Journal of Mathematics Instruction, Social Research and Opinion
Vol. 5, No. 3, September 2026, pp. 2111 – 2126, https://doi.org/10.58421/misro.v5i3.1507
ISSN 2962-7842

Legal Protection for Doctors Performing Pregnancy Termination in Anencephaly Cases under Law Number 17 of 2023 on Health

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Article Info

Article history:

Received 2026-04-28
Revised 2026-07-20
Accepted 2026-07-20

Keywords:

Anencephaly
Criminal Code
Healthcare Professionals
Legal Protection
Pregnancy Termination

ABSTRACT

Legal protection for healthcare professionals remains a significant issue in Indonesia, particularly regarding pregnancy termination in cases of anencephalic fetuses. Although Indonesian law permits abortion on limited grounds, including medical emergencies and pregnancies resulting from rape or other sexual violence, legal uncertainty persists when anencephaly is diagnosed after 14 weeks of gestation. This study analyzes the legal regulation of pregnancy termination in such cases and examines the legal protection available to doctors performing these procedures. Using juridical-normative and empirical-juridical approaches with a descriptive-analytical method, the study combines legal analysis with empirical data collected from 34 informants and respondents, including obstetricians, police officers, healthcare professionals, academics, religious leaders, hospital management, and legal practitioners. The findings indicate that the absence of clear operational regulations for late-detected anencephaly creates uncertainty and increases the risk of criminalization, even when procedures are performed in accordance with medical indications, informed consent, professional standards, and accredited healthcare facilities. Respondents emphasized the need for clearer procedural guidelines, stronger legal guarantees, professional protocols, and coordinated medicolegal mechanisms. The study concludes that pregnancy termination in cases of late-detected anencephaly should not automatically be treated as a criminal act when conducted by competent medical personnel in accordance with medical, ethical, and legal standards. It proposes a lex specialis-based legal protection model to strengthen legal certainty and support future health law reform in Indonesia.

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1. INTRODUCTION

Pregnancy termination remains a sensitive and complex issue in Indonesian health law because it is positioned between criminal prohibition, reproductive health protection,

medical ethics, religious values, and human rights. In Indonesian positive law, abortion is generally prohibited and may give rise to criminal liability. Article 463 of Law Number 1 of 2023 on the Criminal Code criminalizes abortion, but it also recognizes exceptions for pregnancy caused by rape or other sexual violence and for cases involving medical emergency indications [1]. This construction shows that Indonesian law does not place pregnancy termination as an ordinary medical procedure, but as an exceptional act that is only justified under limited legal grounds.

The exception to the prohibition of pregnancy termination is further regulated under Law Number 17 of 2023 on Health. Article 60 of the Health Law provides that abortion may only be performed based on criteria permitted under the Criminal Code, by competent and authorized medical personnel, assisted by authorized health workers, conducted in qualified healthcare facilities, and based on the consent of the pregnant woman [2]. The same law also protects medical personnel and health workers through Article 429, which states that medical personnel or health workers who perform abortion due to medical emergency indications or pregnancy resulting from rape or other sexual violence shall not be punished as long as the procedure is carried out in accordance with Article 60 [3]. Therefore, the Health Law serves as a special regulatory framework that links criminal-law exceptions to medical-service requirements.

The 14-week limitation discussed in this article must be clarified within the above legal framework. The 14-week limit does not originate from the authors' interpretation and is not an independent general limit expressly created by Law Number 17 of 2023 on Health for every medical-emergency case. The phrase appears in Article 463 paragraph (2) of Law Number 1 of 2023 on the Criminal Code, particularly in relation to pregnancy caused by rape or other sexual violence [4]. The legal problem arises when this limitation is read together with provisions on medical emergency indications, because late-detected fetal anomalies such as anencephaly may be diagnosed after the 14-week threshold.

Government Regulation Number 28 of 2024, as the implementing regulation of Law Number 17 of 2023 on Health, provides further procedural regulation concerning abortion in cases of medical emergency indications and pregnancy resulting from sexual violence. The regulation recognizes medical emergency indications and requires procedural safeguards, including assessment by competent medical professionals, procedures carried out in healthcare facilities, written recommendation mechanisms, and consent requirements [5]. However, the existing regulatory framework still requires clearer operational norms for cases involving fetal abnormalities incompatible with life when such abnormalities are detected beyond the early gestational period.

The specific medical condition examined in this article is anencephaly. Anencephaly is a severe congenital anomaly caused by failure of closure of the cranial neural tube during early embryonic development. This condition results in the absence of major parts of the brain, skull, and scalp, making the fetus medically non-viable outside the uterus. In many cases, anencephaly leads to miscarriage, stillbirth, or neonatal death shortly after birth [6]. This condition, therefore, creates a serious medical and ethical dilemma because the fetus has no realistic chance of survival, while the pregnant woman may face physical and psychological risks if the pregnancy is continued.

Anencephaly is also relevant to maternal Health because obstetric complications may accompany it. Pregnancy with an anencephalic fetus may increase the risk of polyhydramnios, obstructed labor, cesarean delivery, shoulder dystocia, and antepartum or postpartum bleeding [7]. These risks show that the issue of pregnancy termination in anencephaly cases cannot be reduced merely to the status of the fetus. It must also be examined in the context of maternal safety, medical responsibility, and legal protection for doctors who provide care in exceptional clinical circumstances.

A central difficulty is that anencephaly may not always be diagnosed within the early gestational period. Although some severe fetal abnormalities can be suspected earlier, structural fetal assessment is commonly conducted through ultrasound examination at approximately 18 to 20 weeks of gestation [8]. This medical reality creates tension with the legal discourse surrounding the 14-week threshold. When anencephaly is detected after 14 weeks, doctors may hesitate to recommend or perform pregnancy termination even when medical indications exist, because the legal basis for protection is not sufficiently operational.

This uncertainty directly affects doctors. On the one hand, doctors have professional obligations to provide medical care in accordance with competence, clinical standards, informed consent, patient safety, and the pregnant woman's best interests. On the other hand, abortion remains a criminally sensitive act under Indonesian law. Legal uncertainty may expose doctors to the risk of criminalization, administrative sanction, professional dispute, or social stigma, even when the procedure is medically justified [9]. Therefore, the main issue is not only whether pregnancy termination is prohibited or permitted, but whether the law provides a clear and predictable protection mechanism for doctors acting in accordance with medical indications and professional standards.

Previous studies have discussed pregnancy termination from several perspectives. Sari examined the implementation of pregnancy termination procedures in hospital practice, particularly in relation to medical procedures, counseling, and healthcare service readiness [10]. This study is relevant because it shows that pregnancy termination is not merely a legal issue, but also depends on institutional readiness and service procedures in healthcare facilities.

Other studies have addressed the ethical and legal dilemmas surrounding pregnancy termination in public health services and hospitals. Herman and Wahyuni emphasized that pregnancy termination involves conflict between legal norms, ethical principles, and healthcare responsibilities [11]. However, their discussion remains general and does not specifically examine the legal protection of doctors in cases involving fetal anomalies such as anencephaly.

International literature has also shown that vague abortion laws may discourage healthcare providers from providing medically necessary services. Zampas and Gher argue that unclear legal restrictions can affect access to safe abortion services and may increase the vulnerability of healthcare providers where criminal sanctions remain possible [12]. This finding is significant for the Indonesian context because criminal-law uncertainty may similarly influence doctors' willingness to act in cases that are medically justified.

In the Indonesian context, Rahmawati and Budiman have mapped the legal framework concerning pregnancy termination and emphasized the importance of safe abortion regulation within the limits of Indonesian law [13]. Their work is important because it explains how criminal law and health law interact in regulating abortion. However, the specific issue of late-detected anencephaly and the protection of doctors who perform pregnancy termination after 14 weeks remains insufficiently explored.

Based on the previous studies, the research gap lies in the limited discussion of doctor protection in cases where anencephaly is diagnosed after 14 weeks of gestation. Most existing studies discuss abortion regulation generally, medical emergency indications broadly, or ethical debates surrounding pregnancy termination. They have not sufficiently connected the medical diagnosis of anencephaly, the legal category of medical emergency, professional medical standards, informed consent, and criminal-law protection under Indonesian health legislation.

The novelty of this study lies in its focused legal analysis of doctor protection in cases of late-detected anencephaly, combining normative legal analysis with empirical findings from medical and legal stakeholders. Unlike previous studies that discuss abortion in general, this article specifically examines how Law Number 1 of 2023 on the Criminal Code, Law Number 17 of 2023 on Health, and Government Regulation Number 28 of 2024 should be harmonized to protect doctors who act in accordance with medical indications, professional standards, and patient consent.

This study aims to analyze the legal regulation of pregnancy termination in cases involving anencephalic fetuses and to examine the legal protection afforded to doctors who perform such procedures after 14 weeks of gestation. This study also seeks to identify practical obstacles faced by doctors and to formulate a protection model that harmonizes criminal law, health law, medical ethics, and hospital governance.

Based on these objectives, this article addresses three research questions. First, how does Indonesian law regulate pregnancy termination in cases of medical emergency involving anencephalic fetuses? Second, how is legal protection provided to doctors who perform pregnancy termination in anencephaly cases diagnosed after 14 weeks of gestation? Third, what legal and institutional safeguards are needed to prevent the criminalization of doctors who act in accordance with medical indications, informed consent, and professional standards?

This article contributes to Indonesian health law by proposing a lex specialis-based protection model for doctors handling late-detected lethal fetal anomaly cases. The model emphasizes written recommendations from a medical assessment team, hospital ethics committee involvement, complete medical documentation, informed consent, psychological counseling, referral to qualified facilities, and legal consultation before the procedure. This contribution is expected to strengthen legal certainty for doctors, support regulatory reform on pregnancy termination for medical emergency indications, and improve access to safe and accountable maternal healthcare in exceptional medical cases.

2. METHOD

This study employed a qualitative legal research design that combined normative and empirical juridical approaches. The normative juridical approach was used to examine statutory norms, legal principles, and the relationship between criminal law and health law in regulating pregnancy termination for medical emergency indications. The empirical juridical approach was used to explore how these legal norms are understood and applied by medical, legal, law enforcement, religious, and hospital stakeholders in practice [14]. This combination was selected because the research problem concerns not only the interpretation of written legal norms, but also the practical uncertainty faced by doctors when dealing with anencephaly cases diagnosed after 14 weeks of gestation.

The research used a descriptive-analytical method. The descriptive element was applied to describe the legal framework governing pregnancy termination in Indonesia, while the analytical element was used to examine whether the current legal framework provides adequate protection for doctors performing pregnancy termination in anencephaly cases. Normative legal analysis focused on interpreting statutes, while empirical analysis focused on identifying the practical gap between legal provisions and medical decision-making [15].

The research was conducted in Indonesia during the 2025 research period. The empirical component involved informants and respondents connected to healthcare institutions, law enforcement institutions, academic environments, religious institutions, and hospital governance structures. The law enforcement informants included police and medicolegal police personnel, including officers connected with Biddokkes Polda Sumbar and AKP-level police informants. These institutional backgrounds were relevant because the study examines pregnancy termination not only as a medical procedure, but also as a legally sensitive act that may involve criminal-law interpretation, medicolegal coordination, and institutional decision-making.

The study involved 34 informants/respondents. They consisted of six obstetrician-gynecologists, three police or medicolegal informants, and twenty-five other stakeholders. The other stakeholders included doctors from other specialties, midwives, legal and medical academics, religious figures, hospital management, medical committee members, a legal practitioner, and other relevant health-sector respondents. The obstetrics and gynecology specialists were selected because they possess clinical competence in pregnancy care, fetal anomaly diagnosis, obstetric decision-making, and medical considerations in anencephaly cases. The police and medicolegal police informants were selected because they have institutional relevance to criminal-law enforcement, medicolegal assessment, and coordination between health facilities and law enforcement authorities. The remaining stakeholders were selected because they represent legal, ethical, religious, institutional, and healthcare perspectives needed to understand the practical obstacles and safeguards in pregnancy termination cases.

The sampling technique used in this study was purposive sampling. Informants were not selected randomly but rather based on professional competence, institutional role, experience, knowledge related to pregnancy termination, relevance to health law or criminal law, and involvement in medical, legal, religious, or hospital governance issues. This

technique was appropriate because the study required information from specific actors who could explain the relationship between written legal norms and practical medical decision-making [16].

The data sources consisted of primary legal materials, secondary legal materials, and empirical data. Primary legal materials included Law Number 1 of 2023 on the Criminal Code, particularly provisions concerning abortion and its exceptions [17]. Primary legal materials also included Law Number 17 of 2023 on Health, particularly provisions concerning abortion, medical emergency indications, healthcare service requirements, and criminal immunity for medical personnel and health workers acting under lawful conditions [18]. Government Regulation Number 28 of 2024 was used as an implementing regulation that further governs abortion in cases of medical emergency indications and pregnancy resulting from sexual violence [19]. Minister of Health Regulation Number 2 of 2025 was also used because it regulates the implementation of reproductive health efforts, including abortion services based on medical emergency indications or pregnancy caused by rape or other sexual violence [20].

Secondary legal materials included legal textbooks, journal articles, official reports, academic writings, and prior studies on pregnancy termination, medical emergency indications, health law, criminal law, medical ethics, and legal protections for doctors. These materials were selected based on their relevance to the research questions, the credibility of the publisher or journal, the availability of a DOI or official link for journal articles, and their connection to Indonesian health law or comparative legal analysis. Secondary legal materials were used to explain legal concepts, support statutory interpretation, and identify gaps in previous research.

Empirical data consisted of interview and questionnaire responses from the 34 informants/respondents. These empirical data were used to understand how doctors, police, or medicolegal police informants, and other stakeholders perceive the clarity of legal norms, the risk of criminalization, the adequacy of legal protection, and the institutional safeguards needed in anencephaly cases. Therefore, the empirical data in this study did not replace normative legal interpretation but rather supported the analysis of how legal norms operate in medical and institutional practice.

Data were collected through literature study, structured interviews, and questionnaires. The literature study identified and examined legislation, implementing regulations, legal doctrines, journal articles, books, and official documents relevant to pregnancy termination and legal protection for doctors. Interviews and questionnaires were used to collect empirical data concerning respondents' knowledge, experiences, and views on abortion legality, anencephaly as a medical emergency, fear of criminalization, institutional procedures, and recommendations for strengthening legal safeguards [21].

The research instruments consisted of legal material review guidelines, interview guidelines, and questionnaire forms. The legal-material review guidelines were used to classify legal provisions according to legal hierarchy, subject matter, and relevance to the research questions. The interview guidelines and questionnaires contained questions on professional background, knowledge of abortion regulation, experience or knowledge concerning anencephaly or medical abortion cases, perception of legal protection, perceived

legal risks, institutional challenges, and recommendations for strengthening legal safeguards for doctors.

This study did not use quantitative variables because it was designed as qualitative normative-empirical legal research. Instead, the study used analytical dimensions, namely legal prohibition and exceptions for pregnancy termination, medical emergency indications, anencephaly as a non-viable fetal condition, gestational-age uncertainty after 14 weeks, doctors' legal protection, fear of criminalization, informed consent, institutional procedure, and regulatory harmonization. These dimensions were used to organize both normative legal analysis and empirical findings.

Normative legal materials were analyzed through statute interpretation, systematic interpretation, and legal-conceptual analysis. Statute interpretation was used to examine the wording of provisions in the Criminal Code, the Health Law, Government Regulation Number 28 of 2024, and Minister of Health Regulation Number 2 of 2025. Systematic interpretation was applied to understand the relationship between general criminal-law prohibitions and specific health-law exceptions. Legal-conceptual analysis was used to examine the concepts of medical emergency, legal protection, criminal immunity, informed consent, professional standards, and the principle of lex specialis derogat legi generali [22].

Interview and questionnaire data were analyzed using qualitative thematic analysis. The analysis began by reading and organizing the responses, identifying relevant statements, coding recurring ideas, grouping codes into themes, reviewing the themes in relation to the research questions, and interpreting the themes alongside the applicable legal framework. The main themes identified from empirical data included uncertainty of legal norms, fear of criminalization, the need for clear standard operating procedures, the importance of informed consent and medical documentation, the need for medical assessment teams, medicolegal coordination, and stronger government guarantees for doctors [23].

Trustworthiness was strengthened through source triangulation and methodological triangulation. Source triangulation was conducted by comparing responses from obstetrician-gynecologists, police or medicolegal police informants, and other stakeholders. Methodological triangulation was conducted by comparing empirical findings with statutory provisions, legal doctrines, and academic literature. Dependability was maintained through a consistent coding process, while confirmability was ensured by maintaining a connection between the interpretation of empirical findings, respondents' answers, and relevant legal materials [24].

Ethical considerations were applied throughout the empirical data collection process. Participation was voluntary, and respondents were informed that their responses would be used for academic research purposes. Consent was obtained through the respondents' willingness to participate in interviews or to complete the questionnaire. Confidentiality was maintained by anonymizing respondents in the analysis and avoiding unnecessary disclosure of personal identities, especially where responses concerned sensitive legal, medical, or institutional views. The study did not use patient-identifiable medical records and did not involve clinical intervention. Data were used only for academic purposes, and the analysis was conducted in a manner that respected professional confidentiality, institutional sensitivity, and the dignity of respondents.

The overall analytical process combined deductive and inductive reasoning. Deductive reasoning was used to interpret legal rules and derive the legal consequences of pregnancy termination under Indonesian law. Inductive reasoning was used to draw patterns from empirical responses regarding the practical concerns of doctors and other stakeholders. By combining these two forms of reasoning, this study sought to identify the gap between legal norms and medical realities and to formulate a legal protection model for doctors performing pregnancy termination in anencephaly cases diagnosed after 14 weeks of gestation.

3. RESULTS AND DISCUSSION

3.1. Results

3.1.1. Legal Framework for Pregnancy Termination in Indonesia

The first finding shows that Indonesian law still places abortion within a prohibitive framework, but it also recognizes limited exceptions. Law Number 1 of 2023 on the Criminal Code criminalizes abortion through Article 463. However, the same provision recognizes exceptions for pregnancy caused by rape or other sexual violence within the 14-week limitation and for pregnancy termination based on medical emergency indications [25]. This means that abortion is not treated as an ordinary medical act under Indonesian law, but as an exceptional act that may only be justified under strict legal grounds.

Law Number 17 of 2023 on Health serves as a special legal framework governing the lawful termination of pregnancy within the health sector. Article 60 requires that abortion be performed only by competent and authorized medical personnel, assisted by authorized health workers, conducted in qualified healthcare facilities, and based on the consent of the pregnant woman. Article 429 provides further protection by stating that medical personnel or health workers who perform abortion due to medical emergency indications or pregnancy resulting from rape or other sexual violence shall not be subject to criminal punishment when the procedure is carried out in accordance with Article 60 [26]. Therefore, criminal immunity under health law depends on two elements: the substantive existence of a lawful indication and procedural compliance with health-service requirements.

Government Regulation Number 28 of 2024 strengthens the Health Law by providing implementing rules for abortion in cases of medical emergency indications and pregnancy resulting from sexual violence. Articles 116 to 123 regulate the general prohibition, exceptions, medical assessment process, written recommendation, consent, and counseling requirements [27]. These provisions are important because they create a procedural bridge between criminal-law prohibition and medical-service implementation. However, the empirical findings show that doctors still need more detailed technical guidance specifically addressing late-detected lethal fetal anomalies such as anencephaly.

Minister of Health Regulation Number 2 of 2025 further regulates the implementation of reproductive health efforts, including technical arrangements for reproductive health services [28]. This regulation is relevant because lawful pregnancy termination cannot be separated from reproductive health services, referral mechanisms, facility readiness, and professional competence. In practical terms, the Criminal Code provides the general criminal prohibition and limited exceptions; the Health Law provides

the legal basis for health-sector implementation and criminal immunity; Government Regulation Number 28 of 2024 provides procedural safeguards; and ministerial regulations are needed to operationalize reproductive health services. For doctors, the implication is clear: legal protection does not arise merely because anencephaly exists, but only when the diagnosis, indication, consent, facility, competence, recommendation, counseling, and documentation are legally and medically fulfilled.

3.1.2. Anencephaly as a Medical Emergency and Non-Viable Fetal Condition

The second finding shows that anencephaly has strong relevance to the legal category of medical emergency because it is a lethal fetal anomaly. Anencephaly is a severe congenital anomaly caused by failure of the cranial neural tube to close, resulting in the absence of major parts of the brain and skull. Medical literature describes anencephaly as a lethal condition with no curative treatment and extremely poor fetal prognosis [29]. Indonesian medical literature also explains that anencephaly is a congenital anomaly of the central nervous system that disrupts the formation of the cerebral hemispheres, cerebellum, spinal cord, and other essential structures, so most affected fetuses cannot survive after birth [30].

The medical significance of anencephaly is not limited to fetal non-viability. It is also related to maternal health and safety. Pregnancy with an anencephalic fetus may be accompanied by obstetric complications, including polyhydramnios, obstructed labor, cesarean delivery, shoulder dystocia, antepartum bleeding, and postpartum bleeding. A study on anencephalic pregnancies beyond viability shows that prenatal diagnosis and counseling are essential because the condition affects both clinical management and parental decision-making [31]. Therefore, anencephaly may be legally relevant as a medical emergency when the diagnosis shows fetal non-viability and continuation of pregnancy creates physical or psychological risks for the pregnant woman.

The empirical findings support this medical classification. One obstetrics and gynecology specialist stated that the main medical consideration in anencephaly cases is “poor prognosis,” because the fetus has no realistic chance of survival. Another specialist explained that the decision should be based on “obstetric indication, namely the condition of the mother and fetus.” These statements show that pregnancy termination in anencephaly cases is not based on convenience or social preference, but on medical diagnosis, fetal prognosis, maternal risk, and professional clinical judgment.

The legal argument should therefore be constructed through a clear sequence. First, anencephaly must be confirmed through reliable medical diagnosis, especially ultrasonography and supporting medical assessment. Second, the diagnosis must be categorized as a fetal abnormality incompatible with life and, where maternal risk exists, as a medical emergency indication. Third, the procedure must be carried out in accordance with professional medical standards, hospital procedures, and ethical review. Fourth, the pregnant woman must receive adequate explanation, counseling, and informed consent. Fifth, criminal immunity under Article 429 of Law Number 17 of 2023 should apply when the procedure satisfies the requirements of Article 60 and the implementing regulation [32].

3.1.3. Legal Uncertainty Beyond 14 Weeks of Gestation

The third finding concerns the legal uncertainty surrounding the 14-week threshold. The 14-week limitation originates from Article 463 paragraph (2) of Law Number 1 of 2023 on the Criminal Code, particularly in relation to pregnancy caused by rape or other sexual violence [33]. It is not an independent general limit created by Law Number 17 of 2023 on Health for all medical emergency cases. However, in practice, doctors may still interpret this threshold cautiously when dealing with anencephaly cases diagnosed after 14 weeks of gestation.

This uncertainty becomes more serious because fetal anomalies may be detected after the first trimester. Some anencephaly cases may be suspected earlier, but diagnosis may be delayed depending on access to antenatal care, timing of ultrasound, facility readiness, and referral delays. In an Indonesian case report, an anencephalic fetus was diagnosed by ultrasound at 24 weeks of pregnancy [34]. This shows that medical reality does not always correspond with early gestational thresholds found in legal texts.

The problem is not merely the wording of the law, but the absence of operational certainty. Even when the law recognizes medical emergency indications, doctors still need clear confirmation that late-detected anencephaly falls within the protected exception. Without explicit operational norms, statutory protection may not be perceived as practical. This explains why several obstetricians and gynecologists in the empirical data stated that the existing regulation is “less clear” or “not clear at all.”

This issue also reflects a deeper conflict between the fetal right to life, maternal health rights, and doctors’ professional obligations. The fetal right to life is reflected in the criminal-law prohibition of abortion. Maternal health rights are reflected in the right to Health, bodily integrity, and access to safe medical services. Doctors’ professional obligations require them to act in accordance with medical standards, patient safety, informed consent, and professional ethics. In anencephaly cases, the fetus is medically non-viable, while the pregnant woman remains a living patient with physical, psychological, and legal interests. Therefore, the law should not treat all pregnancy terminations identically, but must distinguish unlawful abortion from medically justified termination in exceptional cases [35].

3.1.4. Doctors’ Practical Concerns and Fear of Criminalization

The fourth finding shows that doctors’ fear of criminalization remains a practical barrier. Among the six obstetrics and gynecology specialists, most stated that they did not feel legally safe or felt hesitant when making medical decisions in severe fetal anomaly cases. One obstetrics informant stated, “There is still fear if complications occur in the medical procedure, because it may lead to complaints from the patient, family, or legal counsel.” This quotation shows that doctors’ fear is not limited to prosecution by law enforcement, but also includes family complaints, medicolegal disputes, and professional accountability.

Another obstetrics informant stated that the government and professional organizations should issue “clear and non-multiple-interpretation implementing regulations” and prepare uniform professional standards and SOPs for obstetricians. This finding

indicates that doctors experience procedural uncertainty as legal uncertainty. Doctors do not only need a general statutory statement that abortion is permitted in medical emergency cases; they need concrete operational tools to prove that their action is medically, ethically, and legally justified.

The broader stakeholder responses show a similar pattern. Among the twenty-five broader respondents, the dominant perceived legal risks were criminal prosecution and ethical or professional disputes. Several respondents considered the current law inadequate to protect healthcare workers, while others were uncertain whether the existing rules were sufficient. The most frequently recommended form of protection was a stronger government guarantee, followed by written procedures, special certification, institutional approval, and protection from family complaints. These findings indicate that the central issue is the gap between formal legality and practical legal protection.

The police or medicolegal police informants provided a more procedurally oriented perspective. One informant stated that termination in anencephaly cases should not be treated as a criminal act when it is based on a valid medical indication because "anencephaly is a lethal case" and the fetus will not survive after birth. Another informant stated that "to make a criminal-law decision, it must be in accordance with the medical decision." This view supports a medicolegal model in which law enforcement should not assess medical abortion cases without a competent medical assessment.

Another police or medicolegal informant recommended strengthening SOPs, legal-medical forms, and a medicolegal coordination forum involving health offices, professional organizations, police, child and women protection units, prosecutors, and police doctors. This empirical evidence reinforces the argument that doctors' legal protection requires institutional coordination. Legal protection should not rely only on individual courage or personal interpretation of the law, but must be supported by structured medical, legal, and institutional mechanisms.

3.1.5. Need for SOPs, Referral Mechanisms, and Regulatory Harmonization

The fifth finding is that the current legal framework requires stronger operational safeguards. The normative framework already provides important elements, namely medical emergency exception, competent medical personnel, qualified healthcare facilities, written recommendation, consent, and counseling. However, these elements must be translated into hospital-level SOPs and referral mechanisms so that doctors can act consistently and safely in cases of late-detected anencephaly.

Practical safeguards should begin with a written recommendation from a medical assessment team. The assessment team should confirm the diagnosis of anencephaly, evaluate maternal risk, determine whether the case falls within the medical emergency indication, and provide written justification. The doctor who performs the procedure should not act alone. This separation between assessment and execution is important to reduce subjective decision-making and to show that the action is based on institutional medical judgment.

Hospital ethics committee approval should also be used in complex cases. The ethics committee can assess whether the proposed action satisfies the principles of medical ethics,

including patient autonomy, beneficence, non-maleficence, justice, and proportionality. This is especially important because anencephaly cases may involve conflict between fetal interests, maternal Health, family beliefs, religious views, and doctors' professional responsibility. The ethics committee does not replace legal requirements, but it strengthens the ethical and institutional legitimacy of the clinical decision.

Complete medical documentation is another essential safeguard. Medical records should include ultrasound findings, diagnosis, prognosis, maternal risk assessment, counseling notes, informed consent, medical assessment team recommendation, ethics committee note, referral record, and post-procedure care plan. Documentation is crucial because criminal immunity under health law can only function effectively if doctors can prove that all legal and medical requirements were met.

Informed consent must be understood as more than a signature. It requires disclosure of diagnosis, fetal prognosis, maternal risks, available options, risks of termination, risks of continuing pregnancy, psychological support, and the possibility of referral. Family counseling may be useful in cases involving cultural or religious considerations, but it must not erase the autonomy of the pregnant woman. The empirical data show that doctors often face family pressure and socio-cultural hesitation; therefore, informed consent should be supported by psychological counseling and, where needed, spiritual or religious counseling chosen by the patient.

Referral to certified or qualified facilities is also necessary. Not all healthcare facilities have the capacity to perform medically and legally sensitive pregnancy termination. Referral mechanisms should identify which facilities are authorized, which doctors are competent, what documents must accompany the referral, and how emergencies should be handled. Without referral clarity, patients may face delays, and doctors may avoid action due to legal uncertainty.

Regulatory harmonization is required at three levels. At the statutory level, the relationship between the Criminal Code, the Health Law, and Government Regulation Number 28 of 2024 must be interpreted consistently through the principle of lex specialis derogat legi generali. At the ministerial level, technical reproductive health regulations must provide operational clarity for medical emergency abortion, including late-detected lethal fetal anomalies. At the hospital level, SOPs must translate national regulations into concrete steps for diagnosis, assessment, consent, referral, documentation, and medicolegal consultation.

3.2. Discussion

Legal Meaning of the Findings

The main finding of this study is that Indonesian law has begun to provide a legal basis for pregnancy termination in exceptional cases, but the protection remains operationally incomplete for late-detected anencephaly. Formal protection is provided by Articles 60 and 429 of Law Number 17 of 2023, supported by Government Regulation Number 28 of 2024. However, empirical data show that doctors remain concerned about criminal prosecution, ethical complaints, family pressure, unclear SOPs, and lack of uniform guidance.

These findings support previous studies showing that unclear abortion regulation may affect healthcare providers' willingness to provide medically necessary services. In the Indonesian context, the problem is intensified by the interaction between criminal-law prohibition and health-law exception. When doctors are uncertain whether late-detected anencephaly is fully protected, they may delay or avoid intervention even when medical indications exist. This creates a risk that legal uncertainty may reduce access to safe and accountable maternal healthcare.

Theoretically, this study strengthens the concept of legal protection as both preventive and repressive protection. Preventive protection requires clear rules, SOPs, medical assessment, counseling, and referral pathways before a dispute occurs. Repressive protection requires immunity from criminal liability, professional defense mechanisms, and institutional support if a complaint arises after the procedure. In anencephaly cases, preventive protection is more important because doctors need legal certainty before acting, not merely legal defense after being reported.

The principle of lex specialis derogat legi generali provides the most appropriate legal construction. The Criminal Code is the general criminal-law framework, while the Health Law and its implementing regulations are special rules governing medical procedures in specific health circumstances. Therefore, when pregnancy termination is performed because of medically confirmed anencephaly, in a qualified facility, by competent medical personnel, with informed consent, proper counseling, written recommendation, and complete documentation, the health-law framework should operate as the controlling legal basis.

Implications for Policy and Hospital Governance

The policy implication of this study is that Indonesia needs more explicit technical regulation on pregnancy termination in late-detected lethal fetal anomaly cases. The regulation should clarify that anencephaly may fall within medical emergency indications when it is medically confirmed as a non-viable fetal condition and when continuation of pregnancy creates physical or psychological risk to the pregnant woman. The regulation should also clarify the position of the 14-week threshold so that it is not incorrectly applied to all medical emergency cases.

The hospital-governance implication is that hospitals should not leave doctors to make decisions individually in legally sensitive cases. Hospitals should establish a multidisciplinary pathway involving obstetrics and gynecology specialists, anesthesiologists when needed, hospital management, medical committees, ethics committees, psychologists or counselors, and legal units. This pathway should produce written recommendations and ensure that every decision is documented.

Hospitals should also develop medicolegal consultation mechanisms before the procedure. This mechanism may involve hospital legal units, medical committees, professional organizations, and, in highly sensitive cases, coordination with medicolegal police or relevant authorities. Such coordination should not be used to criminalize doctors, but to prevent misunderstanding and ensure that legal decision-making follows competent medical assessment.

Professional organizations should prepare clinical practice guidelines or national professional standards specifically addressing severe congenital anomalies incompatible with life. Such guidelines would help standardize diagnosis, counseling, informed consent, referral, and documentation. They would also reduce variation in practice and provide doctors with stronger professional justification.

The number and scope of informants/respondents limit this study. The empirical data represent selected professional, legal, religious, and institutional perspectives but do not represent all regions, hospitals, or law enforcement institutions in Indonesia. Future research should examine hospital-level implementation after Government Regulation Number 28 of 2024 and Minister of Health Regulation Number 2 of 2025, compare practices across provinces, and evaluate whether SOPs and referral mechanisms are effective in reducing doctors' fear of criminalization.

In summary, the findings show that pregnancy termination in anencephaly cases requires a legal model that connects medical diagnosis, medical emergency classification, professional standards, informed consent, written institutional recommendation, and criminal immunity under health law. Legal protection for doctors cannot rely only on broad statutory exceptions. It must be operationalized through clear SOPs, referral mechanisms, ethics committee involvement, complete documentation, psychological counseling, medicolegal coordination, and regulatory harmonization.

4. CONCLUSION

This study concludes that Indonesian law already recognizes pregnancy termination as an exception to the general prohibition of abortion, particularly in cases of medical emergency indications and pregnancy resulting from sexual violence. However, legal protection for doctors who perform pregnancy termination in anencephaly cases beyond 14 weeks of gestation remains operationally uncertain. This uncertainty arises because the 14-week limitation is rooted in the Criminal Code provision concerning pregnancy caused by rape or other sexual violence. At the same time, the Health Law and its implementing regulations do not yet provide sufficiently explicit technical rules for late-detected lethal fetal anomalies such as anencephaly. Therefore, pregnancy termination in anencephaly cases should not automatically be treated as a criminal act when the diagnosis confirms fetal non-viability, the condition falls within medical emergency indications, and the procedure is performed by competent medical personnel in accordance with professional standards, informed consent, proper documentation, and health-law requirements. Theoretically, this study contributes to Indonesian health law by strengthening the lex specialis-based construction that places health-law provisions as the primary legal basis for protecting doctors in medically justified exceptional cases.

The practical implication of this study is that doctors and hospitals require more than general statutory protection. Doctors need clear institutional safeguards before performing pregnancy termination in anencephaly cases, especially when the diagnosis is made after 14 weeks of gestation. Such safeguards include written recommendation from a medical assessment team, approval or review by the hospital ethics committee, complete medical documentation, informed consent from the pregnant woman, psychological counseling,

referral to qualified healthcare facilities, and legal consultation before the procedure. Hospitals should not leave doctors to make decisions on their own in legally sensitive cases. Instead, hospitals must establish multidisciplinary pathways involving obstetrics and gynecology specialists, medical committees, hospital management, ethics committees, counselors, and legal units. These mechanisms are necessary to reduce fear of criminalization, prevent medicolegal disputes, and ensure that maternal healthcare is delivered safely, ethically, and accountably.

The regulatory recommendation of this study is that the government should issue more specific technical regulations or guidelines governing pregnancy termination in cases of severe congenital anomalies incompatible with life, including anencephaly. These regulations should clarify the legal position of medical emergency indications after 14 weeks, standardize referral mechanisms, determine the required medical and legal documents, and provide explicit protection for doctors who comply with professional and statutory requirements. Professional organizations should also develop national clinical guidelines and standard operating procedures for diagnosis, counseling, consent, referral, documentation, and post-procedure care. This study is limited by its normative-empirical scope and the number of informants/respondents, so future research should examine the implementation of hospital SOPs, compare practices across regions, and analyze court or medicolegal cases involving pregnancy termination for lethal fetal anomalies. Overall, the principal contribution of this article is the formulation of a practical legal protection model that connects medical diagnosis, medical emergency classification, professional standards, informed consent, hospital governance, and criminal immunity under health law.

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