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# Dissecting justice: the legal significance of medical records and informe consent in malpractice cases

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## ABSTRACT

This study examines the legal position and strength of medical records and informed consent as evidence in medical malpractice cases in Indonesia. Using normative legal research methods, this study applies a statutory approach and an analytical approach to understand the aspects of health law and related evidentiary law. The study results indicate that medical records have a strong position as written evidence in civil procedural law and as written evidence in criminal procedural law. Meanwhile, informed consent plays an important role in proving the fulfilment of the doctor's obligation to provide information to patients. However, the existence of informed consent does not necessarily eliminate the doctor's responsibility if proven to have committed negligence. This study also reveals that the use of medical records and informed consent as evidence must consider aspects of patient confidentiality and the development of electronic medical record technology. In conclusion, although medical records and informed consent have significant evidentiary power, their use must be carried out carefully by considering the case context, medical professional standards, and applicable health law principles to ensure justice in resolving medical malpractice cases in Indonesia.

**Keywords:** medical records; informed consent; medical malpractice; legal evidence; protection medical personnel.

## 1. INTRODUCTION

Medical records and informed consent are two important elements in modern medical practice (Sylvia & Abiyasa, 2023). Medical records serve as documentation of the patient's medical history and treatment, while informed consent guarantees the patient's right to obtain information and give consent for medical actions to be carried out (Sarake, 2014). Both have a vital role in efforts to provide optimal health services while protecting patient rights. In recent years, Indonesia has also recorded a significant number of alleged medical malpractice complaints, which shows that disputes between patients and health workers are not sporadic incidents but part of a broader pattern of patient safety and accountability issues.

In legal aspects, medical records and informed consent have a significant position. Medical records can be used as written evidence containing notes and documents about the identity, examination, treatment, actions and other services provided to patients during treatment (Kesuma, 2023; Sulistyaningrum et al., 2021). Meanwhile, informed consent is a form of patient approval for medical procedures to be carried out after receiving a complete explanation from health workers (Daud et al., 2024). In legal proceedings, these two instruments are increasingly requested as evidentiary tools to assess the presence or absence of negligence by healthcare professionals in civil, criminal, and professional disciplinary domains.

Law Number 29 of 2004 concerning Medical Practice has regulated that every medical or dental action to be performed on a patient must obtain approval. This emphasizes the importance of informed consent as a form of legal protection for patients and health workers. Informed consent aims to provide comfort and support for patients in making decisions, as well as improving communication between doctors and patients. At the same time, recent regulatory developments, such as Law Number 17 of 2023 on Health and Ministry of Health Regulation Number 24 of 2022 on Medical Records, have expanded the normative framework governing medical documentation obligations, the implementation of Electronic Medical Records (RME), and the protection of patient data.

However, in practice, various problems related to medical records and informed consent are still encountered. Many patients do not fully understand their rights as recipients of health services (Chazawi, 2022; Purwoto, 2024). On the other hand, there are still health workers who are less than optimal in providing explanations to patients before performing medical procedures. This has the potential to cause misunderstandings and disputes in the future. This phenomenon is reflected in numerous public complaints and empirical studies indicating that informed consent is often treated merely as an administrative formality, rather than as a comprehensive and meaningful process of communication between physicians and patients.

Recent cases of alleged medical malpractice have increasingly highlighted the importance of medical records and informed consent (Yunanto & Helmi, 2024; Mannas et al., 2023). In the process of proof in court, medical records can be crucial evidence to determine whether or not there is an error or negligence from health workers. Meanwhile, informed consent is proof that the patient has received sufficient information and agrees to the medical actions taken. A number of court decisions and medical dispute cases demonstrate that the completeness and quality of medical record documentation, as well as the presence or absence of valid informed consent, often become crucial factors in determining the legal liability of healthcare professionals.

The position of medical records as evidence in medical malpractice cases is regulated in various laws and regulations. Article 184 paragraph (1) of the Criminal Procedure Code states that valid evidence is witness statements, expert statements, letters, instructions, and statements from the defendant. In this case, medical records can be categorized as written evidence. However, its evidentiary power still needs to be studied further considering its non-absolute nature. Several previous studies have primarily positioned medical records as documentary evidence in civil law contexts (for instance, in compensation claims or therapeutic breach of contract disputes), without providing an in-depth examination of how judges comparatively assess the probative value of medical records and informed consent across civil, criminal, and professional disciplinary proceedings (Ginting, 2019; Sudiyanto, 2019).

Meanwhile, informed consent has a dual function in the legal aspect. For health workers, informed consent can provide a sense of security in carrying out medical procedures (Pebrina et al., 2022). Meanwhile, for patients, informed consent guarantees the fulfilment of the right to obtain information and provide consent (Matippanna, 2019). However, it should be noted that informed consent is not an agreement that frees health workers from absolute legal responsibility. Several normative legal studies tend to emphasize the protective function of informed consent either for physicians or for patients in isolation, leaving the reciprocal relationship between the two as a mechanism for distributing risk and responsibility in medical practice only partially and unsystematically mapped.

In the context of proving malpractice cases, medical records and informed consent cannot stand alone as remaining evidence (Sudiyanto, 2019). Other evidence such as expert testimony is needed to strengthen the position of medical records and informed consent in the judicial process. This is considering the complexity of medical malpractice cases involving technical aspects of medicine (Rizka & Arief Budiono, 2022). At the same time, much of the literature on the proof of medical malpractice in Indonesia focuses primarily on the role of expert testimony and professional standards, while relatively few studies examine in detail how the integration of medical records, informed consent, and expert opinions collectively shapes a convincing evidentiary construction before the court.

Another problem that often arises is related to the confidentiality of medical records. On the one hand, medical records contain personal information of patients that must be kept confidential. However, on the other hand, medical records are also needed as evidence in legal proceedings (Hapsari, 2014). A balance is needed between protecting patient privacy and the interests of law enforcement in this case. The advent of RME adds a new dimension to this issue, as medical records are now stored in electronic systems that are interoperably connected under the control of a national health data platform, thereby increasing the risk of breaches of confidentiality and misuse of patient data and necessitating more detailed regulation on access, authorization, and data audit trails.

In addition, there are still differences in understanding and implementation related to medical records and informed consent in various healthcare facilities. Standardization of the format and procedures for filling out medical records and providing informed consent still needs to be improved to ensure their quality and validity as legal evidence (Darwis, 2024). Various studies on Ministry of Health Regulation Number 24 of 2022 predominantly focus on the technical and institutional readiness of hospitals to implement RME, whereas the evidentiary strength of electronic medical records and their interaction with informed consent documents in malpractice litigation has not yet become a central focus of legal analysis. This condition raises important legal questions regarding how electronic medical records can function as reliable evidence in court, particularly when disputes arise concerning medical negligence or malpractice. In practice, electronic medical records are expected to provide accurate, complete, and traceable documentation of medical services, including information related to patient consent, diagnosis, treatment procedures, and clinical decisions made by healthcare professionals. However, without clear guidelines and uniform standards, inconsistencies in documentation practices may reduce the credibility of these records as legal evidence. Therefore, strengthening regulatory frameworks, improving documentation procedures, and increasing the legal awareness of healthcare providers are essential to ensure that electronic medical records and informed consent documents can effectively support both patient protection and legal accountability within the healthcare system.

Given the complexity of the problem, a comprehensive study is needed on the position of medical records and informed consent as evidence in medical malpractice cases. This research is important and urgent to be conducted in order to provide legal clarity for health workers and patients. The results of the study are expected to be input for regulatory updates in the field of health law and to improve the quality of health services in Indonesia. More specifically, several gaps make this study particularly urgent. First, there is a contextual gap, as most prior studies examined medical records and informed consent before the enactment of Ministry of Health Regulation Number 24 of 2022 and Law Number 17 of 2023, and therefore did not yet account for the context of digital transformation and the strengthening of the health data protection regime. Second, there is a theoretical and methodological gap because existing normative legal scholarship tends to discuss medical records and informed consent separately, or to treat them merely

as documentary evidence in general, without developing an integrated analytical model for assessing their probative value in malpractice cases across different legal regimes (civil, criminal, and professional discipline).

This study contributes by filling these gaps through providing an updated analysis of the legal position of medical records and informed consent as evidence in malpractice disputes that incorporates the new context of Electronic Medical Records implementation following Ministry of Health Regulation Number 24 of 2022 and recent health-sector regulations; developing a more robust analytical mechanism for evaluating the evidentiary strength of medical records and informed consent in an integrated manner together with expert testimony in various law-enforcement fora; and identifying boundary conditions related to confidentiality, access, and standardisation of the completion of medical records and informed consent that need to be clarified in policy and practice, thereby offering more operational normative recommendations for policymakers, healthcare facilities, and law enforcement authorities.

## 2. METHODOLOGY

This research employs a normative legal research design that systematically examines legal norms, doctrines, and case law related to the position of medical records and informed consent as evidence in medical malpractice cases in Indonesia (Juliardi et al., 2023). The unit of analysis consists of written legal materials and judicial decisions, including statutory provisions, implementing regulations, doctrinal writings, and selected malpractice cases in which medical records and/or informed consent are explicitly used in the evidentiary construction (Syarif et al., 2024; Qamar & Rezah, 2020). The population of legal materials covers primary, secondary, and tertiary sources concerning medical practice, the law of evidence, and medical malpractice; from this population, documents are purposively selected such as the Medical Practice Act, the Health Act, the Criminal Procedure Code (KUHAP), and ministerial regulations on medical records, as well as civil, criminal, and professional disciplinary decisions and scholarly works that directly address the legal status of medical records and informed consent with documentary data collection continued until theoretical saturation is reached (Nawi, 2017; Sulolipu & Handoyo, 2019).

Analytically, the study combines a statute approach and an analytical (doctrinal-conceptual) approach to interpret and systematise legislative provisions and to examine in depth the concepts, doctrines, and expert views regarding the probative value of medical records and informed consent, including their relationship with expert testimony in malpractice litigation (Juliardi et al., 2023; Sulolipu & Handoyo, 2019; Qamar & Rezah, 2020). The main analytical technique is qualitative juridical-normative analysis, involving interpretation of legal texts, harmonisation of norms across different regulations, and reconstruction of judicial reasoning, which is considered most appropriate for research questions that focus on clarifying legal status and mapping how judges evaluate medical records and informed consent in civil, criminal, and professional disciplinary cases, and therefore cannot be adequately addressed through quantitative methods. Potential bias is minimised through triangulation of different categories of legal materials (legislation, case law, doctrinal writings) and comparison of multiple academic perspectives to avoid over-reliance on a single source (Sulolipu & Handoyo, 2019).

Methodologically and contextually, this study has several limitations: first, the "sample" of decisions and documents selected purposively may not fully capture the entire range of judicial practice across regions and court levels; second, the cross-sectional, document-based design limits the ability to trace changes in evidentiary practices over time; third, the absence of empirical data from the direct experiences of physicians, patients, and legal practitioners means that the analysis depends on normative reconstruction and the arguments contained in official texts. As a result, the generalisability of the findings is confined to the Indonesian legal system context and does not automatically extend to other jurisdictions. Future research could address these limitations by developing longitudinal designs that compare malpractice decisions before and after the implementation of Ministry of Health Regulation Number 24 of 2022, conducting comparative studies across regions or countries on the use of electronic medical records and informed consent in proof, integrating multi-source data (legal documents, interviews with

judges, physicians, and patients), and exploring socio-legal or quasi-experimental approaches to test the role of theoretically grounded moderators or mediators such as patients' health-law literacy or hospitals' medical record management capacity in shaping the evidentiary role of medical records and informed consent.

## 3. RESULTS AND DISCUSSION

### 3.1. Legal Position and Power of Medical Records and Informed Consent as Evidence in Malpractice Cases

In the Indonesian legal framework, the discussion of the position and evidentiary power of medical records and informed consent in malpractice cases can be understood more clearly when linked to several core theories in evidence law, contract law, and health law. Medical records, as comprehensive documentation of the course of medical services, occupy a central place within the structure of written evidence envisaged in Article 1866 of the Civil Code and Article 184 paragraph (1) of the Criminal Procedure Code, thereby aligning with classical evidentiary theory which treats documents as a key means of reconstructing past events in both civil and criminal proceedings (Astuti, 2009; Angela et al., 2023). This mapping is consistent with previous normative studies that also classify medical records as documentary evidence in civil disputes and criminal prosecutions, although many of those works mainly stop at formal categorisation and pay less attention to how judges actually weigh completeness, internal consistency, and conformity with professional standards when assessing their probative value (Abduh, 2021). The present analysis, by explicitly connecting the assessment of medical records to the principle of free evaluation of evidence (*vrij bewijs*) and to professional liability theory, shows that the strength of medical records as evidence is not inherent and absolute but depends on the extent to which the record faithfully reflects the therapeutic process and complies with applicable medical and legal standards (YH & Susanto, 2024).

Informed consent, in turn, is best interpreted through the combined lenses of autonomy theory in health law and consent theory in contract law. From a contractual perspective, informed consent evidences the patient's agreement to a medical intervention, including recognition of inherent risks, and thus functions as an expression of will within the therapeutic transaction (Laelatussofah, 2024). From a health-law perspective, however, informed consent operationalises the principle of respect for patient autonomy and the doctrine of duty to inform, which requires physicians to provide adequate, comprehensible information before any intervention. Earlier normative works in Indonesia have often emphasised informed consent either as a shield for physicians or as a right of patients, but have less frequently examined how the document is actually used in judicial reasoning and how it interacts with other evidence such as expert testimony and medical records (Sitepu, 2025). The findings here suggest a more nuanced theoretical position: the existence of written informed consent can support the argument that the duty to inform has been formally fulfilled, yet under professional liability theory it does not extinguish responsibility if the physician's conduct deviates from professional standards or standard operating procedures. This is in line with empirical analyses of malpractice decisions indicating that courts may treat informed consent as a supporting, rather than decisive, element particularly in emergency (cito) situations where consent may not be strictly required, and where the focus shifts to compliance with duty of care.

The interplay between medical records, informed consent, and the burden of proof theory becomes evident when examining how these documents can either facilitate or complicate the patient's task of proving negligence. In classical doctrine, the burden of proving fault and causation generally rests on the claimant; yet complete, consistent medical records and properly obtained informed consent can, in practice, help shift or at least ease this burden by providing objective traces of what was done, when, and with what information base (YH & Susanto, 2024). This interpretation both confirms and extends earlier studies which concluded that medical records and informed consent may serve as written evidence and indications in malpractice cases, but which did not fully articulate their dynamic function within burden-of-proof allocation and judicial deliberation (Abduh, 2021). At the same time, confidentiality theory in health law requires that the use of medical records in court be carefully balanced against the

patient's right to privacy, recognising narrow exceptions for legal proceedings while demanding procedural safeguards such as restricted access, anonymisation where possible, and judicial oversight (Andayani & Puwarni, 2024).

Recent developments in the digitalisation of health services introduce an additional theoretical layer, namely electronic evidence theory, which becomes particularly relevant with the widespread adoption of electronic medical records (RME). Electronic medical records, while functionally analogous to conventional paper-based records, raise distinct questions regarding authenticity, integrity, and security that must be addressed through the legal framework on electronic information and transactions, as well as specific health regulations on medical records (Denianto, 2010). Earlier research has confirmed that RME can be recognised as lawful evidence, supported by the Electronic Information and Transactions Law and ministerial regulations, but those studies have often focused on the legality of RME in abstract terms rather than on how judges actually scrutinise metadata, access logs, and system integrity when resolving malpractice disputes. The present discussion suggests that, under electronic evidence theory, the probative value of RME depends not only on their contents but also on the reliability of the underlying information systems raising boundary conditions related to digital infrastructure, cybersecurity, and institutional capacity which may differ significantly across regions and types of facilities.

Against this theoretical background, the findings can be situated within, and contrasted against, the broader body of high-quality scholarship on medical disputes in Indonesia. Several normative studies have concluded that medical records and informed consent have legal standing as documentary evidence and indications in civil claims and criminal prosecutions, but they tend to treat the two instruments in isolation either focusing on medical records as an administrative and evidentiary tool, or on informed consent as a contractual-autonomy device without designing an integrated framework for how both types of documents, together with expert testimony, form a coherent evidentiary construction before the court (Abduh, 2021; Angela et al., 2023). By contrast, the present analysis conceptualises medical records and informed consent as interdependent components within a "triangular" structure of proof that also involves expert opinion: medical records narrate the clinical course, informed consent captures the informational and volitional dimension of the therapeutic relationship, and expert testimony contextualises both within prevailing standards of care. This integrated reading helps explain why, in some high-profile cases, courts have relied heavily on medical records while giving limited weight to informed consent particularly when consent forms were incomplete, generic, or inconsistent with the actual procedure performed (Abduh, 2021). An alternative explanation that outcomes hinge simply on the persuasive skills of counsel cannot be entirely dismissed, but the pattern across multiple decisions suggests that the structure and quality of documentation itself materially influence judicial assessments of fault and causation.

From a social-legal perspective, the implications of these findings extend beyond doctrinal refinement and speak directly to broader societal issues such as inequality of access to justice, quality of governance in the health sector, public trust in medical institutions, and the emergent digital divide in healthcare. Patients from lower socio-economic backgrounds, or with limited health-law literacy, are particularly vulnerable when medical records are incomplete or incomprehensible, and when informed consent is reduced to a one-sided administrative ritual rather than a meaningful communicative process. In such circumstances, the formal availability of medical records and consent forms as evidence does not automatically translate into effective access to justice, because patients may lack the resources and expertise needed to interpret and leverage these documents in legal proceedings. Conversely, medical professionals may experience heightened legal insecurity in an environment where documentation standards vary widely and where the boundary between acceptable risk and actionable negligence is not consistently articulated in case law, thereby affecting the perceived fairness and sustainability of working conditions for healthcare workers (Angela et al., 2023).

The expansion of RME and the integration of health data into national platforms further intersect with questions of governance quality, data protection, and the digital divide. Facilities with robust digital infrastructure and adequate training are better positioned to produce reliable, auditable RME that strengthen both patient protection and professional accountability, whereas under-resourced facilities face

greater risks of technical errors, data breaches, and evidentiary challenges that may disproportionately affect marginalised communities (Denianto, 2010). These dynamics have implications for public trust: transparent and accurate medical documentation, accompanied by genuine informed consent processes, can reinforce confidence in health services and dispute-resolution mechanisms, while recurrent documentation failures and opaque data practices can fuel distrust, conflict, and perceptions of systemic injustice.

These insights can inform concrete action by multiple stakeholders. For policymakers and legislators, the findings support the need for more detailed regulations and technical standards on the preparation, storage, and use of medical records and informed consent in both paper-based and electronic formats, including clear rules on access, audit trails, and admissibility criteria, as well as guidelines that align evidentiary requirements with data-protection safeguards. For courts and judicial training institutions, the analysis underscores the value of specialised capacity-building on evaluating medical documentation and RME, including how to interpret metadata and how to integrate documentation with expert testimony in a transparent reasoning process. For hospitals and professional organisations, the discussion highlights the importance of investing in documentation quality through standardised templates, structured RME systems, and communication training for informed consent as part of broader governance and risk-management strategies that protect both patients and healthcare workers. Civil society organisations, patient advocacy groups, and educators can also use these findings to develop legal-literacy programmes that empower patients to understand their rights related to medical records and consent, thereby narrowing informational inequalities and supporting more balanced, trust-enhancing relationships between patients, professionals, and institutions.

### 3.2 The Role of Medical Records and Informed Consent in Providing Legal Protection for Medical Personnel

The legal standing and evidentiary power of medical records and informed consent in malpractice cases can be more precisely understood when read through the lenses of evidence law, autonomy theory, contract theory, and professional liability. Medical records, as documents that capture the entire course of medical services provided to patients, fit squarely within the category of written evidence recognised in Indonesian civil and criminal procedural law, namely Article 1866 of the Civil Code and Article 184 paragraph (1) of the Criminal Procedure Code. This position aligns with classical evidentiary theory, which treats documentary records as primary tools for reconstructing past events in litigation, and is consistent with earlier Indonesian studies that characterise medical records as documentary evidence with substantial probative potential in malpractice disputes (Astuti, 2009; Angela et al., 2023). At the same time, the principle of free evaluation of evidence (*vrij bewijs*) in the Indonesian justice system requires judges not to accept medical records as self-evidently decisive but to scrutinise their completeness, internal consistency, and conformity with professional standards, a point echoed in more recent doctrinal analyses that emphasise that medical records must be read in conjunction with expert testimony and other supporting evidence (YH & Susanto, 2024).

Informed consent, by contrast, is best interpreted as the juridical expression of patient autonomy in health law and as a form of consent within contract theory. Its legal position as evidence in malpractice litigation stems from the idea that the consent document records a meeting of minds regarding the proposed intervention and its risks, thereby evidencing both the informational content provided by the physician and the voluntary decision of the patient (Laelatussofah, 2024). This understanding resonates with international scholarship which views informed consent as a core ethical-legal mechanism to uphold patient autonomy and to prevent malpractice, but also cautions that a signed consent form is not, and should not be, treated as a blanket defence against negligence claims (Medicolegal Sidebar: (Mis)Informed Consent in Medical Negligence; Autonomy, Consent and Responsibility). In line with the "duty to inform" doctrine, the findings here suggest that informed consent has strong evidentiary value in demonstrating that the physician has attempted to discharge the obligation to provide adequate information; yet, under professional liability theory, liability remains if the medical act itself falls below

the standard of care, regardless of the existence of consent. This conclusion is broadly consistent with high-quality Indonesian and international studies which have found that while informed consent functions as written evidence of agreement and risk disclosure, courts tend to separate questions of consent from questions of negligence in the performance of the procedure.

The interaction between medical records, informed consent, and the burden of proof is also central to understanding how these instruments contribute to legal protection for medical personnel. In doctrine, the burden of proof in malpractice cases generally rests on the claimant, who must show that the physician's conduct deviated from professional standards and caused harm; comprehensive and accurate medical records, together with properly documented informed consent, can in practice ease this burden by providing an objective narrative of the treatment process and the informational context in which decisions were made (YH & Susanto, 2024). Internationally, similar dynamics appear in discussions of autonomy and consent, where courts have held that patients must prove a causal link between inadequate information and the harm suffered, while physicians must show that the consent process was properly conducted, especially in high-risk procedures. Compared with earlier Indonesian studies that treat medical records and informed consent largely as static documentary evidence, the present analysis suggests a more dynamic, relational model in which these documents interact with expert opinion, professional guidelines, and confidentiality norms to shape judicial conclusions about fault and causation. At the same time, confidentiality theory in health law imposes boundary conditions: the use of medical records as evidence must be carefully balanced against patients' rights to privacy, allowing disclosure only under legally defined exceptions and with appropriate safeguards. Recent shifts to electronic medical records (RME) introduce additional questions about authenticity, integrity, and security that require the application of electronic evidence theory and more robust institutional controls, making clear that the protective function of documentation depends not only on legal rules but also on the quality of governance and digital infrastructure in health facilities.

Viewed against broader social issues, these findings have direct implications for equality of access to justice, quality of health-sector governance, public trust, and the emerging digital divide. Patients with low health-law literacy or from marginalised socio-economic groups are particularly disadvantaged when medical records are incomplete or incomprehensible and informed consent is reduced to a perfunctory signing of forms, because they lack both the information and the resources needed to use these documents effectively in asserting their rights. In such contexts, formal recognition of medical records and informed consent as evidence does not necessarily translate into substantive justice, and may even entrench inequalities if only those with legal and financial resources can mobilise documentation and expert witnesses to their benefit. For medical personnel, on the other hand, clear standards on documentation and consent can enhance legal security and occupational well-being by providing predictable benchmarks for acceptable practice and a defensible evidentiary basis when disputes arise, though excessive formalism or inconsistent judicial interpretation can also generate anxiety and defensive medicine, with knock-on effects on service quality and sustainability (Legal Protection for the Medical Profession; The Role of Informed Consent as Legal Protection for Doctors).

The digitalisation of records amplifies these distributive concerns: well-resourced urban hospitals are better positioned to implement secure EMR systems with audit trails and robust access controls, thereby strengthening both legal protection and data privacy, while under-resourced facilities risk technical failures, data breaches, and evidentiary gaps that can harm patients and expose staff to legal vulnerability. These patterns affect public trust in health institutions and the justice system: where documentation is transparent, reliable, and used fairly in dispute resolution, trust and social cohesion are likely to be reinforced; where records are poor, consent is merely symbolic, or data are mishandled, distrust and conflict may escalate. Accordingly, the findings support concrete actions by multiple actors. Policymakers and regulators can refine technical and procedural standards for medical documentation and consent both paper-based and electronic while strengthening oversight of privacy and data security. Courts and judicial training bodies can develop specialised guidelines on how to evaluate medical records and informed consent in tandem with expert testimony, making their reasoning more transparent and

predictable. Health-care providers and professional associations can invest in improving documentation practices and communication skills, embedding informed consent as a substantive dialogue rather than an administrative ritual. Civil society organisations, educators, and local governments can design legal-literacy and patient-empowerment programmes that reduce informational asymmetries, helping ensure that the evidentiary role of medical records and informed consent contributes not only to the legal protection of medical personnel but also to more equitable access to justice and higher-quality health governance.

## 4. CONCLUSION

Medical records and informed consent occupy a central legal position in medical malpractice litigation as key evidentiary tools to reconstruct the course of treatment and the information exchanged between physicians and patients. Medical records serve as documentary evidence and indications to uncover alleged malpractice, while informed consent although not expressly categorised as a distinct evidentiary type functions as written proof that information about risks, benefits, and alternatives has been provided before the patient agreed to treatment, thereby supporting enforcement of standards of care, protection of patient rights, and assessment of whether medical personnel have fulfilled their professional and informational duties.

To make this role more effective and implementable, the Ministry of Health and professional councils need to set clear, enforceable technical standards for the content, format, and retention of paper-based and electronic medical records and informed consent, accompanied by phased implementation, supervision, and capacity-building at hospital and primary care levels. Health-care facilities should embed structured training on accurate documentation and substantive, patient-centred consent into continuing professional development and internal audits, while judicial training bodies develop modules for judges and prosecutors on evaluating these documents alongside expert testimony and balancing them with confidentiality and data-protection obligations; in parallel, legislators clarify minimum procedural requirements for validity, and local governments together with civil society run legal-literacy programmes so that patients can meaningfully understand and use the documents they sign.

### Ethical Approval

This research did not require ethical approval.

### Informed Consent Statement

This research did not require informed consent.

### Authors' Contributions

Not Applicable.

### Disclosure statement

No potential conflict of interest was reported by the author(s).

### Data Availability Statement

The data presented in this study are available on request from the corresponding author due to privacy reasons.

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## Notes on Contributors

**Muhammad Darwis**
Muhammad Darwis is Vice Dean II of the Faculty of Law, Social Sciences, and Business Andi Sapada, made significant contributions through the delivery of input, conceptual ideas, and the development of research methodologies. His active role was reflected in the formulation of the research framework, discussed with the Institute for Research and Community Service, actively discussing the selection of relevant methods, and strengthening the theoretical foundation so that the research meets academic and institutional standards. In addition, his contributions focused on strengthening practical legal arguments, mapping actual issues relevant to community needs, and integrating consultation results into the structure of analytical studies.

## REFERENCES

Abduh, R. (2021). Kajian hukum rekam medis sebagai alat bukti malapraktik medis. *De Lega Lata: Jurnal Ilmu Hukum, 6*(1), 221–233. https://doi.org/10.30596/dll.v6i1.4661

Angela, L., Widjaja, M., & Juliansen, A. (2023). Analisis yuridis dasar hukum perlindungan hukum terhadap dokter dan dokter gigi dalam menjalankan pelayanan kesehatan. *Innovative: Journal of Social Science Research, 3*(2), 1933–1944. http://j-innovative.org/index.php/Innovative/article/view/521

Andayani, A., Siska, & Purwani, S. P. (2024). *Confidentiality in digital health records: Aligning privacy and care advancement in hospitals*. Journal of Law, Politic and Humanities, 5(1). https://doi.org/10.38035/jlph.v5i1.787

Astuti, D. W. (2009). *Kedudukan hukum rekam medis dan informed consent sebagai alat bukti dalam kasus malpraktek* (Undergraduate thesis). Universitas Islam Indonesia.

Chazawi, A. (2022). *Malapraktik kedokteran*. Sinar Grafika.

Darwis, M. (2024). *Analisis hukum terhadap kedudukan rekam medis dan informed consent sebagai alat bukti dalam kasus malpraktek* (Undergraduate thesis). Institut Ilmu Sosial dan Bisnis Andi Sapada.

Daud, K. R., Sagala, P., Sutarno, S., & Sutrisno, S. (2024). Analisis yuridis kekuatan hukum rekam medis elektronik sebagai alat bukti dalam suatu sengketa medis. *Jurnal Cahaya Mandalika, 2648–2661*. https://doi.org/10.36312/jcm

Denianto, L. (2010). *Rekam medik elektronik ditinjau dari kedokteran dan Islam* (Diploma thesis). Universitas YARSI. https://digilib.yarsi.ac.id/2385/

Ginting, J. P. (2019). Rekam medis sebagai alat bukti dalam penyelesaian sengketa layanan medis. *Al'Adl: Jurnal Hukum, 12*(2), 259–276. https://www.academia.edu/114873273/Rekam_Medis_Konvensional_Dan_Elektronik_Sebagai_Alat_Bukti_Dalam_Perkara_Pidana

Hapsari, C. M. (2014). *Kajian yuridis pemakaian rekam medis elektronik di rumah sakit*.

Juliardi, B., Runtunuwu, Y. B., Musthofa, M. H., TL, A. D., Asriyani, A., Hazmi, R. M., Syahril, M. A. F., Saputra, T. E., Arman, Z., & Rauf, M. A. (2023). *Metode penelitian hukum*. CV. Gita Lentera.

Kesuma, S. I. (2023). Rekam medis elektronik pada pelayanan rumah sakit di Indonesia: Aspek hukum dan implementasi. *Aladalah: Jurnal Politik, Sosial, Hukum dan Humaniora, 1*(1), 195–205. https://doi.org/10.59246/aladalah.v1i1.188

Laelatussofah, S. (2024). *Rekonstruksi regulasi perlindungan hukum sumber daya manusia kesehatan pada penanganan pasien di rumah sakit berbasis keadilan* (Doctoral dissertation). Universitas Islam Sultan Agung.

Mannas, Y. A., & Elvandari, S. (2023). *Aspek hukum telemedicine di Indonesia*. PT RajaGrafindo Persada.

Matippanna, A. (2019). *Pentingnya memahami informed consent dan rahasia medis dalam praktek kedokteran*. Uwais Inspirasi Indonesia.

Nawi, S. (2017). *Penelitian hukum normatif versus penelitian hukum empiris* (5th ed.). PT Umitoha Ukhuwah Grafika.

Pebrina, A. R., Najwan, J., & Alissa, E. (2022). Fungsi penerapan informed consent sebagai persetujuan pada perjanjian terapeutik. *Zaaken: Journal of Civil and Business Law, 3*(3), 468–486. https://doi.org/10.22437/zaaken.v3i3.18966

Purwoto, A. (2024). *Pertanggungjawaban pidana: Sebuah tinjauan yuridis*. Duta Sains Indonesia.

Qamar, N., & Rezah, F. S. (2020). *Metode penelitian hukum: Doktrinal dan non-doktrinal*. CV. Social Politic Genius (SIGn).

Rizka, S. A., & Budiono, A. (2022). *Hukum kesehatan*. Muhammadiyah University Press.

Sarake, H. M. (2014). *Buku ajar rekam medis*. STIKES Husada Borneo.

Sitepu, F. (2025). *Inform consent sebagai perlindungan hukum dalam pelaksanaan tindakan dokter dan paramedis (Studi di Rumah Sakit Umum Bandung)* (Master's thesis, Universitas Medan Area). https://repositori.uma.ac.id/jspui/bitstream/123456789/27443/2/231803021%20-%20Fadel%20Sitepu%20-%20Fulltext.pdf

Sudiyanto, H. (2019). *Etika hukum keperawatan*. STIKes Majapahit.

Sulistyaningrum, H. P., Afrilia, D., & Murty, T. (2021). Medical records: Preventive efforts in medical services for COVID-19 patients. *SOEPRA Jurnal Hukum Kesehatan, 7*(2), 327–345. https://doi.org/10.24167/shk.v7i2.3684

Sulolipu, A. B., & Handoyo, S. (2019). Perlindungan hukum terhadap profesi dokter dalam penyelesaian sengketa medis berdasarkan prinsip keadilan. *Jurnal Projudice, 1*(1), 60–82. https://jurnal.pascasarjana.uniba-bpn.ac.id/index.php/JurnalProjudice/article/view/29

Syarif, M., Ramadhani, R., Graha, M. A. W., Yanuaria, T., Muhtar, M. H., Asmah, N., Syahril, M. A. F., Utami, R. D., Rustan, A., & Nasution, H. S. (2024). *Metode penelitian hukum*. Get Press.

Sylvia Anjani, S., & Abiyasa, M. T. (2023). *Disrupsi digital dan masa depan rekam medis (Kajian Peraturan Menteri Kesehatan Nomor 24 Tahun 2022 tentang rekam medis elektronik)*. Selat Media.

Arthanti, W. B., Rusdi, M. S., Yuliwulandari, R., & others. (2024). *Etika kedokteran dengan hukum kesehatan*. Thalibul Ilmi Publishing & Education.

YH, U. K. R., & Susanto, D. (2024). *Amicus curiae di Indonesia: Suatu penerapan dan tantangan*. Tohar Media.

Yunanto, A., & Helmi, S. H. (2024). *Hukum pidana malpraktik medik: Tinjauan dan perspektif medikolegal*. Penerbit Andi.