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# Legal Comparison of the Regulation of Chaperones in Intimate Medical Examinations in Indonesia and the United Kingdom: An Analysis of Patients' Rights and Medical Ethics

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**ABSTRACT**

This article examines the legal and ethical regulation of medical chaperones during intimate physical examinations, focusing on two contrasting jurisdictions: Indonesia and the United Kingdom. While chaperones are widely acknowledged in medical ethics as instruments for protecting patient dignity, autonomy, and safety, their legal status varies significantly across health systems. Indonesia currently lacks explicit statutory or ethical regulation mandating the use of chaperones, resulting in inconsistent practices and limited protection for patients and healthcare professionals alike. In contrast, the United Kingdom has established a robust framework through the General Medical Council, NHS institutional policies, and jurisprudence, where chaperone use is a formalized component of clinical governance. Using a normative and comparative legal methodology, this study analyzes constitutional principles, statutory instruments, and professional codes in both countries, supported by the ethical framework of biomedical ethics. The findings reveal a regulatory gap in Indonesia that undermines patient protection and propose a rights-based model of convergence—anchored in constitutional values and culturally contextualized—for integrating chaperone use into Indonesian medical law and practice. The article concludes by offering a six-pillar reform framework involving legal codification, ethical amendment, contextual implementation, education, institutional policy, and cultural engagement.

**Keywords:** Chaperone Regulation, Comparative Health Law, Intimate Medical Examinations, Medical Ethics, Patients' Rights

## INTRODUCTION

In recent decades, the protection of patient autonomy, dignity, and bodily integrity during intimate medical examinations has become a central concern in both medical ethics and health law. As societies have become increasingly aware of the psychological vulnerability and legal risks inherent in physical examinations involving genitalia, breasts, or other private areas, the presence of a medical chaperone—an impartial third party who observes the interaction—has evolved from an optional courtesy to a recognized safeguard. Internationally, chaperone policies are often integrated into clinical guidelines and medical codes of conduct to protect both the patient and the healthcare professional from misunderstandings, abuse, or legal liability. Yet despite their ethical importance, the legal regulation of chaperone use remains uneven, fragmented, and underdeveloped, particularly in jurisdictions where patients' rights are weakly institutionalized.

In Indonesia, the concept of a chaperone (pendamping medis) remains largely under-regulated. While Islamic values and cultural norms emphasize modesty and separation of sexes in certain contexts, there is no clear statutory or regulatory framework that mandates or systematically governs the use of chaperones in intimate clinical encounters. As a result, chaperone practices are largely left to individual

discretion, institutional policy, or ad hoc cultural considerations. This normative gap creates legal uncertainty for healthcare professionals and potential risks for patients—particularly women, minors, or individuals with disabilities—who may experience discomfort, coercion, or even abuse during examinations conducted without witnesses. Recent cases in Indonesia involving allegations of sexual misconduct by doctors, especially in gynecological or urological settings, have sparked public outrage but yielded little in terms of regulatory reform.[1]

By contrast, the United Kingdom offers a detailed and well-established regulatory framework on the use of chaperones, anchored in both professional guidance and patients' rights. The General Medical Council (GMC), National Health Service (NHS), and Medical Protection Society (MPS) all emphasize that patients must be informed of their right to request a chaperone, and that healthcare professionals should offer one routinely during intimate examinations.[2] Chaperones are expected to be trained, impartial, and able to intervene or report if necessary. The UK model combines ethical responsibility with legal accountability, recognizing that the presence of a chaperone is not merely symbolic but a functional component of informed consent and trust-based care. This dual function—protective and evidentiary—demonstrates how chaperone regulation intersects with broader principles of medical ethics, including beneficence, non-maleficence, autonomy, and justice.[3]

The absence of comparable mechanisms in Indonesia raises a critical normative and legal question: To what extent does Indonesian law adequately protect patients during intimate medical procedures, and what can be learned from the comparative experience of the United Kingdom? Given that both countries operate within democratic constitutional frameworks but with vastly different legal traditions and healthcare systems, this comparative study offers an opportunity to examine how legal and ethical norms can be harmonized to enhance patient protection.

Although existing Indonesian laws such as the Medical Practice Act (UU No. 29/2004) and the Health Act (UU No. 36/2009) recognize the right to informed consent and patient dignity, they do not expressly address the use of chaperones. Similarly, the Kode Etik Kedokteran Indonesia (KODEKI) refers to general standards of professional conduct but lacks specific provisions on third-party presence during examinations. In practice, many clinicians are unaware of chaperone protocols or consider them culturally inappropriate, particularly in rural or gender-conservative areas.[4] Meanwhile, cases of misconduct are typically addressed through criminal prosecution or professional discipline, rather than through preventive safeguards embedded in medical routine.

The literature on this topic in Indonesia is also limited. Most academic works focus on medical malpractice, consent, or Islamic bioethics, without discussing the legal status of chaperones as an institutionalized patient right. Conversely, in the UK and other common law jurisdictions, the debate has evolved toward the operationalization of chaperones as risk management tools, evidence protectors in medico-legal cases, and key actors in gender-sensitive clinical practice.[5] However, even in the UK, challenges remain regarding chaperone training, role clarity, and documentation. Thus, a comparative legal study can reveal both best practices and implementation gaps that are relevant across jurisdictions.

This article aims to contribute to the growing but underdeveloped field of comparative health law, particularly in the intersection of patients' rights, medical ethics, and legal regulation of clinical procedures. Its novelty lies in bringing together doctrinal legal analysis, ethical reasoning, and

[1] See Komnas Perempuan, Catatan Tahunan Kekerasan terhadap Perempuan 2023 (Jakarta: Komnas Perempuan, 2023); Tempo.co, "Dokter Kandungan Cabul Dipolisikan, Korban Mengaku Trauma," Tempo.co, 12 Oktober 2022.
[2] General Medical Council, Intimate Examinations and Chaperones (London: GMC, 2013); NHS England, Chaperone Policy Guidelines (London: NHS, 2020).
[3] Beauchamp, Tom L. and James F. Childress, Principles of Biomedical Ethics, 7th ed. (Oxford: Oxford University Press, 2013).
[4] Fadilah, N. R., "Pelayanan Kesehatan Perempuan dan Tantangan Etik di Daerah," Jurnal Bioetika dan Hukum Kesehatan 6, no. 1 (2021): 45–56.
[5] Coggon, John, What Makes Health Public? (Cambridge: Cambridge University Press, 2012).

comparative regulatory practice, using chaperones as an entry point for broader inquiry into how legal systems institutionalize protection in private bodily interactions. The study does not advocate for rigid transplantation of UK law into Indonesia, but rather proposes normative alignment through constitutional values, patient dignity, and legal precision.

In addressing this issue, the article formulates three central research questions. First, how are chaperones in intimate medical examinations legally and ethically regulated in Indonesia and the United Kingdom, and what normative principles guide these regulations? Second, to what extent do existing laws in both jurisdictions adequately safeguard patients' rights during such examinations? Third, how can Indonesia develop a regulatory model that incorporates ethical sensitivity, legal clarity, and cultural legitimacy without undermining medical autonomy?

To answer these questions, the article is structured as follows. Following this introduction, Section 2 presents the methodological approach, which is based on normative legal analysis and comparative law, supported by documentary review and ethical frameworks. Section 3 discusses the results in three interrelated parts: the constitutional and human rights foundations of patient protection during intimate examinations; the comparative analysis of chaperone regulation in Indonesia and the UK; and a proposed model for regulatory convergence. Finally, Section 4 synthesizes the findings and offers practical and normative recommendations for policymakers, professional associations, and medical educators. By combining legal doctrine with comparative insight, the article seeks to advance a rights-based approach to medical regulation in sensitive contexts.

**RESEARCH METHODOLOGY**

This research employs a normative legal method, focusing on the systematic analysis of legal norms, ethical codes, and doctrinal interpretations that govern the presence of chaperones during intimate medical examinations in Indonesia and the United Kingdom.[6] The study does not attempt to measure empirical behavior or institutional effectiveness but rather seeks to understand how legal systems conceptualize, regulate, and justify the use of chaperones as a mechanism for protecting patients' rights and supporting ethical medical practice.

At its core, the normative approach rests on the interpretation of written legal instruments, including constitutions, statutory laws, ministerial regulations, medical codes of ethics, and official clinical guidelines. These texts are examined as expressions of normative commitments—namely, the value placed on bodily integrity, informed consent, patient autonomy, and legal accountability. Particular attention is given to the extent to which chaperone use is explicitly regulated, implicitly assumed, or entirely omitted from legal and ethical frameworks. In this regard, the study analyzes both positive law (*lex lata*) and prescriptive proposals for legal reform (*lex ferenda*).

The comparative dimension of the research involves a structured analysis of two jurisdictions: Indonesia, representing a mixed legal system influenced by civil law, Islamic values, and customary practice; and the United Kingdom, representing a common law system with highly developed health law and medical ethics infrastructure. The comparison is functional rather than formalistic—focusing on how each system addresses the problem of intimate clinical examinations and what safeguards are provided to protect vulnerable patients. The choice of the UK is strategic, as it offers a mature example of chaperone regulation, codified through professional standards such as the General Medical Council's *Intimate Examinations and Chaperones* (2013), NHS Chaperone Guidelines (2020), and the Medical Protection Society's best practice guidance.[7]

In contrast, Indonesia presents a normative gap: while the right to informed consent and protection of patient dignity is enshrined in Law No. 29/2004 on Medical Practice and Law No. 36/2009 on Health,

[6] Dr. Johnny Ibrahim, *Teori & Metodologi Penelitian Hukum Normatif* (Bayu Media, 2013).

[7] General Medical Council, Intimate Examinations and Chaperones (London: GMC, 2013); NHS England, Chaperone Policy Guidelines (London: NHS, 2020); Medical Protection Society, Chaperones: Best Practice (London: MPS, 2021).

there is no express provision on chaperone rights or obligations in either legal or ethical instruments. Therefore, the comparative method serves not merely to contrast legal texts but to identify doctrinal voids, regulatory ambiguities, and opportunities for normative borrowing that preserve cultural legitimacy while advancing patients' rights.

This analysis is supported by a hermeneutic approach to legal interpretation, employing three primary techniques. First, grammatical interpretation is used to parse the language of existing legal texts to determine whether they implicitly support third-party presence, privacy rights, or clinical documentation during examinations. Second, systematic interpretation places individual provisions within the broader structure of the legal system—linking chaperone practices to broader health law themes such as medical accountability, consent doctrine, and gender-sensitive care. Third, teleological interpretation seeks to uncover the purposes behind these norms, particularly as they relate to the ethical principles of non-maleficence, autonomy, and justice as articulated by Beauchamp and Childress in the biomedical ethics literature.[8]

The study also integrates medical ethical frameworks to ensure that the analysis does not become overly legalistic. While law provides the formal regulatory boundary, ethics supplies the moral justification for requiring a chaperone—especially in asymmetrical power relationships between clinicians and patients. Chaperones serve not only a forensic function (e.g., legal protection in complaints) but also a moral function by reinforcing trust, reducing anxiety, and ensuring gender appropriateness. Thus, ethical codes such as the Kode Etik Kedokteran Indonesia (KODEKI) and the GMC's Good Medical Practice are treated not as secondary material but as part of a hybrid normative corpus relevant to legal development.

To maintain analytical rigor, this study excludes empirical data such as patient interviews or clinical case studies. While such data would be valuable for implementation studies, the focus here is to provide a conceptual and normative legal foundation for future regulatory reform. The study also avoids constitutional review or judicial statistics, as there are no prominent constitutional cases in Indonesia on this specific topic, and UK electoral or human rights courts have not yet adjudicated chaperone rights in a binding precedent. Sources for this study include:

1. Primary legal texts: national statutes, ministerial regulations, constitutional provisions.
2. Professional and ethical guidelines: GMC, NHS, KODEKI, WHO reports on patient safety.
3. Doctrinal commentary: peer-reviewed legal articles, monographs on medical law and ethics, and regulatory analyses.
4. International instruments: such as the Universal Declaration on Bioethics and Human Rights (UNESCO 2005), where relevant to cross-border ethical standards.

The method thus allows the article to develop a context-sensitive yet rights-driven model of chaperone regulation—drawing normative inspiration from the UK while grounding its recommendations in the doctrinal structure of Indonesian health law. The ultimate goal is not transposition but contextual harmonization: constructing a model that is ethically sound, legally precise, and culturally adaptable.

## RESULT AND DISCUSSIONS

### Constitutional and Ethical Foundations of Patient Protection in Intimate Medical Contexts

The protection of patient dignity, bodily autonomy, and privacy during intimate medical examinations stands at the intersection of constitutional rights and medical ethics. Intimate examinations—defined as any clinical procedure involving direct contact with the breasts, genitalia, or rectum—are not only physically invasive but psychologically sensitive. They involve inherent asymmetries of power, vulnerability, and potential for misunderstanding or abuse. In this context, the use of medical chaperones

[8] Tom L. Beauchamp and James F. Childress, Principles of Biomedical Ethics, 7th ed. (Oxford: Oxford University Press, 2013).

serves as both an ethical obligation and a legal safeguard, grounded in the constitutional imperatives to protect human dignity, bodily integrity, and the right to health.

Across many jurisdictions, the legal protection of patients during medical procedures is rooted in constitutional principles. The right to bodily integrity is universally acknowledged as a fundamental human right, often associated with the broader right to life and personal liberty. In the Indonesian constitutional framework, this protection is enshrined in Article 28G paragraph (1) of the *Undang-Undang Dasar 1945*, which guarantees "the right to personal protection, family, honor, dignity, and property." Moreover, Article 28H affirms the right to access health services and to enjoy a good and healthy environment. These provisions form the constitutional backbone of patients' rights in Indonesia, although they are not always operationalized in statutory law or clinical practice.[9]

In the United Kingdom, the constitutional foundation of patient protection is less codified but equally robust, embedded in common law traditions and statutory protections such as the Human Rights Act 1998, which incorporates the European Convention on Human Rights (ECHR). Article 8 of the ECHR—"the right to respect for private and family life"—has been interpreted by British courts to encompass bodily autonomy, informed consent, and medical confidentiality. In *R (Burke) v. GMC* [2005], the High Court underscored the legal importance of patient choice and dignity in clinical settings.[10] Although the UK lacks a written constitution, these human rights principles serve a constitutional function, guiding professional standards, administrative practices, and judicial review.

From an ethical perspective, the four pillars of biomedical ethics—autonomy, beneficence, non-maleficence, and justice—provide a normative framework that complements legal protections. Autonomy demands that patients be informed, respected, and given control over their bodies. Beneficence and non-maleficence require that healthcare providers act in the patient's best interest and avoid harm, including emotional discomfort, embarrassment, or trauma during intimate procedures. Justice entails fair treatment, including sensitivity to gender, religion, and cultural norms that may affect a patient's experience of vulnerability. The presence of a chaperone, when properly explained and implemented, supports all four principles: it protects the patient's autonomy by allowing choice; promotes beneficence by increasing trust; prevents harm by deterring misconduct; and advances justice by reducing gender-based power imbalances.[11]

However, the legal and ethical imperative to protect patients during intimate examinations faces several structural and conceptual obstacles. One of the most significant is the conceptual invisibility of chaperone use in many legal systems. In Indonesia, although the law guarantees health rights and informed consent, the presence of a third-party observer during examinations is not mentioned in Law No. 36/2009 on Health, Law No. 29/2004 on Medical Practice, or Government Regulation No. 32/1996 on Health Workers. Similarly, the Kode Etik Kedokteran Indonesia (KODEKI)—which outlines ethical obligations of physicians—lacks provisions on chaperone usage. This regulatory vacuum leaves medical professionals without clear legal guidance and patients without institutionalized safeguards. The result is a clinical space where subjective discretion replaces normative obligation, increasing legal risk and eroding trust.

By contrast, the United Kingdom has developed a comprehensive regulatory environment on the use of chaperones in intimate examinations. The General Medical Council (GMC) advises that a chaperone should be offered in any examination involving breasts, genitalia, or rectum, and that refusal by the patient must be clearly documented.[12] The National Health Service (NHS) further recommends that healthcare institutions adopt formal chaperone policies, including staff training and patient notification procedures. These recommendations have been institutionalized as part of Good Medical Practice, and failure to comply can trigger disciplinary action or legal liability. Moreover, British courts have recognized

[9] Undang-Undang Dasar Negara Republik Indonesia Tahun 1945, Art. 28G dan Art. 28H.
[10] R (Burke) v. General Medical Council [2005] EWCA Civ 1003.
[11] Tom L. Beauchamp and James F. Childress, Principles of Biomedical Ethics, 7th ed. (Oxford: Oxford University Press, 2013).
[12] General Medical Council, Intimate Examinations and Chaperones (London: GMC, 2013), sec. 13–17.

that the absence of a chaperone in certain contexts may constitute professional negligence, particularly if misconduct is alleged.[13]

This contrast between Indonesia and the UK reflects deeper differences in how legal and ethical norms are conceptualized and institutionalized. In Indonesia, patients' rights remain largely procedural and aspirational, often dependent on post-hoc mechanisms such as malpractice litigation or professional discipline. By the time harm occurs, the damage to trust, dignity, and bodily integrity may be irreversible. In the UK, by embedding chaperone practices in professional codes and routine clinical protocols, the legal system moves toward preventive protection, minimizing the opportunity for abuse or dispute before it occurs.

Moreover, the ethical obligation to offer a chaperone must also be contextualized within broader frameworks of gender sensitivity and religious accommodation. In Indonesia, where the majority of the population is Muslim, modesty norms are strong, and many female patients prefer to be examined by female physicians. When this is not possible, the presence of a female chaperone becomes not only a matter of comfort but of cultural and religious necessity. The *Majelis Ulama Indonesia* (MUI) has issued fatwas on medical ethics and emergency treatment, but these do not specifically address the institutionalization of chaperone rights. Nevertheless, Islamic bioethics generally supports the use of chaperones as a means of avoiding *fitnah* (temptation) and preserving moral integrity.[14] Legal recognition of this practice would align secular regulatory frameworks with dominant ethical-religious expectations.

From a legal-theoretical standpoint, the absence of express chaperone rights in Indonesian law creates a normative ambiguity regarding the scope of informed consent and patient autonomy. Is consent truly informed if a patient does not know that a chaperone may be present—or worse, is unaware that they are entitled to request one? Without legal obligation to inform patients of this right, the potential for coercion, misunderstanding, or fear remains latent. Conversely, in the UK, the right to be offered a chaperone is itself a legal and ethical component of informed consent, elevating the patient from passive recipient to active agent in clinical decision-making.[15]

In terms of legal enforceability, chaperone-related protections in Indonesia are difficult to litigate unless misconduct escalates to the level of criminal assault or administrative complaint. This gap between ethical expectation and legal enforceability creates a double burden: patients lack protection, and healthcare providers lack procedural clarity. A chaperone regime that is left to "common sense" or "cultural practice" is neither consistent nor reliable. Therefore, formal recognition of chaperones as a legal safeguard—grounded in constitutional rights and supported by statutory mandates—is essential for bridging this gap.

Internationally, the move toward codifying patients' rights, including protection during sensitive procedures, is gaining momentum. Instruments such as the Universal Declaration on Bioethics and Human Rights (UNESCO, 2005) emphasize the need for human dignity, autonomy, and integrity in healthcare. While not binding, such declarations signal emerging normative consensus, which national legal systems may draw upon in developing domestic regulation. In this light, the regulation of chaperone use should not be viewed as a narrow clinical issue but as part of the constitutionalization of patient protection in intimate spaces—a project that aligns legal doctrine with evolving moral and democratic expectations.

Ultimately, the presence of a chaperone during intimate examinations should be seen not as an intrusion or administrative burden but as a structural expression of care, respect, and accountability. It embodies the legal system's commitment to protecting vulnerable persons, the medical profession's duty to act ethically, and the patient's right to dignity and informed participation. In both Indonesia and the United Kingdom, the legal and ethical foundations for this protection already exist. What is needed is a deliberate

[13] Royal College of Nursing, Chaperoning: The Role of the Nurse as Chaperone (London: RCN, 2020).
[14] Majelis Ulama Indonesia, Fatwa tentang Etika Pengobatan Pasien dalam Perspektif Islam, No. 53/2010.
[15] NHS England, Patient Consent and Chaperone Guidance (London: NHS, 2020).

effort to connect principle with practice and to translate abstract rights into concrete institutional safeguards.

**Comparative Analysis: Chaperone Regulation in Indonesia and the United Kingdom**

The regulatory landscape surrounding chaperone use in intimate medical examinations reveals a profound divergence between Indonesia and the United Kingdom—not merely in terms of legal formality, but in conceptual clarity, institutional design, and normative implementation. This comparative analysis examines the legislative, professional, and procedural frameworks that govern chaperone policy in both countries, focusing on the extent to which each system recognizes the practice as a legal obligation, ethical mandate, or clinical option. The analysis illuminates how Indonesia's underdeveloped chaperone regulation contrasts sharply with the United Kingdom's codified and culturally institutionalized approach, raising questions about the capacity of legal systems to operationalize patient dignity and autonomy in clinical contexts.

In Indonesia, the chaperone is an invisible legal subject. There is no mention of chaperone use in any of the primary laws governing healthcare practice. Neither Law No. 29/2004 on Medical Practice, Law No. 36/2009 on Health, nor Law No. 44/2009 on Hospitals contains provisions that require or recommend the presence of a third party during intimate physical examinations. Likewise, Government Regulation No. 32/1996 on Health Workers and Ministerial Decree No. 290/Menkes/Per/III/2008 on Informed Consent do not mention or imply the role of chaperones. This regulatory silence stands in stark contrast to the growing public awareness of patient vulnerability during examinations involving reproductive organs, breasts, or rectal areas.

Indonesia's Kode Etik Kedokteran Indonesia (KODEKI)—the national code of medical ethics—also fails to regulate chaperone practice. Article 9 of KODEKI mandates that doctors "maintain the dignity of the patient" and act in good faith, while Article 10 emphasizes the obligation to provide adequate explanations prior to medical procedures. However, these articles stop short of specifying protective mechanisms. Chaperones are not discussed, even as optional safeguards. As a result, decisions regarding the presence of a third party are left entirely to the subjective judgment of the physician, or in some cases, the religious or cultural insistence of the patient or their family. There is no binding duty to offer, document, or explain the option of chaperone presence, which raises serious concerns regarding informed consent, legal defensibility, and ethical consistency.[16]

In practice, some hospitals in Indonesia—especially private Islamic hospitals—have adopted informal chaperone practices. Female nurses are often present during gynecological exams, especially when the physician is male and the patient is female. However, these practices are not standardized, regulated, or monitored. In state-owned or rural facilities, such considerations are frequently overlooked. A study conducted by Fadilah (2021) revealed that over 65% of patients undergoing pelvic examinations in provincial clinics were not informed of their right to request a companion, and many reported emotional discomfort or feelings of exposure, especially in the absence of gender-congruent providers.[17]

Meanwhile, recent legal controversies involving allegations of sexual misconduct by physicians have not yet triggered systemic reform. High-profile cases, such as the 2022 case in Surabaya involving a gynecologist accused of indecent behavior, led to criminal prosecution but did not result in policy change at the national level. Victims and professional watchdogs have called for clearer chaperone regulation, but the legal discourse remains reactive, rather than preventive. Misconduct is addressed only after harm occurs—often through criminal or administrative mechanisms—rather than being prevented through mandatory chaperone protocols or institutional supervision.[18]

[16] Kode Etik Kedokteran Indonesia (KODEKI), Majelis Kehormatan Etik Kedokteran (MKEK), 2012.
[17] Fadilah, N. R., "Pelayanan Kesehatan Perempuan dan Tantangan Etik di Daerah," Jurnal Bioetika dan Hukum Kesehatan 6, no. 1 (2021): 45–56.
[18] Tempo.co, "Dokter Kandungan Cabul Dipolisikan, Korban Mengaku Trauma," Tempo.co, 12 Oktober 2022.

By contrast, the United Kingdom offers a layered, proactive, and legally supported framework for chaperone use, integrating regulatory expectations, ethical norms, and clinical guidelines. The foundation lies in the General Medical Council (GMC) guidance titled *Intimate Examinations and Chaperones*, issued in 2013. Paragraphs 13–20 of this guidance outline the responsibilities of physicians to offer a chaperone during any examination involving breasts, genitalia, or rectal areas. The GMC states that doctors "should offer the patient the option of having an impartial observer present wherever an intimate examination is conducted, and should always explain why the examination is necessary, what it will involve, and seek the patient's consent."[19]

More importantly, the offer of a chaperone is not discretionary. The GMC expects that refusal or acceptance of the chaperone must be clearly documented in the medical record. If a chaperone is declined, and the physician believes the examination should still proceed, they are encouraged to consider whether it is appropriate to continue without one, especially in settings where misunderstandings could arise. Failure to comply with these protocols can result in disciplinary sanctions, including loss of licensure.

The National Health Service (NHS) builds upon the GMC's guidance by issuing detailed institutional chaperone policies. These policies standardize the recruitment, training, and assignment of chaperones in hospital and clinic settings. Chaperones are typically healthcare workers (nurses, assistants, or designated staff) who are trained to understand their role: to witness the examination, support the patient, and intervene or report if inappropriate behavior occurs. NHS Trusts also require that patient leaflets and posters inform patients of their right to request a chaperone, thereby fulfilling both informed consent and procedural justice obligations.[20]

The UK's regulatory approach also extends into legal doctrine. Courts have implicitly recognized that the absence of a chaperone—especially when offered but refused without documentation—can exacerbate liability in civil or criminal proceedings. In *R v. Darroux* [2018], the Court of Appeal dealt with issues of evidentiary value and witness presence in cases of alleged indecent assault by a healthcare provider. While not directly focused on chaperone obligations, the case illustrates how institutional protocols matter in establishing credibility and procedural fairness.[21]

This contrast between the UK and Indonesia illustrates divergent regulatory philosophies. In the UK, chaperone use is legally endorsed, ethically expected, institutionally embedded, and culturally normalized. In Indonesia, the practice is discretionary, informal, uneven, and largely unacknowledged in legal texts. This regulatory gap is not merely a matter of policy detail—it reflects deeper tensions in how law conceptualizes patient rights, medical power, and clinical vulnerability.

Culturally, both countries have sensitivities around modesty and exposure. However, the UK addresses this through structured accommodation, whereas Indonesia leaves it to moral discretion. For example, UK policy encourages the availability of same-gender chaperones where feasible but allows patients to accept or decline based on preference. In Indonesia, requests for same-gender examiners or chaperones are often negotiated informally and can be dismissed due to lack of personnel or institutional unawareness. The absence of procedural entrenchment means that cultural concerns, while salient, are not operationalized as rights.

From a regulatory design standpoint, the UK's approach offers clarity, consistency, and accountability, supported by written guidelines, patient education, and disciplinary mechanisms. Indonesia lacks all three. There is no legal mandate, no national chaperone guideline, and no requirement for documentation. Moreover, Indonesian medical education curricula do not consistently train future doctors in chaperone protocol or patient communication around intimate examinations.[22]

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[19] General Medical Council, Intimate Examinations and Chaperones (London: GMC, 2013), paras. 13–20.
[20] NHS England, Chaperone Policy Guidelines (London: NHS, 2020).
[21] R v. Darroux [2018] EWCA Crim 1895.
[22] Azhari, Rizky, "Urgensi Kurikulum Hukum Kedokteran dalam Pendidikan Dokter," Jurnal Pendidikan Kedokteran Indonesia 8, no. 2 (2022): 109–121.

Importantly, the UK's model is not without challenges. A 2020 audit by the Care Quality Commission (CQC) found that in several primary care settings, chaperone policies were not consistently implemented. Staff were sometimes unaware of their responsibilities, and documentation was occasionally absent. However, the existence of a regulatory structure allowed these deficiencies to be identified and corrected. Regulatory oversight, rather than its absence, enables quality improvement.

Indonesia, by contrast, cannot audit what it does not regulate. In the absence of national chaperone protocols, clinical silence becomes the norm. Without standard operating procedures, staff training programs, or public awareness materials, even well-intentioned clinicians may overlook the need for a chaperone. Worse, in cases of alleged misconduct, the lack of documentation or institutional procedure may hamper the defense or reporting process, placing both doctors and patients in vulnerable positions.

Comparatively, Indonesia can draw key lessons from the UK model without simply transplanting its entire structure. The UK's emphasis on clear communication, patient choice, trained chaperones, and documentation can be adapted to Indonesian healthcare settings with sensitivity to resource constraints and cultural diversity. For instance, guidelines could allow family members to serve as chaperones where trained staff are unavailable, provided patients consent. Likewise, religious institutions such as *Majelis Ulama Indonesia* could endorse chaperone usage as ethically congruent with Islamic principles, strengthening social legitimacy.

In sum, this comparative analysis reveals not just a difference in regulatory maturity, but a divergence in how two legal cultures understand patient dignity, clinical power, and institutional responsibility. Where the UK treats chaperone presence as a right-based safeguard, Indonesia continues to view it—when acknowledged at all—as an optional act of physician courtesy. Bridging this normative gap requires more than policy copying; it demands a paradigm shift in regulatory thinking, one that repositions the chaperone not as a passive observer but as a constitutive element of ethical, legal, and accountable clinical care.

**Modeling Normative Convergence: Toward a Legal-Ethical Framework for Indonesia**

The legal void surrounding chaperone regulation in Indonesia reflects not merely a policy omission but a broader failure to institutionalize patient dignity, gender sensitivity, and preventive protection within clinical law. While the constitutional and ethical principles supporting chaperone use are present—such as the rights to bodily integrity, privacy, and informed consent—they remain under-activated in the absence of regulatory instruments and professional mandates. Drawing from the comparative analysis with the United Kingdom, this section outlines a contextualized framework for Indonesia to develop its own legal-ethical regime for regulating chaperones during intimate medical examinations. The framework emphasizes normative convergence, rather than mechanical legal transplantation, and advocates a hybrid model rooted in statutory clarity, professional responsibility, and cultural-religious legitimacy.

A critical first step is to recognize the chaperone not merely as a procedural convenience but as a legal expression of patient rights. In this light, chaperone availability and the obligation to offer it must be seen as an extension of the right to informed consent. According to the 2008 Ministerial Decree No. 290/Menkes/Per/III/2008 on Informed Consent, patients must receive adequate information about the nature, risks, and alternatives of any procedure. While the decree focuses primarily on invasive treatments and surgery, it can be interpreted—teleologically—to include safeguards during sensitive physical examinations, particularly those that could trigger trauma, embarrassment, or ethical conflict. The inclusion of chaperone information within consent discussions would therefore not introduce a new legal right but activate an existing one.[23]

Second, the legal foundation must be supported by professional codification. Indonesia's Kode Etik Kedokteran Indonesia (KODEKI), issued by the Indonesian Medical Association, should be amended to

[23] Peraturan Menteri Kesehatan RI Nomor 290/Menkes/Per/III/2008 tentang Persetujuan Tindakan Kedokteran (Informed Consent).

include a clear and operational clause on chaperone use during intimate examinations. This clause should (a) require physicians to offer a chaperone in all such procedures, (b) oblige documentation of the offer and the patient's response, and (c) define minimum standards for the qualification and neutrality of the chaperone. Importantly, the ethical requirement should apply regardless of gender, though in practice, sensitivity to religious and cultural preferences—such as the desire for a female chaperone during a male physician's examination of a female patient—must be formally recognized.[24]

Third, the framework must accommodate contextual implementation across Indonesia's diverse healthcare settings. Unlike the UK, where most facilities are under the NHS and operate under a relatively standardized infrastructure, Indonesia's healthcare ecosystem is pluralistic: it includes public hospitals, private clinics, Islamic health foundations, and community health centers (puskesmas). A one-size-fits-all chaperone policy would be neither enforceable nor sensitive to logistical disparities. Therefore, the proposed regulatory model should establish a two-tiered system:

1. In tier-one facilities (urban hospitals, tertiary care centers, medical schools), chaperones should be institutionally appointed, trained, and documented.
2. In tier-two facilities (rural clinics, puskesmas), where trained personnel may not be available, patients should be offered the option to be accompanied by a trusted family member or community health worker, with the same documentation protocol.

This graduated approach allows for functional convergence without imposing unrealistic administrative burdens. The fourth component is legal reinforcement through ministerial regulation. A dedicated Peraturan Menteri Kesehatan (Permenkes) on chaperones is necessary to formalize expectations, provide definitions, and authorize institutional enforcement. Such a regulation should define:

1. What constitutes an intimate examination
2. When chaperones must be offered or required
3. Who qualifies as a chaperone (e.g., nurses, midwives, trained assistants)
4. What documentation must be maintained in medical records
5. Exceptions (e.g., emergency care)
6. Mechanisms for monitoring and compliance.

The regulation can be integrated into broader patient protection instruments or issued as a supplement to the Permenkes on Patient Safety.[25] Fifth, training and awareness must be institutionalized. Medical education curricula in Indonesia rarely include modules on gender-based sensitivity, patient rights in intimate care, or chaperone protocol. The Indonesian Medical Council (KKI) and academic institutions must incorporate this into both undergraduate and continuing professional development. Similarly, hospitals and clinics should provide orientation sessions for all clinical staff, including nurses, regarding their roles as chaperones, ethical duties, and patient communication skills.

Equally important is public awareness. Patients cannot exercise a right they do not know exists. The regulatory framework should mandate healthcare providers to display posters and distribute leaflets informing patients—especially women and adolescents—of their right to a chaperone. This mirrors the approach taken by the UK's NHS, where patient-facing communication is a formal part of policy enforcement.[26]

A potential innovation, adapted to the Indonesian context, is to involve religious institutions and civil society in promoting chaperone awareness. For instance, Majelis Ulama Indonesia (MUI) can be engaged to issue an ijtihad or updated fatwa affirming that chaperone usage in clinical care aligns with Islamic principles of maslahah (public benefit) and sadd al-dzari'ah (preventing harm). Similarly, women's organizations and medical NGOs can assist in monitoring compliance and collecting feedback from

[24] Kode Etik Kedokteran Indonesia (KODEKI), Majelis Kehormatan Etik Kedokteran, 2012.
[25] Permenkes No. 11 Tahun 2017 tentang Keselamatan Pasien.
[26] NHS England, Chaperone Policy Guidelines (London: NHS, 2020).

patients in underserved areas. This strategy would translate normative regulation into socio-cultural legitimacy.[27]

Additionally, the regulation must avoid reinforcing paternalistic structures. Patients should not be forced to accept a chaperone. The right must be one of availability and autonomy, not imposition. While institutional policy may recommend a chaperone for medico-legal protection, patient refusal must be respected, documented, and handled with discretion. In this sense, the chaperone model operates as a structural option within a rights-based clinical environment, reinforcing rather than restricting patient agency.

To ensure effectiveness, the framework should include periodic evaluation mechanisms. Hospitals can be encouraged to conduct internal audits, checking whether chaperone offers are documented, whether staff are trained, and whether patients understand their rights. The Ministry of Health can integrate this into existing accreditation and licensing inspections. Moreover, malpractice review boards and ethical councils should consider the absence of chaperones as an aggravating factor in claims of misconduct—thereby reinforcing the protective function of the model without criminalizing failure to comply.

Finally, it is essential to reiterate that this framework is not about importing British norms but about realizing Indonesian constitutional and ethical values through clearer legal design. The right to bodily integrity, the protection of vulnerable patients, and the duty to act ethically are not foreign to Indonesian legal or religious thought. What is missing is institutional translation: the conversion of abstract commitments into concrete rules, procedures, and protections. By developing a homegrown but globally informed regulatory regime for chaperones, Indonesia can fulfill its constitutional obligation to protect patient dignity while enhancing medical professionalism. In conclusion, the proposed framework rests on six pillars:

1. Legal recognition of chaperone rights within informed consent law.
2. Professional codification in KODEKI and clinical SOPs.
3. Contextual implementation through a tiered model.
4. Formal regulation via a dedicated Permenkes.
5. Training and public communication strategies.

Multistakeholder engagement including religious, civil, and professional bodies.
Together, these elements would establish a preventive, rights-based, and culturally coherent system of protection for Indonesian patients undergoing intimate examinations. Harmonization does not mean uniformity. Rather, it means that Indonesia affirms its own commitment to justice and dignity, informed by ethical reason, comparative insight, and constitutional fidelity.

**CONCLUSION AND SUGGESTIONS**

This study has demonstrated that the presence of medical chaperones during intimate examinations is not merely a matter of clinical protocol but a reflection of how legal systems institutionalize dignity, trust, and bodily integrity in healthcare settings. While the ethical foundation for chaperone use is widely accepted—grounded in the principles of autonomy, non-maleficence, and justice—its legal regulation remains inconsistent across jurisdictions. A comparative analysis of Indonesia and the United Kingdom reveals a stark contrast: the UK has developed a structured, enforceable, and ethically coherent framework for chaperone policy, while Indonesia continues to rely on discretionary practice, lacking formal legal norms, ethical mandates, or procedural guidelines.

The normative implications of this divergence are significant. In the absence of regulation, Indonesian patients—particularly women, minors, and those in rural settings—remain vulnerable to violations of privacy, unwanted exposure, or even abuse. Physicians, too, lack institutional protection in cases of false accusation or misunderstanding. The current legal silence fosters uncertainty, inconsistency, and in some cases, preventable harm. As such, regulatory reform is not only desirable but necessary, aligning

[27] Majelis Ulama Indonesia, Fatwa Tentang Etika Pengobatan Pasien Dalam Perspektif Islam, No. 53/2010.

Indonesia's health law with its constitutional commitments to personal protection, dignity, and access to ethical healthcare.[27]

Drawing upon the UK's regulatory experience, this article has outlined a context-sensitive model for Indonesia, one that avoids legal transplantation but embraces principled convergence. The proposed model involves the integration of chaperone rights into informed.

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