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Understanding without consent? medical explanation, patient autonomy, and the linguistic limits of informed consent in Indonesia

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ABSTRACT

Background: Informed consent in Indonesia is often treated as a legal and administrative requirement, yet patient autonomy remains ethically fragile when medical explanation is difficult to understand, insufficiently dialogic, or detached from health-literacy realities. **Objective:** This study examines how Indonesian consent-related discourse linguistically frames medical explanation, patient choice, refusal, clarification, relational support, and comprehension as conditions of meaningful autonomy. **Method:** This study applies qualitative discourse analysis to 25 coded units drawn from 20 publicly accessible legal, institutional, patient-education, and scholarly documents, using a plain-language comprehension audit, patient autonomy and agency framework, and interactional access lens. **Results:** Consent discourse strongly recognizes explanation, approval, and patient rights, but explicit risk elaboration, alternative explanation, and refusal space appear less consistently. Patient agency is more visible as rights vocabulary than as practical interactional design, especially because clarification prompts and understanding checks remain largely absent or unclear. Health literacy is relevant across all coded units, while language accommodation, relational mediation, and digital or AI-supported explanation remain unevenly embedded. **Implication:** These findings suggest that consent should be evaluated through comprehensibility, agency, and access, not merely procedural documentation. **Novelty:** This study offers an integrated medical-linguistic model for analyzing informed consent as a communicative threshold where legal validity, patient autonomy, and ethical understanding intersect.

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1. INTRODUCTION

Informed consent has become a decisive test of whether contemporary health care treats patients as legal subjects, communicative partners, or merely recipients of expert action. Globally, patient safety remains fragile: the World Health Organization [1] reports that around one in ten patients is harmed in health care, more than three million deaths occur annually from unsafe care, and more than half of such harm is preventable. In Indonesia, consent is not optional procedure; Article 293 of Law No. 17 of 2023 is cited by an official Ministry of Health source as requiring approval for individual health-service actions performed by medical and health personnel. Yet formal approval cannot by itself secure understanding. When technical explanation, institutional hierarchy, family mediation, and limited health literacy converge, patients may

sign, nod, or remain silent without practical comprehension of diagnosis, risk, alternatives, or refusal. This makes informed consent a linguistic problem as much as legal or ethical obligation.

Existing scholarship has clarified important parts of this problem without fully integrating them. Indonesian medical-linguistic studies have examined medical jargon and patient comprehension (Laila, 2026 [2]), directive speech acts in doctor–patient interaction (Nazulpa, 2026 [3]), multilingual barriers in clinics (Nurtyas, 2026 [4]), and emergency communication breakdowns where symptoms, language, and urgency intersect (Anandasari, 2026 [5]). Internationally, informed-consent research has shown persistent gaps between disclosure and comprehension (Pietrzykowski & Śmiłowska, 2021 [6]), links between health literacy and chronic-disease care in Indonesia (Malini et al., 2023 [7]), and comprehension risks in hospitals shaped by functional literacy limitations (Zhang et al., 2024 [8]). Ethical literature has also questioned whether consent alone adequately protects autonomy (Lewis, 2023 [9]; Ng, 2024 [10]). However, less attention has been given to how Indonesian public consent discourse linguistically constructs understanding, choice, refusal, institutional dependence, family mediation, and patient agency within the same analytical frame across legal, institutional, and educational texts, especially in multilingual Indonesian care settings.

This study addresses that gap by examining informed consent as a discourse-mediated process rather than a document-bound administrative act. It asks three related questions: how is medical explanation linguistically framed in Indonesian consent-related discourse; how are patient autonomy, refusal, and choice made visible or obscured; and what linguistic conditions make consent ethically fragile even when disclosure and approval are formally present? To answer these questions, this study analyzes publicly accessible Indonesian legal, institutional, patient-education, and scholarly materials through three complementary tools: a plain-language comprehension audit, a patient autonomy and agency framework, and an interactional access and relational autonomy lens. This design does not claim to measure actual patient understanding, professional intention, or clinical outcomes. Instead, it evaluates the textual and pragmatic conditions through which consent is made more or less intelligible, voluntary, contestable, and ethically defensible in Indonesia's medical-legal environment and public health communication for diverse patient populations.

This study advances the argument that informed consent in Indonesia should be evaluated not only by whether information is disclosed, but by whether language creates usable understanding and recognizable agency. Consent becomes ethically limited when explanation is dominated by technical terms, risk clauses are procedurally present but pragmatically opaque, and patient rights are acknowledged without clear linguistic space for questions, alternatives, second opinion, or refusal. Recent work on limited understanding in routine consent processes (Bär et al., 2025 [11]), accessible consent for people with intellectual disability (Dunn et al., 2023 [12]), and AI-supported consent as decision scaffolding rather than replacement for clinical dialogue (Allen, Levy, & Wilkinson, 2025 [13]) indicates that autonomy depends on communicative support, not mere information transfer. This study therefore treats linguistic accessibility as an ethical threshold: without comprehensible explanation, consent may document institutional compliance while leaving patient autonomy only partially protected in practice across clinical and digital contexts.

2. LITERATURE REVIEW

2.1. Informed consent

Informed consent is commonly defined as a patient's authorization for medical action after receiving adequate information, yet scholarship increasingly rejects a narrow equation between disclosure and consent. Legal studies in Indonesia emphasize consent as a protective instrument for patients and medical personnel, especially in high-risk procedures, malpractice disputes, emergency care, and civil liability (Adnan et al., 2022 [14]; Chandra et al., 2024 [15]; Kurniawan et al., 2024 [16]; Firma et al., 2025 [17]). Bioethical scholarship, however, treats consent as valid only when disclosure is accompanied by comprehension, voluntariness, and decision-making capacity (Lewis, 2023 [9]; Ng, 2024 [10]). This tension positions informed consent as both legal form and communicative achievement.

The operational dimensions of informed consent therefore extend beyond signature, form completion, or administrative compliance. Recent studies identify several indicators: disclosure of diagnosis and procedure, explanation of risks and benefits, presentation of alternatives, opportunity for refusal, documentation of patient decision, and protection from coercion or misunderstanding (Kim, 2024 [18]; Putu et al., 2025 [19]; Kusumastuti et al., 2025 [20]). Surgical and hospital-based research further highlights timing, risk specificity, patient questioning, and procedural clarity as crucial elements (Hassan et al., 2025 [21]; Nsaful et al., 2026 [22]; Sadh et al., 2025 [23]). These indicators show that consent should be assessed as a staged communicative process rather than a single institutional event.

2.2. Patient autonomy

Patient autonomy provides the ethical foundation for informed consent, but autonomy is interpreted differently across medical, legal, and sociocultural contexts. Liberal accounts emphasize individual choice, personal rights, and freedom from unwanted intervention, while relational approaches argue that decisions

are shaped by family, trust, vulnerability, dependency, and social authority (Akpa-Inyang & Chima, 2021 [24]; Tillman, 2025 [25]). Indonesian health-law literature often frames autonomy through patient rights to consent, refuse, receive information, and obtain legal protection (Desdiani et al., 2024 [26]; Dhanudibroto & Heliany, 2025 [27]). However, autonomy becomes unstable when formal rights are expressed in language that patients cannot practically interpret.

Indicators of patient autonomy in consent discourse include visibility of choice, explicit refusal options, access to second opinion, clarity of alternatives, and non-directive explanation. Studies on therapeutic communication and health-service law suggest that respectful communication reduces dispute risk, but respect must be shown linguistically, not merely declared normatively (Sriwijayanti et al., 2024 [28]; Khairunnisa et al., 2024 [29]; Purwati & Ruslita, 2025 [30]). Research on directive speech acts, bad-news delivery, empathy, and diagnostic inequality in Indonesian clinical encounters further indicates that institutional voice may subtly organize patient compliance (Nazulpa, 2026 [3]; Nugroho, 2026 [31]; Rusita, 2026 [32]; Andayani, 2026 [33]). Autonomy thus depends on how language distributes authority.

2.3. Medical explanation

Medical explanation is the linguistic bridge between information and patient understanding, yet it is also a site where consent may fail. Health-communication studies distinguish between information transmission and patient-centered explanation: the former prioritizes biomedical accuracy, whereas the latter translates knowledge into usable understanding. Research on medical jargon, radiology simplification, language barriers, and multilingual emergency care shows that technically correct language may remain inaccessible when patients lack terminology, literacy, language concordance, or situational calm (Laila, 2026 [2]; Nurtyas, 2026 [4]; Islami, 2026; Anandasari, 2026 [5]). International studies similarly link health literacy limitations to compromised consent comprehension (Pietrzykowski & Śmiłowska, 2021 [6]; Zhang et al., 2024 [8]; Malini et al., 2023 [7]).

The main indicators of accessible medical explanation include plain-language wording, defined terminology, risk framing, dialogic repair, patient-question prompts, interpreter support, and sensitivity to digital mediation. Recent work on intellectual disability, language-discordant care, and communication barriers shows that equitable consent requires explanation adapted to patient capacity rather than standardized disclosure alone (Dunn et al., 2023 [12]; Mustafa et al., 2022 [34]; Seo et al., 2025 [35]). Emerging AI literature adds a further complication: large language models may scaffold patient education, but they may also create fluent yet unsafe simplifications if uncertainty and clinical accountability are poorly managed (Allen, Levy, & Wilkinson, 2025 [13]; Aydin et al., 2024; Rudra et al., 2025 [36]; Dewi, 2026 [37]). This study therefore positions consent as a linguistic threshold where legal validity, autonomy, and comprehensibility must be evaluated together.

3. METHOD

This study uses document-based discourse units as its material object: clauses, sentences, list items, paragraphs, and document sections that explain medical consent, patient rights, medical action approval, refusal, health literacy, language access, and autonomy. The corpus comprises 20 verified public documents collected from official Indonesian health institutions, health facilities, public patient-education sources, and peer-reviewed literature. These documents produced 25 analyzable text units and 25 coding rows. Primary data consist of public-facing consent and patient-rights texts; secondary data consist of scholarly sources; context data consist of legal and institutional materials that define regulatory conditions for consent.

Table 1. Dataset composition

Code	Data Type	Source	Location	Period	Count	Characteristics	Status
IC-ID-001	Context	Ministry of Health law page	Indonesia	2023	1	Law No. 17/2023 health regulation context	Verified
IC-ID-002	Primary	Directorate General of Advanced Health Services	Indonesia	2024	1	Public explanation of informed consent	Verified
IC-ID-003	Primary	Ministry hospital-linked article	Indonesia	2024	1	Consent content, timing, form, language	Verified
IC-ID-004	Context	Ministry of Health official article	Indonesia	2023	1	Rights and obligations of medical personnel and patients	Verified
IC-ID-005	Primary	RSUP Fatmawati	Indonesia	2024	1	Hospital public explanation of medical consent	Verified; full-text check needed
IC-ID-006	Primary	Public primary-care facility webpage	Indonesia	n.d.	1	Patient rights, refusal, second opinion	Verified
IC-ID-007	Primary	Public health-information media	Indonesia	2024	1	Patient protection and patient rights education	Verified
IC-ID-008	Secondary	NCBI Bookshelf	International	2026 access	1	Medical ethics reference on informed consent	Verified
IC-ID-009	Secondary	International Journal of Science and Society	Indonesia	2025	1	Legal protection in high-risk consent	Verified
IC-ID-010	Secondary	Jurnal ARSI	Indonesia	2025	1	Patient safety and malpractice context	Verified
IC-ID-011	Secondary	BIO Web of Conferences	Indonesia	2025	1	Implementation challenges in	Verified

						hospital consent	
IC-ID-012	Secondary	Law and Justice	Indonesia	2023	1	Consent implementation and patient safety	Verified
IC-ID-013	Secondary	Journal of Public Health	Indonesia	2025	1	Health literacy in Indonesian patients	Verified
IC-ID-014	Secondary	Frontiers in Medicine	Indonesia/LMIC	2024	1	Cultural sensitivity and patient-centered care	Verified
IC-ID-015	Secondary	Trials	International	2021	1	Systematic review on patient comprehension	Verified
IC-ID-016	Secondary	BMC Medical Ethics	International	2024	1	Functional health literacy and consent	Verified
IC-ID-017	Secondary	Clinical Ethics	International	2025	1	Interpretation, paternalism, relational autonomy	Verified
IC-ID-018	Secondary	Pakistan Journal of Medical Sciences	International	2023	1	Language barriers in doctor–patient relations	Verified
IC-ID-019	Secondary	Artificial Intelligence in Medicine	International	2025	1	AI informed consent and clarity strategies	Verified
IC-ID-020	Secondary	Bioethics	International	2026	1	LLMs and scaffolded patient autonomy	Verified

This study applies qualitative discourse analysis with structured document coding. This design is appropriate because the research problem concerns how consent is linguistically organized in public and institutional discourse, not whether individual patients empirically understood specific procedures. The method therefore avoids clinical outcome claims, prevalence claims, and causal explanations. Instead, it examines textual conditions that may support or weaken intelligibility, voluntariness, and agency. The design combines legal-medical discourse analysis, health-literacy analysis, and relational autonomy theory, enabling this study to read informed consent as a communicative arrangement in which medical explanation, institutional authority, and patient decision-making are textually mediated.

Information sources were selected to represent three levels of consent discourse. Primary sources include public-facing institutional and health-facility texts that directly explain consent, patient rights, refusal, second opinion, or medical action approval. Context sources include official legal and policy materials that define consent as part of Indonesian health governance. Secondary sources include peer-reviewed literature on informed consent, health literacy, language barriers, relational autonomy, malpractice, patient safety, and AI-mediated medical explanation. This separation prevents analytical overreach: official documents are not treated as clinical interaction data, and international literature is used for conceptual comparison rather than evidence of Indonesian patient experience.

Data collection followed a transparent search and verification procedure. Keywords included “informed consent,” “persetujuan tindakan medis,” “persetujuan tindakan kedokteran,” “hak pasien,” “penjelasan medis,” “penolakan tindakan,” “second opinion,” “health literacy,” and “patient autonomy.” The period covered 2021–2026 for scholarly literature and 2023–2024 for core Indonesian public regulatory and institutional documents available in the corpus. Each item was recorded with document code, title, date, source, author or institution, source type, URL or DOI, verification status, relevance context, inclusion reason, and deduplication key. Duplicate or overlapping items were removed through title, source, year, and URL matching.

Data analysis proceeds in five stages. First, documents are unitized into clauses, sentences, list items, or sections. Second, each unit is classified as primary, secondary, or context evidence. Third, units are coded through three instruments: a plain-language comprehension audit, a patient autonomy and agency framework, and an interactional access and relational autonomy lens. Fourth, coding focuses on jargon density, risk explanation, alternatives, refusal space, directive force, language accommodation, family mediation, digital explanation, and ethical fragility. Fifth, interpretive synthesis compares patterns across data types while preserving methodological boundaries between textual description, discourse interpretation, theoretical discussion, and practical recommendation.

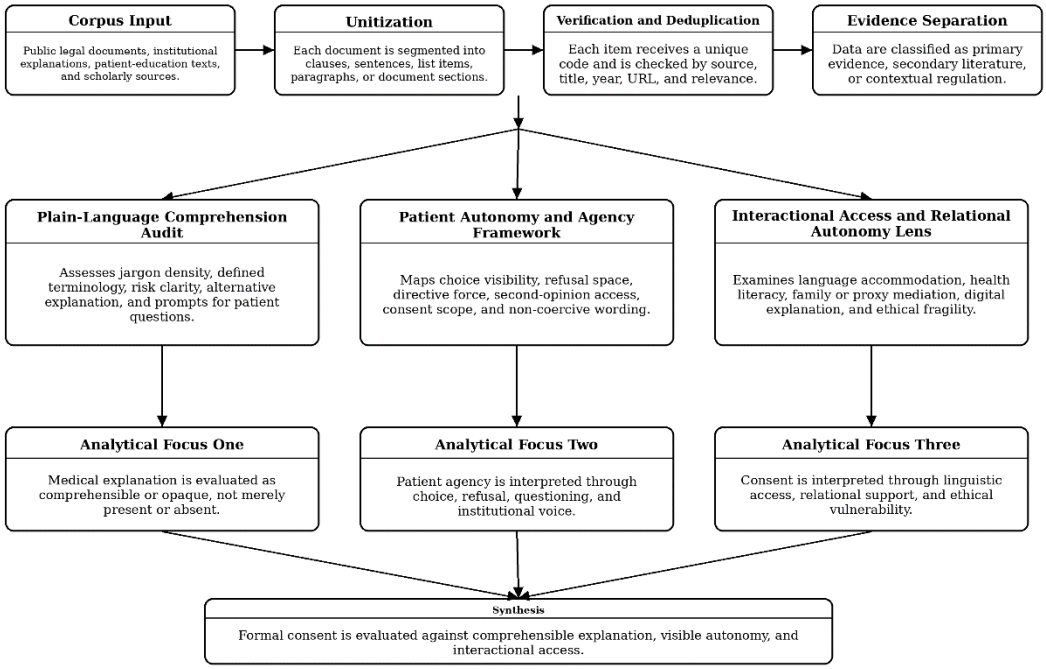


Figure 1. Operational analysis matrix

4. RESULTS

4.1. Medical explanation, comprehension support, and linguistic fragility in consent discourse

Medical explanation in the corpus is organized around a visible but uneven movement from institutional disclosure to patient comprehension. Across 25 coded units, consent is repeatedly framed as a formal requirement, provider obligation, or patient-rights issue, yet only part of the corpus makes linguistic accessibility explicit. The strongest comprehension-oriented evidence appears where information is required to be "jelas, sederhana, mudah dimengerti," indicating that consent validity depends on language that can be processed by patients rather than merely recorded by institutions. This pattern corresponds with Laila's (2026) [2] concern with medical jargon, Malini et al.'s (2023) [7] focus on health literacy in Indonesia, and Pietrzykowski and Śmiłowska's (2021) [6] critique of consent practices that assume understanding after disclosure.

Table 2. Medical explanation, comprehension support, and linguistic fragility in consent discourse

Main Category	Subcategory	Operational Indicator	Frequency	Percentage	Data Variation	Example / Textual Evidence	Data Codes
Explanation as institutional requirement	Formal consent framing	Consent or explanation is framed as legal, institutional, or procedural obligation	8	32%	Primary = 4; Secondary = 2; Context = 2	Official discourse links individual health-service action to approval; several texts define consent as permission after medical explanation.	IC-ID-001-U01; IC-ID-002-U01; IC-ID-002-U02; IC-ID-003-U01; IC-ID-004-U01; IC-ID-005-U01; IC-ID-011-U01; IC-ID-012-U01
Plain-language comprehension	Accessibility of explanation	Plain-language support is present or partially present	9	36%	Primary = 7; Secondary = 2; Context = 0	"Bahasa informasi harus jelas, sederhana, mudah dimengerti..." is treated as a direct linguistic criterion for consent explanation.	IC-ID-002-U02; IC-ID-003-U01; IC-ID-003-U02; IC-ID-005-U01; IC-ID-006-U01; IC-ID-006-U02; IC-ID-007-U01; IC-ID-012-U01; IC-ID-019-U01
Risk communication	Risk disclosure visibility	Risk, complication, or procedural uncertainty is explicitly visible	3	12%	Primary = 2; Secondary = 1; Context = 0	Consent information includes diagnosis, procedure, purpose, risks, complications, prognosis, and alternatives, but explicit risk elaboration remains limited across coded units.	IC-ID-003-U03; IC-ID-006-U01; IC-ID-009-U01
Alternative explanation	Choice architecture	Alternative options are explicitly visible	3	12%	Primary = 3; Secondary = 0; Context = 0	Facility and public education texts mention refusal, second opinion, or alternatives as part of patient-rights discourse.	IC-ID-003-U03; IC-ID-006-U02; IC-ID-007-U01
Dialogic repair	Questioning and clarification space	Patient-question or clarification opportunity is absent or unclear	25	100%	Primary = 9; Secondary = 14; Context = 2	Consent is often described through information provision, approval, or rights listing, but explicit invitation to ask, challenge, or repair misunderstanding is not clearly coded.	IC-ID-001-U01–IC-ID-020-U01
Health-literacy relevance	Comprehension vulnerability	Health literacy is present or indirectly relevant	25	100%	Primary = 9; Secondary = 14; Context = 2	Indonesian and international literature links consent validity to patient capacity to understand and apply medical information.	IC-ID-001-U01–IC-ID-020-U01
Ethical fragility	Consent without secured understanding	Ethical fragility is medium or high	19	76%	Primary = 5; Secondary = 12; Context = 2	Formal explanation, rights recognition, and legal protection appear more consistently than evidence of comprehension testing, clarification, or patient uptake.	IC-ID-001-U01; IC-ID-002-U01; IC-ID-002-U02; IC-ID-003-U01; IC-ID-003-U03; IC-ID-004-U01; IC-ID-005-U01; IC-ID-009-U01; IC-ID-010-U01;

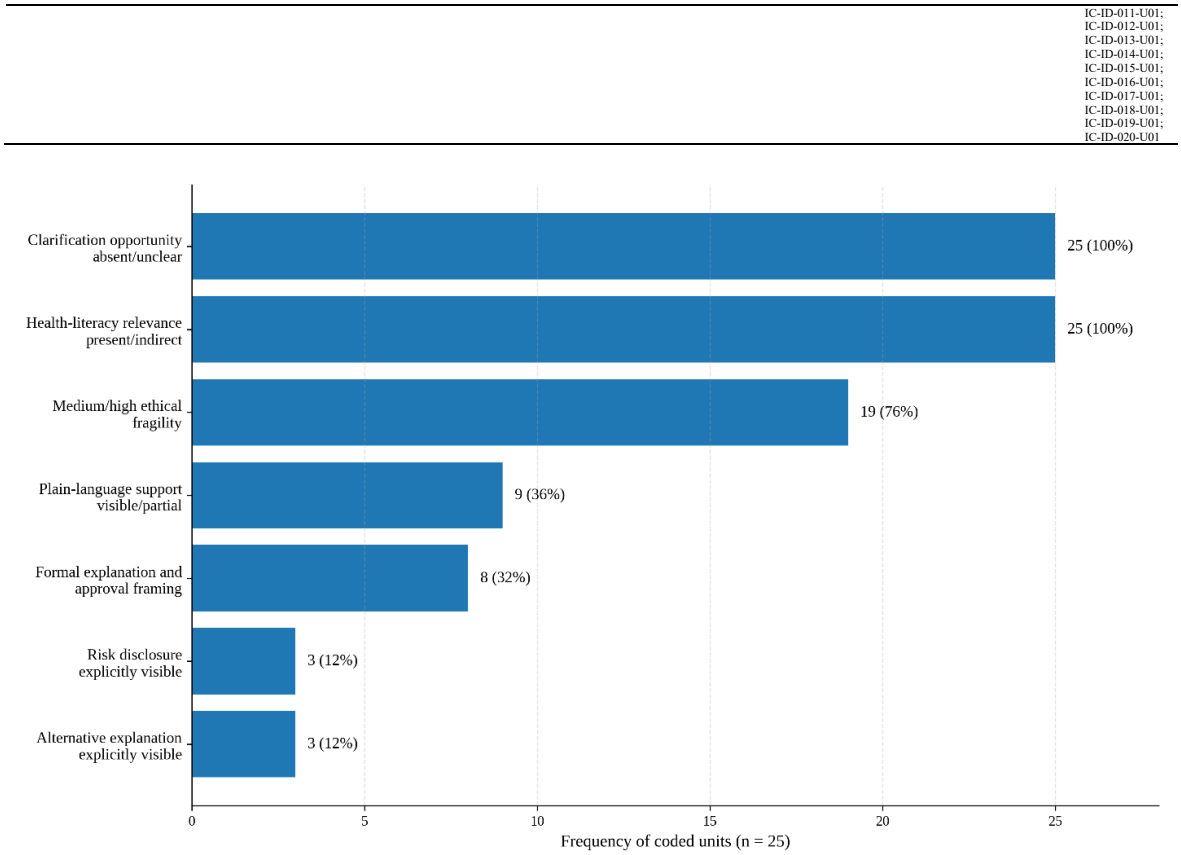


Figure 2. Distribution of medical explanation, comprehension indicators

The dominant pattern is a gap between explanation as provision and explanation as dialogic verification. All 25 coded units are relevant to health literacy, and all show absent or unclear evidence of patient-question or clarification opportunities. By contrast, explicit risk disclosure appears in only 3 units, and alternative explanation also appears in 3 units. The corpus contains important rights-oriented language, including consent/refusal and second-opinion clauses, but these do not automatically establish whether patients can ask follow-up questions, repair misunderstanding, or compare options. The strongest textual contrast lies between the direct accessibility requirement "Bahasa informasi harus jelas, sederhana, mudah dimengerti" and the broader pattern in which consent remains structured through institutional explanation, lists of rights, and legal protection.

These findings position informed consent as a threshold of communicative adequacy rather than a binary legal event. A consent process may satisfy formal disclosure while remaining ethically vulnerable if language does not create usable understanding, visible alternatives, and opportunities for clarification. Lewis (2023) [9] and Ng (2024) [10] question whether consent alone is sufficient to secure autonomy, while Dunn et al. (2023) [12], Zhang et al. (2024) [8], and Bär et al. (2025) [11] show that comprehension depends on accessibility, capacity, and routine communicative support. In this corpus, linguistic fragility emerges not because explanation is absent, but because explanation is often insufficiently dialogic. This study therefore treats medical explanation as ethically adequate only when it supports understanding, refusal, and patient agency together.

4.2. Consent, refusal, and the visibility of patient agency in public consent language

Patient agency appears most strongly where consent is framed through approval, rights, refusal, and second opinion, but this visibility remains uneven when measured against the fuller requirements of autonomous decision-making. In 20 of 25 units, choice is present either explicitly or indirectly, showing that autonomy is not absent from Indonesian consent-related discourse. However, refusal space appears in only 6 units, family or proxy roles in 5 units, and emergency exceptions in 2 units. This distribution suggests that agency is more often named than operationalized. Recent Indonesian legal and health-communication literature similarly stresses that informed consent must protect patient rights and professional accountability, yet the linguistic conditions that make choice practically usable remain less consistently foregrounded (Desdiani et al., 2024 [26]; Khairunnisa et al., 2024 [29]; Kusumastuti et al., 2025 [20]).

Table 3. Patient autonomy, refusal space, and agency visibility in consent-related discourse

Main Category	Subcategory	Operational Indicator	Frequency	Percentage	Data Variation	Example / Textual Evidence	Data Codes
Patient agency	Choice visibility	Patient choice is explicitly or implicitly visible	20	80%	Primary = 9; Secondary = 9; Context = 2	Consent is repeatedly linked to approval, patient rights, refusal, or decision-making after explanation.	IC-ID-001-U01; IC-ID-002-U01; IC-ID-002-U02; IC-ID-003-U01; IC-ID-003-U02; IC-ID-003-U03; IC-ID-004-U01; IC-ID-005-U01; IC-ID-006-U01; IC-ID-006-U02; IC-ID-007-U01; IC-ID-008-U01; IC-ID-009-U01; IC-ID-011-U01; IC-ID-012-U01; IC-ID-012-U02; IC-ID-014-U01; IC-ID-017-U01; IC-ID-019-U01; IC-ID-020-U01
Patient agency	Choice invisibility	Choice remains unclear rather than textually developed	5	20%	Primary = 0; Secondary = 5; Context = 0	Some scholarly units discuss weak consent, comprehension limits, or communication barriers without giving a patient-facing choice formulation.	IC-ID-010-U01; IC-ID-013-U01; IC-ID-015-U01; IC-ID-016-U01; IC-ID-018-U01
Refusal rights	Explicit refusal space	Refusal, withdrawal, or second opinion is visible	6	24%	Primary = 3; Secondary = 3; Context = 0	Public patient-rights language includes refusal and second-opinion clauses; ethical sources also frame refusal or withdrawal as part of valid consent.	IC-ID-006-U01; IC-ID-006-U02; IC-ID-007-U01; IC-ID-008-U01; IC-ID-012-U02; IC-ID-017-U01
Refusal rights	Limited refusal space	Refusal is unclear, absent, or absent in quoted unit	19	76%	Primary = 6; Secondary = 11; Context = 2	Consent is often described as approval after explanation, while refusal is not equally elaborated in the same textual space.	IC-ID-001-U01; IC-ID-002-U01; IC-ID-002-U02; IC-ID-003-U01; IC-ID-003-U02; IC-ID-003-U03; IC-ID-004-U01; IC-ID-005-U01; IC-ID-009-U01; IC-ID-010-U01; IC-ID-011-U01; IC-ID-012-U01; IC-ID-013-U01; IC-ID-014-U01; IC-ID-015-U01; IC-ID-016-U01; IC-ID-018-U01; IC-ID-019-U01; IC-ID-020-U01
Institutional voice	Low directive force	Language does not strongly push compliance	14	56%	Primary = 7; Secondary = 7; Context = 0	Several units describe consent, rights, or autonomy without strong obligation markers beyond legal or procedural context.	IC-ID-001-U01; IC-ID-002-U02; IC-ID-003-U01; IC-ID-003-U02; IC-ID-005-U01; IC-ID-006-U01; IC-ID-006-U02; IC-ID-007-U01; IC-ID-008-U01; IC-ID-012-U01; IC-ID-012-U02; IC-ID-017-U01; IC-ID-019-U01; IC-ID-020-U01
Institutional voice	Medium or unclear directive force	Directive force is medium or cannot be determined	11	44%	Primary = 2; Secondary = 7; Context = 2	Mandatory-approval language such as “harus mendapat persetujuan” marks consent as obligatory procedure, while some literature units remain non-patient-facing.	IC-ID-002-U01; IC-ID-003-U03; IC-ID-004-U01; IC-ID-009-U01; IC-ID-010-U01; IC-ID-011-U01; IC-ID-013-U01; IC-ID-014-U01; IC-ID-015-U01; IC-ID-016-U01; IC-ID-018-U01
Dialogic autonomy	Clarification prompt absent or unclear	Opportunity to ask, challenge, or repair misunderstanding is not clearly visible	25	100%	Primary = 9; Secondary = 14; Context = 2	Rights and consent are named more frequently than patient questioning, clarification, or confirmation of understanding.	IC-ID-001-U01–IC-ID-020-U01
Relational decision-making	Family or proxy role visible	Family, proxy, or relational decision context appears	5	20%	Primary = 3; Secondary = 2; Context = 0	Some texts refer to patient/family consent or community/family decision support.	IC-ID-003-U01; IC-ID-004-U01; IC-ID-005-U01; IC-ID-012-U01; IC-ID-014-U01
Relational decision-making	Family or proxy role unclear or absent	Relational mediation is not specified	20	80%	Primary = 6; Secondary = 12; Context = 2	Most units frame consent through patient rights, legal duties, or comprehension rather than family-mediated decision-making.	IC-ID-001-U01; IC-ID-002-U01; IC-ID-002-U02; IC-ID-003-U02; IC-ID-003-U03; IC-ID-006-U01; IC-ID-006-U02; IC-ID-007-U01; IC-ID-008-U01; IC-ID-009-U01; IC-ID-010-U01; IC-ID-011-U01; IC-ID-012-U02; IC-ID-013-U01; IC-ID-015-U01; IC-ID-016-U01; IC-ID-017-U01; IC-ID-018-U01; IC-ID-019-U01; IC-ID-020-U01
Exceptional consent	Emergency exception visible	Emergency or exceptional consent condition appears	2	8%	Primary = 2; Secondary = 0; Context = 0	Emergency-related patient-rights clauses appear in limited primary units.	IC-ID-006-U01; IC-ID-006-U02
Exceptional consent	Emergency exception unclear or not present	Emergency condition is unclear or not specified	23	92%	Primary = 7; Secondary = 14; Context = 2	Consent discourse is more strongly organized around routine explanation and rights than exceptional decision conditions.	IC-ID-001-U01; IC-ID-002-U01; IC-ID-002-U02; IC-ID-003-U01; IC-ID-003-U02; IC-ID-003-U03; IC-ID-004-U01; IC-ID-005-U01; IC-ID-007-U01; IC-ID-008-U01; IC-ID-009-U01; IC-ID-010-U01; IC-ID-011-U01; IC-ID-012-U01; IC-ID-012-U02; IC-ID-013-U01; IC-ID-014-U01; IC-ID-015-U01; IC-ID-016-U01; IC-ID-017-U01; IC-ID-018-U01; IC-ID-019-U01;

IC-ID-020-U01

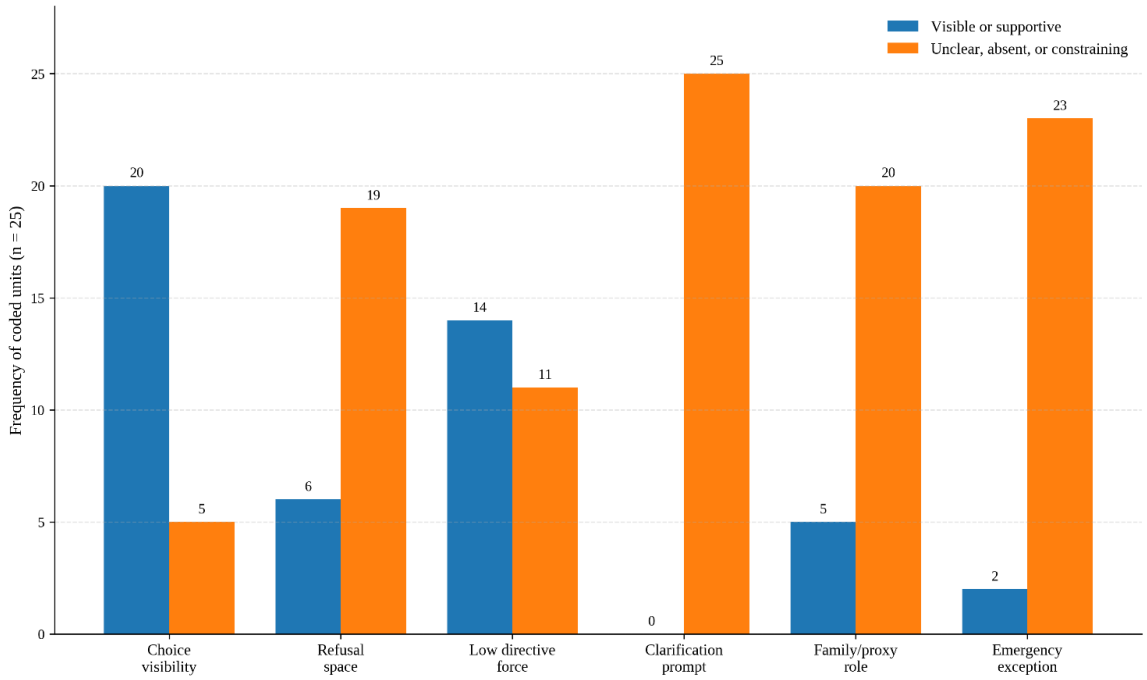


Figure 3. Patient agency indicators in consent-related discourse

The dominant pattern is an asymmetry between consent as approval and consent as negotiable decision. The corpus includes direct institutional language such as "harus mendapat persetujuan," which confirms the procedural necessity of consent, and patient-rights formulations that include refusal and second opinion. Yet the same corpus gives weaker evidence of dialogic autonomy: all 25 units show absent or unclear clarification prompts. Refusal is visible in 24% of coded units, while unclear or absent refusal space reaches 76%. Family or proxy involvement is visible in only 20% of units, despite Indonesian clinical decision-making often being relationally embedded. Objectively, the dataset shows that patient agency is recognized most consistently at the level of rights vocabulary, but less consistently at the level of actionable interactional design.

Patient autonomy in this corpus is best understood as partially textualized rather than fully communicatively secured. Rights-based language can acknowledge the patient as a decision-maker, but autonomy requires more than naming consent, refusal, or approval. It requires conditions under which patients can question, compare options, involve trusted others, and decline without being positioned as obstructive. This is consistent with Lewis's (2023) [9] critique that consent alone does not exhaust respect for autonomy and Tillman's (2025) [25] emphasis on non-paternalistic support in interpreted consent contexts. Akpa-Inyang and Chima (2021) [24] further show that autonomy is shaped by cultural and relational values rather than isolated individual choice. This study therefore reads agency as a linguistic accomplishment: visible only when choice, refusal, clarification, and relational support appear together.

4.3. The linguistic limits of consent: health literacy, relational mediation, and digital explanation

Consent discourse becomes most fragile where health literacy is universally relevant but linguistic accommodation remains limited. Across the same 25 coded units used in the previous findings, all units require attention to health literacy, yet only 8 units show visible language accommodation. Family or proxy mediation appears in 5 units, while digital or AI-mediated explanation appears in only 2 scholarly units. The pattern indicates that consent is framed as an informational and legal process more often than as an adaptive interaction for patients with unequal literacy, language, family dependence, or digital access. This finding aligns with Malini et al. (2023) [7], Zhang et al. (2024) [8], and Dunn et al. (2023) [12], who show that comprehension depends on accessible communicative design rather than disclosure alone.

Table 4. Interactional access, relational autonomy, and ethical fragility in consent-related discourse

Main Category	Subcategory	Operational Indicator	Frequency	Percentage	Data Variation	Example / Textual Evidence	Data Codes
Health literacy	Comprehension vulnerability	Health-literacy relevance is explicit or indirectly necessary	25	100%	Primary = 9; Secondary = 14; Context = 2	Consent discourse depends on whether patients can understand medical information, risks, alternatives, rights, and consequences.	IC-ID-001-U01–IC-ID-020-U01
Linguistic access	Language accommodation visible	Simplification, accessible wording, or patient-oriented language support appears	8	32%	Primary = 5; Secondary = 3; Context = 0	Public-facing language includes requirements that information be clear, simple, and understandable; scholarly sources link consent to	IC-ID-002-U02; IC-ID-003-U01; IC-ID-005-U01; IC-ID-006-U01;

						literacy and accessible communication.	IC-ID-007-U01; IC-ID-013-U01; IC-ID-015-U01; IC-ID-016-U01
Linguistic access	Language accommodation absent or unclear	No explicit accommodation mechanism is visible	17	68%	Primary = 4; Secondary = 11; Context = 2	Several units describe consent, rights, or legal protection without specifying how patients with different literacy or language capacities are supported.	IC-ID-001-U01; IC-ID-002-U01; IC-ID-003-U02; IC-ID-003-U03; IC-ID-004-U01; IC-ID-008-U01; IC-ID-009-U01; IC-ID-010-U01; IC-ID-011-U01; IC-ID-012-U01; IC-ID-012-U02; IC-ID-014-U01; IC-ID-017-U01; IC-ID-018-U01; IC-ID-019-U01; IC-ID-020-U01
Relational autonomy	Family or proxy mediation visible	Family, proxy, or relational decision context appears	5	20%	Primary = 3; Secondary = 2; Context = 0	Some institutional and scholarly units refer to patient/family consent, relational decision support, or culturally mediated patient-centered care.	IC-ID-003-U01; IC-ID-004-U01; IC-ID-005-U01; IC-ID-012-U01; IC-ID-014-U01
Relational autonomy	Family or proxy mediation absent or unclear	Relational support is not specified	20	80%	Primary = 6; Secondary = 12; Context = 2	Most units foreground patient rights, legal duties, or comprehension problems without detailing how family-mediated decision-making is linguistically managed.	IC-ID-001-U01; IC-ID-002-U01; IC-ID-002-U02; IC-ID-003-U02; IC-ID-003-U03; IC-ID-006-U01; IC-ID-006-U02; IC-ID-007-U01; IC-ID-008-U01; IC-ID-009-U01; IC-ID-010-U01; IC-ID-011-U01; IC-ID-012-U02; IC-ID-013-U01; IC-ID-015-U01; IC-ID-016-U01; IC-ID-017-U01; IC-ID-018-U01; IC-ID-019-U01; IC-ID-020-U01
Digital consent explanation	AI or digital explanation visible	Digital/AI-mediated consent explanation is directly discussed	2	8%	Primary = 0; Secondary = 2; Context = 0	AI-related sources discuss informed consent support, clarity strategies, and scaffolding of patient autonomy.	IC-ID-019-U01; IC-ID-020-U01
Digital consent explanation	AI or digital explanation absent	Digital/AI mediation is not part of the unit	23	92%	Primary = 9; Secondary = 12; Context = 2	Most Indonesian public and legal consent texts remain organized around human-delivered explanation and institutional documentation.	IC-ID-001-U01; IC-ID-002-U01; IC-ID-002-U02; IC-ID-003-U01; IC-ID-003-U02; IC-ID-003-U03; IC-ID-004-U01; IC-ID-005-U01; IC-ID-006-U01; IC-ID-006-U02; IC-ID-007-U01; IC-ID-008-U01; IC-ID-009-U01; IC-ID-010-U01; IC-ID-011-U01; IC-ID-012-U01; IC-ID-012-U02; IC-ID-013-U01; IC-ID-014-U01; IC-ID-015-U01; IC-ID-016-U01; IC-ID-017-U01; IC-ID-018-U01
Comprehension verification	Understanding check absent or unclear	Explicit verification of patient understanding is absent or unclear	22	88%	Primary = 9; Secondary = 11; Context = 2	Explanation is often described as giving information, obtaining approval, or protecting rights, but few units specify confirmation of patient understanding.	IC-ID-001-U01; IC-ID-002-U01; IC-ID-002-U02; IC-ID-003-U01; IC-ID-003-U02; IC-ID-003-U03; IC-ID-004-U01; IC-ID-005-U01; IC-ID-006-U01; IC-ID-006-U02; IC-ID-007-U01; IC-ID-009-U01; IC-ID-010-U01; IC-ID-011-U01; IC-ID-013-U01; IC-ID-014-U01; IC-ID-015-U01; IC-ID-016-U01; IC-ID-018-U01; IC-ID-019-U01; IC-ID-020-U01
Ethical fragility	Medium/high fragility	Consent is vulnerable because explanation, autonomy, or verification remains incomplete	19	76%	Primary = 5; Secondary = 12; Context = 2	Formal rights and legal language are more consistently visible than patient uptake, clarification, or adaptive linguistic support.	IC-ID-001-U01; IC-ID-002-U01; IC-ID-002-U02; IC-ID-003-U01; IC-ID-003-U03; IC-ID-004-U01; IC-ID-005-U01; IC-ID-009-U01; IC-ID-010-U01; IC-ID-011-U01; IC-ID-012-U01; IC-ID-013-U01; IC-ID-014-U01; IC-ID-015-U01; IC-ID-016-U01; IC-ID-017-U01; IC-ID-018-U01; IC-ID-019-U01; IC-ID-020-U01

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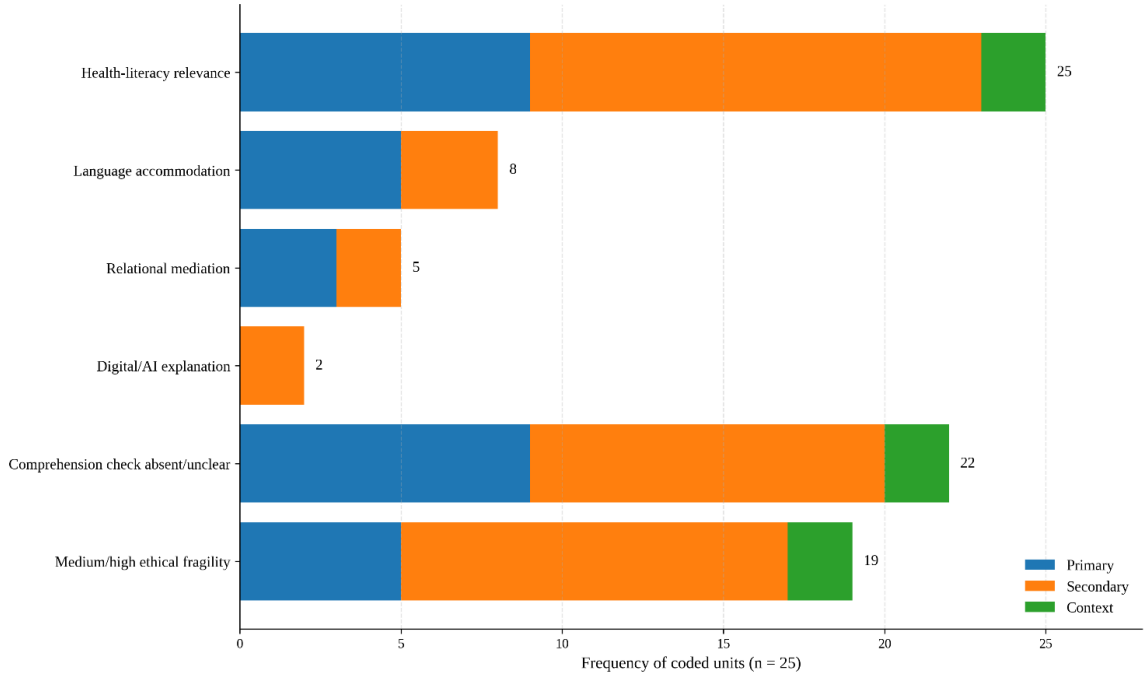


Figure 4. Interactional access and relational autonomy indicators

The most dominant empirical pattern is not the absence of patient rights, but the incomplete operationalization of access. The corpus contains language requiring information to be "clear, simple, and understandable," yet this principle is not consistently paired with mechanisms for checking understanding, accommodating language difference, or supporting relational decision-making. Understanding checks are absent or unclear in 22 units, while medium or high ethical fragility appears in 19 units. Digital explanation is marginal in the corpus, appearing in 8% of coded units, despite recent scholarship arguing that large language models may scaffold informed consent when carefully governed. Objectively, the data show that linguistic access is recognized as relevant but not yet systematically embedded across consent-related discourse.

Informed consent therefore emerges as a communicative threshold shaped by social vulnerability, not merely as a legal threshold satisfied by disclosure and approval. Patients may be formally positioned as rights-bearing subjects while still lacking practical access to the language through which risks, alternatives, refusal, and consequences are made meaningful. Relational autonomy helps explain why this matters: decision-making is often mediated by family, trust, authority, disability, literacy, and language concordance rather than isolated individual preference. Work by Tillman (2025) [25], Akpa-Inyang and Chima (2021) [24], Allen, Levy, and Wilkinson (2025) [13], and Rudra et al. (2025) [36] supports this position by showing that consent requires interpretive support and accountable explanation. This study thus treats consent as ethically defensible only when comprehension, agency, and access are jointly secured.

5. DISCUSSION

The first implication of the findings is that medical explanation cannot be treated as ethically adequate simply because information is present. The corpus shows that consent discourse recognizes explanation as an institutional and legal requirement, yet linguistic accessibility appears less consistently than formal disclosure. This matters because informed consent functions only when information becomes usable knowledge for patients. If explanation remains technical, legally framed, or organized as provider obligation rather than patient comprehension, consent risks becoming documentation of compliance rather than evidence of understanding. This finding extends Laila's (2026) [2] concern with medical jargon and supports Pietrzykowski and Śmiłowska's (2021) [6] argument that patient comprehension is persistently weaker than consent procedures assume. It also resonates with Malini et al. (2023) [7] and Zhang et al. (2024) [8], who link health literacy to patients' ability to process medical information. This study therefore shows that linguistic intelligibility is not an accessory to consent but one of its ethical conditions.

This pattern appears to emerge from a structural imbalance between institutional disclosure and dialogic verification. Indonesian consent discourse is shaped by legal obligations, professional protection, and patient-rights vocabulary, all of which are necessary but insufficient when they are not matched by mechanisms for checking understanding. Legal scholarship on informed consent in Indonesia often emphasizes consent as protection for patients, hospitals, and health workers in high-risk procedures and malpractice disputes (Adnan et al., 2022 [14]; Chandra et al., 2024 [15]; Kurniawan et al., 2024 [16]; Firma

et al., 2025 [17]). Such emphasis may explain why discourse frequently privileges formal explanation, approval, and documentation. Yet medical-linguistic research suggests that understanding depends on pragmatic accessibility, not legal completeness alone (Nurtyas, 2026 [4]; Anandasari, 2026 [5]). This study does not claim that legal framing causes poor comprehension; rather, it indicates that procedure-centered discourse can leave comprehension verification underdeveloped when institutional certainty is prioritized over patient uptake.

The second implication concerns patient autonomy: rights may be textually recognized while agency remains unevenly operationalized. The findings show that patient choice is visible in much of the corpus, but refusal, second opinion, clarification, and relational support are less consistently articulated. This is significant because autonomy does not only require that patients be told they may consent; it requires that they can meaningfully compare options, ask questions, and decline without being positioned as noncompliant. The finding supports Lewis's (2023) [9] critique that consent alone cannot exhaust respect for autonomy and Ng's (2024) [10] observation that old problems of informed consent persist in contemporary clinical practice. It also deepens Nazulpa's (2026) [3] and Andayani's (2026) [33] insights into how clinical authority and credibility are distributed through language. This study therefore interprets patient autonomy as a communicative accomplishment: agency becomes visible only when choice, refusal, and clarification are linguistically available together.

The underlying structure behind this uneven agency is the persistence of institutional asymmetry within consent discourse. Medical institutions need standardized language to manage legal accountability, but standardization can flatten patient participation when rights are expressed as clauses rather than interactional opportunities. Indonesian legal and health-service studies often associate informed consent with dispute prevention, professional accountability, and legal certainty (Gustina et al., 2022 [38]; Sriwijayanti et al., 2024 [28]; Kusumastuti et al., 2025 [20]). Those functions are legitimate, yet they may coexist with a weaker model of patient voice if consent language is oriented toward approval rather than deliberation. Pragmatic studies of clinical communication show that directive force, institutional turn-taking, and expert authority can subtly guide patient response even without overt coercion (Nazulpa, 2026 [3]; Nugroho, 2026 [31]). This study therefore suggests that autonomy is constrained not necessarily by the absence of rights, but by the limited linguistic space through which rights are enacted.

The third implication is that linguistic access should be understood as a patient-safety and equity issue, not merely as a matter of style. The corpus indicates that health literacy is universally relevant, yet language accommodation, relational mediation, and digital explanation are unevenly visible. This matters because patients do not enter consent situations with equal literacy, language competence, emotional stability, family support, or confidence before medical authority. Dunn et al. (2023) [12] show that accessible consent is crucial for people with intellectual disability, while Mustafa et al. (2022) [34] and Seo et al. (2025) [35] demonstrate how language-discordant care creates barriers to safe participation. Indonesian studies on multilingual clinics and emergency communication similarly warn that symptoms and decisions may be lost between languages (Nurtyas, 2026 [4]; Anandasari, 2026 [5]). This study therefore reframes informed consent as an access problem: consent becomes ethically fragile when linguistic support is assumed rather than institutionally designed.

The deeper reason for this fragility lies in the mismatch between individualistic consent models and relational realities of health decision-making. Consent discourse often imagines an autonomous patient receiving information and making a decision, but clinical decisions are shaped by family involvement, cultural deference, disability, urgency, language mediation, and trust in professional authority. Akpa-Inyang and Chima (2021) [24] show that autonomy is interpreted differently in communities where collective values shape decision-making, while Tillman (2025) [25] argues that interpreted consent must avoid paternalism by incorporating respect and relational autonomy. Emerging AI literature adds another layer: large language models may scaffold patient education, but they cannot replace accountable clinical dialogue when uncertainty, risk, and responsibility remain unresolved (Allen, Levy, & Wilkinson, 2025 [13]; Rudra et al., 2025 [36]; Dewi, 2026 [37]). This study therefore positions informed consent as valid only when legal disclosure, comprehensible explanation, relational support, and accountable interaction are held together.

6. CONCLUSION

This study concludes that informed consent in Indonesia is not only a legal-administrative requirement but a linguistically mediated condition of patient autonomy. Its central finding is that medical explanation may be formally present while understanding remains ethically unsecured, especially when consent discourse privileges disclosure, approval, and documentation over clarification, refusal, and accessible patient uptake. The main lesson is that consent cannot be reduced to information delivery or signed authorization; it must be evaluated through comprehensibility, agency, and interactional access. This study contributes to medical

linguistics and bioethics by integrating plain-language audit, autonomy-agency analysis, and relational autonomy into one discourse-based framework.

This study is limited by its reliance on publicly accessible documents rather than direct clinical interaction, patient interviews, or comprehension testing. Consequently, its findings identify textual and pragmatic conditions that may weaken informed consent, but they do not measure actual patient understanding, physician intention, or clinical outcome. Future research should extend this inquiry through ethnographic observation, recorded consultations, patient-centered interviews, multilingual consent analysis, and comparative hospital-based studies across urban, rural, emergency, surgical, and digital-care settings. Further work should also examine how AI-generated explanations, family mediation, interpreter use, and health-literacy interventions can support consent that is not merely documented, but genuinely understood.

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Eka Emilia Salsabila: conceptualization, methodology, formal analysis, writing – original draft, writing – review and editing.

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Author states no conflict of interest.

AI USE DECLARATION

The author used artificial intelligence tools to assist with the generation of illustrative figures and with the formatting and layout of this manuscript. AI was not used to generate the substantive content, conceptualization, data, analysis, or conclusions of the research, all of which remain the sole responsibility of the author.

INFORMED CONSENT

Not applicable – this study did not involve direct human participants. Data consisted solely of publicly accessible legal, institutional, patient-education, and scholarly documents.

ETHICAL APPROVAL

This research did not involve human or animal subjects; it analyzed publicly accessible legal, institutional, patient-education, and scholarly documents, and therefore no institutional review board approval was required. Where research does involve human subjects, the author affirms that such research would be conducted in full compliance with all relevant national regulations and institutional policies, in accordance with the tenets of the Declaration of Helsinki, and would be approved by the author's institutional review board or equivalent committee.

DATA AVAILABILITY

The corpus of publicly accessible legal, institutional, patient-education, and scholarly documents analyzed in this study are available from the corresponding author upon reasonable request.

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