



Dispute Resolution Between Patients And Perpetrators Who Provide Access To The Contents of Electronic Medical Records (RME) Unlawfully

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Abstract: This study aims to describe and analyze the form of violation of the law committed by the perpetrator who gives unauthorized access to the content of RME documents that cause disputes with patients and analyzes the dispute resolution mechanism due to the violation of the law that harms the patient. The research method used is normative juridical with legislative, conceptual, and case approaches, and is supported by secondary data in the form of primary, secondary, and tertiary legal materials that are analyzed qualitatively. The results of the study show that: 1) Forms of violation of the law committed by perpetrators who provide unauthorized access to the contents of RME documents include opening, sending, or disseminating patient medical record data without consent or a valid legal basis, which is contrary to Law Number 17 of 2023 concerning Health, Law Number 27 of 2022 concerning Personal Data Protection, and Regulation of the Minister of Health Number 24 of 2022 concerning Medical Records, so as to cause both material and immaterial losses for patients; 2) Dispute resolution due to violations of the law by the perpetrator who gives unauthorized access to the contents of RME documents that are detrimental to the patient can be pursued through civil law on the basis of Article 1365 of the Civil Code, where the patient has the right to file a lawsuit for compensation for unlawful acts, as well as non-litigation settlements such as mediation within the hospital or through alternative dispute resolution institutions. However, the effectiveness of protecting patients' rights depends heavily on the implementation of an adequate data security system, health facilities' compliance with regulations, and the legal awareness of actors in maintaining confidentiality and protection of patient data.

Keyword: Dispute, Patient, Perpetrator, Medical Record, Invalid

INTRODUCTION

Advances in information technology have brought significant changes in various sectors, including the health sector. The application of electronic medical records, hereinafter referred to as RME, allows digital recording of patient data, facilitates access to information for medical

personnel, and improves the efficiency of health services. This digitization is expected to be able to reduce manual recording errors, accelerate medical decision-making, and improve coordination between health professionals. These benefits are an encouragement for various health facilities to adapt to modern information systems (Nasution et al., 2022).

Medical records contain personal information and a person's medical history, which should be kept confidential. The confidentiality of medical records has an important role in maintaining trust between doctors and patients. Patients who feel their personal information is safe tend to be more open about revealing health conditions, allowing doctors to provide more precise diagnosis and therapy. Such confidentiality violations have the potential to damage trust, cause discomfort, and open up opportunities for disputes (Darmawan, 2023).

The risk of electronic medical record data leakage is increasingly evident as the use of technology in healthcare increases. Unauthorized access, system hacking, and data management negligence trigger the unauthorized dissemination of patient medical information. The impact not only harms patients psychologically and socially, but also triggers legal problems, especially when data leaks are considered to have an impact on the patient's health or reputation. This situation shows that the security of information technology is not fully guaranteed (Chintia & Kusumaningrum, 2020).

Medical disputes due to the leak of electronic medical records are often a source of disputes/conflicts/disputes between doctors and patients. A lawsuit against a doctor or health facility may arise if a patient feels that his or her right to privacy has been violated. The cause of the leak could be a weakness in the technology system, an administrative error, or other factors beyond the doctor's control. The position of doctors becomes vulnerable because, in addition to being medically responsible, they are faced with the demands of understanding the legal aspects related to patient data management. This condition gave birth to a debate about the settlement of civil law as an effort to handle disputes (Suparman, 2020).

Legal aspects related to electronic medical records have been regulated in various laws and regulations. Law Number 17 of 2023 concerning Health, hereinafter referred to as the Health Law, regulates the obligation of health service facilities to maintain the confidentiality of patients' personal health information. The articles in this law affirm that medical records are legal documents that contain identity, diagnosis, treatment, and medical procedures that must be kept confidential except with the consent of the patient or based on legal provisions (Wahyudi, 2021). This provision reinforces the principle that any leak of patient health data, whether intentional or negligent, has the potential to lead to legal sanctions.

Personal data protection is also strengthened through Law Number 27 of 2022 concerning Personal Data Protection (PDP Law). This law classifies health data as personal data that is specific, so it requires special treatment in its management. The articles in the PDP Law give individuals the right to control their personal data, including the right to obtain information in the event of a data leak. Healthcare facilities and medical personnel have a legal responsibility to ensure the security of patient data, including electronic medical records, from being misused by unauthorized parties (Christanto et al., 2024).

Regulation of the Minister of Health Number 24 of 2022 concerning Medical Records also provides a legal basis for the management of electronic medical records. This regulation contains technical provisions related to digital recording, storage, and access to patient data. Health care facilities are required to implement adequate data security systems, including authentication and encryption mechanisms, to prevent the leakage of medical information. Failure to comply with this provision has legal implications for the medical personnel and institutions involved.

Violations of the confidentiality of electronic medical records, if they cause medical disputes, have the potential to be resolved through civil law channels. Patients who feel that their right to privacy is violated can file a lawsuit for damages based on Article 1365 of the

Civil Code, which states that any unlawful act that harms another person requires the guilty party to provide compensation. This lawsuit aims to recover the losses suffered by patients, both materially and immaterially. This situation reflects that civil law settlement is a relevant mechanism to protect patients' rights and ensure legal liability for negligent medical personnel or health facilities.

The legal basis that is very important in resolving disputes between patients and the perpetrators who illegally provide access to the contents of electronic medical records (RME) documents is clearly stated in Article 310 of Law Number 17 of 2023 concerning Health. The article states that "in the event that a Medical Worker or Health Worker is suspected of making an error in the exercise of his profession that causes harm to the Patient, the dispute arising from the error is resolved first through an alternative dispute resolution outside the court". This provision represents a new paradigm in Indonesian health law, where priority is given to alternative dispute resolution efforts such as mediation or arbitration before taking cases to litigation. The implementation of Article 310 is very important because it is able to provide legal protection for all parties, both patients and medical personnel, and encourage faster, more efficient, and peaceful dispute resolution. This at the same time strengthens public trust in the healthcare system and supports the restoration of relationships between patients and medical personnel who may be affected by the leak or misuse of access to electronic medical record data.

METHOD

The research method used in this thesis is normative legal research that focuses on laws and regulations, legal doctrines, and relevant legal principles to analyze legal issues regarding electronic medical records (RME). This study does not use field data, but analyzes legal materials in the form of legal texts as the main source. Normative legal research is conceptual and aims to find logical and systematic legal arguments for the problem posed (Marzuki, 2019). The focus of the study is on the laws and regulations that regulate the confidentiality of RME, such as Law Number 17 of 2023 concerning Health, Law Number 27 of 2022 concerning Personal Data Protection, and Regulation of the Minister of Health Number 24 of 2022 concerning Medical Records.

The research approach used is a normative juridical approach with a descriptive qualitative analysis method. This research combines a statute *approach*, a conceptual approach, and a case approach to dissect the problem holistically. The legal materials analyzed consisted of primary legal materials in the form of laws and regulations, secondary legal materials such as books, journals, and scientific articles, and tertiary legal materials in the form of legal dictionaries and encyclopedias (Sugiyono, 2019). Literature studies are the main method of data collection, which is carried out through the review of documents, scientific literature, and official sources on the websites of related institutions. The analysis technique is carried out by describing and interpreting relevant legal provisions in order to draw conclusions about the form of violation of the law and dispute resolution due to unauthorized access to the contents of RME documents.

The data processing in this study is carried out systematically through the interpretation of established legal norms, and is associated with the concept of legal protection, accountability of medical personnel, and the patient's right to data confidentiality. The data that has been collected is not presented in the form of numbers or statistics, but in a narrative, description arranged based on a logical structure. Data analysis aims to fully describe the legal problems that arise, identify elements of law violations, and offer solutions through civil law mechanisms as well as alternative non-litigation dispute resolution such as mediation. The qualitative

approach in this study emphasizes an in-depth and reflective understanding of each legal norm studied, in order to formulate appropriate protection for patients as legal subjects harmed by RME data leaks.

RESULTS AND DISCUSSION

Forms of Civil Legal Acts against Electronic Medical Record Documents that Cause Disputes with Patients

Electronic medical record (RME) documents have a central position in modern healthcare because they serve as legitimate legal evidence in the resolution of disputes between patients and healthcare facilities. In practice, the RME can be a source of legal problems when its management is not in accordance with legal principles, medical ethics standards, or administrative provisions. Violations of these documents can lead to serious disputes, especially when the data in them is used as the basis for clinical decision-making or the evidentiary process in legal cases. Inaccuracies or manipulations in filling out the RME are not only technical problems, but also legal issues that have an impact on justice for patients (Daud & Sagala, 2024).

One form of violation that often occurs is filling out an incomplete, inaccurate, or inconsistent RME. Disconnected medical data, irrelevant information, and errors in recording medical procedures will damage the integrity of the document. When a patient feels aggrieved and files a lawsuit, the contents of the medical record become the main reference in the legal process. Incompleteness of records will complicate the evidentiary process in court, leaving the patient in a weak position. RMEs that do not reflect the facts of medical services objectively can make patients lose the opportunity to obtain justice, while hospitals or medical personnel cannot be held accountable to the maximum.

The act of deletion, alteration, or manipulation of data in the RME without legitimate legal procedures constitutes a serious violation. This practice is usually done to hide medical errors or correct data without official process. This action undermines the integrity of the recording system and takes away the authenticity of medical records as legal documents. Without a trail audit or a valid record of changes, modifications to the RME cannot be accounted for. If found in legal proceedings, this manipulation strengthens the patient's position as an aggrieved party and magnifies the potential for civil liability from hospitals or medical personnel.

Data leaks due to the weak RME information security system are a real threat in the digital era. Weak encryption, easily hacked systems, or the use of insecure passwords can cause patient data to fall into unauthorized hands. In some cases, these leaks are leveraged for crimes such as fraud, extortion, or defamation. When this happens, the losses are not only material, but also emotional and social. Hospitals that are unable to guarantee the protection of patient data can be sued civilly because they are considered negligent in fulfilling legal obligations related to information confidentiality.

Handing over access or delegating the task of filling the RME to an unauthorized party is also a violation of the principles of professionalism and legal responsibility. Medical records are records that are supposed to be kept by medical personnel who understand the clinical procedure and have legal responsibility for the information. If the filling is carried out by a non-medical party without supervision, then the validity of the data in the RME becomes weak. When a dispute occurs, patients have a strong basis to sue because they have been provided with services based on legally invalid documents, while healthcare institutions can be sued for systemic negligence.

The mismatch between the data in the RME and the actual medical procedures performed can be caused by copy-paste or bulk filling practices that do not pay attention to the patient's individual condition. This makes medical records lose their objective value and pose a great

risk in legal proof. When the contents of the RME do not reflect clinical reality, it will be difficult for the court to accept the document as authentic evidence. This discrepancy not only worsens the patient's position, but also damages the hospital's reputation and reflects a weak internal documentation system.

Data loss due to system failure or lack of data backup is a form of administrative negligence that has an impact on patient rights. Medical data that cannot be accessed or lost due to system failures, cyberattacks, or technical errors erase the historical traces of the medical services that have been provided. When patients need data to continue treatment or file a lawsuit, the unavailability of such information becomes a serious obstacle. The loss of this document can be classified as an unlawful act if it results in real harm and weakens the legal position of the patient in an effort to obtain protection and justice.

The absence of transparency and notification to patients regarding the management and use of RME data is also a violation of the principle of the right to information. Patients have the right to know who can access their data, how it is stored, and whether it is used for other purposes such as research or training. When patients are not informed or do not give consent to the use of their data, the potential for legal disputes will increase. Patients' trust in health institutions has also decreased because they feel that their privacy rights are being ignored.

Non-compliance with legal standards in the storage, retention, and deletion of RMEs becomes a serious problem, especially if documents are deleted before the retention period ends. The Regulation of the Minister of Health expressly regulates the duration of storage of medical documents based on the category of patients. Violations of these provisions indicate administrative negligence and may be held legally liable. If the relevant documents are not available in the event of a dispute, the patient loses important evidence and potentially cannot claim his rights to the fullest (Adrian et al., 2023).

The act of denying or inhibiting a patient's access to the RME to which he or she is entitled can be categorized as a violation of civil rights. Patients need these documents for a variety of purposes, from follow-up care to legal claims. When access is denied without a justifiable reason, it reflects bad faith on the part of the hospital or medical personnel. This obstacle narrows the patient's space to seek justice and causes losses that can be used as the basis for a civil lawsuit.

The use of RME as evidence that does not meet formal and material requirements has fatal consequences in the legal process. Documents that do not have authentication, digital signatures, or accurate record-keeping information cannot be used as strong evidence. When an RME is submitted to the court but does not pass verification as a valid document, the patient's position becomes weak in the evidentiary process. On the other hand, medical personnel or hospitals can escape responsibility even if there are indications of negligence. The quality of the digital medical recording system greatly affects the validity of documents and the level of success of patients in claiming their legal rights.

Dispute Resolution Due to Civil Legal Acts on the Content of Electronic Medical Record Documents That Harm Patients

Dispute resolution that arises due to violations of the content of electronic medical record documents requires a comprehensive approach, based on the principles of justice, protection of patient rights, and compliance with applicable legal norms. These disputes generally arise when there are irregularities in recording, information manipulation, or data leakage that directly or indirectly harm patients. The settlement process can be taken through non-litigation or litigation, depending on the agreement of the parties and the level of loss experienced by the patient. This approach not only aims to restore violated patient rights, but also encourages improvement in the quality of health information governance in healthcare facilities (Sinaga, 2017).

Mediation is one of the initial options in resolving disputes peacefully and efficiently. In this process, patients and hospitals are provided with an open dialogue space facilitated by a neutral mediator to reach an agreement without having to go through a complicated court process. Mediation in electronic medical record disputes is regulated by the provisions of Law Number 17 of 2023 concerning Health. This forum allows the parties to present arguments equally, explore alternative solutions, and maintain professional relationships going forward. The success of mediation is highly dependent on information transparency, willingness to cooperate, and the mediator's ability to maintain a balance between the interests of the patient and the healthcare facility.

If mediation efforts do not yield results or are not agreed by one of the parties, the patient has the right to take legal action through a civil lawsuit. This lawsuit is intended to demand compensation for the losses suffered, both material and immaterial. The electronic medical record in question can be used as written evidence if it meets the provisions of civil procedure law and evidentiary regulations. Article 184 of the Criminal Procedure Code and the Regulation of the Minister of Health provide a legal basis for the use of these documents in proving cases. The lawsuit must be supported by other supporting evidence such as the opinion of a medical expert, electronic evidence, and documentation showing any procedural violations or negligence of medical personnel.

The validity of electronic medical record documents as evidence requires the fulfillment of certain standards, especially authentication and information integrity. Valid medical records must have certified electronic signatures and security systems that guarantee the data is not illegally altered. This is regulated in Law Number 11 of 2008 concerning Information and Electronic Transactions and its amendments. The trail audit system must also be able to record every activity in the document to ensure transparency. The existence of this system gives confidence to the judge that the documents submitted do indeed reflect the actual medical incident and are not subject to interference or intervention from unauthorized parties (Rubiyanti, 2023).

In complex dispute cases, the opinions of medical experts and information technology experts are required to strengthen the evidence. Medical experts can assess whether medical procedures are in accordance with applicable service standards, while IT experts can evaluate digital footprints, system security, and data integrity. The collaboration of these two areas of expertise allows the court to obtain an objective picture of the truth of the disputed event. Technical and medical verification of the RME adds weight to the evidence, as well as assisting the judge in assessing the suitability between the electronic record and the actual medical actions performed on the patient.

Patients' right of access to electronic medical record documents is part of the fundamental right to information and control over personal data. Patients have the right to know, request a copy, and understand how their data is managed and used. When a hospital denies or impedes access without a valid reason, it is a lawsuitable violation of the law. The availability of open information is a guarantee for patient participation in medical decision-making and a control tool against potential violations by health workers. The recognition of this access right is part of the protection of personal data as stipulated in national laws and regulations.

Healthcare facilities have a legal and moral responsibility to maintain the confidentiality and security of electronic medical data. Actions such as information leaks, unauthorized access, or weak data protection systems are forms of negligence that can be subject to sanctions. The Health Act and the Personal Data Protection Act affirm the importance of institutional responsibility in building a reliable information security system. The use of encryption, training of medical personnel, periodic system audits, and access control are mandatory components in the management of RME. Failure in this case shows a violation of the patient's trust and opens up the possibility of a lawsuit.

A restorative justice approach can be an alternative to resolving relationships and acknowledgment of patient harm. In this approach, the focus is directed at humane problem resolution, such as the granting of an apology, proper compensation, and a guarantee of system improvement. This process can be facilitated by a competent mediator or independent institution, and takes place through direct dialogue between the aggrieved party and the responsible party. The goal is not only to resolve disputes, but also to prevent the recurrence of similar violations in the future and to rebuild trust in health institutions (Ekawati et al., 2023).

Before moving on to a formal legal process, patients are encouraged to use the internal complaint mechanism available at healthcare facilities. The Patient Complaint Service Unit (ULPP) serves as an initial bridge between patients and hospital management. This path allows for fast, structured and documented settlement, as long as the mechanism is executed professionally and responsively. The existence of an effective complaint system reflects good risk management in an institution and is able to prevent conflicts from developing into legal disputes. Quick response to complaints is also a form of appreciation for patients' voices as part of a transparent service system.

Regulators such as the Ministry of Health have an important role in monitoring the implementation of electronic medical record systems. Periodic evaluations carried out on legal, technical, and ethical aspects are a guarantee that the hospital complies with applicable operational standards and regulations. The regulator can impose administrative sanctions or recommend system improvements if discrepancies are found. This supervisory task not only serves as an external control, but also as a means to drive improved quality of data management and protection of patient rights in the ever-evolving digital healthcare sector (We'e et al., 2023).

CONCLUSION

In conclusion, violations of civil law against electronic medical record documents that cause disputes with patients include incomplete or manipulative data filling, data leakage due to weak security systems, granting access to unauthorized parties, and denying patients access to their medical records. This violation violates the provisions of Government Regulation Number 28 of 2024, Law Number 27 of 2022 concerning Personal Data Protection, and Law Number 11 of 2008 concerning Information and Electronic Transactions. Dispute resolution can be carried out through mediation as stipulated in Article 789 of PP 28/2024, and if it is not achieved, the patient can file a civil lawsuit with electronic medical records as evidence in accordance with Article 790. Patients' rights to data access are still guaranteed, and violations of data confidentiality and security can lead to lawsuits and legal sanctions, so legal assistance and internal supervision are important elements in the settlement process.

REFERENCES

- Adrian, H., Purnami, C. T., & Suryoputro, A. (2023). Analisis Dokumentasi Rekam Medis Elektronik di Fasilitas Pelayanan Kesehatan: Literature Review: Analysis of Electronic Medical Record's Documentation In Health Care Facilities : Literature Review. *Media Publikasi Promosi Kesehatan Indonesia (MPPKI)*, 6(11).
- Chintia, D., & Kusumaningrum, A. E. (2020). Peran Rekam Medis Sebagai Alat Bukti Dalam Penyelesaian Sengketa Medis Antara Dokter Dan Pasien. *Jurnal JURISTIC*, 1(01).
- Christanto, E. A., Yuyut Prayuti, Y. P., & Arman Lany, A. L. (2024). Perlindungan Hukum Terhadap Pasien Korban Malpraktik Medis Dalam Perspektif Hukum Perdata. *JURNAL HUKUM MEDIA JUSTITIA NUSANTARA*, 14(1).
- Darmawan, A. (2023). Analisis Pelepasan Informasi Rekam Medis Sebagai Penjamin Aspek Hukum Kerahasiaan Data Pasien. *Jurnal Manajemen Informasi Kesehatan Indonesia (JMIKI)*, 11(1).

- Daud, K. R., & Sagala, P. (2024). Analisis Yuridis Kekuatan Hukum Rekam Medis Elektronik Sebagai Alat Bukti Dalam Suatu Sengketa Medis. *Jurnal Cahaya Mandalika*.
- Ekawati, P. D., Ravena, D., & Susiarno, T. H. (2023). Implementasi Pendekatan Restoratif dalam Penyelesaian Sengketa Medis Perspektif Manfaat Hukum. *Intellectual Law Review (ILRE)*, 1(1).
- Marzuki, P. M. (2019). *Penelitian Hukum*. Prenadamedia Group.
- Nasution, M. A. S., Satria, B., & Tarigan, I. J. (2022). Mediasi Sebagai Komunikasi Hukum Dalam Penyelesaian Sengketa Medik Antara Dokter Dan Pasien. *JURNAL HUKUM KESEHATAN INDONESIA*, 1(02).
- Rubiyanti, N. S. (2023). Penerapan Rekam Medis Elektronik di Rumah Sakit di Indonesia: Kajian Yuridis. *ALADALAH: Jurnal Politik, Sosial, Hukum Dan Humaniora*, 1(1).
- Sinaga, D. N. A. (2017). Hal-hal Pokok dalam Pembuatan Suatu Kontrak. 7(2).
- Sugiyono. (2019). *Metode Penelitian Kualitatif, Kuantitatif, dan R&D*. Alfabeta.
- Suparman, R. (2020). Perlindungan Hukum Dan Tanggung Jawab Rumah Sakit Terhadap Dokter Dalam Sengketa Medis. *Syar Hukum : Jurnal Ilmu Hukum*, 17(2).
- Wahyudi, R. (2021). Perlindungan Hukum Terhadap Dokter, Dokter Gigi Dan Pasien Pada Penerapan Rekam Medis Elektronik Di Rumah Sakit. *Badamai Law Journal*, 6(1).
- We'e, A., Nugroho, H., & Siswatibudi, H. (2023). Evaluasi Aspek Keamanan Dan Kerahasiaan Rekam Medis Elektronik Di Rumah Sakit Panti Nugroho. *Jurnal Permata Indonesia*, 14(2).