Indonesian Journal of Cardiology
Indonesian J Cardiol • Vol. 47 • 2026
pISSN: 2830-3105 / eISSN: 2964-7304
doi: 10.30701/ijc.2524

Viewpoint

An Affiliative Relationship Reflects Institutional Equality, Organizational Autonomy, and Mutual Respect, Rather Than Hierarchical Authority or Subordination

Muhammad Munawar[1], Dolly Richard Daniel Kaunang[2], Sasmojo Widito[3], Sunarya Soerianata[4], Achmad Fauzi Yahya[5], Anna Ulfah Rahajoe[6], Sunu Budhi Raharjo[6], Pradana Tedjasukmana[7], Lucia Kris Dinarti[8], Agnes Lucia Panda[9], Syarief Hidayat[5]

[1]Binawaluya Cardiac Center, Jakarta, Indonesia
[2]RSAU dr. Esnawan Antariksa, Jakarta, Indonesia
[3]RSUD Saiful Anwar, Malang, Indonesia
[4]RSPI Pondok Indah, Jakarta, Indonesia
[5]RSUP Hasan Sadikin, Bandung, Indonesia
[6]RS Jantung dan Pembuluh Darah Harapan Kita, Jakarta, Indonesia
[7]RS EMC Grha Kedoya, Jakarta, Indonesia
[8]RSUP Dr. Sardjito, Yogyakarta, Indonesia
[9]RSUP Kandou, Manado, Indonesia

Correspondence:
Muhammad Munawar,
Binawaluya Cardiac Center, Jakarta, Indonesia

Email: muna286@gmail.com

The relationship between the Indonesian Heart Association (PERKI) and the Indonesian Medical Association (IDI) deserves reassessment because professional governance must connect clinical expertise with effective ethical oversight. National coordination remains valuable, but its legitimacy depends on protecting patients and ensuring fair physician assessment. This article proposes an affiliative relationship with defined responsibilities, meaningful specialty authority, and independent review. The objective is to make professional unity compatible with accountable specialty governance.

Keywords: Public Trust, Medical Ethics, Professionalism, Cardiology, Patient-centered Care

Why this Matters in Cardiology

Patients may be unable to judge whether a recommended intervention is necessary, even when it is technically successful. Information asymmetry is a longstanding feature of medical care.[1] Its implications extend beyond informed consent: oversight cannot depend solely on patients recognizing questionable practice and complaining.

In cardiology, an angiographic abnormality alone does not establish the appropriateness of intervention. For selected patients with angiographically intermediate coronary stenoses, revascularization guidelines recommend physiological assessment to guide percutaneous coronary intervention.[2] Ethical review therefore requires attention to the clinical presentation, evidence available at the time, expected benefit, alternatives, and disclosure. A guideline deviation requires contextual assessment; it is not, by itself, proof of unethical conduct.

The same expertise protects physicians. Complications and unfavorable outcomes can occur despite appropriate care. Review should distinguish reasonable clinical judgment from inadequate disclosure, misrepresentation, or decisions improperly influenced by financial interests. Clinical appropriateness and ethical conduct overlap, but neither can be inferred automatically from the other.

Generative artificial intelligence and digital promotion introduce further challenges. World Health Organization (WHO) guidance identifies inaccurate or biased outputs and automation bias as risks of large multimodal models.[3] The World Medical Association calls for accurate professional communication and protection of confidentiality on social media.[4] Assessing such concerns requires both ethical judgment and understanding of the technology and clinical claims involved.

The Governance Question in Indonesia

The text adopted at IDI's 2025 congress recognizes specialty ethics councils as responsible for ethical education and oversight in Article 21(1)(l) of its bylaws, while Article 21(1)(m) reserves ethical hearings to *Majelis Kehormatan Etik Kedokteran* (MKEK), IDI's Medical Ethics Council. Article 21(1)(j) also provides for specialty society representation within the central MKEK.[5] These provisions acknowledge specialty participation while concentrating adjudicative authority.

The relationship between the organizations' governing documents is also relevant. Article 28 of the Constitution and Article 42(1) of the bylaws require the governing documents of societies described as being under IDI to conform to IDI's governing framework.[5] The issue is therefore more specific than an informal expectation of hierarchy: the congress-adopted text contains an express organizational alignment requirement. Its legal effect must be distinguished from its wording, including the commencement condition in Article 29 of the Constitution.

Centralized adjudication can support consistent ethical standards and common procedures. Nevertheless, formal representation does not ensure that a particular case receives appropriate subspecialty assessment. A governance gap may arise when those able to identify a concern lack an effective route to adjudication, or when decision makers lack the expertise to evaluate it. This is a plausible institutional risk, not an established finding that IDI's arrangements have caused particular failures.

PERKI's Internal Framework for Ethical Oversight

PERKI's 2025 constitution identifies the physician's oath and *Kode Etik Kedokteran Indonesia* (KODEKI), the Indonesian Code of Medical Ethics, as its ethical foundation in Article 6. Its bylaws provide an organizational route for education, oversight, assessment, and membership consequences. Article 30(1), (7), and (8) establish an autonomous Ethics Council accountable to the PERKI congress (Kongres PERKI, KOPERKI); Article 30(9) defines its relationship with the Central Board as coordinative and consultative. Article 31(2) assigns autonomous ethical education, oversight, and assessment; Article 31(4) requires good relations with MKEK; and Article 31(7) expressly addresses adjudicative duties and advises assistance for the respondent through PERKI's legal and member-support department. Article 32(4) permits Council activity on written reports.[6]

Ethical assessment and termination of membership involve different organs. Article 30(10) requires PERKI officers to implement final Ethics Council decisions, while Article 31(5) requires the Central Board to

follow up Council recommendations. Articles 8(3) and 9(1)(c) place membership termination with the Central Board, on an Ethics Council proposal, with reporting to KOPERKI. Article 11(2)(h) authorizes the congress to assess and determine termination status. Article 8 also provides access to assistance and an opportunity to defend oneself, with further procedures assigned to PERKI's organizational rules of procedure (*Organisasi dan Tata Laksana*, ORTALA).[6] Thus, the Ethics Council should not be described as unilaterally terminating membership.

Both organizations therefore retain a role for common professional ethics, but their governing texts allocate adjudicative responsibility differently. PERKI's provisions establish an internal mandate; they do not, by themselves, settle their compatibility with IDI's reservation of hearings to MKEK. Nor do they show that PERKI's procedures are consistently implemented or provide protection equivalent to MKEK's. This perspective examines governing texts rather than case records or a complete set of implementing procedures. Its proposal requires harmonization and independent scrutiny of both systems.[5-6]

Boundaries with Statutory Professional Discipline

Reform should distinguish ethical assessment, organizational membership decisions, and statutory professional discipline. Article 304(3) of Law No. 17 of 2023 assigns determination of professional disciplinary violations to the statutory disciplinary body; the implementing framework identifies *Majelis Disiplin Profesi* (MDP, Professional Discipline Board).[7-8] MKEK and PERKI's Ethics Council address professional ethics within their respective organizational mandates. MDP determines alleged professional disciplinary violations through the statutory process. An affiliation agreement would neither place MDP under either organization nor make MDP an appellate body for society membership decisions.

The same clinical event may raise ethical and disciplinary questions, but an organizational finding cannot automatically determine the statutory outcome. Each body must establish its own jurisdiction, evaluate the relevant evidence, and afford applicable procedural protections. PERKI membership sanctions do not themselves suspend medical registration or a practice license. Article 305(1), as enacted, identifies patients or their families whose interests are harmed as complainants. An affiliation agreement cannot itself expand statutory standing or guarantee MDP acceptance of a referral. Any transmission of information must have a lawful basis and follow the applicable procedure; confidentiality and evidence provenance remain essential.[7]

What International Comparison Can Establish

The United States offers two relevant examples. Under Bylaw 2.0.1.6 of the American Medical Association's (AMA) July 2026 bylaws, participation in its House of Delegates is voluntary, and AMA policy actions do not automatically bind participating organizations.[9] This supports a limited proposition: national representation can coexist with organizational autonomy. It does not establish an identical legal relationship for Indonesia.

The American College of Cardiology (ACC) provides a more directly relevant example of specialty ethical authority. Its professional conduct procedures provide for complaint assessment, relevant professional expertise, conflict management, membership sanctions including expulsion, and an appeal process.[10] These organizational powers coexist with state medical boards' authority over licensure.[11]

These examples illustrate compatible functions rather than a universal institutional model. They support considering specialty membership jurisdiction within a coordinated profession, but cannot establish its legal availability or superior performance in Indonesia. Those questions require examination of domestic governing documents and experience.

The ACC example illustrates that a specialty society may exercise autonomous ethical and membership authority without being institutionally subordinate to a national medical association, while remaining accountable to applicable professional and legal standards.

An Affiliative Arrangement with Defined Authority

An affiliative relationship should recognize PERKI and IDI as equal and autonomous institutional partners, with distinct responsibilities and a shared commitment to professional ethical standards. Such a

relationship is neither hierarchical nor subordinate, nor should it be understood as merely coordinative; rather, it is founded on institutional equality, mutual respect, and recognition of each organization's autonomous authority. Equality in this context does not imply identical functions or exemption from accountability.

IDI should retain a central role in national representation, common ethical principles, and coordination across specialties. PERKI's Ethics Council should exercise autonomous authority in cardiovascular ethical assessment and adjudication within its organizational jurisdiction, subject to applicable law, its governing documents, and procedural safeguards. Decisions within this jurisdiction should not be subject to hierarchical appeal to IDI's Ethics Council (MKEK), while appropriate independent review should remain available through procedures established within PERKI's own governance framework. Alleged professional disciplinary violations should proceed through the competent statutory process.

This article favors recognition of specialty adjudication within an expressly defined organizational jurisdiction. Placing assessment closer to relevant expertise supports this model, provided it is coupled with independent review. The recommendation is prospective: it does not validate any existing society decision or justify disregarding governing provisions.

A written arrangement should be concluded by the competent organs of IDI and PERKI, with MKEK and PERKI's Ethics Council responsible for the agreed ethical procedures. It should identify the receiving office, require acknowledgment and jurisdictional triage, specify access to relevant subspecialty expertise, establish response periods, and require written reasons for accepting, redirecting, or declining a concern. It should also define evidence handling, notice to the respondent, decision authority, implementation, and independent review. These obligations could reduce the organizational gap between identifying a concern and obtaining an accountable decision; their effectiveness would still require evaluation.

Implementation has two stages. Within existing authority, an agreement could provide documented referrals to MKEK and case-specific cardiovascular expertise. Recognition of autonomous specialty adjudication would require prior harmonization of inconsistent governing provisions, particularly IDI Bylaw 21(1)(m), through the competent amendment processes.[5–6] An agreement cannot override a binding constitution or bylaws, create statutory jurisdiction, or retrospectively validate individual decisions. Any effect on membership of the other organization must be determined by that organization's authorized organs.

For example, a concern about a potentially misleading claim for a cardiovascular intervention could first receive documented specialty assessment, followed by a reasoned decision on the appropriate ethical forum. The respondent would have an opportunity to contest the evidence and expert interpretation. An agreed process could help prevent the assessment from disappearing between organizations, but would not predetermine misconduct. Any suspected professional disciplinary violation would require a separate, legally admissible statutory pathway. A joint mechanism should resolve organizational jurisdictional disputes without displacing MDP's independent mandate.[7–8]

Safeguards Are Part of Autonomy

Specialty expertise does not guarantee impartiality. Professional proximity, financial relationships, competition, and prior involvement may influence both allegations and decisions. Examiners should disclose relevant interests and withdraw when a conflict compromises their independence. External expertise should be available when an impartial internal panel cannot be formed. The same safeguards should apply whether the forum is MKEK or PERKI's Ethics Council.

Preliminary assessment, adjudication, and review should be assigned to sufficiently independent participants. Respondents should receive clear allegations, appropriate access to evidence subject to confidentiality protections, adequate time to respond, and reasoned decisions. Review should consider the information available when care was delivered and avoid judging solely by an unfavorable outcome. ACC procedures offer a useful comparison, but Indonesian arrangements require their own legitimate rules.[10]

Patients and those reporting concerns should be protected from retaliation and unnecessary disclosure. Confidentiality should protect their rights while permitting investigations authorized by law. Coordination rules should identify concurrent proceedings and allow lawful use of relevant findings, with reasons for further examination where necessary.

Such coordination should limit unjustified duplication without allowing inaction in one forum to obstruct another body's lawful responsibilities.

Accountability as the Test of Reform

A practical first step is a joint, documented review of governing provisions and referral pathways, with meaningful participation by specialty societies and patient representatives. The review should identify where concerns can enter the system, who must assess them, and who is accountable for completing the process.

Performance should be assessed through response times, relevant expert involvement, referral completion, implementation of decisions, and reasons for appeal outcomes. Sanction counts alone would be misleading: effective oversight must identify substantiated misconduct and dismiss unsupported allegations. These measures would allow evaluation of reform rather than assuming its benefits.

PERKI and IDI should therefore consider a written affiliative arrangement that combines shared ethical standards with defined specialty responsibility and independent review. PERKI provides a concrete institutional illustration; equivalent arrangements cannot be assumed for every specialty society. The proposed framework requires lawful rule changes where necessary and prospective evaluation. Professional solidarity entails fairly examining concerns, protecting respondents from unsupported allegations, and acting on substantiated findings within the competent jurisdiction.

List of Abbreviations

ACC	American College of Cardiology
AMA	American Medical Association
IDI	Indonesian Medical Association
KODEKI	Indonesian Code of Medical Ethics
KOPERKI	PERKI congress
MDP	Professional Discipline Board
MKEK	IDI's Medical Ethics Council
ORTALA	PERKI's organizational rules of procedure
PERKI	Indonesian Heart Association
WHO	World Health Organization

Conflict of Interest

All authors are members of the Ethics Council of the Indonesian Heart Association (PERKI). Muhammad Munawar serves as its Chair. These roles constitute nonfinancial institutional interests relevant to the subject of this article. The views expressed are those of the authors and do not necessarily represent the official positions of PERKI, IDI, or the authors' institutions.

Funding

No external funding was received for the preparation of this manuscript.

Generative AI and AI-Assisted Technologies in the Writing Process

During manuscript preparation and revision, the authors used Grammarly to assist with language editing and Perplexity to help identify relevant sources. ChatGPT assisted editorial revision and preparation of responses to reviewers. The authors remain responsible for reviewing the manuscript, verifying its sources, and approving the version submitted to the journal.

References

1. Arrow KJ. Uncertainty and the welfare economics of medical care. Am Econ Rev. 1963;53(5):941-73.
2. Lawton JS, Tamis-Holland JE, Bangalore S, Bates ER, Beckie TM, Bischoff JM, et al. 2021 ACC/AHA/SCAI guideline for coronary artery revascularization: a report of the American College of Cardiology/American Heart Association Joint Committee on Clinical Practice Guidelines. J Am Coll Cardiol. 2022;79(2):e21-129. doi:10.1016/j.jacc.2021.09.006.
3. World Health Organization. Ethics and governance of artificial intelligence for health: guidance on large multi-modal models. Geneva: World Health Organization; 2024. Available from: https://www.who.int/publications/i/item/9789240084759
4. World Medical Association. WMA statement on the professional and ethical use of social media [Internet]. Ferney-Voltaire: World Medical Association; 2022 [cited 2026 Nov

3]. Available from: https://www.wma.net/policies-post/wma-statement-on-the-professional-and-ethical-use-of-social-media/
5. Ikatan Dokter Indonesia. *Anggaran dasar dan anggaran rumah tangga Ikatan Dokter Indonesia hasil Muktamar XXXII Mataram, 14 Februari 2025*. Jakarta: Pengurus Besar Ikatan Dokter Indonesia; 2025. AD Pasal 28-29; ART Pasal 21(1)(j), 21(1)(l-m), 42(1).
6. Perhimpunan Dokter Spesialis Kardiovaskular Indonesia. *Anggaran dasar dan anggaran rumah tangga PERKI tahun 2025: hasil KOPERKI Luar Biasa dan KOPERKI XX, Medan, 1-2 Mei 2025*. Pengurus Pusat PERKI; 2025. AD Pasal 6; ART Pasal 8-9, 11, 30-32.
7. Republik Indonesia. *Undang-Undang Republik Indonesia Nomor 17 Tahun 2023 tentang Kesehatan*. Lembaran Negara Republik Indonesia Tahun 2023 Nomor 105; Tambahan Lembaran Negara Republik Indonesia Nomor 6887. Pasal 304-306.
8. Kementerian Kesehatan Republik Indonesia. *Peraturan Menteri Kesehatan Nomor 3 Tahun 2025 tentang Penegakan Disiplin Profesi Tenaga Medis dan Tenaga Kesehatan*. Berita Negara Republik Indonesia Tahun 2025 Nomor 342. Available from: https://jdih.kemkes.go.id/documents/peraturan-menteri-kesehatan-nomor-3-tahun-2025
9. American Medical Association. Constitution and bylaws [Internet]. Chicago: American Medical Association; 2026 Jul [cited 2026 Nov 15]. Bylaw 2.0.1.6. Available from: https://www.ama-assn.org/system/files/ama-constitution-and-bylaws.pdf
10. American College of Cardiology. Code of ethics and ACC professional conduct program procedures [Internet]. Washington (DC): American College of Cardiology; 2025 Oct 23 [cited 2026 Nov 3]. Available from: https://www.acc.org/-/media/Non-Clinical/Files-PDFs-Excel-MS-Word-etc/About-ACC/Governance/ACC-Code-of-Ethics.pdf
11. Federation of State Medical Boards. About physician discipline [Internet]. Euless (TX): Federation of State Medical Boards; [cited 2026 Nov 3]. Available from: https://www.fsmb.org/guide-to-medical-regulation-in-the-united-states/about-physician-discipline/