

Legal Analysis of Hospital Responsibilities in Implementing Electronic Medical Records Integrated with Satu Sehat

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Abstract

Hospitals in Indonesia have undergone digital transformation through the implementation of Electronic Medical Records. This study seeks to ensure that the legal regulations governing the integration of Electronic Medical Records with SatuSehat in healthcare services comply with Indonesian law. This study is classified as a descriptive normative legal study, using secondary data. A literature review was conducted to apply the data collection methodology, then evaluated through a qualitative study. The study findings indicate that the legal regulations governing the implementation of Electronic Medical Records in healthcare services in Indonesia are outlined in Law No. 17/2023 concerning Health, Minister of Health Regulation No. 24/2022 concerning Medical Records, and their implementing regulations. This regulation requires healthcare facilities and medical personnel to maintain electronic based Medical Records, regulate the organizers of Electronic Medical Records systems, regulate the arrangement and distribution of Medical Records data, provide a summary of Medical Records to patients, and define the characteristics of Electronic Medical Records. The principles of electronic system interoperability, Protection of Patient Personal Data, guarantee of Medical Records confidentiality, and the obligation to implement Electronic Medical Records integrated with SatuSehat as a form of legal protection for patient data. If a violation occurs in the implementation of Electronic Medical Records integrated with SatuSehat, the hospital will be subject to civil, administrative, and criminal liability. This liability is based on legal obligations related to the implementation of Electronic Medical Records, recognition of electronic documents as valid evidence, and the principles of protecting patient data confidentiality and security.

Keywords : Hospital, Health, Medical Records, Electronic Medical Records, SatuSehat.

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Introduction

Health is a human right and a component of welfare that must be achieved in line with the goals of the Indonesian state, according to the 1945 Constitution. Everyone has the right to good health and welfare. Another important right that everyone has is the health and welfare of themselves and their families, as well as an adequate standard of living. The 1945 Constitution indicates in Article 28H, paragraph 1, that everyone has the right to a place to live, a healthy and comfortable environment, health care, and physical and spiritual well-being [1].

To fulfill the right to health services, the provision of health services must be accompanied by a reliable and accountable recording system. A comprehensive Medical Record is an official document that includes patient identity, medical history, examination findings, diagnosis, procedures, treatment, follow-up care, and a follow-up plan. Medical Records serve as the basis for rational clinical decision-making, coordination between service providers, and legal evidence in the event of a medical dispute. Medical Records serve as the primary instrument for monitoring and assessing service quality. The dimensions of completeness, accuracy, timeliness, legibility, and consistency are usually implemented to evaluate the quality of Medical Records. The importance of creating Medical Records is underscored in Law No. 17/2023 concerning Health, which requires the provision of quality, safe, and accountable health services. This is reinforced by Minister of Health Regulation No. 24/2022, which requires all health facilities to keep Medical Records [2].

Medical Record Administration has transformed from manual to electronic format as a result of advances in information technology. Electronic Medical Records are classified as electronic documents under Article 11 of Law No. 19/2016 concerning ITE. Electronic Medical Record data must originate from a secure and accountable electronic system in order to be used as evidence, as it is an electronic document. Legal implications must be assessed when implementing Medical Records, regardless of whether they are electronic or manual. This aspect must be maintained to ensure legal protection and clarity for all components related to medical services or healthcare in hospitals. Electronic Medical Record functions include electronic prescriptions, electronic investigation ordering and receipt of investigation findings, patient billing, and in some cases, clinical information recording, as well as decision support software [3].

In the digital transformation, institutions in Indonesia are adopting Electronic Medical Records (EMR). All patient medical data is stored electronically in the Electronic Medical Record, thus facilitating, accelerating, and optimizing the accuracy of access to health information for authorized medical personnel. In accordance with Minister of Health Regulation No. 24/2022, the Indonesian government has ordered all health institutions to adopt EMR by December 31, 2023, as an effort to control expenses and optimize the quality of health services. Hospitals must have more human resources capabilities to digitize health services, in addition to legal constraints. Medical and administrative staff must be trained in the use of digital systems, data security, and ethics to handle patient data efficiently. To maintain patient trust, ensure the accuracy of information, and reduce data entry errors, hospitals must implement this [4]. Quality health data must at least include completeness, accuracy, timeliness, and consistency, according to Article 7 paragraph 4 of Minister of Health Regulation No. 18/2022 concerning the Implementation of One Data in the Health Sector Through the Health Information System.

The government created the SatuSehat platform to facilitate the integration of national health data. This platform originated from the PeduliLindungi application developed during the pandemic. This application helps the Indonesian government detect COVID-19 and record vaccinations to reduce its spread. The transformation of the PeduliLindungi application into the SatuSehat application was implemented on March 1, 2023. The government requires health facilities to immediately integrate RME with SatuSehat in accordance with Minister of Health

Regulation No. 24/2022 concerning Medical Records. Hospitals are required to store each patient's Medical Record in the SatuSehat application, which guarantees electronic access to all health services with SatuSehat access [5].

Both a business and an individual, hospitals have a legal obligation to manage medical records, with a particular focus on patient privacy, in accordance with this integration mandate. Violations of patient privacy can result in warnings, fines, license revocation, compensation, and administrative, civil, and criminal consequences. Patients who witness medical staff misconduct can legally hold hospitals accountable. If medical records are lost, damaged, altered, or misused by unauthorized individuals, healthcare institutions are also liable, as per Article 25 of Minister of Health Regulation No. 24/2022. Following established guidelines for the storage and protection of medical records that have direct patient interaction is necessary to ensure the integrity of medical services [6]. Law No. 27/2022 concerning Personal Data Protection, Article 12 paragraph 1 states that individuals whose personal data is violated in medical record procedures have the right to file a claim and receive compensation.

Despite the numerous benefits of implementing EMRs, such as improved quality of care, more accurate patient documentation, and increased revenue, their implementation still faces numerous challenges in various healthcare facilities. These challenges include gaps in technical knowledge among staff, system disruptions, and resistance from medical personnel to the ease of use of the system. These challenges can be further complicated by technical issues, such as frequent system errors and confusion among staff regarding EMR procedures. The implementation of EMRs has not been fully optimized, as demonstrated by this situation. The willingness of healthcare professionals to operate the system and the ease of use of the system are additional aspects that affect the implementation of EMRs, in addition to technical aspects. To facilitate a more efficient implementation, it is crucial to provide practical guidance regarding EMR completion, policy dissemination, and the development of user guidelines for all healthcare professionals [7].

Given that hospitals are legally responsible for the accuracy, confidentiality, and security of medical information, the urgency of this study stems from the need to ensure that the integration of EMR with SatuSehat complies with legal provisions and patient data protection principles. The accelerated digitalization of healthcare services is accompanied by challenges related to regulatory compliance, system limitations, and resources, which can lead to legal violations and jeopardize patient rights. By providing a foundation for hospitals to optimize the effectiveness, security, and accountability of digital healthcare services, this study is crucial for a comprehensive understanding of hospital obligations, legal protection mechanisms, and legal accountability for the implementation of Electronic Medical Records.

Research Methodology

This study uses a normative legal study, which is carried out by analyzing secondary data or library materials as the basis of investigation. Includes a literature search and regulations relevant to the problem being studied [8]. This descriptive study is carried out in the field and is mainly related to natural phenomena or symptoms, with a tendency to use analysis [9]. Solving legal problems and providing prescriptions requires sources of study in normative legal studies. Sources in normative legal studies include primary, secondary, and tertiary legal materials [10]. Library study is a data collection technique used in this study. This method involves the collection and examination of notes or documents in the form of writing, pictures, and individual works. So, the identification of discourse in this study is to analyze information from books, journals, articles, magazines, websites, and other sources that are relevant to the study topic [11]. The data collected will be analyzed qualitatively. This method involves the use of inductive logic to connect each data item with the principles and legal provisions relevant to the problem being investigated, and data observation [12].

Results

Legal Regulations Regarding the Implementation of EMR in Health Services in Accordance with Indonesian Law

RM is a comprehensive collection of information regarding past, present, and projected future medical care processes. One of the most important elements of a healthcare facility is the Medical Record. Properly organizing Medical Records in accordance with current developments is driven by patients' thoughtful and critical thinking regarding their rights as consumers of healthcare services, as well as the rapid advancement of medical science, health law, and technological developments. The process of organizing Electronic Medical Records is [13]:

1. Social data is entered into the computer at the registration desk and then sent to the patient care center according to the patient's needs.
2. The doctor performs a physical examination and history taking at the patient care center, and the findings are recorded on a computer. A request is recorded on the computer and sent to the appropriate testing center if the doctor determines that the patient requires additional testing. Support staff then forward the findings to the appropriate doctor.
3. The doctor makes a diagnosis and prescribes appropriate therapy based on the findings of the history, physical examination, and supporting tests. The pharmacy receives the patient's prescription, which is recorded in a computer system. The pharmacist then dispenses the medication according to the doctor's instructions, which are recorded in the computer system.
4. This information is entered into a computer system if the doctor intends to provide further care for the patient. The findings and their implementation are digitally documented.
5. Patients are discharged to their homes if they do not require additional care. Recorded data is only accessible when necessary, including for follow-up visits, insurance claims with the patient's written consent, studies with the healthcare provider's approval, and legal purposes. The data is stored on the hospital's central EMR server.
6. Additional care may be required by the patient, and their Medical Record is sent to the patient's care facility.
7. The computer records all examination findings and treatments that occur during a patient's hospitalization. The culmination of the Electronic Medical Record (EMR) process is at the end of the patient's hospitalization. The data is sent to a server for storage.

The transition from traditional paper-based medical records to electronic medical records (EMR) systems reflects the evolution in healthcare delivery. Studies and developments in the healthcare industry increasingly emphasize the need for comprehensive transformation in patient registration and reengineering of medical records through the implementation of electronic medical records (EMDR) systems. This demonstrates the growing recognition of the crucial role of EMR systems in optimizing the efficiency and quality of healthcare services. The implementation of efficient EMR systems plays a crucial role in optimizing the quality of healthcare services. EMR managed with blockchain technology has been identified as a potential solution to create a more efficient and interoperable infrastructure for managing medical records, ultimately leading to improved healthcare outcomes. This approach ensures the maintenance of ownership and privacy of patient data, while addressing ethical concerns regarding data security and patient confidentiality.

Article 9, paragraph 3 of Minister of Health Regulation No. 24/2022, stipulates that electronic system providers in EMR must be registered as electronic system providers in the health sector with the ministry responsible for communications and informatics, in accordance with statutory provisions. Furthermore, Article 13 states that Electronic Medical Record providers must consist of at least:

1. Patient registration;
2. Electronic Medical Record data;

3. Filling in clinical information;
4. Electronic Medical Record Information Processing;
5. Data input for financing claims;
6. Electronic Medical Record Storage ;
7. Electronic Medical Record Guarantee ; and
8. Electronic Medical Record contents.

Evolution of healthcare delivery is evidenced by the transition from traditional paperbased Medical Records to Electronic Medical Records systems. The need for comprehensive transformation of patient registration and reengineering of Medical Records through the implementation of Electronic Medical Records systems is increasingly emphasized in studies and developments in the healthcare industry. The growing recognition of the crucial role of EMR systems in optimizing the quality and effectiveness of healthcare services is illustrated by this. An efficient EMR system is crucial for optimizing the quality of healthcare services. A potential solution for developing a more efficient and interoperable infrastructure for Medical Records management, which will ultimately lead to improved healthcare outcomes, has been identified as Electronic Medical Records managed with blockchain technology. In addition to addressing ethical issues related to patient confidentiality and data security, this methodology ensures the preservation of patient privacy and ownership [14].

Electronic system organizers in Electronic Medical Records are required to register themselves as electronic system organizers in the health sector with the ministry responsible for communication and informatics in accordance with legal provisions, according to Article 9 paragraph 3 of Minister of Health Regulation No. 24/2022. Electronic Medical Record Organizers must consist of at least 2 people [15].

Article 26 of the Minister of Health Regulation No. 24/2022 concerning Medical Records explains that a summary of MR can be provided, recorded or copied by the patient or a person authorized or with the written consent of the patient or the patient's family who has the right to use it with the following provisions [16]:

1. Patients are informed regarding the contents of the MR.
2. MR can be disclosed to the patient's closest relatives or other related parties.
3. Distribution of MR to the patient's closest relatives is carried out if the patient is under 18 years old/or in an emergency.
4. MR is only distributed to other parties after patient consent is obtained.
5. The mr must contain at least the following:
 - a. Patient identification;
 - b. Physical and supporting examination findings;
 - c. Patient diagnosis, treatment, and follow-up health care plans;
 - d. Name and signature of the health worker providing care.
6. The individual responsible for care must compile a MR.
7. After discharge from the hospital, the MR must be disclosed to inpatients and emergency patients or to the referring health care facility after referral.
8. MR can be distributed to outpatients if necessary in addition to inpatients and emergency patients.
9. In accordance with statutory regulations, a referral letter in the health service referral system includes a MR addressed to the health service facility that received the referral.
10. After the patient is discharged from the hospital, the MR is provided in the form of a letter that is sent and received electronically using a computer network or other electronic communication device, such as a mobile phone or printed form.

The key characteristics of EMRs differentiate them from traditional medical records and make them more suited to the needs of healthcare in the digital age. EMRs aim to optimize the security, accuracy, and effectiveness of medical information, as well as strengthen their status as a reliable source of legal evidence. Data digitization, which involves the electronic storage

of all medical information, system integration, which facilitates connectivity and synchronization with other health information systems, and accessibility, which allows authorized medical personnel to access patient data in real-time, are some of the key characteristics of EMRs. Interoperability is crucial as EMRs must be able to exchange information securely and efficiently across multiple platforms and institutions. Finally, data security is a top priority, and multi-layered security systems are being implemented to protect sensitive patient data from the risk of leaks or manipulation [17].

Every medical personnel and health professionals who provide individual health services are required to create a Medical Record in accordance with Article 296 paragraph 1 of Law No. 17/2023 concerning Health. In accordance with Article 296 paragraph 4, the name, signature, and time of the medical personnel or health professionals who carry out the service or procedure must be included in each Medical Record. Article 217 paragraph 2 of PP No. 28/2024 concerning the Implementing Regulations of Law No. 17/2023 concerning Health stipulates that family-based health data and information are health data and information for all family members obtained from Medical Records, recording and/or reporting of Health Service activities, as well as data and information regarding family behavior and environment.

Some of the main advantages of EMR include easy and fast access, data changes that leave an electronic trail, increased patient satisfaction, fast and accurate retrieval of medical information, integrated systems across departments within the hospital and even outside the hospital, compact storage without the need for special rooms, and increased patient safety. Electronic Medical Records are not without their drawbacks, such as the potential for malware (viruses) and server errors, data input or alteration errors, potential for piracy, high system development and maintenance costs, and dependence on electricity availability [18].

The main challenges in meeting the implementation of Electronic Medical Records are inadequate human resources, lack of technological sensitivity, and lack of human resource integrity in sending Electronic Medical Record data. System incompatibility, network disruptions, and device limitations are among the technological or infrastructure aspects that result in errors and delays. Policy support for SOPs and device maintenance implemented for the implementation of Electronic Medical Records are among the organizational aspects [19].

Another challenge faced is inadequate oversight and enforcement of violations. The health sector's oversight process for implementing data protection is suboptimal, and the lack of consistent law enforcement and strict regulations has resulted in perpetrators not facing significant consequences. This allows data privacy violations to continue without adequate action. To comprehensively address this issue, it is crucial to implement strategic measures to optimize oversight and law enforcement, as well as strengthen the human resources capacity of the health sector [20].

The legal regulations governing the implementation of Electronic Medical Records in healthcare services in Indonesia are outlined in Law No. 17/2023 concerning Health, Ministerial Regulation No. 24/2022 concerning Medical Records, and their implementing regulations. These regulations explicitly require healthcare facilities and medical personnel to maintain Electronic Medical Records, regulate the organizers of Electronic Medical Records systems, regulate the organization and distribution of Medical Record data, establish mechanisms for providing Medical Record summaries to patients, and define the characteristics of Electronic Medical Records, which must comply with the principles of digitalization, integration, interoperability, accessibility, and data security. The government's dedication to enabling the digital transformation of healthcare services to optimize efficiency, service quality, legal certainty, and the preservation of patient data confidentiality and security is reflected in these regulations.

Forms of Legal Protection for Patient Data in the Implementation of RME Integrated with SatuSehat

One of the advances in healthcare technology that emerged from the accelerated development of digital technology is the PeduliLindungi application, which was widely implemented during the COVID-19 pandemic. The Ministry of Health transformed this application into SatuSehat Mobile on March 1, 2023, a data integration platform for healthcare facilities across Indonesia. In accordance with Ministerial Regulation No. 24/2022 concerning Medical Records, which establishes standards for data exchange between systems, this platform is designed to facilitate the interoperability of electronic systems, including EMRs. SatuSehat, a component of the Indonesian Health Office, is responsible for integrating various health data from various facilities, including hospitals, community health centers, pharmacies, and laboratories into a single integrated system. Despite its potential to optimize the efficacy and effectiveness of healthcare services, its implementation continues to face obstacles, such as a lack of user understanding, limited infrastructure in some areas, and technological readiness [21]. The single data regulation in the health sector is intended to regulate the governance of health data found by the Ministry of Health to support the planning, implementation, evaluation, and control of health development, in accordance with Article 2 paragraph 1 of Minister of Health Regulation No. 18/2022 concerning the Implementation of Single Data in the Health Sector Through the Health Information System. In accordance with Article 10 of Minister of Health Regulation No. 24/2022 concerning Medical Records, the electronic system used for the implementation of EMR must have compatibility and/or interoperability capabilities. Compatibility is the level of similarity or suitability between 2 electronic systems, while interoperability is the ability of various electronic systems to communicate and exchange data in accordance with certain data exchange standards [15].

According to Article 173 paragraph 1 letter c of Law No. 17/2023 concerning Health, Medical Records are electronic documents that include patient identity data, examinations and treatments, procedures, and other services provided to patients. If a health facility is unable to maintain Electronic Medical Records Due to technical difficulties, non-electronic Medical Records may be implemented until the problem is resolved, after which the data can be resubmitted to the Electronic Medical Records system. Medical Records must include patient identity, examination, treatment, procedures, and other services, as well as consent for health services, in accordance with Article 778 paragraph 3 of PP No. 28/2024 [22].

The rapid development of information technology has made legal protection against data intrusion an increasingly important issue. The purpose of this protection is to ensure the security and confidentiality of personal data so that it does not fall into the hands of unauthorized parties, which can result in financial, reputational, and privacy losses. Legal protection is essential to prevent data misuse and instill a sense of security. Throughout the entire chain of the EMR personal data process, Law No. 27/2022 regulates the implementation of Personal Data Protection in accordance with the principles of protection, legal certainty, prudence, and confidentiality. According to Article 16 paragraph (1), data processing includes the acquisition, processing, storage, correction, display, announcement, transfer, dissemination, and deletion or destruction of data. The principle of protection is upheld by preventing unauthorized access, disclosure, modification, misuse, destruction, or deletion of data. This provision is considered general because the data controller is responsible for data protection in practice [13]. The health sector is subject to specific regulations regarding personal data, as stipulated in Law No. 17/2023 concerning Health. These regulations cover health confidentiality and exceptions to the confidentiality of health data and Medical Records. Under the Health Law, all individuals have the right to the confidentiality of their personal health data and information. Health confidentiality covers patient personal data, both specific and general, as stipulated in Law No. 27/2022 concerning Personal Data Protection. The Health Law imposes limitations on this confidentiality, such as exempting personal health data and information from its protection under certain circumstances [23]:

1. Responding to requests from law enforcement officials for law enforcement purposes;
2. Monitoring epidemics, disasters, or outbreaks;
3. Educational and study purposes are limited;
4. Efforts to protect others, both individually and collectively;
5. Patient care, treatment, rehabilitation, and health maintenance;
6. Request from patient;
7. Insurance payments, administrative purposes, or health financing guarantees; and/or
8. Additional purposes subject to legislative and regulatory oversight.

Every medical professional and health worker is required to create a Medical Record that includes patient identity, examination findings, treatment, and other actions taken, in accordance with Article 46 paragraph 1 of Law No. 17/2023 concerning Health. The purpose of this obligation is not solely medical; it also functions as official documentation that has legal significance. This document is a source of material truth in the event of a dispute or alleged violation of the law. Paragraph 2 of Article 46 emphasizes the confidentiality of Medical Records and confirms that Medical Records may only be disclosed for certain purposes, such as criminal legal proceedings. This provision is further strengthened by Minister of Health Regulation No. 24/2022, which limits access to Medical Records to authorized parties in accordance with statutory regulations in response to an official request [24]. The mechanism for requesting Medical Record data by third parties, such as insurance companies, educational or study institutions, courts, and the police, is regulated by Minister of Health Regulation No. 24/2022 concerning Medical Records. Medical Record data is disclosed by each third party for its own purposes and requirements. Healthcare facilities are required to maintain optimal infrastructure and facilities to ensure the legal and secure release of data and to prevent unauthorized access [25].

Nevertheless, the government has implemented a policy in Article 304 of Law No. 17/2023 concerning Health to protect patient rights by strictly enforcing professional discipline and establishing a permanent or ad hoc commission through the Minister of Health. If medical and health personnel commit violations, this panel will determine whether the violation constitutes a detrimental act. In the event of a patient data breach, legal responsibility is stipulated in PP No. 71/2019 concerning the Implementation of Electronic Systems and Transactions. Data breaches must be acknowledged and reported to consumers by system providers, such as PSE. Law No. 27/2022 concerning Personal Data Protection can also impose sanctions on RM system providers for failing to protect personal data [26].

Legal protection for healthcare workers is regulated in Law No. 17/2023 concerning Health, specifically Articles 439 and 440. Healthcare workers who comply with the professional code of ethics, service standards, standard operating procedures, and professional standards are immune from lawsuits, as stipulated in Article 439. At the same time, Article 440 offers legal protection to healthcare workers who implement life-saving or disability-preventing measures in emergency situations or during special and limited circumstances. Despite the limitations of hospital infrastructure and resources, the integration of RME with SatuSehat continues to create legal uncertainty regarding compliance with service standards, security standards, and patient data confidentiality [27].

This discussion has concluded that the legal protection of patient data in the implementation of Electronic Medical Records integrated with SatuSehat has been regulated comprehensively through a legal framework that includes the principle of electronic system interoperability, mandatory implementation of Electronic Medical Records, guarantees of Medical Record confidentiality, and Protection of Patient Personal Data. This protection is achieved by regulating the obligations of health care facilities and health workers to maintain the confidentiality of Medical Records, imposing administrative, civil, and criminal sanctions for violations of Personal Data Protection, and regulating access restrictions and mechanisms for releasing data to third parties based on official requests. Electronic system organizers are required to ensure data security and provide notification in the event of a data leak.

Legal Responsibility for Hospitals in the Event of Violations in the Implementation of Integrated RME with SatuSehat

Healthcare services in Indonesia are currently undergoing a digital transformation, including the implementation of Electronic Medical Records. Policymakers and all healthcare industry players will implement this digital transformation in a participatory manner with a focus on health data development, the enhancement of a sustainable, scalable, and integrated healthcare technology ecosystem, and the development of healthcare service applications. The implementation of this digital health transformation is integrated into the SatuSehat platform, which is overseen by the Indonesian Ministry of Health. Facilitating the integration of healthcare industry players into a comprehensive and integrated health data system is the main objective of this platform. In an effort to facilitate efficient information exchange and collaboration between stakeholders, SatuSehat aims to accurately document and optimize the utilization of all healthcare transactions [28]. In Article 7 paragraph 4 of Minister of Health Regulation No. 18/2022 concerning the Implementation of Single Data in the Health Sector Through the Health Information System, quality health data is defined as data completeness, data accuracy, timeliness, and data consistency.

In hospitals, Electronic Medical Records are the collection, storage, processing, and access of patient Medical Records maintained in a multimedia database management system that aggregates various medical data sources. The main purpose of Electronic Medical Records is to optimize the efficiency and integration of healthcare services by providing or optimizing a patient's lifetime Medical Record in electronic format. This information is recorded by one or more healthcare professionals in an integrated manner during each encounter between healthcare professionals and patients. Electronic Medical Records can be accessed using a computer from a network [29]. The use of EMR by healthcare facilities aims to optimize patient satisfaction, reduce clinical errors, optimize documentation accuracy, and accelerate patient data access. However, hospital IT infrastructure faces significant challenges in terms of IT infrastructure readiness, IT management, and budget constraints, which can result in violations of EMR implementation [30][31].

Minister of Health Regulation No. 24/2022 concerning Medical Records is based on the digital transformation of health services, which is driven by the development of digital technology in society. Health facilities are required to maintain electronic medical documents. The Medical Records Regulation aims to optimize the quality of health services, ensure the security, confidentiality, integrity, and availability of Medical Records data, and facilitate the implementation and arrangement of digitally integrated Medical Records. This regulation aims to provide legal certainty in the implementation and arrangement of Medical Records. Law No. 19/2016 concerning amendments to Law No. 11/2008 concerning ITE is closely related to the adoption of electronic IT systems in health services [32].

Medical records must be maintained by health facilities in accordance with Article 173 paragraph 1 letter c of Law No. 17/2023 concerning Health. The explanation of this provision explicitly states that an electronic system can be implemented to find Medical Records. In addition, every health facility is required to implement Medical Records in accordance with Article 3 paragraph 1 of Minister of Health Regulation No. 24/2022 concerning Medical Records. The provisions of Article 5 paragraph 2 of Law No. 19/2016 concerning ITE stipulate limitations related to requests from law enforcement officers regarding electronic information and/or electronic documents in the context of wiretapping or recording findings as part of wiretapping. Consequently, authorization or requests from authorized law enforcement officers are only required for electronic data in the form of wiretapping findings. For the collection of other electronic data, such as CCTV, photos, videos, etc., law enforcement officers are not required to submit requests as long as the data is authentic and has not been manipulated [33]. This regulation also recognizes electronic documents as valid evidence. Valid legal evidence is electronic information, electronic documents, and/or their reproductions in accordance with Article 5 paragraph 1. Article 5 paragraph 4 sets out the criteria for recognizing electronic

documents as evidence, which requires that the information contained therein can be accessed, displayed, its integrity guaranteed, and taken into account [17].

In medical malpractice cases, Medical Records are crucial in the evidentiary process. MRs can be used as valid evidence similar to letters and expert testimony in accordance with Articles 184 and 187 of the KUHP, which explain the doctor's procedures for patients. The concepts of evidence and EMRs are fundamentally different. While written Medical Records are recognized as documentary evidence non-digital EMRs are not considered valid documentary evidence due to their classification as indicative evidence, which is considered weak or lacking in evidentiary power [34].

This is directly related to the privacy and confidentiality of Medical Records as outlined in Article 4 letter i of Law No. 17/2023 concerning Health. This article stipulates that all individuals have the right to the confidentiality of their personal health data and information. This is reaffirmed in Article 296 paragraph 5 of the Health Law, which requires medical personnel, health workers, and health facility managers to maintain and protect the confidentiality of patient Medical Records. To reduce the risk of unauthorized access and data intrusion that could compromise patient safety, it is crucial for all healthcare providers to provide strict protection for patient medical information. Maintaining the confidentiality of MR is crucial to foster trust between healthcare providers and patients. Patients must have assurance that their confidential information will not be accessed or misused by unauthorized parties [5].

Many healthcare professionals are unaware of the importance of medical records, leading to negligent and inaccurate record-keeping practices. Hospitals lack adequate oversight of the healthcare professionals they employ to create medical records, despite their crucial role as evidence for patients and physicians in determining medical procedures. Hospitals are also crucial workplaces for physicians and other healthcare professionals. Physicians who fail to maintain medical records may be held liable [35]. When performing their professional duties, physicians are required to comply with legal regulations. This is known as legal liability. Healthcare professionals' obligations are classified into three categories: civil liability, criminal liability, and administrative liability. Physicians are required to create medical records as part of their duties in providing healthcare [36]. Consequently, physicians are prohibited from avoiding questions about their actions. The categories of responsibilities imposed by hospitals regarding the confidentiality of medical records and the actions taken to disclose confidential information contained in medical records by healthcare professionals are [37]:

1. Civil legal liability

As in private law, the accepted principle is that any individual who causes harm to another individual is obligated to provide compensation. Article 1365 of the KUHP permits a patient who feels aggrieved to sue for compensation. There must be a causal link between the fault and the harm, the patient must have suffered harm, and the act must be unlawful.

2. Administrative legal responsibility

Policies or provisions covering administrative requirements for healthcare services that must be met to provide quality healthcare services constitute administrative law implications in the hospital-patient legal relationship. In the case of hospitals, administrative legal sanctions can include revocation of business licenses or legal entity status, as well as suspension of fixed salaries and revocation of practice permits. Doctors and other healthcare workers may receive verbal or written warnings for violating policies or administrative legal provisions.

3. Criminal legal responsibility

Criminal provisions under Indonesian law apply to all individuals who commit violations in Indonesia, as stipulated in Article 2 of the KUHP. Individuals under Indonesian jurisdiction can be held criminally liable for their actions. Criminal sanctions are imposed on doctors or other healthcare professionals who disclose medical secrets under Article 322 of the KUHP. The maximum penalty is nine months' imprisonment.

The 2022 Personal Data Protection Law also highlights the potential for all personal data controllers, including hospitals to be held liable for patient data protection violations. This legal liability encompasses civil, administrative, and criminal matters. In the civil realm, Article 12 of the Personal Data Protection Law grants data subjects the right to seek compensation for losses resulting from data protection violations. This establishes a legal basis for patients who suffer financial or non-financial losses due to hospital negligence to sue for damages in court. Regarding administrative capacity, Article 57 of the Personal Data Protection Law authorizes the Personal Data Protection Authority to impose sanctions on data controllers. Administrative sanctions that can be applied include the imposition of administrative penalties, temporary suspension of data processing activities, deletion of personal data, and written warnings. Criminal sanctions are also included in the VAT Law. Parties who unlawfully disclose or misuse personal data can be subject to a maximum prison sentence of six months and a substantial fine as stipulated in Article 67 of the VAT Law. If a business entity, such as a hospital commits a violation the legal entity will be subject to a fine, and the individuals directly responsible may be subject to criminal sanctions [38].

The hospital's legal responsibility in the event of a violation in the implementation of Electronic Medical Records integrated with SatuSehat can be concluded from this description. This responsibility is based on legal obligations in the implementation of Electronic Medical Records, the recognition of electronic documents as valid evidence, and the principles of protecting the confidentiality and security of patient data. This includes civil, administrative, and criminal liability. The hospital is responsible for the availability, integrity, accuracy, and confidentiality of Medical Record data as well as compliance with interoperability standards with SatuSehat, as the controller and operator of the electronic system. Consequently, any negligence, including data leakage, unauthorized access, inaccurate recording or system security failures, can result in compensation for patients, administrative sanctions ranging from warnings to license revocation, and criminal sanctions for parties who unlawfully disclose or misuse personal data.

Conclusion

The legal regulations governing the implementation of Electronic Medical Records in health services in Indonesia are described in Law No. 17/2023 concerning Health, Minister of Health Regulation No. 24/2022 concerning Medical Records, and its implementing regulations. These regulations require health care facilities and medical personnel to organize electronicbased Medical Records, regulate the organizers of Electronic Medical Records systems, regulate the arrangement and distribution of Medical Record data, provide Medical Record summaries to patients, and comply with the principles of Electronic Medical Records. The obligation to implement Electronic Medical Records, the principle of electronic system interoperability, guarantee the confidentiality of Medical Records, and Protection of Patient Personal Data as a form of legal protection for patient data in the integration of SatuSehat with Electronic Medical Records. The hospital's legal responsibility in the event of a violation in the implementation of Electronic Medical Records integrated with SatuSehat is based on legal obligations in the implementation of Electronic Medical Records, the recognition of electronic documents as valid evidence, and the principle of protecting the confidentiality and security of patient data. These responsibilities include civil, administrative, and criminal liability.

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