be considered a violation of the obligation to provide health services.

The construction of palliative obligations is also linked to the competency and ethical standards of health workers through Law Number 36 of 2014 concerning Health Workers. This law emphasizes that health workers must work in accordance with their competencies, authority, and code of ethics, and must meet professional standards, professional service standards, and standard operating procedures. The implications for health facilities are direct because facilities are the parties that regulate the placement, credentials, training, and clinical supervision of health workers. In palliative care, competency requirements include pain assessment, rational use of analgesics, communication about treatment goals, shared decision-making with patients, and interprofessional collaboration. The Health Workforce Law also emphasizes the obligation to improve competency, so health facilities should have internal training programs or access to external training related to palliative care. This obligation is important for facilities that do not yet have a formal palliative care team, as a minimum level of compliance can be demonstrated through the provision of basic palliative care training for primary care physicians and nurses, the availability of referral guidelines, and quality assurance through clinical audits. The obligation to provide palliative care is not merely an obligation to provide physical facilities or medicines, but rather an institutional obligation to ensure that human resources have adequate competence in providing services in accordance with palliative care practice standards (World Health Organization, 2011). The quality of palliative care services is highly dependent on the ability of health workers to control symptoms, communicate about end-of-life issues, and make clinical decisions that are in line with the values and preferences of patients (Quill & Abernethy, 2013). If health facilities neglect competency development through training, supervision, and strengthening of interdisciplinary teams, then service failures in terminal patients can be understood as a failure of the service system, not merely the fault of individual clinicians (Institute of Medicine, 2015). This principle of individual professional accountability within the system is clearly illustrated in cases of medical malpractice, where the actions of specific healthcare providers, such as midwives, are subject to juridical scrutiny based on prevailing health laws (Vitrianingsih et al., 2023). This perspective emphasizes that responsibility for palliative care quality lies with organizational governance and institutional commitment to building professional capacity on an ongoing basis (Gawande, 2014).

The relationship between doctors, patients, and facilities in end-of-life decisions is greatly influenced not only by the Health Workforce Law, but also by Law No. 29 of 2004 on Medical Practice, particularly the principles of service based on professional standards and standard operating procedures, as well as the obligation to obtain consent for medical procedures. During the terminal phase, many decisions are sensitive in nature, such as determining treatment goals, restricting certain actions, or choosing palliative sedation when indicated. The Medical Practice Law places doctors as subjects of clinical authority, while health facilities are required to ensure that such practices take place within an orderly system. This means that facilities need to have policies that allow for responsible clinical decision-making, while also providing administrative guidelines that prevent actions without medical basis or without a valid approval process. This law also relates to the development and supervision of medical practices, so that facility management is required to establish credentialing mechanisms, medical committees, and clinical quality reviews for complex terminal cases. In normative construction, palliative obligations are part of the obligation to conduct good medical practice, because palliative goals remain within the realm of medical actions that require clinical consideration, standard procedures, and accountability. This means healthcare facilities are the ones who have to make sure that end-of-life clinical decisions are backed up by proper documentation, communication, and supervision.

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The aspect of documentation as the foundation of accountability is regulated through Minister of Health Regulation No. 269 of 2008 concerning Medical Records. In palliative care, medical records are not merely records of actions, but evidence of clinical decision-making processes, evidence of pain and symptom assessment, evidence of care plans, and evidence of communication with patients and families. This Minister of Health Regulation regulates the obligations of creating, filling out, storing, and maintaining the confidentiality of medical records. For health facilities, these obligations mean providing a medical record system that allows for structured recording of terminal status, treatment goals, resuscitation decisions, palliative team referrals, and evaluation of therapeutic responses. Medical records also serve as a means of coordination between service units, such as between the emergency room, inpatient care, intensive care unit, and outpatient care, so that failure to document can trigger actions that are not in line with the agreed palliative plan (Institute of Medicine, 2012). This situation encourages healthcare facilities to organize clinical information management and establish consistent entry standards, including the use of special forms for pain assessment, psychosocial assessment, and recording communication with the patient's family (The Joint Commission, 2012). Medical confidentiality is also an important aspect because terminal patients are often in an environment with the involvement of extended family, so facilities need to regulate the mechanism for providing information so as not to violate the principles of confidentiality and patient privacy (Rumbold & Pierscionek, 2014). Good medical record management not only serves as a clinical communication tool but also as legal protection for facilities and health workers, especially in end-of-life care situations that are fraught with sensitive decisions (Kruse et al., 2016). Fulfilling palliative obligations requires strict compliance with medical record standards as a key element of service quality and institutional legal protection.

The construction of health facility obligations in terms of patient protection as service recipients is also based on Law No. 8 of 1999 concerning Consumer Protection. Although health services have specific characteristics, the principle of consumer protection provides relevant standards of conduct for service providers, particularly the right to obtain accurate, clear, and honest information, the right to be treated properly, and the right to compensation if the service does not comply with the agreement or causes harm. In palliative care, accurate information includes explanations about the purpose of treatment, the limitations of intervention, the possibility of deterioration, and treatment options. The right to be treated properly is related to the prohibition of treatment that degrades the dignity of terminal patients, such as ignoring complaints of pain, performing procedures without explanation, or delaying the treatment of symptoms because they are considered "terminal." For healthcare facilities, the Consumer Protection Law encourages the strengthening of complaint mechanisms, complaint resolution, and cost transparency, as families of terminal patients often face high psychological and financial burdens. This obligation serves as a normative incentive for facilities to establish auditable palliative care service standards, including response time standards for severe pain, drug availability, and communication training. Palliative care is thus positioned as part of the obligation to provide health services that meet standards of fairness, openness, and prudence.

The dimension of human rights reinforces palliative obligations through Law No. 39 of 1999 on Human Rights. This law affirms that everyone has the right to life, the right to defend their life, and the right to obtain health services, as well as demanding respect for human dignity. In the terminal phase, the meaning of "right to life" cannot be reduced to the obligation to perform all medical actions without limits, because actions that are not beneficial can prolong suffering and demean dignity. In normative construction, the obligation of health facilities is to provide humane care, free from degrading treatment, and to give patients space to express their wishes regarding the care they receive. The Human Rights Law also affirms the prohibition of discrimination, so that terminal patients remain entitled to equal services, including access to adequate pain management. At the operational level, facilities need to ensure that internal policies do not deny poor patients access to palliative care, for example by refusing them because they are considered unprofitable. The Human

Rights Law can also be interpreted as the basis for justifying services that emphasize comfort and supportive care, as this preserves dignity. The obligation to provide palliative care is part of fulfilling the obligation to respect, protect, and fulfill the human rights of terminal patients, which is carried out through service standards, staff training, and effective complaint mechanisms.

The construction of obligations is incomplete without financing, so Law No. 40 of 2004 concerning the National Social Security System and Law No. 24 of 2011 concerning the Social Security Administration Agency become the normative framework that determines the affordability of palliative services. The SJSN emphasizes health insurance as part of social protection, while the BPJS Law establishes an implementing agency that manages health insurance programs. For health facilities, these two laws give rise to contractual and administrative obligations when working with BPJS Kesehatan, including compliance with benefit packages, claim standards, tiered referrals, and quality and cost control. For terminal patients, good palliative care often reduces the use of unnecessary services, but requires the availability of analgesic drugs, counseling, and follow-up visits. Healthcare facilities have a dual obligation: to ensure that patients receive services according to their medical needs, and to ensure that these services are accessible under the applicable insurance scheme. This requires managerial capacity, such as strengthening diagnosis recording, coding, and treatment plans that are consistent with insurer requirements. If facilities fail to organize administrative aspects, patients risk bearing the costs themselves or experiencing barriers to access. Palliative care obligations include orderly cooperation with BPJS, establishing palliative care service flows in referrals, and preparing pharmacy units so that the availability of essential medicines is not disrupted by financing issues.

At the level of health insurance policy implementation, operational arrangements are strengthened through Presidential Regulation No. 82 of 2018 concerning Health Insurance and its amendments, which are still in effect. This Presidential Regulation regulates participants, benefits, guaranteed services, referral mechanisms, and service payment management. For palliative care services, benefit and referral norms influence how facilities design their workflow: primary services identify palliative needs and follow-up, referral services handle complex cases, and continuity of care is maintained through coordination. The Presidential Regulation emphasizes the obligation of health facilities that collaborate with BPJS to provide services in accordance with regulations and standards, so that facilities cannot refuse services that are included in the benefits as long as the medical indications are met. At the management level, facilities need to organize realistic palliative care service packages within the applicable payment framework, for example through pain clinics, palliative consultations, or home visit services if supported by regional policies and contracts. The Presidential Regulation also requires compliance with quality control, so facilities need to integrate palliative quality indicators, such as pain recording, family satisfaction, and evaluation of analgesic use. Palliative obligations become part of the JKN service delivery obligations that can be audited through referral compliance, standard compliance, and claim accountability.

The obligation of health facilities to provide services systematically is also influenced by Government Regulation No. 47 of 2016 concerning Health Care Facilities, which emphasizes the responsibility of the central and regional governments in providing health facilities and ensuring their availability, equity, and affordability. For facilities as providers, this PP emphasizes the importance of infrastructure standards, service quality, and service networks, which are prerequisites for the implementation of palliative care across service levels. Primary facilities need to be able to conduct basic assessments, family education, and orderly referrals. Referral facilities need to have more comprehensive clinical capabilities, including complex pain management, psychological support, and coordination of patient discharge with a clear care plan. PP 47/2016 supports the argument that palliative care obligations are inherent in the system, so that service failures can be network failures, such as interrupted referrals or a lack of primary service reinforcement. The managerial implications are the need for referral cooperation agreements, communication protocols between facilities, and strengthening of the information system for medical summary transfers. The construction of palliative care obligations becomes a traceable obligation from service planning, provision of facilities, flow arrangements, to quality control, in accordance with the mandate of the Government Regulation on the implementation of health facilities.

Two additional norms that often determine the quality of palliative care implementation are pain medication management and professional ethics. For medication, the use of opioids as analgesics is subject to drug control regulations, so facilities must balance patient access to pain management with compliance with security and documentation requirements. Law No. 35 of 2009 on Narcotics regulates the procurement, storage, distribution, and use of narcotics for health services. In palliative care, the facility's obligations include ensuring the availability of opioids for legitimate medical indications, ensuring storage and recording procedures are in accordance with regulations, and ensuring prescriptions are made by authorized personnel. The Indonesian Medical Code of Ethics directs doctors to respect the dignity of patients and provide services according to their medical needs, including efforts to reduce suffering. Although the code of ethics is not a law, it serves as a professional standard referenced in various health legal regimes. The normative construction is clear: facilities are required to establish systems that enable doctors to carry out their ethical and professional obligations without irrational administrative barriers, such as internal policies that hinder access to necessary analgesics. Palliative obligations include ensuring access to essential medicines, safe pharmacy management, and procedural certainty for medical personnel in pain control.

The health facility's obligation to provide palliative care for terminal patients is structured as a series of mutually reinforcing norms from the constitutional level to implementing regulations. The 1945 Constitution provides the basis for the right to health and the responsibility of the state, the Health Law establishes the right to safe and quality services, the Hospital Law requires safe, quality, non-discriminatory services and orderly administration, while the Minister of Health Regulation on Palliative Care establishes the characteristics of services, targets, and a multidisciplinary approach at various levels of facilities. The Health Workers Law and the Medical Practice Law provide a structure for competence, authority, consent to treatment, and professional standards, which compel facilities to organize credentials, training, and supervision. The Minister of Health Regulation on Consent to Medical Treatment and the Minister of Health Regulation on Medical Records transform palliative obligations into measurable procedures through explanation, consent, and documentation. The Consumer Protection Law and the Human Rights Law strengthen patient protection from misleading information, inhumane treatment, and discrimination. The National Social Security System (SJSN), the Social Security Administration Agency (BPJS) Law, and the Presidential Regulation on Health Insurance ensure access and financing, while the Health Facility Regulation emphasizes strengthening networks and equalizing services. Based on this construct, healthcare facilities must prioritize palliative care as a core service in terminal care through clinical policies, referral systems, availability of human resources and medicines, communication mechanisms, and continuous quality audits.

Health Facility Accountability Standards for the Quality of Palliative Care Services for Terminal Patients

Healthcare facilities' accountability for the quality of palliative care for terminal patients needs to be regulated as a testable standard, both through administrative oversight mechanisms and dispute resolution. Law No. 17 of 2023 on Health provides direction that healthcare services should be oriented towards the degree of health and quality of life of patients, including in the terminal phase when curative goals are no longer dominant. From a legal perspective, this change in orientation affects the measure of "quality" as an institutional obligation. Quality cannot be narrowed down to successful healing, but must be manifested in patient safety, honest communication, symptom control, and respect for dignity. This view of quality is in line with the comprehensive need for legal protection for patients against all forms of negligence by medical personnel, which includes systemic and procedural failures within institutions (Lethy et al., 2023). The 2023 Health Law also emphasizes the obligation of healthcare providers to implement good service and governance standards, so that systemic errors, such as the absence of consent procedures or a shortage of essential analgesic drugs, can be assessed as institutional failures. Therefore, accountability does not stop at the actions of individual medical personnel. Facilities are required to demonstrate internal policies, training, quality audits, and mechanisms for following up on adverse events. In palliative care, these mechanisms must be able to trace three critical points: medical consent, medical records, and pain management (Sidi, 2024).

The first accountability standard concerns medical consent, which is stipulated by the 2023 Health Law as a prerequisite for the legitimacy of medical procedures through the principle of informed consent. The institution's obligations in this area go beyond the provision of forms. Facilities must establish a process for providing complete, honest, clear, and understandable information to patients or their families, especially when treatment options shift to supportive and palliative care. To meet quality standards, facilities must ensure that the information covers the purpose of treatment, realistic benefits, relevant risks, alternative actions including comfort-focused options, and the consequences of not taking action. The extent of responsibility can be seen from the existence of standard operating procedures, clinical communication training, and mechanisms for verifying patient understanding, for example through brief notes of the discussion. Consent that is merely signed without substantive discussion will be weak in terms of evidence and may be considered a violation of standards. In terminal patients, the issue of decision-making capacity often arises, so facilities need procedures for assessing capacity, determining guardians or authorized family members, and handling family conflicts. These processes are fundamental to the protection of patient rights, which must be analyzed from the integrated perspective of both law and medical ethics (Herisasono et al., 2023). Failure to manage this process can result in civil liability for actions without valid consent, as well as administrative sanctions for violations of service governance (Sumali et al., 2024).

The obligation to obtain consent must also be aligned with Law No. 39 of 1999 on Human Rights, which guarantees respect for human dignity and the right to health care. In palliative care, dignity is reflected in the recognition of the patient's wishes, including the right to accept or refuse treatment after receiving adequate information. Human rights require healthcare facilities to treat patients as autonomous subjects, not objects of clinical treatment or objects of their families' wishes. The normative consequence is that informed consent must be established as a process that respects the patient's choices, values, and preferences, as long as those choices do not conflict with the law and professional standards. Facilities must avoid covert coercion, such as scaring families into agreeing to aggressive interventions, or conversely pressuring families to accept restrictions on treatment without explanation. Human rights law also demands non-discrimination, so that terminal patients are entitled to equal explanations, access to adequate analgesia, and respectful treatment. If negligence causes preventable severe suffering, human rights issues can strengthen the argument that the quality of service has been seriously violated (Rindianti & Nugraheni, 2023). This underscores the broader challenge of national health development in Indonesia, where legal perspectives must continuously adapt to safeguard service access and uphold dignity amidst complex health challenges (Harianto et al., 2024). Facilities that meet accountability standards must therefore demonstrate that they have end-of-life communication guidelines, privacy policies, and secure complaint channels for patients and families to raise concerns without fear of reprisal.

The second accountability standard concerns medical record documentation as a pillar of accountability. Law Number 17 of 2023 concerning Health emphasizes the obligation of service providers to manage medical records correctly, completely, accurately, and accountably. In palliative care, medical records must include an assessment of symptoms, functional status, care plans, agreed treatment goals, consent for treatment, and evaluation of pain control responses. Without proper documentation, it is difficult for facilities to prove that actions have been taken in accordance with standards, to ensure continuity of service between units, and to conduct quality audits. Medical records also serve as a means of risk prevention, for example, preventing the repetition of unnecessary actions, preventing the administration of drugs that are contraindicated for the patient's condition, and preventing conflicts due to the next shift team not being aware of the treatment plan. Quality standards in medical records mean that there is a guided recording format, internal validation, and a deadline for completion that must be adhered to. In the event of a dispute, incomplete medical records are often considered detrimental to the facility because they obscure the clinical facts. Institutional accountability in this area is active, namely building systems, monitoring compliance, and following up on documentation audit findings.

The strengthening of the evidentiary value of medical records is clearly evident in Law No. 44 of 2009 concerning Hospitals, particularly Article 46, which stipulates that medical records are documents that must be created and maintained by hospitals and are legally significant. This norm transforms documentation from a mere clinical practice into a legal obligation inherent to the institution. In palliative care, Article 46 requires hospitals to manage medical records in a way that maintains integrity, confidentiality, and traceability, including who wrote them, when they were written, and the clinical basis for the decisions made. Accountability standards can be measured through the existence of a medical records unit, retention policies, valid record correction mechanisms, and access arrangements for patients in accordance with regulations. Hospitals are also obliged to ensure that important records, such as consent for procedures and end-of-life care decisions, are documented. If a patient suffers harm due to miscommunication between teams because of unclear records, the hospital may be held liable for system failure. Article 46 requires collective compliance, so that repeated documentation violations may indicate quality management issues that could trigger coaching, administrative sanctions, or consequences for accreditation status.

This documentation requirement must be implemented with technical references, so that Minister of Health Regulation No. 269 of 2008 concerning Medical Records becomes a concrete procedural standard reference. This Minister of Health Regulation regulates the minimum content, procedures for filling out, storage, confidentiality, and utilization of medical records. For palliative care services, the minimum content must be interpreted functionally, i.e., sufficient to demonstrate the assessment of palliative needs, justification for therapy, and the communication process. Minister of Health Regulation 269/2008 also requires the accuracy of patient identity and recorder authentication, so facilities are required to manage a system of valid signatures, stamps, or electronic authentication. Confidentiality regulations have real consequences for terminal patients, who are often surrounded by family and relatives. Facilities must establish policies for providing information and accessing medical records that prevent data leaks but still allow authorized family members to obtain the information needed to make care decisions. In quality inspections, this Ministerial Regulation allows auditors to assess compliance based on documents, such as the completeness of pain assessments, medication education records, and periodic evaluations. If facilities do not organize procedures in accordance with the Ministerial Regulation, administrative accountability becomes easier to enforce because the extent of violations is clear and measurable. The third accountability standard concerns pain management, which is a key indicator of palliative care quality because it is directly related to patient suffering. The 2023 Health Law mandates patient-centered care, requiring facilities to ensure effective and humane pain management. From a quality perspective, pain management is not merely about administering medication, but rather involves a standardized pain assessment system, setting pain targets, titrating therapy, monitoring side effects, and educating patients and their families. Failure to assess pain or delaying therapy without valid clinical reasons can be considered negligence. In terminal care, pain is often complex and influenced by physical and psychological factors, so healthcare facilities are responsible for providing internal referral mechanisms, such as pain anesthesia consultation, palliative care, or psychiatry when needed (Caraceni et al., 2012). Institutional accountability also includes the availability of essential analgesic drugs and the stability of the pharmaceutical supply chain as part of service quality assurance.

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et al., 2012). Institutional accountability also includes the availability of essential analgesic drugs and the stability of the pharmaceutical supply chain as part of service quality assurance.

Pain management is often associated with the use of opioids, so it must be analyzed in conjunction with Law No. 35 of 2009 on Narcotics. The Narcotics Law regulates the procurement, storage, distribution, and use of narcotics for health care purposes, while emphasizing supervision to prevent abuse. For healthcare facilities, the standard of accountability here is a balance: ensuring access to opioids for patients with valid medical indications, and ensuring compliance with safety procedures. Facilities must have a pharmacy policy regarding storage in locked cabinets, recording of entries and exits, stock reconciliation, and reporting in accordance with regulations. If the procedures are too strict to the point of preventing patients from obtaining analgesia, the facility may be criticized for failing to meet its service quality obligations. The procedures are lax and loss or misuse occurs, the facility may face legal and administrative consequences. The quality of pain management in palliative care must therefore include both access and safety indicators, such as the response time for administering analgesics for severe pain, the availability of opioids in accordance with the formulary, and the orderliness of dispensing records. The Narcotics Law provides the basis that "fear of the law" should not be used as a reason to allow patients to suffer, as legitimate medical use is protected as long as the procedures are followed.

Palliative care accountability also gains dimension from Law No. 8 of 1999 on Consumer Protection, as patients as service recipients have the right to accurate, clear, and honest information, as well as the right to safe and quality services. The principles of consumer protection in healthcare are critical, especially regarding how medical advertising is regulated to ensure truthful information and protect patients from misleading claims (Sahidu et al., 2023). In palliative care, consumer rights require facilities to transparently explain what can be achieved by therapy, the limitations of treatment, the possible side effects of medication, and relevant cost estimates. Violations may arise if facilities make unrealistic promises, conceal the risks of sedation, or allow families to purchase medication themselves without explaining the available alternatives. The Consumer Protection Law also reinforces the obligation to have a complaint mechanism, as consumers have the right to submit complaints and obtain resolution. Institutional accountability standards at this point include complaint handling procedures, complaint recording, and system improvements based on complaint trends, such as complaints of unaddressed pain or complaints of inconsistent doctor communication. In civil disputes, consumer norms can be used to assess whether the services provided meet the promised standards or reasonable expectations. Facilities that wish to meet palliative quality standards must manage public information, informed consent, patient education, and cost transparency as part of quality management, not as an administrative burden.

In the realm of ethics and professional discipline, the Indonesian Medical Code of Ethics serves as the standard of conduct for doctors, while healthcare facilities are obliged to create an environment that enables compliance with these ethical standards. The code of ethics demands respect for patient dignity, confidentiality, and the provision of assistance according to medical needs. In terminal care, ethical obligations mean that doctors must strive to reduce suffering, explain treatment options honestly, and avoid medical interventions that are disproportionate to the clinical benefits that patients may obtain (Emanuel et al., 2016). Institutional accountability arises when healthcare facilities establish policies that encourage practices that conflict with ethical principles, such as financial targets that trigger invasive procedures without meaningful benefits or restrictions on analgesics without a clinically justifiable basis (Truog et al., 2015). When an ethical violation is suspected, the investigation process often assesses whether the facility has an ethics committee or clinical forum that serves as a means of consultation in dealing with difficult cases in end-of-life care (Slowther et al., 2012). Good palliative care quality standards require the availability of ethical consultation channels, palliative sedation guidelines, end-of-life communication guidelines, and psychological support for healthcare workers so that clinical decisions are not made hastily or individualistically (Rietjens et al., 2013). The code of ethics also interacts closely with documentation requirements, as the ethical decision-making process must be clearly traceable through medical records. Accountability for the quality of palliative care encompasses moral and professional dimensions that can lead to professional organization reviews and affect the reputation of healthcare institutions (Bernat, 2013).

The link between professional disciplinary sanctions for violations of ethical standards and service standards is confirmed by Law No. 29 of 2004 on Medical Practice. This law regulates the obligation of doctors to practice in accordance with professional standards and standard operating procedures, and provides a channel for professional discipline enforcement through mechanisms recognized within the system. In palliative care, professional discipline can be tested in sensitive actions such as the administration of palliative sedation, opioid titration, decisions to limit treatment, and prognosis communication. For health facilities, the Medical Practice Law requires the development and supervision of practices through clinical credentials, clinical authority, and performance assessments. This means that institutional accountability can arise from a failure to ensure that doctors treating terminal patients have the appropriate authority and competence. Facilities must also manage the supervision of junior doctors and residents so that palliative decisions are not made without supervision. The Medical Practice Act also encourages administrative order, including the use of medical records and proper consent for procedures, which then become indicators of quality. If there is an incident of unmanaged pain or a procedure performed without proper consent, liability can fall on three levels simultaneously: professional discipline, licensing administration, and civil liability through a claim for damages.

Palliative care quality standards will be fragile if financing is not well organized, so Law No. 40 of 2004 on the National Social Security System and Law No. 24 of 2011 on BPJS must be placed as part of institutional quality measures. The SJSN establishes health insurance as social protection, while the BPJS Law forms program administrators that bind facilities through cooperation patterns, referral systems, and payment management. For terminal patients, financing often becomes a barrier to accessing analgesics, certain medical devices, or control visits, so service quality must include the facility's ability to connect patients with legitimate, transparent, and accountable insurance schemes. Institutional accountability arises when facilities fail to manage administration, resulting in patients not receiving the benefits they are entitled to, or when facilities impose costs beyond the provisions without explanation. Navigating these financing and administrative frameworks is a complex challenge that becomes even more intricate for multinational corporate health services, which must reconcile their operations with specific local legal obligations (Waluyo et al., 2024). Testable quality standards include compliance with referral procedures, clarity of cost information, accuracy of diagnosis coding, and recording of actions in accordance with the services provided. These indicators are widely used in health service quality assessments because they are directly related to patient safety and service system accountability (Berwick, Nolan, & Whittington, 2008; Jha et al., 2010). Financial management is also closely related to medical records, as the claims process and cost control require accurate and consistent documentary evidence. A lack of synchronization between clinical and administrative practices has the potential to lead to claim rejections, service delays, and waste of resources (Porter, 2010). Health facilities that meet accountability standards will therefore view the integration of clinical and administrative processes as a single system, so that terminal patients are not caught up in bureaucratic obstacles that exacerbate their suffering and reduce the quality of care (Berwick, 2011).

Finally, palliative care quality accountability has a regulatory oversight dimension that leads to administrative sanctions, guidance, and continuous evaluation. The 2023 Health Law mandates the government to set service standards and conduct oversight, while the accreditation instrument implemented through the Hospital Accreditation Commission serves as a mechanism for assessing compliance with quality standards, patient safety, and clinical governance. Although KARS is not a law, accreditation serves as a relevant systemic compliance measurement tool for institutional accountability, as accreditation survey findings often intersect with three critical areas of palliative care: the informed consent process, documentation completeness, and pain management. Under the Ministry of Health's oversight scheme, facilities that do not meet standards may be subject to warnings, guidance, administrative fines, service restrictions, and even revocation of licenses in accordance with health sector licensing regulations. Effective accountability standards require facilities to develop palliative care quality indicators, conduct internal audits, develop improvement plans, and evaluate the results. During the dispute resolution stage, audit records, staff training, clinical policies, and evidence of procedural compliance serve as proof that the facility has exercised due diligence. With this set of standards in place, the quality of palliative care can be objectively assessed through procedural records and relevant outcomes, ensuring that terminally ill patients receive humane care until the end of their lives.

CONCLUSIONS

The obligation of health facilities to provide palliative care for terminal patients is based on the right to health and reinforced by the health law regime, hospitals, health workers, medical practices, and technical regulations on palliative care. Institutional accountability standards for the quality of these services can be tested primarily through three main points, namely substantive approval of medical actions, the implementation of complete and orderly medical records as legal documents, and safe pain management with the availability of analgesic therapy in accordance with regulations, including the management of opioids under narcotics regulations. With this set of norms, the quality of palliative care services becomes an obligation that requires governance, procedures, and documentary evidence that can be examined by supervisors and dispute resolution forums.

The measure of accountability of health facilities for end-of-life services has shifted from assessing clinical outcomes alone to assessing procedural compliance and traceable patient safety. Adequate informed consent serves as evidence of respect for patient autonomy and control of dispute risks. Medical records are central to proving assessments, care plans, communication, and pain monitoring, so weaknesses in documentation will weaken the institution's position when tested. Poor pain management can be assessed as a failure in service quality, while disorderly opioid management poses legal risks and hinders access to therapy. The practical implication is the need for consistent internal audits and targeted training of health workers so that compliance does not depend on individual habits.

Healthcare facilities need to establish palliative care policies and SOPs that cover the identification of terminal patients, the formulation of treatment goals, the procedure for obtaining consent for treatment, and discharge and referral plans. Consent forms must be accompanied by clinical conversation notes that show the explanation material and verification of understanding. Medical records need to use a structured format for pain assessment, symptom evaluation, therapy plans, follow-ups, and clinical summaries between units to maintain service continuity. For pain management, facilities must organize an analgesic formulary, training in titration and monitoring, and an opioid safety and recording system in accordance with regulations. In terms of governance, managers need to conduct periodic quality audits, complaint mechanisms, and findings-based improvements to maintain and account for service standards.

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