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Ethical-Medicolegal Aspects of Installation and Removal of Ventilator in Life Support Efforts for Critical Patients during Covid-19 Pandemic

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ABSTRACT

This study aims to analyze the procedures and considerations of medical and medicolegal aspects regarding the installation and removal of the use of ventilators in life support for patients during the COVID-19 pandemic. This study uses a normative juridical legal research method. The results showed that the ethical aspects regarding the installation and removal of the use of ventilators in the effort to support patients' life during the COVID-19 pandemic were based on an agreement that was born by agreement (therapeutic agreement). The decision to stop or postpone life support therapy for medical treatment for patients is made by a team of doctors who treats patients after consulting a team of doctors appointed by the Medical Committee or the Ethics Committee based on *Permenkes* Number 37 of 2014. Meanwhile, the legal basis of procedures is in the process of making the installation decision and releasing the use of ventilators in critical patients during the COVID-19 pandemic, referring to the provisions of *Permenkes* No. 37/2014, *Permenkes* No. 290 of 2008, and *Permenkes* RI No. 290 of 2008 concerning the rejection of medical action, which patients and or their closest relatives can do. The legal basis refers to the medicolegal aspect in critical patients when installing and removing a ventilator. It is used as an indicator for determining whether to withdraw life support or withhold life support. Besides being adjusted to the validity of an agreement according to the Civil Code as stipulated in Article 1320, a doctor can initiate to understand a patient in the preparation and legal consequences of this agreement.

Keywords: Ethical-Medicolegal, Ventilators, Life Support Efforts, COVID-19 Pandemic

I. Introduction

Ventilator (mechanical ventilation) plays an important role in critical nursing because 90% of critically ill patients require intubation and ventilator assistance (PERDATIN Indonesia, 2020). The ventilator's role is a substitute for the ventilation function for patients with impaired respiratory function (Rehatta, Hanindito, & Tantri, 2019). The ventilator maintains optimal alveolar ventilation to meet the patient's metabolic needs, improves hypoxemia, and maximizes oxygen transport (Sundana, 2018). However, using

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ventilators in the long term can lead to many risks, namely death and Ventilator-Associated Pneumonia (VAP). In addition, there is a risk of VAP due to the installation of a ventilator, so weaning is necessary (PERDATIN Indonesia, 2020).

Weaning removes a mechanical ventilator as a breathing apparatus, either gradually or directly. Ventilator weaning in critical patients is the act of releasing the ventilator from the patient to return the task of breathing to the patient (PERDATIN Indonesia, 2020). Weaning can be successful if the patient can breathe freely without assistance from a ventilator for 48 hours (Sundana, 2018). Weaning methods include T-tube, SIMV (Synchronized Intermittent Mandatory Ventilation) weaning, and PSV (Pressure Support Ventilation). However, improper weaning can prolong ventilator use, cause a risk to the patient and even lead to death (Rehatta et al., 2019).

In Epstein's study of 289 patients on a ventilator, 247 patients (85%) were successfully extubated, and 42 patients (15%) had to be reintubated. Of the total 42 patients who were reintubated, 43% died (Sari, Wisudarti, & Widodo, 2017). The American Society of Anesthesiology (ASA) Closed Claims Study between 1990 and 2007 found effects on the respiratory system after extubation in 35 cases out of 522 cases (7%), which included lack of ventilation power, airway obstruction, bronchial spasm and aspiration. The reports obtained that 4-9% of serious respiratory events occur immediately after extubation (Waladani, Mediani, & Anna, 2016). Conditions in Indonesia, based on the report of the Indonesian Critical Care Nurses Association (known as HIPERCCI), the ventilator weaning process, both from the hospital and from HIPERCCI as an association of ICU nurses in Indonesia has not issued a clear protocol on the role of nurses in the ventilator weaning process (Sari et al., 2017).

The current COVID-19 pandemic affects various aspects of life and requires massive and disruptive adjustments in health services. The symptom of the disease caused by COVID-19 is similar to a symptom of influenza, which consist of fever, cough, and shortness of breath and can end in respiratory failure (Acute Respiratory Distress Syndrome) (Medical Education Unit FKUI, 2020). The patient is required to install a ventilator. However, various ethical issues arise, especially in medical ethics, where doctors and nurses must immediately decide when dealing with COVID-19 patients (PERDATIN Indonesia, 2020). What criteria should doctors and nurses use to treat too many COVID-19 patients while doctors and nurses are limited? If there are fewer ventilators than critically ill COVID-19 patients, which patients should the breathing apparatus be given to (Tumanggor, 2020)? Critically ill patients are treated immediately, treatment of seriously ill patients is delayed, and mildly sick patients are treated later. Patients who have no chance of survival receive pure palliative care (Grunau, 2020).

According to data from the Ministry of Health on July 25, 2020, all hospitals in Indonesia have around 3,637 ventilators for critical COVID-19 patients. A total of 1,167 units are installed in ICU (Intensive Care Unit) beds and 1,145 units in negative pressure isolation beds. Then, there are 829 ventilators installed in isolation beds without negative pressure and 496 units in natural air flow isolation beds. However, only some of these

quantities are still available. Around 20-30% of them are being used to treat COVID-19 patients (Lidwina, 2020).

On the one hand, the number of patients due to COVID-19 is increasing. East Java recorded the number of positive COVID-19 patients, as many as 887 people, on January 1, 2021. Thus, the total number of positive cases of COVID-19 reached 85,039 in East Java. The highest number of positive Corona Virus patients was in Blitar Regency, with as many as 175 people. Probolinggo City, 62 people; and Jember Regency, 86 people. Meanwhile, 803 people recovered from COVID-19 in East Java. The total number of patients recovered from COVID-19 reached 72,938 people. The highest number of patients recovered from COVID-19 included 127 people in Jember Regency, 85 people in Blitar Regency, and 46 people in Tulungagung Regency, while in Surabaya City, 18,018 people (Melani, 2021)**.**

If reviewed from the Basic Bioethical Rules (known as KDB), the doctor must make the right decisions to take action related to the patient's life. KDB that is concerned with the issue of critical COVID-19 patients is beneficence, non-maleficence and autonomy. A big dilemma is if the patient or the patient's family, based on KDB autonomy, requests a postponement or discontinuation of using a ventilator as a means of life support. In the non-maleficence rule, this should not be done because it will worsen the patient's condition and is an immoral act. The release of ventilators for COVID-19 patients due to limited ventilators is not following KDB beneficence; namely, doctors must strive for a minimum good life for patients, but special considerations are needed if the purpose of the action is to relieve the patient's suffering. On the other hand, this is contrary to non-maleficence KDB because it puts the patient in danger. Meanwhile, based on KDB autonomy, doctors are obliged to respect the rationality of the patient's family in making decisions about medical actions that the doctor will take next (Suryadi, 2017).

If viewed from the medicolegal aspect, it is intended as a form of health service carried out by medical personnel using medical science and technology based on the authority possessed for legal purposes and to implement applicable regulations (Atmadja & Purwani, 2018). The medicolegal aspect considers that delaying and stopping the ventilator will make the patient vulnerable, although it may be done for the patient’s convenience (Afandi, 2018). As stipulated in Article 5 of the Indonesian Medical Code of Ethics (known as KODEKI), any actions or advice that may weaken psychological or physical endurance is only given for the patient’s benefit after obtaining the patient’s consent. In line with the Regulation of the Minister of Health of the Republic of Indonesia No. 290 of 2008 Chapter 4 Article 16 concerning Approval of Medical Actions in particular situations, namely withdrawing/withholding life support, a patient must obtain the approval of the patient’s closest family.

Furthermore, Article 18 emphasizes that the patient or his closest family can refuse medical action after receiving an explanation of the medical action to be carried out (Suryadi, 2017). Therefore, decisions regarding the action of delaying and discontinuing ventilators for critical patients during the COVID-19 pandemic must be made with the consent of the patient’s family. The patient’s family can request or refuse the action. Life

support therapy that can be discontinued or delayed installation and removal of ventilator use in patients during the COVID-19 pandemic is only therapeutic measures or special treatments, namely ICU care, cardiopulmonary resuscitation, tracheal intubation, mechanical ventilation, as well as other actions specified in the medical service standards. It is explained in Article 7 (d) KODEKI that every doctor needs to study medical, bioethical and medicolegal aspects regarding the installation and removal of the use of ventilators to support patients' life during the COVID-19 pandemic, where a doctor must continue to seek alleviation of the patient's suffering, but not allowed to end the patient's life.

Based on the explanation above, this study aims to analyze the considerations of ethical aspects and the legal basis of procedures in the decision-making process for installing and removing ventilators used in critical patients during the COVID-19 pandemic.

II. Method and Legal Material

This research is normative legal research using a statutory approach (Marzuki, 2017) and a conceptual approach (Achmad, 2009). Normative legal research is legal research conducted based on the norms and rules of the legislation (Ali, 2015).

The source of this research material is legal material, not data or social facts, because the normative legal research studied is legal material that contains normative rules (Nasution, 2008). Legal materials are materials derived from primary legal materials and secondary legal materials that are related to the issues discussed.

a. Primary legal materials are materials sourced from statutory regulations (main legal materials) such as:
    1) The Constitution of 1945;
    2) Law Number 29 of 2004 concerning Medical Practice;
    3) Law Number 36 of 2009 concerning Health;
    4) Law Number 44 of 2009 concerning Hospital;
    5) Law Number 36 of 2014 concerning Health Worker;
    6) Law Number 38 of 2014 concerning Nursing;
    7) Regulation of the Minister of Health Number 290/Menkes/PER/III/2008 concerning Approval of Medical Action;
    8) Regulation of the Minister of Health Number 519/Menkes/PER/III/2011 concerning Guidelines for the Implementation of Anesthesiology Services and Intensive Therapy in Hospitals;
    9) Decree of the Minister of Health of the Republic of Indonesia Number HK.01.07/MENKES/413/2020 concerning Guidelines for the Prevention and Control of Coronavirus Disease 2019.
b. Secondary legal material. Legal materiall that provide an explanation of primary legal materials in the form of literature books written by law scholars, papers, scientific articles, journals, theses that are related and have relevance to the problem being studied.

The procedures for collecting legal materials are carried out by tracing, reviewing and analysing library material, written regulations or other legal material-the processes of finding the rule of law, legal principles and legal doctrine to answer legal issues. Next, choose the articles that contain the rule of law and analyse them. After the legal materials were collected, then they were analysed in an evaluative manner as follows.

a) Stating the legal rules with it's main tenets;
b) Listing the common arguments againts these aspects;
c) Putting forward counter-aguments;
d) Illustrating the consequences of particular points being accepted or denied.

III. Results and Discussion

Consideration of ethical aspect regarding the installation and removal of the use of ventilator in life support effort for patients during Covid-19 pandemic

Regarding the explanation of the legal, especially about the relationship between doctor and patient, in following the law on approval of medical action (informed consent), the medicolegal aspect is used as the basis for health services carried out by medical personnel using medical science and technology based on their authority for legal purposes and to implement applicable regulations (Lontoh, 2008). After the issuance of the Medical Practice Law, the medicolegal aspect has become a disciplinary norm and a new thing that needs to be considered and studied. Medicolegal is a specific approach to problems arising from the practice of the medical profession. This approach is different from legal science in general because it is included in consideration of two fields of science, namely medical science and law. Medicolegal focuses on medical jurisprudence. The essence of this medicolegal approach is based on the right to health care, namely the right to self-determination and the right to information (Herkutanto, 2015). Therefore, it can be concluded whether the actions taken by the doctor in carrying out the treatment can be justified. According to Arifinindar, Amelia, & Ismaniar (2019), it is necessary to understand the basic principles of the doctor-patient relationship in terms of a medicolegal approach:

1. Health Service in relation to medical record
   This medical record was previously based on an agreement called a therapeutic agreement or therapeutic transaction. There are several important things that underlie the importance of a therapeutic transaction, namely:
   a. The parties to the agreement (in law there are parties who are unable to act as parties to the agreement).
   b. Agreement with Hospital (especially in handling health services to the community).
2. The requirement that must be met for the agreement to be valid according to law.
3. The medicolegal aspect of medical records, namely the necessity to be signed by the parties (medical staff and patients).

4. Degree of Health Services as stated or reflected in medical records. Medical records reflect neatness, speed and determination in implementing professional rights and obligations.
5. Function of medical record as legal document. Written medical records are evidence based on the law that are valuable as witness/expert testimony.
6. The parties in the Health Service and their rights and obligations according to ethics and law.
7. Patient right which is the basic right for the foundation of medical law between doctor and patient. The therapeutic transaction has issued reciprocal rights and obligations, and if these rights and obligations are not fulfilled by one of the parties.
8. The Medicolegal aspect of the relationship between the parties in Health Services.

In line with those principles above, in medicolegal cases, there is usually the case of injury, disability or death where an investigation from law enforcement agencies is very important to find out who is responsible for the case, whether the doctor or the patient himself accountable for the injury, disability or death? In other words, a legal matter requires medical expertise in its settlement (Afandi, 2018). Moreover, as stipulated by the Indonesian Medical Council, there is an institution called the Indonesian Medical Discipline Honorary Council, which aims to enforce the discipline of doctors and dentists in the implementation of medical practice in the doctor-patient relationship (Arifinindar et al., 2019).

Medicolegal case in critical patients during the COVID-19 pandemic, especially in the installation and removal of the use of ventilators in life support effort for the patient, is associated with medical ethics and based on morality. Morality is the basis of the emergence of ethics, which every human being will then contemplate in the process of reflection (Herkutanto, 2015). In a doctor's job, before taking action, he must think about "can it" and "will it". After the action occurs, then what is believed to is did it. The question "can it" refers to responsibility, something the doctor has previously held. Doctors should equalize professional standards, learn, and continue to increase their knowledge. The question "will it" refers to professionalism applied when the patient comes. The question "did it" relates to liability, namely the time after the action has been taken against the patient. In the case of critical medicolegal patients who get the installation and removal of the use of a ventilator, malpractice often occurs, including misconduct (which is an intentional error), lack of skill (unintentional error, but lack of doctor skills), and medical negligence (Afandi, 2018). The doctor's mistakes must be accounted for. Patients harmed due to the doctor's negligence during medical actions can claim compensation.

The patient's right to compensation has been regulated in Article 58, paragraph (1) of the Health Law that everyone has the right to claim compensation against a person, health worker, or health provider who causes losses due to errors or negligence in the health services. The legal basis for providing health services by doctors is contained in the Medical Practice Law. As for nurses, the legal basis is contained in Law Number 36

of 2014 concerning Health Workers. Nurses have an obligation to meet patient needs, including bio-psycho-socio and spiritual. It is not owned by a doctor regarding cognitive how to treat and review the patient's condition. A doctor focuses more on treatment and medicine (Suryadi, 2017). To determine the responsibility for installing and removing ventilators for critical patients during the COVID-19 pandemic for medical actions, in assigning subordinates, it is recommended that doctors pay attention to the following.

1. Doctor only carry out diagnosis, therapy, and medical instructions.
2. Assignment of medical action should only be done if the doctor believes in the ability of his staff, so that the patient gets treatment that does not endanger his life. This assignment must be done in writing, with clear instructions on how to do the instructions and the possible complications that can occur and how to handle them.
3. Doctor must always monitors the patients progress both during and after receiving medical treatment (treatment measures) and doctor always ready if at any time he must be present to treat patients directly.
4. Patient who undergoes medical actions that is not carried out by the doctor themselves (there is a delegation of authority). A patient has the right to refuse or accept (Suryadi, 2017).

Furthermore, to save the patient's life or prevent disability, approval of medical action is not required in an emergency situation. As previously explained, approval of medical action as information provided must be vital information. In this case, how clear the information must be given to the patient. If in an emergency situation were accompanied by the closest family, then approval can be requested from the next of kin in the following order: legal husband/wife, biological child, biological father or mother, sibling or guardian (Sundana, 2018). Approval of medical action as a form of accountability for the installation and release of ventilator use in critical patients during the COVID-19 pandemic for doctors' medical actions can be seen from 3 standards, namely:

1. Reasonable physician standard
   That the obligation to provide information and the criteria for the accuracy of information is determined by how it is usually carried out in the medical community, this standard refers to the values that exist in the medical community, regardless of the curiosity and understanding ability of the individual who is expected to receive the information.
2. Subjective standard
   That the decision must be based on the values held by the patient personally so that the information provided must be sufficient for the patient to make a decision, this standard is complicated to implement or almost impossible. Impossible is meant for medical personnel to understand the values that patients individually hold.
3. Reasonable patient standard
   This standard is the result of a compromise from the two previous standards, which is considered sufficient if the information provided has met the needs of ordinary people in general (Busro, 2018).

The ethical aspect of installing and removing ventilators is related to 4 basic moral principles: autonomy, beneficence, non-maleficence and justice. Autonomy means that every medical action must obtain the consent of the patient (or his closest family, if he cannot give his consent), beneficence means that every medical action must be for the good of the patient, non-maleficence means that every medical action must not worsen the patient's condition. Justice implies that medical attitudes or actions must be fair – especially from a distributive-justice perspective. A moral dilemma may still occur if the moral principle of autonomy is confronted with other ethical principles or if the principle of beneficence is confronted with non-maleficence, for example, if the patient's wishes (autonomy) are contrary to the principles of charity or non-maleficence, and if an action contains beneficence and non-maleficence simultaneously as in the rule of double effect.

The ethical consideration that must be known in determining the installation and removal of the ventilator is when, where, and under what conditions the doctor conveys this to the patient's family. Firstly, a doctor must respect the dignity of patients (patient autonomy). In this condition, the patient and his family must have the autonomy to receive relevant information about the disease. The doctor must determine whether the patient, family or relatives understand the latest health condition of the patient. The most crucial thing in determining when to install and remove a ventilator is when a medical procedure has changed from ordinary to extraordinary.

The ordinary measures are all medical, surgical or medicinal procedures that offer a reasonable expectation of "improvement of the condition", which can be obtained or performed without the high cost, pain/effort or other inconvenience. Meanwhile, the extraordinary measures are all medical, surgical, or drug procedures that cannot be obtained/performed without the high cost, effort or inconvenience, or which, if performed, do not offer a reasonable hope of "improvement of the situation". Determining which is ordinary or extraordinary is very important so that doctors and nurses believe that their professional actions do not violate ethics or law.

Legal Basis for proceDures in the Decision-Making Process of Installing and Removing Ventilator for Critical Patients during COVID-19 Pandemic

Regarding the medicolegal aspect, critically ill patients in the installation and removal of the ventilator are used as indications for determining the action of withdrawing life support or withholding life support. In simple terms, withholding means no longer doing resuscitation. On the contrary, withdrawal means that once the patient is withdrawn or withdrawn, the patient's ventilator and inotropes, even if severe. Usually, withdrawal appears as a decision as the ultimate solution to life expectancy for patients (Atmadja & Purwani, 2018). Withholding and withdrawing life support adhere to the basic moral principles, namely autonomy, beneficence, non-maleficence, and justice. These four rules can be used by medical personnel to make decisions before installing and removing ventilators in critical patients (Sundana, 2018).

Beneficence is used as a medical action aimed at the patient's good. For example, if removing the ventilator is for the patient's convenience, with a note that there is no longer

any benefit in installing a ventilator, this is understandable. This principle is described as a self-evident tool and is widely accepted as an appropriate medical goal. Implementing the beneficence principle is essential in morality because it takes action for the patient's good. This is not the only principle that must be considered, but one of several other principles must also be considered. This principle is limited to the balance of benefits, risks, and costs (as a result of the action) and does not determine the achievement of all obligations. The criticism that often arises against applying this principle is that the public interest is placed above personal interest. For example, in medical research, procedures that harm individual research subjects are allowed based on benefit for the public interest. In fact, we should also consider other principles.

The principle of beneficence must be applied to both the individual good of the patient and the good of society as a whole. Because of the broad scope of goodness, many provisions in practice (medical) arise from the principle of beneficence. The following are some forms of application of the beneficence principle, they are:

1. Protecting and safeguarding the rights of others.
2. Preventing harm that can befall others.
3. Eliminating conditions that can harm others.
4. Helping people with various limitations (disability).
5. Helping people in danger

Non-maleficence allows patients, their guardians and health workers to accept or reject an action or therapy after analyzing the benefit and obstacles in a particular situation or condition. This principle relates to the Hippocratic phrase: "I will use therapy to help sick people based on my abilities and opinions, but I will never use it to harm them." The principle of non-maleficence is often discussed in the medical field, especially for controversial cases related to cases of terminal illness, severe illness and serious injury. This principle plays an essential role in making-decision to maintain or end life. Its application can be carried out on a competent and incompetent patient.

The principle of non-maleficence is an integral part of the principle of beneficence (prioritizing action for the patient's good). However, many also distinguish them. The considerations include the idea that the obligation not to harm the patient is undoubtedly different from the obligation to help the patient, even though both are for the patient's good. Furthermore, if the ventilator is stopped, symptoms of severe sedation will appear, and death will soon occur, so this action is against this rule. Therefore, it is very important to know the natural course of the disease, not to decide to hasten death and end life.

Autonomy, namely, the doctor must determine whether the patient, family or relatives understand the latest health condition of the patient. For example, if the patient or family decides to postpone or stop using the ventilator, the doctor must follow the patient's decision. The central meaning of individual autonomy is a personal or individual rule that comes from oneself or is free from interference from others or from limitations that can hinder the right choice. Initially, autonomy was associated with a territory with self-rule, self-government, or self-law. However, autonomy is also used in an individual condition with various meanings such as self-government, the right to be free, personal

choice, freedom of will and being oneself. The important thing in applying the principle of autonomy is assessing the patient's competence. One acceptable definition of patient competence is "the ability to carry out or perform a task or command."

There are several ways to apply the principle of autonomy, especially in medical practice.

1. Tell the truth or real news
2. Respect the privacy of others
3. Protect confidential information
4. Obtain consent for interventions with patients
5. Help others make important decisions (If they ask)

Justice means that medical attitudes or actions must be fair, especially in distributive justice (Atmadja & Purwani, 2018). The principle of justice comes from an awareness that the number of goods and services is limited, while those in need often exceed the limit. A justice situation is someone who gets benefits or burdens according to their rights or conditions. An unfair situation is a negligent act such as negating a benefit to someone with rights or unequal distribution of responsibilities. There are several criteria in the application of the principle of justice, including:

1. for each person there is an equal share
2. for each person based on need
3. for each person based on his effort
4. for each person based on his contribution
5. for each person based on the benefits or uses (merit)
6. for each person based on free-market exchange (Suryadi, 2017).

Based on the ethical aspect, this can actually be seen from two sides, namely: on the one hand, the act is immoral because it causes the loss of a person's life, but on the other hand, it can be considered a noble act because it intends not to prolong the suffering experienced by the patient. The American Medical Association makes basic guidelines (procedures) for making decisions as the ultimate life expectancy solution for critically ill patients.

1. Can a doctor legally request all possible life-sustaining therapies? No, the patient has the right to refuse medical treatment including life-sustaining therapies such as mechanical ventilation, or artificial hydration and nutrition.
2. Is withholding and withdrawing life support same as euthanasia? No, withholding and withdrawing life support aims at general consensus to follow the natural course of the disease not to make a decision to hasten death and end life. While active euthanasia makes decisions to hasten death and end life.
3. Does the doctor "kill" the patient if he removes the ventilator? No, if the purpose of removing the ventilator is for the patient's comfort (or because the installation of a ventilator is no longer beneficial) not death (Sundana, 2018).

Based on the three guidelines above, the most important thing in determining when to take withholding and withdrawing life support is when a medical action has changed from ordinary to extraordinary. Choosing which is standard or extraordinary is essential

so that doctors and nurses believe their professional actions do not violate ethics or law. Ordinary action is performed on all medical, surgical or medicinal procedures that offer a reasonable expectation of "improvement of the condition", which can be obtained or performed without high cost, pain or effort or other inconvenience. Meanwhile, extraordinary measure is performed on all medical, surgical or drug procedures that cannot be obtained or performed without high cost, effort or inconvenience or do not offer a reasonable hope of "improvement of the situation". If the patient has died, it can only be done by a team of doctors and must be made in the ICU. The examination must be under the procedures and requirements to diagnose the patient's death (Sundana, 2018).

Furthermore, the handling of critically ill patients is carried out in the ICU to provide titrated and continuous medical services as stipulated in the provisions of Article 1 Point 3 of the Regulation of the Minister of Health Number 37 of 2014 that "an institution in a hospital with special staff and special equipment intended for observation, care and therapy of patients suffering from acute illness, injury or life-threatening or potentially life-threatening complications with an expected prognosis that is still reversible".

In line with the quote above, patients in the ICU with critical to terminal conditions receive medical services, including life support therapy. Life support therapy is like doing mechanical ventilation. Mechanical ventilation is a method of breathing support given to a patient unable to maintain spontaneous (adequate) ventilation and oxygenation. Mechanical ventilation is achieved through the insertion of an artificial airway (e.g. ET or tracheostomy), which is then connected to a positive-pressure mechanical ventilator whose pressure, timing and volume are regulated. Life support therapy, such as mechanical ventilation in terminal state patients, has a dependency effect because, without the device, the patient cannot survive. Therefore, the question is how long the patient is given treatment or life support while the doctor's actions cannot improve the patient's condition.

As for medical treatment for cessation or release of the ventilator, as explained by Firmansyah & Lubis (2004), if the hemodynamic function has been going well, oxygenation has been adequate, the patient is conscious, and the ventilator is ready to be released. Then, the ventilator can be stopped or terminated. The following are procedures for ventilator discontinuation.

1. If the partial pressure of oxygen (PaO_2) in the blood is normal and the chest X-ray does not show hyperinflation or pulmonary atelectasis;
2. If the fraction of inhaled oxygen (FiO_2) to optimize gas exchange in the patient is 60%, then the patient's positive end-expiratory pressure (PEEP) needs to be discontinued;
3. If the partial pressure of carbon dioxide ($PaCO_2$) dissolved in the blood has fallen to normal, then the amplitude is stopped;
4. When the amplitude reaches the lowest limit (10 ml), normal breathing can be started

During the discontinuation of ventilator use, it is necessary to monitor electrolytes, calcium, glucose, urea, and creatinine because metabolic disorders will affect the process

of stopping the ventilator. Patients fasted for 4 hours before extubation or food was given via a nasogastric tube. Marrelli (2008) argued that it is the same with Do Not Resuscitation (DNR), namely the order not to resuscitate the patient. Health workers do not perform or provide relief measures in the form of CPR (cardiopulmonary resuscitation) if there is an emergency problem with the patient's heart, or the patient stops breathing. Instead, the patient is allowed to die for medical reasons, and the patient's family has agreed to this action.

Thus, the decision to install and remove the use of ventilators in critically ill patients is in line with the euthanasia measure, for which clear regulations regarding the action have not yet been established. Euthanasia is intentionally ending the life of a creature (person or pet) who is seriously ill or seriously injured with a quiet and easy death on humanitarian grounds. According to the Indonesian Medical Code of Ethics, the word euthanasia is used in three meanings, namely:

1. Moving to the afterlife quietly and safely without suffering and for those who believe with the name of Allah on the lips.
2. The time of life will end. The patient's suffering is alleviated by giving sedatives.
3. Ending the suffering and life of the patient intentionally at the request of the patient himself and his family.

The rules in Article 1 paragraph (1) Regulation of the Minister of Health no. 37 of 2014 concerning the determination of death and utilization of donor organs, it is stated that the termination of life support therapy (withdrawing live support) is to stop some or all of the life support therapy that has been given to the patient. Death by means of euthanasia, especially passive euthanasia in terminal patients for the patient's benefit, not for the convenience of those closest to the patient, such as the patient's family, medical staff, or even other parties. Implementation must take place voluntarily. That is after a request has been made expressly and repeatedly by the person concerned for their interests. It can also occur in critically ill patients who have been in a coma for months and survive only with a breathing apparatus (ventilator); euthanasia is the only way to stop the suffering experienced by patients in a terminal state.

IV. Conclusion

To sum up, the ethical aspect refers to 4 basic moral principles: autonomy, beneficence, non-maleficence, and justice. Autonomy means that every medical action must obtain the consent of the patient or nearest neighbour (if the patient cannot give his consent), beneficence means that every medical action must be aimed at the good of the patient, non-maleficence means that every medical action must not be in the condition of the patient's condition. Justice means that medical attitudes or actions must be fair, especially in distributive justice. A moral dilemma is still possible if ethical principles are confronted with other moral principles or if the principle of beneficence is confronted with non-maleficence, for example, if the patient's wishes (autonomy) are contrary to the principle of beneficence non-maleficence, and if an action contains beneficence and non-

maleficence simultaneously as in the rule of double effect. The ethical consideration that must be analysed in determining the installation and removal of a ventilator is when, where, and under what conditions the doctor conveys the patient's conditions to his family. First, a doctor must respect the patient's dignity (patient autonomy). In this condition, the patient and his family must have the autonomy to receive relevant information about his illness. The doctor must determine whether the patient, family or relatives are aware of the patient's current health condition. The most crucial thing in determining when to install and remove the use of a ventilator is when a medical procedure has changed from ordinary to extraordinary. Determining which is ordinary or extraordinary is very important so that doctors and nurses believe that their professional actions do not violate ethics or law.

Then, referring to the provisions of the Minister of Health Number 37 of 2014 Chapter 3 Articles 14 and 15 concerning Termination or Postponement of Life Support Therapy; Chapter 4 Article 16 Permenkes No. 290 of 2008 concerning Approval of Medical Actions in particular situations; and Chapter 5 Article 18 of the Minister of Health of the Republic of Indonesia number 290 of 2008 concerning Refusal of Medical Actions, which patients and or their closest family can carry out. The legal basis refers to the medicolegal aspect in critical patients in the installation and removal of the ventilator as an indication for determining the action of withdrawing or withholding life support. All actions taken by the doctor in a non-emergency situation or the patient is aware need the patient's consent. Meanwhile, in the case of the patient requesting the termination of life support, the doctor does not speed up or kill the patient but respects the patient's decision and restores the natural state of the patient's disease course. In addition to adjusting the conditions for the validity of an agreement according to the Civil Code as stipulated in Article 1320, doctors must ensure that they truly understand the therapeutic agreement, both from the preparation of the agreement and the legal consequences, to comply with the existing legal rules, so that doctors can initiate to be able to understand a patient in the preparation and legal implications of this agreement.

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Juridical Analysis of Patients' Rights to Information Disease and Action Medical by Doctor in Hospital

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ABSTRACT

This study analyzed juridical analysis of patients' rights to disease information and medical action by doctors in hospitals. The method used is a legal research method that aims to find solutions to legal issues and problems that arise from them. The results of the study show that the legal implications of regulating the right to information on diseases and medical actions given to patients by doctors in hospitals have an impact on the patient's right to receive disease information openly and transparently from doctors related to diseases experienced by patients and patients have the right to be served maximally in obtaining medical treatment (Health services) by doctors at the hospital so that patients have the right to file claims if these rights are not fulfilled. Then, the presence of new health law, namely Law Number 36 of 2009, gives patients the right to refuse actions taken against themselves and to end treatment and care for their own responsibilities after obtaining clear information about their disease. In conclusion, the emergence of the Prita Mulyasari case was based on the non-fulfilment of the patient's right to medical information. It was due to the absence of adequate and accurate communication between the doctor and the patient. Conflicts can be avoided if all parties, in this case, the doctor, patient and hospital, negotiate through deliberation and consensus by considering their respective rights and obligations.

Keywords: Patient Rights; Disease Information; Medical treatment; Hospital

I. Introduction

The preamble to the 1945 Constitution clearly stated the goals of the Indonesian nation. The national objective is to protect the entire Indonesian country and homeland of Indonesia and promote public welfare, educate the nation's life and participate in carrying out a world order based on freedom, eternal peace and social justice. Achieve the national goals needs a sustainable development effort, which is a series of development that are comprehensively directed and integrated, including health development (see Law No. 36 of 2009 concerning Health).

One of the elements of national development in all fields is development in the health sector. The health sector has a great degree in human resources development because

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everyone has the right to obtain medical services. The doctors in their profession are obliged to provide information and medical services for everyone, namely to provide medical services, such as said by Imam Al-Ghazali that providing services for patients is "Fardhu Kifayah" (Fuady, 2005).

The role of information in the health service relationship means that the importance of the role and communication must concern the obligations of patients as individuals who need help to overcome complaints about their health, as well as regarding the obligations of doctors as professionals in the health sector (see Faria & Cordeiro, 2014; Liang et al., 2017; Syafruddin, Rohman, & Ilyas, 2020). Furthermore, they should provide medical services optimally, and correct information is needed from the patient to make it easier for doctors to diagnose, perform therapy, and perform other stages required by the patient. In other words, the delivery of information from patients about their illnesses can affect patient care and the quality of health services.

The success rate of the quality of health services can be seen from three subjects: user, organizer and provider of health service funds. For users of health services, the quality of service is more related to the dimensions of the responsiveness of officers to meet patient needs and smooth communication between officers and patients. For health service organizers, the quality of health services is more related to the dimensions of the suitability of services provided with the latest developments in science and technology or professional autonomy in delivering health services. Meanwhile, for those with health service funds, it is more related to the dimensions of efficiency in the use of funding sources, the fairness of health financing, and the ability of health services to reduce losses for those with health service funds (Busro, 2018; Tutik & Febriana, 2010).

Along with the development of health services and medical services, the role of law in health services and medical services is increasing, according to Article 52 of Law No. 36 of 2009 concerning Health, which states that health services consist of individual health services and public health services. According to this law, health services include promotive, preventive, curative and rehabilitative activities.

Health services are divided into two types: public health services and Medical Health Services. Medical services can be held to their primary purpose, namely to treat (Curative) disease and recover (Rehabilitative) health, and the main target is individuals. Meanwhile, public health services are generally held together in an organization and even have to involve the potential of the community and prevent disease. The main target is the community as a whole. In addition to health services, there are also medical services where these services include all efforts and activities in the form of prevention (preventive), treatment (curative), improvement (promotive), and recovery (rehabilitative) based on individual relationships between experts in the field of medicine with individuals who need it.

Based on rights, every patient has the right to know how the treatment procedure will be experienced, including the risks that must bear due to specific treatments. The patient also has the right to know whether other alternatives exist, including the risks. There is also the opinion that patients have the right to know things outside the scope of health but

are related, such as social factors. That is what is commonly called "informed consent". It means that consent is given after obtaining complete information (Soekanto, 1989).

Informed consent is an agreement regarding a doctor's medical action for his patient. This consent can be in oral or written form. In essence, informed consent is a communication process between doctors and patients regarding the agreement on medical actions that doctors will carry out on patients. The signing of informed consent in writing is only a confirmation of what has been previously agreed. The purpose is for the patient to make his own decisions. Therefore, the patient also has the right to refuse the recommended medical treatment. Patients also have the right to seek the opinion of other doctors and the doctors who treat them.

The person in charge of care for the patient is obligated to provide explanations or information to patients, for example, a doctor. In certain circumstances, the doctor can delegate his authority to other health workers, but the legal responsibility remains with him. Juridically, a nurse is not authorized to carry out the informed consent process. It is the duty of the doctor. If there is a delegation of authority, the doctor must be sure that the nurse assigned understands the problem and can provide an explanation that the patient understands. Therefore, from a legal point of view, the responsibility for informed consent remains with the doctor (Soekanto, 1989). For example, the poor quality of services provided by doctors or hospitals, so the patient, Prita Mulyasari, claimed compensation for the bad service on her rights is not given by the doctor or hospital. Prita Mulyasari's right is to receive the results of the medical record, but the hospital, International Omni Alam Sutera Tangerang, does not provide the results of the medical record (see Dickerson, 2022; Guzik-Makaruk, Pływaczewski, & Mroczko, 2018; Kluge, 2020; Petersson & Backman, 2022). Whereas the patient's the right to receive information about the disease she suffers from so that before the doctor takes further action, there is an agreement between the patient and the doctor. It is in accordance with the provisions of Permenkes No. 290/ MENKES/PER/III/2008 concerning Approval for Medical Action Article 1 Letter 'a' states that informed consent is an approval given by the patient or his immediate family after receiving a complete explanation regarding the medical or dental action to be performed against a patient.

Actually, the patient's right to disease information has been regulated in the law (see Carstens, 2020; Faria & Cordeiro, 2014; Nicolás, 2009; Petersson & Backman, 2022). However, in practice, doctors always do not obey or ignore these rules, so the victim is the patient himself. Therefore, this study aims to examine the legal implications of regulating the right to disease information and medical actions given to patients by the doctor and analyze the legal consequences of not fulfilling patients' rights to disease information and medical actions by the doctor.

II. Method and Legal Material

The method used is a normative legal that aims to find a solution to legal issues and problems that arise in them so that the results are achieved, then are given prescriptions on what should be on the issues raised. According to Marzuki (2017), legal research is a

process of finding the rule of law, legal principles, and legal doctrines to answer the legal issues faced.

The approach used is statutory, conceptual approach and case approach. A statutory approach is essential to examine the legal basis for regulating patients' rights to disease information and medical treatment. Theoretically, the legal arrangement provides a legal basis for acting and making certain decisions based on the law given or attached to it based on statutory regulation (Hadjon, 1997). Therefore, it is necessary to analyze the legislation through a statutory approach which is the legal basis. Thus, the statutory approach is intended to conduct a study and analyze the statutory regulations relating to the regulation of patients' rights to information on diseases and medical actions. The conceptual approach is used to examine and analyze the framework of thought as well as the theoretical basis in accordance with the purpose of this study, namely to discuss the normative basis of regulation of the patient's right to information on the disease and medical action. Therefore, it is necessary to put forward basic concepts regarding patient rights, health principles, and so on. Finally, the case approach is used to find and provide examples and explanations of cases that have occurred in accordance with this research.

Research material in the form of primary legal materials and secondary legal materials. Primary legal material is legal materials that are authoritative, meaning they are made by those who have authority. Primary legal material consists of statutory regulations, official records or minutes in making laws and rules and judges' decisions. This is included as a source of primary legal material used in this research: Law Number 36 of 2009 concerning Health and Law Number 29 of 2004 concerning Medical Practice and other implementing regulations regarding health and regulations. Minister of Health of the Republic of Indonesia Number 290/Menkes/Per/III/2008 concerning Approval of Medical Actions. Secondary legal materials are legal materials in the form of all publications on the law that are not official documents. Publications on law include textbooks, legal dictionaries, legal journals, and commentary on the court decision.

III. Results and Discussion

Legal Implication for Regulation of the Right to Information on Diseases and Medical Actions Given to Patients by Doctor in Hospital

The efforts to improve the quality of human life in the health sector are an extensive and comprehensive endeavour. These efforts include improving public health, both physical and non-physical. The national health system states that health concerns all aspects of life, whose scope is vast and complex. It is under the definition of health given by the international community, namely a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity (Koeswadji, 1984; Nasution, 2013).

Health Law, as formulated by Leenen (1981) that all legal provisions that are directly related to health care and the application of provisions of criminal law, civil law and administrative law; in this connection also international guidelines, customary law and jurisprudence relating to health care; also autonomous law, science and literature, is a

source of health law (see Ameln, 1991; Guwandi, 2004; Kansil, 1992; Wiradharma, 1996). According to Van der Mijn (1999), health law can be formulated as a collection of regulations relating to the provision of care and its application to civil, criminal, and administrative law. Medical law, which studies juridical relationships in which the doctor is a party, is part of the health law. If viewed, health law includes Medical Law, Nursing Law, Hospital Law, Environmental Pollution Law (Environmental Law), Waste Law (industrial, household waste, and so on), Pollution laws (noise, smoke, dust, odours, toxic gases), laws on equipment using X-rays (cobalt, nuclear), Work safety law, law and other regulation that have a direct connection that can affect human health (Is, 2017).

Formulating definitions above are comprehensive and imply that all parties play a crucial role in realizing good health services, especially the Government, which the people have chosen to hold the mandate to run the government activities.

The phrase "health is not everything without health is nothing" emphasizes the importance of health, that in principle, health is everyone's dream because health is the foundation of everything (Iskandarsyah, 2010). Health is a fundamental and inherent right of human existence throughout their lives. Health is a human right, in this case, the right to optimal health, with the consequence that every human being has the right to an optimal health degree and the state is obliged to fulfil that right; of course, it is not something without basis (Kurnia, 2015). Health is a crucial issue that every country must face because it is directly correlated with the development of the personal integrity of each individual to live with dignity.

The right to optimal health status will include the right to health care and the right to health protection; or refers to the idea, the right to access to health services and the right to the social order, which includes obligations of the state to take specific measures to safeguard public health. The right to optimal health is a fundamental concept that covers two sub-concepts; the right to health services and the right to health protection/public safeguarding (Suhartini, Roestamy, & Yumarni, 2019).

The right to health services in health law is also an individual right or the right to self-determination. Therefore, it is due to individual human rights and social rights. That is, the two categories of human rights reveal the individual and social dimensions of the existence or existence of something. For example, the personal rights of legal subjects, namely patients, include: a) the right to life, b) the right to die a natural death, c) the right to respect for bodily and spiritual integrity, and d) the right to one's own body (Rias, 2007).

Human right is a set of principles that arise from values. It can be distinguished between positive human rights and negative human rights. Positive human rights contain elemental powers that must fully guarantee. At the beginning of the nineteenth century, there was a trend towards the emergence of several rights, namely: a) the right to work for an adequate income, b) the right to health care, c) the right to housing, d) the right to security against financial risks, accidents at work, pensions, financial conditions, etc. illness, old age and so on (Rias, 2007).

Based on the above systematics, it is clear that the right to health services is a positive human right. However, it should be emphasized that the right to health care is not a right to health. That is, what becomes a human right is the authority to guarantee that the process of maintaining health exists. With these two fundamental rights, the doctor and patient together find the most appropriate therapy to be used. Because, in a doctor-patient relationship, the patient's position is equal to that of a doctor. Even the status of a human (patient) in medical science is no longer an object but a subject on the same level as a doctor. Before healing efforts, the patient's consent is required, known as informed consent. The patient's consent is based on the doctor's information regarding the disease, alternative treatment efforts and all consequences arising from the treatment effort (Komalawati, 1990).

Informed consent is the patient's consent to medical efforts based on information from the doctor regarding the disease, alternative medical remedies and all the risks that were previously given, and the data obtained by the patient can be in the form of the right to choose a doctor and hospital, the right to refuse treatment, the right to stop, the right of a second opinion, and the right to examine medical records (see Ciliberti et al., 2018; Liang et al., 2017; Petersson & Backman, 2022; Syafruddin et al., 2020; Elvandari, 2015).

As we know, holistic health is not only physically healthy but also spiritually and socially in society. To create such health conditions, we need harmony in maintaining a healthy body. Hendrik L. Blum (in Elvandari, 2015) explained that there are at least 4 main factors that affect the degree of public health, namely behavioural factors/lifestyle, environmental factors (economic, political, social and cultural), health service factors (type of coverage and quality), and genetic factors. These four factors interact with each other that affect individual health and the degree of public health. Among these 4 factors, human behaviour is the biggest and most challenging to handle, followed by environmental factors. It is because the behavioural factor is more dominant than the environmental factor. After all, community behaviour also strongly influences the human environment (Elvandari, 2015).

Basically, the perspective on health services today is changing. If in the past the sick paradigm was used, namely health was only seen as an effort to heal the sick where there was a relationship between the patient and the doctor, now the concept used is the healthy paradigm, where health efforts are seen as an action to maintain and improve the health status of individuals or communities.

A healthy society is not seen from the point of view of curing the disease but from a continuous effort to maintain and improve the health status of the community. Enhancing the degree of public health requires the work of all parties, both individually and in society and, of course, the government. In addition, healthy living culture must emerge from within the community, so a program is needed to mobilize the community to understand the importance of health and increase the availability of facilities that support the implementation of health services.

Furthermore, in the field of health services, it has characteristics that are different from other services or products, namely consumer ignorance, the influence of consumer

or patient health service providers not having bargaining power of choice (supply induced demand), health service products are not homogeneous concepts, restrictions on competition, uncertainty about illness, and nutritional health as human rights. In this case, the patient is a liveware factor. Patients must be viewed as subjects who significantly influence the final service outcome, which is not just an object. Patients' rights must be fulfilled, considering that patient satisfaction is one of the barometers of service quality, while patient dissatisfaction can be the basis of lawsuits (Tutik & Febriana, 2010).

What are patients' expectations of these health service providers? Based on the dimensions of the quality of health services, the expectations of patients as consumers of medical services include:

1. Provision of promised services promptly and satisfactorily;
2. Assist and provide responsive services without distinguishing elements (ethnicity, religion, race and between groups);
3. Guarantee of security, safety and comfort;
4. Good communication and understanding of patient needs (Tutik & Febriana, 2010).

In addition to these expectations, there are several rights owned by a patient that a doctor must carry out. There are consequences for a doctor in carrying out his profession to realize the rights held by a patient by communicating each therapeutic action to his patient. Of course, the doctor can choose what to share and how to express it. The right to information from the doctor is very much needed by a patient so that the patient can choose or determine the request of his own destiny, the patient's right to receive attention from the doctor in the transaction, and then what kind of treatment is given to the patient. In making a patient's decision, of course, there must also be an agreement from the doctor.

Patients, as health consumers, have self-protection from possible irresponsible healthcare efforts such as neglect. Patients also have the right to safety, security and comfort for their health services. With these rights, consumers will be protected from professional practices that threaten safety or health.

Another patient's right as a consumer is the right to be heard and get compensation if the service provided is not as it should be. The public, as consumers, can submit their complaints to the hospital to improve the hospital in its services. In addition, consumers have the right to choose the doctor they want and have the right to get a second opinion. They are also entitled to a medical record containing a history of their illness.

Patient rights are also explained in Law No. 36 of 2009 on Health. Article 14 of Law Number 36 of 2009 concerning Health reveals that everyone has the right to obtain optimal health. Article 53 states that every patient has the right to information, medical secrets and the right to a second opinion. Article 55 states that every patient is entitled to compensation due to errors and negligence of health workers. If formulated, the rights of patients as consumers of medical services as stipulated in Law Number 36 of 2009 concerning Health are as follows.

1. Obtain correct and complete information about their condition;
2. Give approval or rejection of the therapy performed on him;
3. Keep medical secrets related to other medical conditions and services;

4. Second opinion.

The Indonesian Doctors Association (IDI), at the end of October 2000, also pledged the rights and obligations of patients and doctors, which all doctors in Indonesia must know and obey. One of the main patient rights in the pledge is the right to self-determination, which is part of human rights, as well as the right to medical secrets regarding the history of the disease he is suffering.

The right to self-determination means choosing doctors, nurses and health facilities, and the right to accept, refuse or stop treatment or care for him, of course, after receiving complete information about his health condition or illness. Meanwhile, the patient is obliged to provide correct information to the doctor in good faith, to comply with the doctor's or nurse's recommendations for diagnosis, treatment and care and to provide appropriate compensation for services. The patient is also obliged not to force his will to be carried out by a doctor if it is contrary to the validity and nobility of the doctor's profession.

The process to determine what actions will be taken on our bodies as patients after getting enough information in the medical world is known as an explicit agreement (Informed Consent). The statement of IDI regarding informed consent, namely:

1. Adults who are physically and mentally healthy have the right to fully determine what they want to do with their bodies. Doctors have no right to take medical actions against the will of the patient, even for the benefit of the patient himself.
2. All medical require informed consent procedures oral and written,
3. Every medical action that has a large enough risk, requires written consent signed by the patient after the patient has previously obtained sufficient information about the need for the relevant medical action and the risks
4. For actions that are not included in point 3, only verbal consent or silence is required.
5. Information about medical treatment must be provided to the patient, whether requested or not requested by the patient.

The content of the information includes the advantages and disadvantages of the planned medical action. Information is usually given orally and in writing (Tutik & Febriana, 2010). Based on this formulation, it is clear that patients have full rights to obtain information that is as clear and has the right to participate in determining the actions to be taken in curing diseases and has the right to get proper services for our health. In addition to the rights of patients, they also have obligations, which is an obligation so that patients, as consumers themselves, can obtain optimum results for protection or legal certainty for themselves

Legal Responsibilities of Doctor and Hospital as a Result of Not Fulfilling Patients' Rights to Information on Diseases and Medical Actions

Therapeutic transactions usually involve three parties: the patient, the doctor and the hospital. The parties' legal position will determine the level of liability that must be carried out when there is a suspicion of malpractice. Legal problems arising from health services

provided by doctors or hospitals begin with a failure to provide medical services to patients, so failure is considered an error that must be accounted for.

In carrying out its function as a health service provider, the hospital has a legal relationship with both doctor and patient. It is possible because, in some instances, the patient does not agree with the doctor but with the hospital. If the hospital participates in providing patient care and treatment, there are two agreements regulating the relationship between the hospital and the patient:

1. System All in Contract means the hospital and patient agreement, the position of the hospital is only obliged to carry out treatment.
2. System Arts Out means an agreement between the Hospital and the patient, the position of the Hospital in addition to being obligated to carry out treatment is also to take other actions, for example laboratory examinations, and treatment carried out by doctor (Komalawati, 1990).

Therefore, the hospital's responsibility to the patient in medical services is closely related to the doctor's responsibility as an element of implementing the hospital's main duties. The hospital's position as a legal entity with rights and obligations then applies the provisions of Article 1367 of the Civil Code, which states that a person is not only responsible for losses caused by his own actions but also for losses caused by people under his supervision. Therefore, the hospital can be sued for acts committed by its representative as an organization; in the context of health law, this is known as the Respondent Superior Doctrine. Hospital responsibilities include three things, they are:

1. Responsibility related to personal;
2. Responsibility relating to facilities and equipment;
3. Responsibility relating to good care obligations;

Hospital responsibilities, as mentioned above, can be applied if the doctor performs professional duties for and on behalf of the hospital concerned and carries out his duties by the work regulations in the hospital. Thus, if a doctor makes a mistake outside the professional framework of the hospital, then the responsibility lies with the doctor concerned.

Suppose this is related to the case of Prita Mulyasari and the doctor. In that case, Prita Mulyasari should be able to ask the Omni International Hospital to be accountable for fulfilling all of their rights as stated in Article 52 of Law Number 29 of 2004 concerning Medical Practice regarding the Rights of Patients in Receiving Services as follows:

1. Obtain a complete explanation of medical actions as referred to in Article 45 paragraph (3) of Law Number 29 of 2004 concerning Medical Practice;
2. Seek the opinion of another doctor or dentist;
3. Get services according to medical needs;
4. Refuse medical treatment;
5. Obtain the contents of the medical record;

The provisions of the new health law, namely Law Number 36 of 2009 concerning Health, also regulate the right of everyone to claim compensation due to errors or

omissions in health services. As for Article 58, paragraph (1) of Law Number 36 of 2009 concerning Health as follows:

> "Everyone has the right to claim compensation against a person, health worker, or health provider who causes losses due to errors or omissions in the health services he receives."

This provision indicates that anyone can claim compensation if they suffer a loss due to an error or negligence in the health service. In comparison, legal subjects which can be asked for compensation for losses are every person, health workers and health providers.

The patient is a human being, and the rights possessed by the patient are also part of or a basis for their human rights as human beings, as stated in Article 4 of Law no. 23 of 1992 concerning Health. For example, the right to self-determination. With this right, a patient can be involved in any decisions that affect them being free to choose to accept or reject the action or treatment imposed on them, obtain all information regarding their Health, and is free to choose the doctor, nurse, or health facility they want.

With the right to information, the patient deserves to obtain information that is accurate and easy for the patient to understand. This information relates to the patient's health plan and available health care providers, including the diagnosis, medical procedure, disease prognosis, therapy or medication the patient is receiving, and other patient conditions. Sometimes doctors do not provide clear information about the disease because they are worried about causing an emotional reaction in the patient's family or thinking that the patient will not be able to understand what is being explained. Doctors can avoid any unpleasant confrontation by avoiding, distorting reality, or stopping the conversation. With the right to information, it means that we also have the right to access medical records and the right to obtain a second opinion. In addition to getting a second opinion, we also have the right to choose a doctor or health service provider.

Participation in making decisions related to their health is also a right for every patient. For example, doctors and patients can jointly discuss various alternatives for continuing treatment or the actions imposed on them. The doctor can provide input on each of the advantages and disadvantages. Then the patient has the full right to consider and be involved in making decisions.

In the case of Prita Mulyasari, she did not fulfil her rights as a patient to obtain optimal health status, as already mentioned; of them. Article 52 of Law Number 29 of 2004 concerning Medical Practice states that patients have the right to obtain medical records. However, in this case, the hospital did not provide the contents of the patient's medical record, contrary to Article 52 of Law Number 29 of 2004 concerning Medical Practice. Furthermore, in Article 47, paragraph (1) of Law Number 29 of 2004 concerning Medical Practices, Medical Record documents are owned by doctors or health services, in this case, the Omni International Hospital, while patients own the contents of medical records. Such formulation is indeed standard in the medical world, but in daily application, it is not easy because it will be very difficult for the patient, even if he wants to know his own medical record. Therefore, it is contrary to the patient's right to information, which should be part of their rights. Moreover, this medical record has a

strategic role for the patient because it can be used as evidence of a letter in the event of malpractice. Therefore, if physical medical records become the property of doctors, dentists and healthcare facilities, it will be difficult for patients to access these medical records.

Especially in the case of "medical malpractice", there is no explicit regulation of terms or definitions in Indonesian laws and regulations, so if there are demands or accusations of alleged medical malpractice, the settlement that can use is criminal law, civil law, administrative law, the Disciplinary Council or other regulations.

Civil compensation and imprisonment must be proven based on examination before a court. Therefore, the judge in court has the authority to decide whether a person is guilty or not. Responsibilities in terms of administrative law, health workers can be subject to sanctions in the form of revocation of practice licenses if they take medical actions without the consent of the patient or his family (see Detik.com, 2012). Administrative actions can also be imposed if a health worker:

1. Neglects the obligation
2. Do something that should not be done by a health worker, either by remembering his oath of office or remembering his oath as a health worker;
3. Ignoring something that should be done by health workers;
4. Violate a provision under or under the law.

In addition to the law, the health profession is regulated by a professional code of ethics. However, according to Dr. Siswanto Papanjang, ethical and legal issues sometimes need to be clarified, so the meaning is blurred. For example, someone who violates ethics can violate the law; of course, someone who violates the law will also violate ethics. Therefore, according to Davis & Smith (in Samil, 2000) that there is a relationship between medical ethics and medical law, namely:

1. According to ethics and law;
2. Contrary to ethics and against the law;
3. According to with ethics but against the law;
4. Contrary to ethics but in accordance with the law.

IV. Conclusion

Based on the finding above, researchers concluded that the legal implications of regulating the right to disease information and medical actions given to patients by a doctor in a hospital have an impact on the patient's right to receive disease information openly and transparently from doctor related to the disease experienced by patients and patients have the right to be served optimally in acceptance of medical actions (health services) by doctors in hospitals so that patients have the right to file claims if their rights are not fulfilled. Then, the regulation of the right to disease information and medical actions given to patients by doctors in hospitals is regulated in Law Number 29 of 2004 concerning Medical Practices; Law Number 36 of 2009 concerning Health and other implementing regulations concerning Health and regulation of the Minister of Health of the Republic of Indonesia Number 290/Menkes/Per/III/2008 concerning Approval of

Medical Actions, Regulation of the Minister of Health No.269/MENKES/PER/III/2008 substitute for the Regulation of the Minister of Health of the Republic of Indonesia Number 749/Menkes/Per/XII/1989 concerning Medical Records. In Law No. 29 of 2004 concerning Medical Practice, patients receiving services in medical practice have the right to get a complete explanation of medical actions, ask for a doctor's opinion, get services according to medical needs, refuse medical action and get the contents of the record. Patients are also obligated to doctors to provide complete and honest information about their health problems, comply with applicable regulations in health care facilities and doctor's advice/instructions and provide compensation for services received. However, in its implementation, Law No. 29 of 2004 concerning Medical Practice still cannot be used optimally to protect patient rights. There are still weaknesses in its application, so cases or lawsuits or claims for compensation by patients are often caused by the lack of maximum service in Health, especially in medical action.

Furthermore, the legal consequence of not fulfilling the patient's rights to information on illness and medical action by doctors at the hospital is that the patient can file a claim for compensation for negligence in implementing health services by doctors at the hospital. Then, the doctor must be fully responsible for the consequences of providing services that are not optimal for the patient so that the patient has the right to file a claim for compensation for the losses suffered. The emergence of the Prita Mulyasari case was based on the non-fulfilment of the patient's right to medical information. It was due to the absence of adequate and accurate communication between the doctor and the patient. Conflicts can be avoided if all parties, in this case, the doctor, patient and hospital, negotiate through deliberation and consensus by considering their respective rights and obligations. So, neither the doctor nor the patient feels harmed by the medical actions taken by the doctor and the lawsuit filed by the patient Prita Mulysari who feels that her rights to health services provided by the hospital or doctor have been harmed.

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Karya Digital dan Perlindungan Hak Kekayaan Intelektual di Era Digital

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ABSTRACT

Digital Works and Protection of Intellectual Property Rights in the Digital Age

Advances in technology and information today have a significant impact on changes in human life. The digital era today is very dependent on internet-based technology media. The existence of internet-based platforms has brought people closer to the digital world. Changes in the dynamics of the society in a digital society, of course, have an impact on the knowledge or understanding of the community on the legal impact of the use of digital platforms, such as knowledge of one's intellectual property rights on digital media. Work that was still physically in the form of now turned into digital media or digital copyright works. In this case, the regulations governing the intellectual property rights of a person/organization should accommodate and protect the digital intellectual creation of the Indonesian people as a form of legal protection for the rights possessed by the owner of the Cipta work. This study aims to protect intellectual property rights in digital-based products/works. This study uses a normative juridical research method using the source of literature, including applicable laws, legal literacy, and other legal materials. Technological advances have made it easier for everyone to steal and duplicate the digital work of others to make a profit. Therefore, the existence of an existing legal umbrella and policy, namely Law Number 11 of 2008 concerning Information on Electronic Transactions and Law Number 28 of 2014 concerning Copyright, is expected to increase innovation increase competitiveness in the digital era and support the protection of rights of Intellectual Property for Digital Work for all parties who are entitled.

Keywords: Intellectual property rights; Digital works; Violation; legal protection

I. Pendahuluan

Seiring perkembangan ilmu pengetahuan dan teknologi, zaman pun berubah yang ditandai dengan era digital. Dimana semua masyarakat luas yang terkoneksi dengan internet dapat menikmati karya/ciptaan dalam bentuk digital. Konsep digitalisasi saat ini telah mengubah pola/gaya hidup masyarakat dalam berkarya. Ada yang mulai membuat karya/ciptaan di media digital (yang sebelumnya dibuat dalam wujud fisik) dan ada yang lebih menikmati karya/ciptaan pada platform digital (yang sebelumnya melihat bentuk fisiknya). Salah satu hak atas kekayaan intelektual adalah hak cipta. Hak cipta adalah hak

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penuh bagi si pemegang hak moral maupun hak ekonomi atas karya ciptaannya. Hak Cipta memberi kewenangan yang sangat luas bagi pencipta. Secara konseptual kedudukan pencipta berada pada tempat yang sangat terhormat di tengah-tengah masyarakat (Hasibuan, 2008).

Dalam era digital ini karya cipta dalam bentuk digital tidak dapat dihindari karena saat ini hal tersebut telah menjadi suatu hal yang wajar dalam aktivitas masyarakat luas. Pengaruh kemajuan teknologi digital saat ini bisa jadi memberikan ancaman dibandingkan dengan dampak kemudahan dan manfaatnya, terutama di kalangan generasi muda yang belum mengerti mengenai hukum/sanksi akibat pelanggaran hukum dalam memanfaatkan platform digital. Prinsip keterbukaan informasi dan mudah diakses merupakan hal yang dapat mengancam, semakin mudah diakses dan aksesnya terbuka maka semakin banyak pula pihak-pihak yang melakukan duplikasi, menggandakan atau menyebarkan. Potensi pelanggaran atas hak kekayaan intelektual baik moral maupun ekonomi si pencipta dan atau pemegang Hak Cipta semakin besar ketika karyanya yang diakses tanpa mencantumkan identitas apalagi menggunakan karya cipta tidak sesuai peruntukannya. Di era digital yang sarat teknologi, dalam perkembangannya lahirlah teknologi informasi yang produknya adalah rekayasa perangkat lunak, kecerdasan buatan, komputer serta internet. Hal ini turut membuat masyarakat harus menyesuaikan kebutuhan hidupnya dengan pemanfaatan teknologi yang semakin berkembang terutama dalam teknologi informasi dan komunikasi (Ramli, Permata, Mayana, Ramli, & Lestari, 2021).

Karya cipta digital memang lebih mudah dipublikasi bahkan dikomersilkan secara digital dengan koneksi internet. Faktanya saat ini karya cipta digital telah banyak diminati dan telah memiliki konsumen/pasarnya sendiri. Karya cipta digital menjadi popular di kalangan masyarakat internet dikarenakan memiliki keuntungan dibanding produk fisik, produk digital dinilai lebih efisien dan lebih praktis dibandingkan dengan produk fisik yang membutuhkan ruang simpan khusus untuk menyimpan produknya dibanding dengan karya cipta digital yang tidak memerlukan tempat fisik untuk disimpan, begitu juga cara mendapat karya cipta digital hanya dengan cara mengunduh juga menjadi nilai tambah karena sifatnya yang cepat dan efektif. Disamping memberikan manfaat, tingginya penggunaan internet justru telah memberi akibat berupa ancaman terhadap eksistensi karya cipta dan invensi yang ditemukan oleh para penghasil Hak Kekayaan Intelektual. Internet memiliki beberapa karakteristik teknis yang membuat masalah-masalah Hak Kekayaan Intelektual tumbuh dengan subur (Syahdeini, 2009).

Pelanggaran Hak Kekayaan Intelektual seringkali terjadi di negara Indonesia, banyak contoh pelanggaran hak terhadap karya cipta digital kerap kali diabaikan. Sebab masih banyak orang yang tidak mengerti akan hal ini. Contoh yang sering ditemui di dunia maya adalah penjiplakan konten di internet yang berupa gambar/foto, video, tulisan, dan lainnya. Hal ini terjadi akibat semakin mudahnya akses menikmati konten digital di dunia internet dan akses informasi di internet juga hampir tanpa batas. Hal tersebut membuat pengguna internet dan penikmat konten digital dapat dengan mudah menduplikasi konten milik orang lain, lalu mengakuinya sebagai milik diri sendiri (plagiarisme). Perbuatan

seperti itu sangat rentan terjadi dan dapat berujung pada pelanggaran yang mana sangat merugikan pembuat karya/konten asli atas hak yang dimilikinya sebagai pemilik asli.

II. Metode dan Bahan Hukum

Penelitian ini menggunakan metode penelitian yuridis normative. Metode penelitian yuridis normatif adalah penelitian hukum kepustakaan yang dilakukan dengan cara meneliti bahan-bahan kepustakaan atau data sekunder belaka. Penelitian ini dilakukan guna untuk mendapatkan bahan-bahan berupa: teori-teori, konsep-konsep, asas-asas hukum serta peraturan hukum yang berhubungan dengan pokok bahasan. Dengan demikian, objek yang dianalisis dengan pendekatan yang bersifat kualitatif adalah metode penelitian yang mengacu pada norma-norma hukum yang terdapat dalam peraturan perundang-undangan (Soekanto, 2003). Penelitian ini menggunakan sumber data sekunder yang terdiri dari Undang-Undang serta bahan hukum dan literatur hukum yang menunjang penelitian ini.

III. Hasil dan Pembahasan

Karya Digital dan Hak Kekayaan Intelektual

Inovasi di masa pandemi Covid-19 melahirkan pemanfaatan teknologi informasi yang menyebabkan terciptanya beragam produk dengan nilai ekonomis memiliki kaitan erat dengan sebuah keharusan untuk diadakan keselarasan dari agar dapat mendukung setiap kreatifitas masyarakat dengan implementasi berupa pelindungan hukum terhadap karya cipta yang telah dibuat (Nasution, 2020). Tidak hanya itu, pemanfaatan teknologi dalam era digital yang sebelumnya sudah eksis kian menunjukkan perkembangan yang signifikan dikarenakan terdapat perilaku baru selama karantina yang melahirkan kreatifitas setiap orang yang kebanyakan ada di platform *Over The Top* (*unpad.ac.id*., diakses 20 Februari 2022). Bentuk layanan *Over The Top* tersebut antara lain adalah layanan aplikasi dan layanan konten seperti: YouTube, Netflix, Spotify. Youtube adalah platform digital berbasis internet yang menyuguhkan layanan kepada publik untuk menikmati ataupun mempublikasikan konten video. Kehadiran Youtube juga menghadirkan konten kreatif yang dihasilkan oleh pengguna atau yang dikenal dengan Youtuber. Netflix adalah layanan penyedia streaming dengan biaya langganan yang memungkinkan penggunanya menikmati tayangan favorit dari berbagai negara seperti tontonan acara televisi dan film tanpa iklan di perangkat yang terkoneksi ke internet. Spotify adalah layanan musik digital, *podcast*, dan video yang memberikan akses kepada pelanggan untuk menikmati musik atau lagu dan konten lain dari seluruh dunia. Masyarakat luas saat ini telah disuguhkan berbagai kemudahan dalam mengakses dan memanfaatkan produk/karya digital dalam menjalankan aktivitas sehari-hari.

Dibalik kemudahan tersebut terdapat risiko yang dapat terjadi. Kemudahan tersebut justru dimafaatkan oleh pihak-pihak yang tidak berwenang melakukan penyebaran/pendistribusian oleh pihak yang tidak memiliki hak secara melawan hukum, mudahnya suatu ciptaan dirubah, dimodifikasi, dan lain-lain. Meluasnya internet dalam kehidupan bermasyarakat membuat semakin banyaknya pelanggaran terhadap ciptaan,

sulit melakukan identifikasi siapa saja yang melakukan pelanggaran, menjadi bukan hal yang mudah untuk melindungi suatu ciptaan dalam bentuk digital. Apabila pelanggaran pelanggaran tersebut tidak ditangani dapat memberikan dampak negatif kepada industri maupun kepada pencipta (Simatupang, 2021). Perkembangan teknologi informasi begitu pesat, sehingga bentuk-bentuk pelanggaran hak cipta akan semakin berkembang. Contoh pelanggaran HKI yaitu pembajakan buku di platform digital khususnya e-commerce (*dgip.go.id*, diakses 15 Februari 2022). HKI tidak sekadar menghargai dan mengakui eksistensi para pencipta/pembuat karya akan tetapi juga melindungi hak-hak ekonomi mereka.

1. Pelanggaran Hak Kekayaan Intelektual (HKI) di Indonesia masih sering terjadi baik yang disengaja maupun yang tidak disengaja, karena masyarakat Indonesia masih minim pengetahuan tentang HKI. Konsumen di Indonesia ada yang sadar tentang HKI dan ada yang belum sadar tentang HKI. Faktor-faktor yang menjadikan kendala dalam peningkatan pemahaman HKI, diantaranya adalah (Pratomo, 2017) :
2. Lemahnya kepercayaan masyarakat akan sistem hukum yang berlaku di Indonesia. Hal ini juga member dampak rendahnya kepercayaan masyarakat terhadap perlindungan HKI termasuk juga terhadap kualitas kinerja birokrasi dan penegakan hukumnya.
3. Biaya yang harus dikeluarkan untuk mendapatkan HKI masih membebani.
4. Kurangnya minat dan apresiasi terhadap HKI, karena ada atau tidaknya HKI belum berdampak pada pendapatan bagi pelaku usaha.
5. Lamanya proses pendaftaran HKI.
6. Berbenturan dengan budaya lokal. Prinsip dasar HKI adalah penghargaan terhadap hak individu sedangkan masih banyaknya karya yang berkembang dimasyarakat bersifat komunal yang cenderung kurang mendorong tumbuhnya kreatifitas dan inovasi.
7. Sosialisasi baru dapat menjangkau kota-kota besar di Indonesia, padahal lokasi UMKM terletak di wilayah yang masih jauh dari pusat kota. Diharapkan peran aktif pemerintah daerah dan kantor wilayah untuk dapat menjangkau sampai ke wilayah yang jauh dari pusat kota dalam pembinaan HKI bagi UMKM.

Perlindungan Hukum Pada Karya Digital

Eksistensi hukum kekayaan intelektual yang telah diatur sedari lama dalam beberapa regulasi, sejatinya memerlukan komponen hukum lain dalam pengimplementasiannya (Yunus, 2012). Di Indonesia regulasi mengenai pelindungan hukum kekayaan intelektual telah diakomodir masing-masing sesuai bentuknya seperti misalnya, dalam melindungi ilmu pengetahuan, bidang seni dan kesusastraan mendapatkan proteksi regulasi kekayaan intelektualnya yang dapat dirujuk dengan Undang-Undang Nomor 28 Tahun 2014 tentang Hak Cipta (UUHC). Upaya dalam memberikan pelindungan hukum dilakukan melalui pemberian hak eksklusif sebagaimana ditegaskan dalam Pasal 1 Ayat (1) UUHC bahwa pencipta memiliki kewenangan yang disebut sebagai hak eksklusif berdasarkan prinsip

deklaratif yang diperolehnya secara otomatis setelah kekayaan intelektualnya dimiliki oleh tersebut berwujud (dideklarasikan), hak ini sederhananya merupakan hak yang diperoleh oleh pencipta.

Dalam UUHC menegaskan adanya hak moral dalam setiap karya cipta yang tertuang dalam Pasal 5 (1) Hak moral merupakan hak yang melekat secara abadi pada diri Pencipta untuk:

a. tetap mencantumkan atau tidak mencantumkan namanya pada salinan sehubungan dengan pemakaian Ciptaannya untuk umum;
b. menggunakan nama aliasnya atau samarannya;
c. mengubah Ciptaannya sesuai dengan kepatutan dalam masyarakat;
d. mengubah judul dan anak judul Ciptaan; dan
e. mempertahankan haknya dalam hal terjadi distorsi Ciptaan, mutilasi Ciptaan, modifikasi Ciptaan, atau hal yang bersifat merugikan kehormatan diri atau reputasinya.

Pada ayat (2) Hak moral sebagaimana dimaksud pada ayat (1) tidak dapat dialihkan selama Pencipta masih hidup, tetapi pelaksanaan hak tersebut dapat dialihkan dengan wasiat atau sebab lain sesuai dengan ketentuan peraturan perundang-undangan setelah Pencipta meninggal dunia. Pada ayat (3) Dalam hal terjadi pengalihan pelaksanaan hak moral sebagaimana dimaksud pada ayat (2), penerima dapat melepaskan atau menolak pelaksanaan haknya dengan syarat pelepasan atau penolakan pelaksanaan hak tersebut dinyatakan secara tertulis.

Dari pasal di atas jelas tertuang bahwa adanya prinsip moralitas dalam sebuah karya cipta yang mana hak moral tersebut melekat pada diri si pencipta. Maraknya penduplikasian atau penggandaan karya cipta di platform digital sangat bertentangan dengan prisip moral dalam UUHC. Hal tersebut dikarenakan mudahnya setiap orang untuk mengakses layanan digital pada gawai mereka sehingga lupa pada prinsip moralitas.

Selain itu, ditinjau dari Undang-Undang Nomor 11 Tahun 2008 tentang Informasi Transaksi Elektronik (UU ITE) pada Pasal 25 menjelaskan adanya pelindungan Hak Kekayaan Intelektual yaitu Informasi Elektronik dan/atau Dokumen Elektronik yang disusun menjadi karya intelektual, situs internet, dan karya intelektual yang ada di dalamnya dilindungi sebagai Hak Kekayaan Intelektual berdasarkan ketentuan Peraturan Perundang-Undangan. Pasal 26 ayat (1) menyatakan Kecuali ditentukan lain oleh Peraturan Perundangundangan, penggunaan setiap informasi melalui media elektronik yang menyangkut data pribadi seseorang harus dilakukan atas persetujuan Orang yang bersangkutan. Pasal 26 Ayat (2) menyatakan Setiap Orang yang dilanggar haknya sebagaimana dimaksud pada ayat (1) dapat mengajukan gugatan atas kerugian yang ditimbulkan berdasarkan Undang-Undang ini. Dari pasal tersebut dalam informasi elektronik dan/atau dokumen elektronik terkandung hak ekonomi dan moral bagi pencipta/pembuat karya sehingga patut untuk dilindungi.

Fungsi Hak Kekayaan Intelektual adalah untuk mengatur dan melindungi hak seorang pencipta atas hasil karyanya. Di Indonesia tingkat kesadaran masyarakat terhadap pentingnya HKI masih rendah. Tidak banyak pencipta/pembuat karya digital yang menyadari bahwa hasil karyanya perlu mendapat pengakuan dan perlindungan hukum. Perlu diketahui bahwa HKI tidak hanya hanya bermotif ekonomi saja dan hanya menguntungkan pemilik/pemegang hak. Lebih dari itu HKI dapat dirasakan oleh semua orang melalui berbagai dampak positif yang dihasilkan. Hak Kekayaan Intelektual di era digital saat ini perlu disadari oleh masyarakat luas dikarenakan:

a. Melindungi hak pencipta atau pembuat karya digital
   Membuat suatu karya digital bagi pencipta yang sebelumnya membuat dalam bentuk fisik tidak mudah, ada proses transisi pengalihan wujud dari fisik menjadi digital. Mengingat proses panjang yang pencipta/pembuat karya lalui, selayaknya ada pengakuan, penghargaan, dan perlindungan atas karya ciptaannya. Pemerintah berperan penting dalam menegakkan regulasi. Bukan saja soal faktor ekonomi, menghargai dan mengakui karya orang lain adalah bagian dari kemanusiaan maka itu ada hak moral dalam suatu karya cipta.
b. Mencegah pelanggaran/penyalahgunaan karya digital
   Penegakan HKI adalah salah satu cara untuk mengontrol penggunaan produk/karya digital. Sepatutnya setiap orang yang menggunakan produk digital harus mendaftarkan diri ke pemilik produk/pemegang HKI karya digital tersebut. Dengan begitu pemilik asli produk/karya digital tersebut dapat mengetahui siapa saja yang menikmati/menggunakan karya buatannya. Apabila terdapat pelanggaran/penyalahgunaan produk/karya digital tersebut untuk hal-hal negatif pemerintah bisa dengan mudah mendeteksi dan menindaklanjutinya pelanggaran tersebut dan membawanya ke ranah hukum.

Karya cipta digital begitu mudah untuk digandakan bahkan hasil penggandaan/duplikasi tersebut di era digital ini hampir serupa atau tidak dapat dibedakan dengan aslinya (Karya original). Bahkan masyarakat awam pun bisa saja melakukan modifikasi terhadap hasil duplikasi tersebut dan menyebarkannya ke platform digital tanpa biaya. Kemudahan itu menjadi sebab bagi banyak orang untuk melanggar Hak Cipta milik orang lain dalam skala yang sangat besar dan tidak mempertimbangkan aspek moral dan ekonomi dalam pelanggaran tersebut.

IV. Simpulan

Meningkatkan inovasi dan kreativitas di era digital ini merupakan sesuatu yang tidak bisa diabaikan agar bangsa Indonesia mampu bersaing secara global dan tidak tertinggal dalam bidang teknologi digital. Tanpa inovasi dan kreativitas bangsa Indonesia bisa semakin tertinggal, dan tidak akan mampu bersaing di dunia yang semakin bergantung pada perkembangan teknologi. Maka dari itu adanya payung hukum dan kebijakan Undang-Undang Nomor 11 Tahun 2008 tentang Informasi Transaksi Elektronik dan Undang-Undang Nomor 28 Tahun 2014 tentang Hak Cipta diharapkan dapat meningkatkan inovasi untuk meningkatkan daya saing di era digital serta paling penting

mendukung perlindungan hukum terhadap hak kekayaan intelektual atas produk/karya digital. Perlindungan hak kekayaan intelektual tentu merupakan hal yang menjadi fokus, terlebih lagi di era digital saat ini. Kemajuan teknologi telah semakin memberi kemudahan bagi setiap orang untuk mencuri dan menduplikasi hasil karya cipta digital orang lain untuk keuntungannya sendiri. Hal tersebut sangat merugikan orang-orang yang menjadi pembuat karya atau pemegang hak kekayaan intelektual dari karya digital tersebut. Regulasi di Indonesia yang sudah ada dan berlaku diharapkan dengan tegas dapat melindungi hak ekonomi dan hak moral para pencipta/pembuat karya original/pemegang Hak Kekayaan Intelektual khususnya produk/karya berbasis digital. Penegakan hukum yang tegas dan menyeluruh harusnya menjadi tugas utama penegak hukum untuk dapat meminimalisasi tingkat pelanggaran/penyalahgunaan bahkan diharapkan mampu mencegah terjadinya pelanggaran dan memberikan perlindungan hukum bagi produk/karya digital di Indonesia.

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Kewajiban BPJS Kesehatan dalam Pemberian Pelayanan Telekonsultasi Klinis yang Dilakukan Antara Dokter dan Pasien BPJS

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ABSTRACT

BPJS Health Obligations in Providing Clinical Teleconsultation Services Performed between Doctor and BPJS' Patients

By the decree of the minister of health of the Republic of Indonesia HK.01.07/MENKES/4829/2021 on guidelines of telemedicine utilization to prevent coronavirus disease 2019 (covid-19). Telemedicine provided by doctors in medical teleconsultation form has been widely considered in this pandemic era. This research uses normative legal research. The approach used in this research is applying the law and the conceptual approach. The result showed various legal norms for BPJS healthcare medical teleconsultation in terms of service. However, BPJS healthcare users are said to be burdened by medical teleconsultation fees, which is different from the initial legal norms. Therefore, it can be said that BPJS has done unlawful acts and is an opening chance for BPJS healthcare users to sue BPJS. Therefore, the researcher recommends that the government make rules regarding the clinical teleconsultation system so that it can run according to its function when needed, for example, during the current covid-19 pandemic. Thus, the task of BPJS in organizing national health insurance for all Indonesian people can be realized. In addition, BPJS Health is required to guarantee the legal protection of patients in clinical teleconsultation services so that the rights and obligations of BPJS participants can be fulfilled. If the rights of the BPJS participants are not fulfilled, the BPJS participants can make mediation efforts. If the mediation mechanism cannot be implemented, the settlement can be submitted to the District Court in the area where the participant lives.

Keyword: Telemedicine, Medical Teleconsultation, BPJS Healthcare, Default

I. Pendahuluan

Kesehatan merupakan hak asasi manusia dan salah satu unsur kesejahteraan yang harus diwujudkan sesuai dengan cita-cita bangsa Indonesia sebagaimana dimaksud dalam Pancasila dan Pasal 28 Ayat 1 huruf H Undang-Undang Dasar 1945 dijelaskan bahwa setiap orang berhak hidup sejahtera lahir dan batin, bertempat tinggal, dan mendapatkan lingkungan yang baik dan sehat serta berhak memperoleh pelayanan kesehatan. Selain itu dalam Undang-Undang Nomor 36 Tahun 2009 tentang Kesehatan Pasal 5 ayat 1

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dijelaskan bahwa setiap orang mempunyai hak yang sama dalam memperoleh akses atas sumber daya di bidang kesehatan.

Undang-Undang Nomor 40 Tahun 2004 selanjutnya disebut dengan Undang-Undang Sistem Jaminan Sosial Nasional dan kemudian dibentuk Badan penyelenggara Jaminan Sosial melalui Undang-Undang Nomor 24 Tahun 2011 tentang Badan Penyelenggara Jaminan Sosial. Dengan Undang-Undang ini dibentuk 2 (dua) BPJS yaitu BPJS Kesehatan dan BPJS Ketenagakerjaan (BPJS Kesehatan, 2014). BPJS Kesehatan ini resmi mulai berlaku pada tanggal 1 Januari 2014 dan merupakan transformasi kelembagaan PT Askes (Persero).

Undang-Undang Nomor 24 Tahun 2011 tentang Badan Penyelenggara Jaminan Sosial pasal 1 ayat 1 menyatakan bahwa "Badan Penyelenggara Jaminan Sosial adalah badan hukum yang dibentuk untuk menyelenggarakan program jaminan sosial". Tugas utama BPJS Kesehatan adalah menyelenggarakan Jaminan Kesehatan Nasional (JKN) bagi warga negara Indonesia (lihat Putri, 2014; Zaelani, 2012). Pelayanan kesehatan yang dijamin oleh BPJS mencakup pelayanan promotif, preventif, kuratif dan rehabilitatif termasuk pelayanan obat dan bahan medis habis pakai sesuai kebutuhan medis yang diperlukan. Pelaksanaan jaminan kesehatan, BPJS Kesehatan bekerjasama dengan badan-badan penyedia pelayanan kesehatan sebagai mitra dalam melayani peserta BPJS seperti rumah sakit pemerintah maupun swasta, klinik-klinik kesehatan, Praktek Dokter, Apotek, serta Optik, dan lainnya.

Sesuai dengan Keputusan Menteri Kesehatan Republik Indonesia HK.01.07/MENKES/4829/2021 tentang Pedoman Pelayanan Kesehatan Melalui *Telemedicine* Pada Masa Pandemi *Corona Virus Disease 2019* (COVID-19), dalam rangka pencegahan penyebaran *Corona Virus Disease* (Covid-19). *Telemedicine* adalah pemberian pelayanan kesehatan jarak jauh oleh profesional kesehatan dengan menggunakan teknologi informasi dan komunikasi, meliputi pertukaran informasi diagnosis, pengobatan, pencegahan penyakit dan cedera, penelitian dan evaluasi, dan pendidikan berkelanjutan penyedia layanan kesehatan untuk kepentingan peningkatan kesehatan individu dan masyarakat (Cushing, 2022; Mehl dkk., 2022; Zhang dkk., 2022). Pelayanan telekonsultasi klinis dilaksanakan oleh tenaga kesehatan yang memiliki surat izin praktik di Fasyankes penyelenggara. Demikian juga diatur dalam Peraturan Menteri Kesehatan Nomor 20 Tahun 2019 tentang Penyelenggaraan Pelayanan *Telemedicine* Antar Fasilitas Pelayanan Kesahatan Pasal 3 Ayat 1 terdiri atas pelayanan:

1. Teleradiologi
2. Teleelektrokardiografi
3. Teleultrasonografi
4. Telekonsultasi klinis, dan
5. Pelayanan konsultasi *Telemedicine* lain sesuai dengan perkembangan ilmu pengetahuan dan teknologi.

Kementerian Kesehatan telah mengeluarkan Peraturan Menteri Kesehatan Nomor 46 Tahun 2017 tentang Strategi e-Kesehatan Nasional adalah pemanfaatan teknologi informasi dan komunikasi untuk pelayanan dan informasi kesehatan, utamanya untuk

meningkatan kualitas pelayanan kesehatan dan meningkatkan proses kerja yang efektif dan efisien (Oktavira, 2019). Layanan telekonsultasi klinis disebutkan secara eksplisit pada Pasal 65 dalam Peraturan Presiden Nomor 82 Tahun 2018 tentang Jaminan Kesehatan. BPJS Kesehatan bisa memanfaatkan telekonsultasi klinis sebagai kompensasi atau pemenuhan pelayanan pada daerah yang belum tersedia fasilitas kesehatan. Namun, aspek yang lebih teknis dan terinci belum tersedia. Ini mencakup keandalan model bisnis, standar layanan, alur kerja, keselamatan pasien, perlindungan data, jaminan mutu, pembinaan dan pengawasan aplikasi e-Kesehatan. Oleh karena itu, pendekatan baru diperlukan untuk mempercepat regulasi e-Kesehatan.

Telekonsultasi klinis di satu sisi layanan ini memudahkan proses pemberian pelayanan dan upaya kesehatan yang dilakukan oleh dokter maupun pasien dengan tidak adanya batasan jarak, tetapi di sisi lain telekonsultasi klinis tersebut di dalamnya terdapat praktik kedokteran. Jika melihat standart kedokteran yang dilakukan di dalam klinik konvensional tentu hal ini tidak akan menimbulkan suatu masalah karena kejelasan dalam hal pengaturannya tetapi praktik kedokteran yang dilakukan di dalam klinik konvensional tentu hal pengaturannya tetapi praktik kedokteran yang dilakukan di telekonsultasi klinis tentu akan menimbulkan suatu permasalahan tersendiri, karena proses mendiagnosis secara *online* oleh dokter dilakukan dengan tidak bertatap muka dengan pasien sehingga besar kemungkinan terjadi kesalahan diagnosis terhadap pasien (Awaluddin dkk, 2019).

Untuk mendukung pelaksanaan layanan telekonsultasi klinis, kemudian KKI mengeluarkan Peraturan konsil kedokteran No.74 tahun 2020 yang bertujuan untuk memberikan kewewenangan klinis tambahan kepada dokter dan dokter gigi agar bisa melaksanakan pelayanan *telemedicine* khususnya telekonsultasi klinis yang berlaku hanya selama masa pandemic covid-19.

Pembiayaan telekonsultasi klinis yang diberikan oleh dokter melalui *telemedicine* oleh BPJS ini dilandasi banyak alasan. Alasan utamanya adalah untuk membuat telekonsultasi klinis dapat diakses secara lebih merata oleh masyarakat Indonesia. Banyak masyarakat yang rela pergi ke klinik karena BPJS, walaupun menempuh jarak yang jauh (Sansoko, 2020). Selain itu, telekonsultasi klinis juga telah memiliki dasar hukum tentang penerapannya (Humas, 2022b). Di Indonesia, Peraturan Menteri Kesehatan Nomor 20 Tahun 2019 telah mengatur bagaimana telekonsultasi klinis yang diberikan oleh dokter melalui *telemedicine* harus diterapkan. Oleh karena itu, keberadaan kepastian hukum perlu menjadi pendorong lebih lanjut bagi BPJS biayai telekonsultasi klinis.

Terdapat beberapa penelitian mengenai isu telekonsultasi klinis seperti: Kulchar dkk (2022); Nestlerode dkk (2022); dan Tartaglia dkk (2022). Pertama, Kulchar dkk (2022) mengatakan bahwa selama pandemi COVID-19, *telemedicine* menyediakan cara baru dan inovatif untuk mengatasi kebutuhan yang tidak terpenuhi dalam perawatan kesehatan dan dapat membantu meningkatkan pedoman praktik penatagunaan obat yang aman. Kedua, Nestlerode dkk. (2022) yang berjudul "Perspektif pasien dari telemedicine dalam onkologi ginekologi selama Covisd." Penelitian ini menunjukan bahwa hanya 36% yang menyatakan mereka akan merasa nyaman dengan kunjungan telemedicine dengan ahli onkologi ginekologi. Pasien lebih bersedia untuk menyetujui video daripada kunjungan

telepon (41,8% vs 24,5%). Selanjutnya, penelitian tentang *Telemedicine* sebagai landasan bantuan perawatan kesehatan selama wabah pandemi SARS-Cov2 dan peluang besar untuk waktu dekat yang dilakukan oleh Tartaglia, dkk (2022). Hasil penelitian ini menunjukan bahwa *telemedicine* telah menjadi batu kunci yang memungkinkan respons yang cepat dan tepat dari seluruh sistem perawatan kesehatan yang kelebihan beban terhadap Pandemi saat ini.

Kemudian, penelitian tentang "Tinjauan Hukum Atas Layanan Medis Berbasis *Online* [*The Legal Review of Online-Based Medical Services*]"dilakukan oleh Arif (2018). Penelitian ini bertujuan untuk mengetahui dasar hukum terhadap praktik kedokteran layanan medis berbasis *online*. Hasil penelitian ini menunjukkan bahwa belum ada ketentuan nasional yang mengatur sacara spesifik tentang layanan medis berbasis *online;* bentuk tanggung jawab hukum dokter dalam memberikan pelayanan medis *online* adalah tanggung jawab hukum secara perdata, pidana, administrasi dan kode etik kedokteran.

Terakhir, penelitian yang dilakukan oleh Ramanda (2020) berjudul "Tanggung Jawab Hukum Dokter Terhadap Telekonsultasi Via Online Apabila Pasien Mengalami Kerugian." Penelitian ini bertujuan untuk menganalisis dasar hukum layanan medis online dan untuk menganalisis tanggung jawab hukum dokter dalam memberikan pelayanan medis online apabila pasien mengalami kerugian. Metode penelitian yang digunakan oleh penulis adalah yuridis normative. Hasil penelitian menunjukkan bahwa hingga saat ini belum ada aturan yang detail tentang layanan medis berbasis online baik dalam ketentuan Perundang-undangan maupun dalam ketentuan kode etik kedokteran. Tanggung jawab hukum dokter dalam memberikan pelayanan medis online adalah tanggung jawab hukum secara perdata, pidana, administrasi, sedangkan tanggung jawab profesi akan ditindak lanjuti sesuai dengan prosedur yang ada pada kode etik kedokteran.

Jika dibandingkan dengan peneliti sebelumnya, penelitian memfokuskan pada analisis BPJS Kesehatan setelah keluarnya Keputusan Menteri Kesehatan Republik Indonesia HK.01.07/MENKES/4829/2021 tentang Pedoman Pelayanan Kesehatan Melalui *Telemedicine* Pada Masa Pandemi *Corona Virus Disease 2019* (Covid-19) dan Peraturan Presiden Nomor 82 Tahun 2018 tentang Jaminan Kesehatan pada Pasal 65 dalam Layanan telekonsultasi klinis. BPJS sebagai lembaga yang dibentuk untuk menyelenggarakan program jaminan sosial di Indonesia belum mengatur tentang regulasi tentang pelayanan telekonsultasi klinis, sehingga diharapkan dapat dibentuk peraturan perundang-undangan BPJS tentang pelayanan telekonsultasi klinis.

Berdasarkan latar belakang masalah di atas, penelitian ini bertujuan untuk menganalisis norma hukum pelayanan BPJS kesehatan dalam hal pelayanan telekonsultasi klinis dan menganalisis sistem Perlindungan hukum pasien BPJS kesehatan dalam melakukan pelayanan telekonsultasi klinis.

II. Metode dan Bahan Hukum

Penelitian ini merupakan penelitian hukum normatif. Penelitian hukum normatif atau *doktrinal* adalah jenis penelitian yang lazim dilakukan dalam pengembanan ilmu hukum

biasa disebut dogmatik hukum (*rechtsdogmatiek*). Pendekatan masalah yang digunakan adalah pendekatan perundang-undangan (*the statute approach*), yaitu penelusuran peraturan perundang-undangan, dan pendekatan konseptual *(conceptual approach*), yaitu mengidentifikasi norma yang terdiri atas rangkaian konsep; untuk memahami norma harus diawali dengan memahami konsep (Hadjon & Djatmiati, 2009; Marzuki, 2008). Pendekatan tersebut dapat digabung, sehingga dalam satu penelitian hukum normatif dapat menggunakan dua pendekatan atau lebih yang sesuai

Sumber bahan hukum dalam penelitian ini dibedakan yaitu berupa bahan hukum primer, bahan hukum sekunder dan bahan non-hukum.

a. Bahan hukum primer

Bahan hukum primer adalah bahan hukum yang terdiri atas peraturan perundang-undangan berdasarkan UUD 1945, Undang-Undang/Perpu, Peraturan Pemerintah (PP), Peraturan Presiden (Perpres), Peraturan Daerah (Perda). Dalam penelitian ini, bahan hukum primer yang digunakan adalah sebagai berikut.

1) UUD NRI 1945,
2) Undang-Undang Nomor 36 Tahun 2009 tentang Kesehatan
3) Undang-Undang Nomor 40 Tahun 2004 tentang Sistem Jaminan Sosial Nasional.
4) Undang-Undang Nomor 24 Tahun 2011 tentang Badan Penyelenggara Jaminan Sosial.
5) Undang-Undang Nomor 11 Tahun 2008 tentang Informasi Dan Transaksi Elektronik
6) Peraturan Presiden Nomor 82 Tahun 2018 tentang Jaminan Kesehatan
7) Peraturan Menteri Kesehatan Nomor 20 Tahun 2019 tentang Penyelenggaraan Pelayanan *Telemedicine khususnya telekonsultasi klinis* Antar Fasilitas Pelayanan Kesahatan
8) Peraturan Menteri Kesehatan Nomor 46 Tahun 2017 tentang Strategi e-Kesehatan Nasional
9) Keputusan Menteri Kesehatan Republik Indonesia HK.01.07/MENKES/4829/2021 tentang Pedoman Pelayanan Kesehatan Melalui *Telemedicine* Pada Masa Pandemi *Corona Virus Disease 2019* (Covid-19)

b. Bahan Hukum Sekunder

Bahan hukum sekunder yang utama adalah buku mengenai prinsip-prinsip dasar ilmu hukum dan pandangan-pandangan klasik para sarjana yang mempunyai kualifikasi tinggi, seperti: buku-buku ilmiah dibidang hukum, makalah-makalah, jurnal ilmiah dan artikel ilmiah.

Teknik pengumpulan sumber hukum dilakukan dengan studi pustaka. Bahan-bahan hukum yang sudah terkumpul, kemudian dianalisis, diklasifikasikan, diinventarisasi, dideskripsikan dan dieksplanasi berdasarkan rumusan masalah. Akhirnya dijadikan bahan pengambilan kesimpulan dan rekomendasi. Analisa bahan hukum dengan menggunakan *preskriptif*. Analisis bahan hukum yang telah dikumpulkan harus dilakukan menurut cara-cara analisis atau penafsiran hukum, seperti penafsiran autentik, penafsiran menurut tata Bahasa, penafsiran berdasarkan sejarah hukum, penafsiran sistematis, penafsiran

sosiologis atau teleologis, penafsiran fungsional, ataupun futuristik (sebagai prakiraan) (Hartono, 1991).

III. Hasil dan Pembahasan

Norma Hukum Pelayanan BPJS Kesehatan dalam Pelayanan Telekonsultasi Klinis

a. Peraturan Perundang-undangan yang mengatur pelayanan kesehatan BPJS

Badan Penyelenggara Jaminan Sosial Kesehatan (BPJS) adalah badan hukum yang bertanggungjawab kepada Presiden dan berfungsi menyelenggarakan program jaminan kesehatan. BPJS merupakan lembaga yang dibentuk untuk menyelenggarakan program jaminan sosial di Indonesia menurut Undang-Undang Nomor 40 Tahun 2004 tentang Sistem Jaminan Sosial Nasional dan Undang-Undang Nomor 24 Tahun 2011 tentang Badan Penyelenggara Jaminan Sosial.

Di masa pandemi Covid-19, BPJS Kesehatan sebagai penyelenggara Program JKN-KIS memiliki peran strategis dalam upaya pengendalian Covid-19. Berbagai inovasi berbasis digital juga terus dikembangkan untuk memberi kemudahan kepada peserta JKN-KIS dalam mengakses pelayanan, sekaligus dalam upaya mencegah penularan Covid-19 (BPJS Kesehatan, 2020).

Telekonsultasi klinis merupakan pelayanan konsultasi klinis jarak jauh untuk membantu menegakkan diagnosis, dan/atau memberikan pertimbangan/saran tata laksana. Selain itu telekonsultasi klinis dapat dilakukan secara tertulis, suara, dan/atau video yang harus terekam dan tercatat dalam rekam medis sesuai dengan ketentuan peraturan perundang-undangan.

Secara umum, *telemedicine* adalah penggunaan teknologi informasi dan komunikasi yang digabungkan dengan kepakaran medis untuk memberikan layanan kesehatan, mulai dari konsultasi, diagnosa dan tindakan medis, tanpa terbatas ruang (dilaksanakan dari jarak jauh). Untuk menjalankan *telemedicine* dengan baik, sistem ini membutuhkan teknologi komunikasi yang memungkinkan transfer data berupa video, suara, dan gambar secara interaktif yang dilakukan secara *real time* dengan mengintegrasikannya ke dalam teknologi pendukung *video-conference*. Termasuk sebagai teknologi pendukung *telemedicine* khususnya telekonsultasi klinis adalah teknologi pengolahan citra untuk menganalisis citra medis (Jamil dkk., 2015).

Pelayanan *Telemedicine*, khususnya telekonsultasi klinis, dilaksanakan oleh tenaga kesehatan yang memiliki surat izin praktik di Fasyankes penyelenggara. Hal ini juga diatur dalam Peraturan Menteri Kesehatan Nomor 20 Tahun 2019 tentang Penyelenggaraan Pelayanan *Telemedicine* antar Fasilitas Pelayanan Kesahatan Pasal 3 Ayat 1 terdiri atas pelayanan:

1. Teleradiologi
    a. Teleelektrokardiografi
    b. Teleultrasonografi
    c. Telekonsultasi klinis, dan

d. Pelayanan konsultasi *Telemedicine* lain sesuai dengan perkembangan ilmu pengetahuan dan teknologi.

Penyelenggaraan *Telemedicine* dapat dilakukan dengan dua bentuk, yaitu dengan fasilitas pelayanan kesehatan kepada pasien atau antar fasilitas layanan kesehatan di Indonesia. Sesuai dengan Peraturan Menteri Kesehatan HK.02.01/MENKES/4829/2021 tentang Pedoman Pelayanan Kesehatan Melalui *Telemedicine* khususnya telekonsultasi klinis pada Masa Pandemi *Corona Virus Disease 2019* (Covid-19). Fasilitas pelayanan kesehatan penyelenggara pelayanan *telemedicine* khususnya telekonsultasi klinis pada masa pandemi COVID-19, terdiri atas:

1. rumah sakit
2. puskesmas
3. klinik
4. praktik mandiri dokter/dokter gigi dan dokter spesialis/dokter gigi spesialis
5. laboratorium medis
6. apotek.

Pelayanan kesehatan melalui telekonsultasi klinis yang dilakukan oleh fasilitas pelayanan kesehatan tersebut dapat menggunakan aplikasi yang telah dikembangkan oleh fasilitas pelayanan kesehatan itu sendiri atau bekerjasama dengan aplikasi lain milik pemerintah atau swasta.

Tujuan telekonsultasi klinis adalah untuk mengusahakan tercapainya pelayanan kesehatan secara merata di seluruh populasi negara, untuk meningkatkan kualitas pelayanan terutama untuk daerah terpencil dan untuk menghemat biaya, jika dibandingkan cara konvensional (lihat Ma dkk., 2022; Nie dkk, 2022) Telekonsultasi klinis juga ditujukan untuk mengurangi rujukan ke dokter atau pelayanan kesehatan di kota-kota besar, sarana pendidikan kedokteran dan juga untuk kasus-kasus darurat. Perluasan manfaat telekonsultasi klinis bisa menjangkau daerah-daerah bencana, penerbangan jarak jauh, dan bagi wisatawan asing yang sedang berada di daerah wisata (Anwar, 2016).

Telekonsultasi klinis sebagai pelayanan yang sedang dalam proses menjadi tumpuan dalam pelayanan pasien covid dan non-covid-19. Oleh karena itu, banyak pasien yang menanti BPJS membiayai telekonsultasi klinis. Di Indonesia, biaya telekonsultasi klinis masih menggunakan biaya pribadi (Mawuntu, 2020; Sansoko, 2020). Saat ini, Kemenkes dan BPJS Kesehatan sedang melakukan uji coba pembiayaan telekonsultasi klinis untuk peserta Jaminan Kesehatan Nasional (JKN) rujuk balik dan merevisi tarif JKN untuk dimasukkan dalam pembiayaan telekonsultasi klinis.

Norma hukum pelayanan BPJS kesehatan dalam hal pelayanan telekonsultasi klinis, khususnya Peraturan Presiden Nomor 82 Tahun 2018 tentang Jaminan Kesehatan jo pada Pasal 65 dalam Layanan telekonsultasi klinis. Peraturan Menteri Kesehatan Nomor 20 Tahun 2019 Pasal 3 Ayat 1 dan Keputusan Menteri Kesehatan Republik Indonesia HK.01.07/MENKES/4829/2021 tentang Pedoman Pelayanan Kesehatan Melalui

Telemedicine dalam rangka pencegahan penyebaran Corona Virus Disease 2019 tidak meberikan jaminan perlindungan biaya yang cukup bagi peserta BPJS apabila melakukan telekonsultasi klinis.

Perlindungan Hukum Pasien Bpjs Kesehatan Dalam Melakukan Pelayanan Telekonsultasi Klinis

Perlindungan hukum berarti melindungi hak setiap orang untuk mendapatkan perlakuan dan perlindungan yang sama oleh hukum dan undang-undang. Salah satu perlindungan yang diberikan adalah perlindungan terhadap pasien yang mendapatkan pelayanan kesehatan (Mulyana, 2017). Dalam pelayanan kesehatan, pasien berhak memperoleh keamanan dan keselamatan dirinya selama masa perawatan "*agroti salus lex suprema*" atau keselamatan pasien adalah hukum yang tertinggi (Novianto, 2015). Masalah keselamatan pasien berhubungan dengan efektivitas pelaksanaan layanan telekonsultasi klinis sebagai bagian dari penunjang medik yang sangat bergantung pada standar prosedur operasional, standar praktik dan standar kompetensi layanan telekonsultasi klinis, sehingga penyedia layanan kesehatan mampu memberikan jaminan pelayanan kesehatan kepada publik secara aman dan berkualitas. Ada beberapa hal yang perlu diperhatikan, yaitu kejelasan kontrak terapeutik dan pertanggung jawaban medik, standarisasi alat, rekam medis dan kerahasiaan data, serta peresepan online.

Kontrak terapeutik merupakan suatu jenis perjanjian antara dokter dan pasien yang akan mendapatkan pelayanan kesehatan. Pelayanan ini tidak menjanjikan hasil tetapi mengupayakan hasil sebaik mungkin yang dikenal dengan *inspaning verbintenis* (perjanjian upaya). Sebelum terjadinya kontrak terapeutik akan terjadi hubungan antara dokter dan pasien yang dikenal dengan *doctor-patient relationship*.

Transaksi terapeutik merupakan hal yang krusial dalam hubungan antara dokter dan pasien. Dengan adanya transaksi terapeutik, maka masing-masing pihak mulai terikat dengan hak dan kewajiban. Transaksi terapeutik juga memiliki kekuatan hukum yang memberikan tanggung jawab bagi dokter kepada pasiennya serta perlindungan hukum kepada pasiennya. Menurut pasal 1320, 1332, dan 1333 KUHPerdata, terdapat beberapa aspek yang menjadi syarat dalam kontrak terapeutik, antara lain: adanya kesepakatan kehendak, adanya kecakapan pihak yang bersepakat, adanya objek tertentu, dan halal.

Kemudain, pertanyaannya adalah kapankah kontrak terapeutik dimulai dalam layanan telekonsultasi klinis? apakah terdapat hubungan terapeutik yang dapat dipertanggungjawabkan dalam layanan telekonsultasi klinis? Sejauh ini, belum ada regulasi spesifik yang mengatur tentang hal tersebut, terutama terkait pihak yang harus bertanggung jawab jika terjadi kesalahan diagnosis ataupun peresepan pada layanan telekonsultasi klinis.

Permasalahan tersebut menjadi semakin tajam dengan merebaknya layanan telekonsultasi klinis dengan peresepan online (online prescribing). Dalam hal ini, dokter melakukan pemeriksaan kepada pasien hanya dengan anamnesis tanpa melakukan pemeriksaan fisik, kemudian memberikan resep secara online sesuai dengan keluhan pasien. Hal tersebut sangat mengkhawatirkan mengingat belum berkembang teknologi

kesehatan yang mendukung pemeriksaan fisik dan penunjang jarak jauh di Indonesia, sehingga perbedaan diagnosis ataupun kesalahan diagnosis dapat terjadi. Menurut penelitian yang dilakukan oleh Eedy & Wootton (2001) tentang teledermatologi disebutkan bahwa terdapat 33% kasus teledermatologi yang mengalami perbedaan diagnosis ataupun kesalahan diagnosis dengan pemeriksaan nyata. Keadaan tersebut bertentangan dengan prinsip beneficience dan non-maleficience untuk tidak merugikan pasien. Dalam hal ini, standarisasi alat yang digunakan juga menjadi faktor yang krusial. Dalam teledermatologi misalnya, pencahayaan, kompresi data, dan cara pengambilan gambar atau citra akan berpengaruh terhadap diagnosis yang diberikan.

Regulasi yang mengatur tanggung jawab dokter dan perlindungan pasien sangat diperlukan, meskipun layanan kesehatan dilakukan secara online. Selain itu, dalam implementasinya, sebaiknya dokter hanya melakukan layanan preventif dan promotif tanpa kuratif sebelum didukung oleh teknologi kesehatan yang dapat menggantikan atau setidaknya mendekati pemeriksaan fisik atau penunjang jarak jauh.

Selain permasalahan kontrak terapeutik, kerahasiaan data pasien juga menjadi hal yang harus diperhatikan. Meskipun dalam layanan konsultasi tersebut pasien telah bersedia membuka permasalahannya ke pihak penyedia telekonsultasi klinis, tetapi seringkali dalam layanan tersebut konsultasi pasien lain dapat ditampilkan sehingga rahasia pasien kurang terjaga.

Keamanan dan kerahasiaan data pasien tidak terlepas dari fungsi rekam medis pasien. Menurut Pasal 1 Nomor 1, Peraturan Menteri Kesehatan Nomor 269 tahun 2008 tentang Rekam Medis, rekam medis adalah berkas yang berisikan catatan dan dokumen tentang identitas pasien, pemeriksaan, pengobatan, tindakan dan pelayanan lain yang telah diberikan kepada pasien. Dalam praktiknya, kerahasiaan rekam medis harus dijaga dengan meminimalisir pihak yang boleh mengakses rekam medis tersebut. Pihak tersebut juga wajib menjaga kerahasiaan medis pasien. Selain itu, pada pasal 4 ayat (1) Peraturan Menteri Kesehatan Nomor 36 tahun 2012 tentang Rahasia Kedokteran menyebutkan bahwa: “Semua pihak yang terlibat dalam pelayanan kedokteran dan atau menggunakan data dan informasi tentang pasien wajib menyimpan rahasia kedokteran.”

Kemudian, peningkatan keamanan data (cybersecuritty) juga diperlukan dalam layanan telekonsultasi klinis untuk meminimalisir adanya serangan (cyber attack) yang dapat menimbulkan kerusakan atau kebocoran data pasien. Selain itu, back up data (Pencadangan data) perlu dilakukan agar tidak terjadi kehilangan atau kerusakan data pasien.

Apabila timbul sengketa, sesuai Undang-Undang Nomor 11 Tahun 2008 tentang Informasi Dan Transaksi Elektronik Pasal 38 ayat (1), setiap orang dapat mengajukan gugatan terhadap pihak yang menyelenggarakan Sistem Elektronik dan/atau menggunakan Teknologi Informasi yang menimbulkan kerugian.

Dalam proses pembuktian di pengadilan, data medis pasien sangat penting sekali untuk dijadikan alat bukti. Dengan kata lain, pelayanan kesehatan menggunakan telekonsultasi klinis harus memperhatikan ketentuan tentang proteksi data agar dikemudian hari dapat dijadikan bukti. Disamping itu, harus disediakan tenaga ahli dalam

bidang Forensik IT. Forensik IT atau dikenal dengan *computer forensic* adalah suatu disiplin ilmu turunan yang mempelajari tentang keamanan komputer dan membahas tentang temuan bukti digital setelah suatu peristiwa terjadi.

Selain upaya yang dapat dilakukan berdasarkan KUHPerdata, Undang-Undang Nomor 36 Tahun 2009 tentang Kesehatan maupun Undang-Undang Nomor 24 Tahun 2011 tentang Badan Penyelenggara Jaminan Sosial, dalam hal ini pasien BPJS selaku konsumen jasa pelayanan kesehatan dapat menggunakan instrumen hukum perlindungan konsumen, dengan dasar Pasal 45 Undang-Undang Nomor 8 Tahun 1999 tentang Perlindungan Konsumen, yaitu:

a. Bahwa Setiap konsumen yang dirugikan dapat menggugat pelaku usaha melalui lembaga yang bertugas menyelesaikan sengketa antara konsumen dan pelaku usaha atau melalui pengadilan yang berada di lingkungan peradilan umum
b. Penyelesaian sengketa konsumen dapat ditempuh melalui pengadilan atau diluar pengadilan berdasarkan pilihan sukarela para pihak yang bersengketa.
c. Penyelesaian sengketa di luar pengadilan sebagaimana dimaksud pada ayat (2) tidak menghilangkan tanggung jawab pidana sebagaimana diatur dalam Undang-undang
d. Apabila telah dipilih upaya penyelesaian sengketa konsumen di luar pengadilan, gugatan melalui pengadilan hanya dapat ditempuh apabila upaya tersebut dinyatakan tidak berhasil oleh salah satu pihak atau oleh pihak yang bersengketa.

Berkaitan dengan siapa saja yang berhak mengajukan gugatan, mengacu pada Pasal 46 ayat (1) Undang-Undang Nomor 8 Tahun 1999 tentang Perlindungan Konsumen, maka gugatan dapat diajukan oleh: seorang konsumen (pasien) yang dirugikan atau ahli waris yang bersangkutan; sekelompok konsumen (pasien) yang mempunyai kepentingan yang sama; lembaga perlindungan konsumen swadaya masyarakat yang memenuhi syarat; dan pemerintah dan/atau instansi terkait.

IV. Simpulan

Berdasarkan hasil penelitian, tugas BPJS Kesehatan membayarkan manfaat dan/atau membiayai pelayanan kesehatan sesuai dengan ketentuan program jaminan sosial yang mencakup pelayanan promotif, preventif, kuratif dan rehabilitative (Humas, 2022a). Namun, kenyataannya terdapat berbagai norma hukum pelayanan BPJS kesehatan dalam hal pelayanan telekonsultasi klinis, khususnya Peraturan Presiden Nomor 82 Tahun 2018 tentang Jaminan Kesehatan jo pada Pasal 65 dalam Layanan telekonsultasi klinis. Peraturan Menteri Kesehatan Nomor 20 Tahun 2019 Pasal 3 Ayat 1 dan Keputusan Menteri Kesehatan Republik Indonesia HK.01.07/MENKES/4829/2021 tentang Pedoman Pelayanan Kesehatan Melalui *Telemedicine* dalam rangka pencegahan penyebaran Corona Virus Disease 2019, namun realisasinya norma hukum tidak dilakukan terkait biaya bagi peserta BPJS apabila melakukan telekonsultasi klinis. Kemudian, tidak ada perlindungan hukum pasien BPJS kesehatan dalam melakukan pelayanan telekonsultasi klinis, khususnya perlindungan hukum terhadap biaya yang berkenaan dengan pelayanan telekonsultasi klinis. Sehingga dalam hal ini dapat dikatakan

bahwa BPJS telah melakukan perbuatan melawan hukum dan perserta BPJS dapat melakukan tuntutan hukum kepada BPJS.

Melalui penelitian ini, peneliti merekomendasikan bahwa pemerintah seharusnya membuat aturan mengenai sistem telekonsultasi klinis supaya telekonsultasi klinis dapat berjalan sesuai fungsinya pada saat dibutuhkan, misalnya pada pandemi covid-19 sekarang ini. Sehingga, tugas BPJS dalam menyelenggarakan jaminan kesehatan nasional bagi seluruh rakyat Indonesia dapat terwujud. Selain itu, BPJS Kesehatan wajib menjamin perlindungan hukum pasien dalam pelayanan telekonsultasi klinis, agar hak dan kewajiban peserta BPJS dapat terpenuhi. Apabila tidak terpenuhi hak peserta BPJS maka perserta BPJS dapat melakukan upaya mediasi. Apabila mekanisme mediasi tidak dapat terlaksana maka penyelesaiannya dapat diajukan ke Pengadilan Negeri di wilayah tempat tinggal perserta.

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Legal Aspect of Handling of Covid-19 Suspected Patients in Health Services in Hospital

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ABSTRACT

Hospitals function as quarantine, prevention and control of the Covid-19 Pandemic era. However, the crucial issue is the hospital is lying; patients who have not confirmed Covid-19 but are considered positive by the hospital. This study discusses legal protection for hospitals to care for patients with suspected Covid-19. The research is compiled with the type of normative juridical research; namely, research focused on examining the application of the rules or norms in positive law. The result shows that the hospital as a legal entity (*recht* person) has risks under Article 58 (1) of the Health Law, namely compensating for errors/omissions of doctors and health workers. According to the Vicarious Liability doctrine, the hospital is legally responsible for all losses caused by its subordinates. According to the Hospital Liability doctrine, the hospital is responsible for taking over the mistakes or omissions of the hospital. With the right of regress, the hospital will ask for compensation back to the doctor who made a mistake. The Strict Liability Doctrine states that the hospital is responsible for the workhouse. The implementation of hospital legal protection has yet to be precise. Supervision and guidance by the government, including the government's authority on health, still need to be made clear. Medical audits could have gone better. Doctors have the right to obtain legal protection as long as they carry out their duties under professional standards and standard operating procedures under Article 50 of the Medical Practice Act.

Keywords: Legal protection, hospital, suspected Covid-19 patients

I. Introduction

One of the law's objectives is to guarantee legal certainty for the community. In the era of the Corona Virus Disease pandemic in 2019 (Covid-19), legal protection for hospitals that provide Covid-19 patient services as hospital quarantine is urgently needed to prevent and control Covid-19 (see Derek et al., 2021; Prieto Carrero et al., 2021). Likewise, legal certainty must be upheld so that all levels of society unite against Covid-19. Based on Republic of Indonesia Law No. 4 of 1984 concerning Communicable Disease outbreaks (hereinafter referred to as the Infectious Disease Outbreaks Law), an epidemic is an outbreak of an infectious disease in a community where the number of sufferers has increased significantly more than the usual conditions at a particular time and can wreak havoc. A pandemic is an epidemic that covers a large geographical area.

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On December 31, 2019, Wuhan, Hubei Province, China, identified Pneumonia of unknown etiology as a new strain of Covid-19. The World Health Organization (WHO) declared the status of Covid-19 as a Pandemic on March 11, 2020, at the WHO office in Geneva, Switzerland (Kementerian Kesehatan Republik Indonesia, 2020).

The increase in Covid-19 cases took place quickly, and there was a spread between countries. As a result, the Indonesian government declared Covid-19 a public health emergency by issuing Presidential Decree No. 11 of 2020. As of October 28, 2020, data distribution in Indonesia had reported 400,483 confirmed cases, 169,833 suspected cases, 13,613 death cases, and 325,793 recovered cases (PHEOC Kemkes, 2020; WHO, 2020). Excessive worry often leads people to isolate families of patients with suspected Covid-19, resulting in the rejection of patients who will be separated in the hospital and the rejection of Polymerase Chain Reaction (PCR) examinations.

Refusal of treatment in the Covid-19 isolation room by a patient with suspected Covid-19 occurred at Teuku Umar Calang Hospital. As a concrete example, at WSH Hospital, the patient (Mr. S), 55 years old, was escorted by his family with complaints of shortness of breath with weakness and was still conscious in the Emergency Room triage (IGD). He was given a ventilator as a breath aid because the oxygen saturation in Mr. S had gone down. Rapid reactive results and other laboratory examinations also support the diagnosis of suspected Covid-19; lung radiographs show bilateral pneumonia. The doctor explained that the examination results led to a suspicion of Covid-19 and had to be treated in a special Covid-19 isolation room while waiting for the results of the PCR swab. The family of Mr. S immediately shouted angrily at the officers with harsh words that did not deserve to be heard when he was suspected of Covid-19. The health workers called security because of the rowdy condition. The family of Mr. S refused the informed consent to the Covid-19 service protocol, refused to enter the isolation room, and threatened to infect everyone, even though in the ER triage room, six other patients were not necessarily covid-19 patients. Mr. S remained in the emergency room triage and did not want to enter the isolation room until there was a result of the swab, while the swab took 24 hours to 48 hours, according to the queue of the PCR machine. Finally, Mr. S died in the ER for 24 hours, leaving the risk of contact with other patients who came to the ER triage at WSH Hospital.

Another problem relates to the statement that there is no evidence that the hospital deliberately provides patients to pursue profits from claims for medical expenses to the government, further cornering and burdening hospitals and health workers. The chairman of the Indonesian Hospital Association said that this wrong perception and opinion resulted in misinformation and disinformation that was detrimental to hospital services in handling the Covid-19 pandemic, especially for people who did not understand (Prabowo, 2020). Unfortunately, the public will assume that Covid-19 doesn't exist; it's a lie. In addition, this accusation is undoubtedly a cause for concern for health workers (Kontributor Pamekasan, 2020); because the hospital has complied with the provisions of the Decree of the Minister of Health No. HK.01.07/MENKES/446/2020 concerning technical instructions for claiming reimbursement for certain emerging infection disease

patient services for hospitals that provide covid-19 services. In addition, the lack of understanding regarding the emergence of different symptoms in patients, such as clinical gastrointestinal symptoms when the virus attacks the digestive tract and the like (Hadi, 2020), has led some people to accuse doctors of diagnosing patients with Covid-19 status. Even though the SARS-CoV-2 virus that causes Covid-19 can attack organs other than the respiratory tract.

Some patients who are positive for Covid-19 come with various symptoms, such as heart or high blood sugar, caused by the virus's ability, said the chairman of the Indonesian Society of Respirology. Patients who have comorbidities when the Coronavirus has infected the patient's body, it will cause the comorbidities to get worse and even lead to death due to the Covid-19 virus, which infects the disease. Conversely, many people with hypertension or blood sugar sufferers are not infected with Covid-19 and do not die. Therefore, the public does not prejudice against the doctor diagnosed with Covid-19. Doctors will not write a diagnosis of Covid-19 if there is no evidence (Hadi, 2020). Based on the description of the problem above, this study focused on analyzing the health services of patients with suspected Covid-19 by doctors in hospitals based on applicable regulations and legal protection for hospitals for handling patients with suspected Covid-19.

Furthermore, the study on the legal aspect of the handling of the covid-19 issue has been done previously by Aziz, et al. (2020); Firdaus (2022); Lemos, et al. (2021); Phattharapornjaroen et al. (2022); Putera et al. (2022); and Shah et al. (2021). Firstly, research was done by Aziz et al. (2020). This research analyzes how to curb the transmission and better manage the clusters; Malaysia imposed the Movement Control Order (MCO), which is now in its fourth phase. Secondly, Firdaus (2022) examines the issue of the refusal of the COVID-19 vaccine and the legal considerations. The results show that the application of sanctions in informed consent can be in the form of administrative sanctions and criminal sanctions adjusted to the study and observation of local governments. Thirdly, Lemos et al. (2021) examine the legal procedures for procuring corpses for use in higher education institutions' teaching and research. Despite recent technological advancements, this human material continues to be the primary teaching and learning technique for human anatomy. Likewise, Phattharapornjaroen et al. (2022) figured out that under some conditions, it is possible to employ community resources based on the flexible surge capacity idea, which lessened the strain on hospitals during the COVID-19 pandemic.

Then, research was conducted by Putera et al. (2022), in particular, on overcoming Covid-19 in Indonesia. The research results show that the institutional aspect prioritized handling the COVID-19 pandemic in Indonesia from the STI Policy perspective. Lastly, Shah et al (2021) investigate infection prevention and control (IPC) policies. The results show that to stop the transmission of infectious illnesses. Therefore, it may be crucial to make an effort to educate the HCP about the significance of these measures and to promote their use.

Based on the explanation of previous studies, this current study aims to examine the legal aspect of handling suspected COVID-19 patients in health services in the hospital.

II. Method and Legal Material

This type of research is normative juridical. Normative law is intended to examine positive legal provisions and positive legal instruments (Marzuki, 2017). In addition, the problem approach used in this study is the statutory approach, including the conceptual approach and comparative approach (Marzuki, 2017; Ali et al., 2009).

The legal materials used in this research are primary, secondary, and tertiary legal materials. Primary legal materials are sourced from the Act (Marzuki, 2017). Therefore, the primary legal materials in this study are the 1945 law, Law Number 36 of 2009 concerning Health; Law Number 44 of 2009 concerning Hospitals of the Republic of Indonesia; Law of the Republic of Indonesia Number 6 of 2018 concerning Quarantine; Law of the Republic of Indonesia Number 4 of 1984 concerning infectious disease outbreaks; Decree of the Minister of Health of the Republic of Indonesia Number HK. 01.07/MENKES/169/2020; Presidential Decree Number 11 of 2020 concerning the Determination of the Public Health Emergency for Corona Virus Disease 2019; Regulation of the Minister of Health number 4 of 2018 concerning Hospital Obligations and Patient Obligations and various laws and regulations related to the object of the research. Furthermore, secondary legal materials were sourced from literature, journals, and the doctrines and opinions of experts related to the discussion of this research. Finally, tertiary legal materials were sourced from the legal dictionary and the Big Indonesian Dictionary (KBBI).

Analysis of legal materials is carried out by systematizing written legal materials. Systematics means classifying these legal materials to facilitate the analysis and construction of legal materials (Soekanto & Mamudji, 2018). Analysis of legal entities was carried out using descriptive-analytic studies. This study does not intend to test hypotheses or theories but rather assesses legal concepts (analysis van jurisdiction gegevans), which includes legal definitions (derechtsbegrippen) (Rijadi & Priyati, 2011).

III. Results and Discussion

Health Services for Covid-19 Suspected Patients by Doctors in Hospitals based on Applicable Conditions

The legal basis for providing health services is generally regulated in Article 53 of the Health Law, namely individual and public health services. Thus, Covid-19 services include public health services because they impact the wider community. The legal basis for Covid-19 patient health services is Presidential Decree No.11 of 2020 concerning determining Covid-19 Public Health Emergencies. In addition, the management of Covid-19 patient services is guided by the Decree of the Minister of Health Number HK.01.07/MENKES/413/2020 concerning Guidelines for the Prevention and Control of

Covid-19 and the Guidelines for the Prevention and Control of Covid-19 by the Indonesian Ministry of Health Revision 5.

The basic principle of efforts to control Covid-19 focuses on the discovery of suspected/probable cases (find), which is followed by efforts to isolate (isolate) and laboratory tests (test). When the PCR test results are positive and the patient is declared a confirmed case, the next step is administering therapy according to the protocol (Astutik, year). Following the Decree of the Minister of Health Number HK.01.07/MENKES/413/2020 concerning Guidelines for the Prevention and Control of Covid-19, hospital health service facilities that treat suspects must carry out close contact monitoring reports for epidemiological investigations. The daily monitoring results are written in a form, then reported to the city/district health office to be recapitulated into an aggregate daily report. In addition, city/district health offices carry out aggregate daily news through the national Covid-19 daily reporting online application system and as a monitoring tool for city/district health offices to conduct rapid analysis of the development of Covid-19 cases in daily and monthly periods.

Covid-19 suspect service mechanism. If someone from the red zone or in contact with a positive patient with Covid-19 is suspected, then it is followed up with a PCR swab examination. If the result is positive, patient management is carried out based on symptoms or without symptoms experienced. However, the temporary Director General of the Health Services Ministry of Health, Prof. Kadir, said a patient who is confirmed positive for Covid-19 may not experience symptoms and experience moderate or severe symptoms.

The treatment of patients who have confirmed positive for Covid-19 is based on severe or mild symptoms. Therefore, only some patient services are the same. The handling of positive Covid-19 patients who are asymptomatic will be advised to isolate independently at home or in an emergency hospital isolation for at least ten days from diagnosis. After ten days of isolation, the patient is declared to have finished isolation.

It differs from positive patients with Covid-19 with mild-moderate symptoms. Patients are advised to self-isolate at home in Emergency Hospitals and Covid-19 Referral Hospitals. Isolate for at least ten days from the onset of symptoms plus three days free of fever and respiratory symptoms. After that, the patient is declared in complete isolation. Patients who are positive for Covid-19 with symptoms of severe illness will be isolated in a hospital or referral hospital. Patients were separated for at least ten days from the onset of symptoms, plus three days free of fever and respiratory symptoms. The patient will be tested again if the result is negative, the patient will be declared cured (Kementerian Kesehatan Republik Indonesia, 2020).

In the service of positive patients with Covid-19, there are non-isolation outpatient services. This service is intended for patients who have met the criteria for completion of isolation but still require further treatment for certain conditions associated with comorbidities, co-incidence, and complications. The transfer of care process is decided based on the results of a clinical assessment carried out by the doctor in charge of services according to service standards or standard operating procedure.

Patients who are isolated in the hospital, emergency hospital, or Covid-19 Referral Hospital can be discharged based on the consideration of the doctor in charge of the patient because of clinical improvement, comorbidities are resolved, and PCR follow-up is waiting for the results. Confirmed patients without mild, moderate, and severe/critical symptoms are declared cured if they have met the criteria for completion of isolation. A statement letter is issued after monitoring based on the doctor's assessment at the health facility where the monitoring is carried out or by the doctor in charge of the patient.

Confirmed patients with severe symptoms may have a positive, persistent RT-PCR follow-up examination because the RT-PCR test can still detect body parts of the Covid-19 virus even though the virus is no longer active (no longer infectious) in these patients. Therefore, the determination of recovery or not is based on the results of an assessment conducted by the doctor in charge of the patient, said Prof. Kadir. Meanwhile, patients can be discharged from hospital care if they meet the criteria for completion of isolation and the clinical standards.

The doctor in charge of the patient needs to consider the time for the patient's return visit in the context of the recovery period. Specifically, confirmed patients with severe/acute symptoms who have been discharged will continue to self-isolate for at least seven days to recover, be alert to the emergence of Covid-19 symptoms, and consistently apply health protocol. According to the Hospital Law, the central and regional governments are responsible for the administration, financing, guidance, supervision, and protection of hospitals in health services under article 6, paragraph (1) of the Hospital Law. In addition, hospitals, in the event of disasters and extraordinary circumstances, provide emergency services and health information the community needs.

The hospital, along with all human resources in it, strives to carry out epidemic control following article 5 paragraph (1) of the Contagious Disease Outbreaks Law, carry out epidemiological investigations; Examination, treatment, care, and isolation of patients, including quarantine measures; Prevention and immunity; Destruction of disease causes; Handling of corpses due to epidemics; and outreach to the community. In accordance with Article 56 of the Health Quarantine Law, hospital quarantine activity, in this case, the Covid-19 isolation room in a hospital, is a response to a public emergency that has been declared by the president of the Republic of Indonesia through a Presidential Decree of the Republic of Indonesia No. 11 of 2020 concerning the Determination of Covid-19 Public Health Emergencies. The quarantine in question is carried out by all people who visit the hospital, which has been proven based on laboratory results, namely a rapid test with a reactive result and a positive PCR swab. Furthermore, following 57 Health Quarantine Laws, it is stated that all those who have entered the Covid-19 isolation room are prohibited from leaving for the next 14 days. During the hospital quarantine, the basic necessity of the life of all people in the hospital is the responsibility of the central government or regional government following article 58 of the Health Quarantine Law.

Legal Protection for Hospital for Handling Covid-19 Suspected Patient

The legal basis for the legal protection of doctors in providing services is Article 50 of the Medical Practice Act, which states that doctors are entitled to legal protection as long as they carry out their duties following professional standards and standard operating procedures. Likewise, Article 27, paragraph (1) of the Health Law states that health workers have the right to receive compensation and duties according to their profession.

Approval of medical action in carrying out medical action can be done if the patient has received precise information about the medical action to be taken against him. In providing this information, the doctor must disclose and explain to the patient in a simple way about his illness, the recommended treatment, alternative treatment, the possibility of success, and the risks that can arise as well as complications that cannot be changed. If the approval requirements for medical action are not met, the doctor concerned may be subject to administrative sanctions (Komalawati, 1999). Furthermore, according to Soejatmiko, taking action without medical approval can lead to criminal malpractice charges due to carelessness (Isfandyarie, 2005).

The hospital is not responsible for suspected Covid-19 patients who refuse treatment in a particular Covid-19 isolation room and PCR swab examination. Article 45, paragraph (1) of the Medical Practice Law states that a hospital is not legally responsible if a patient and his family refuse or stop treatment which may result in the patient's death after a comprehensive medical explanation is provided. Furthermore, suppose the patient's condition is an emergency, and the doctor requires action to save lives without the consent of the patient's family. In that case, the doctor provides life assistance for the patient following article 45 paragraph (2), that hospitals cannot be prosecuted for carrying out their duties in saving human lives.

Hospitals dealing with suspected Covid-19 patients are entitled to legal protection in carrying out health services and receive compensation for services following Article 30 of the Hospital Law, which reads: hospitals have the right to receive compensation for services and determine remuneration, incentives, and awards following the provisions of the legislation. Furthermore, hospitals have the right to cooperate with other parties to develop services. In the service of covid-19 patients, the hospital is also entitled to receive assistance from other parties following the provisions of the legislation.

The technique for claiming services for Covid-19 patients is technically regulated in the Decree of the Minister of Health of the Republic of Indonesia Number Hk.01.07/Menkes/446/2020 concerning Technical Instructions for Claims for Reimbursement of Services for Certain Emerging Infectious Disease Patients for Hospitals Providing Covid-19 Services. These articles explain the completeness of the primary diagnosis and the suitability of data for online Covid-19 case updates to the relevant health offices and copies of data from the BPJS and the Ministry of Health. So, it is not easy to declare the patient has been positive for Covid-19 because the data must be verified by the BPJS, the Health Service, and the Ministry of Health.

Article 52 of the Hospital Law states that hospitals are required to make records and reports on all hospital operations in the form of a Hospital Management Information System, including recording and reporting of epidemic diseases or other certain diseases

that can cause outbreaks and carried out following with the provisions of laws and regulations. Rahardjo (2005) explained that the essence of law enforcement is a process of realizing legal wishes or ideas into reality. Legal desires are the thoughts of the law-forming bodies in the form of ideas or concepts regarding legal certainty formulated in the legal regulations. Efforts to handle cases of doctors or other health workers who are suspected of making negligence or errors in the actions or services of suspected Covid-19 patients so as not to be directly processed through legal channels, but first ask for an opinion from the Medical Code of Ethics Honorary Council (known as MKEK). Law enforcement includes administrative, civil, and criminal law enforcement.

1. Administrative Law Enforcement

The health law and the medical practice law, which regulates the practice of the medical and dental professions, are substantively administrative law with administrative sanctions (berstafrecht), although there are also criminal sanctions. This administrative law enforcement is carried out due to administrative violations of the medical or dental profession, as well as violations of medical ethics. The Indonesian Medical Discipline Honorary Council, or MKDKI, receives complaints and is authorized to examine and decide whether doctors make errors for violating the application of medical disciplines and applying sanctions.

Suppose there is a violation of medical ethics. In that case, the MKDKI will forward the complaint to the Indonesian Doctors Association's professional organization, IDI, then IDI will take action against the doctor. Recommendations for revocation of registration certificates are submitted to the Indonesian Medical Council. Meanwhile, the request for canceling the medical practice permit is submitted to the competent authority in the district or city. Thus, this administrative sanction can be in the form of a written warning, being required to attend further education or training, revocation of registration letter, revocation of practice license, postponement of periodic salary increases, demotion, and so on. The administrative sanction is related to the violation of medical ethics. Even if professional organizations and authorized officials give administrative sanctions, it does not rule out the possibility of civil or criminal lawsuits from the patient or the patient’s family.

2. Civil law enforcement

The lawsuits or civil claims can be filed against the doctor or dentist and to a legal entity, health service centre, or hospital where the doctor or dentist works. Likewise, doctor or dentist who works in teams can also be sued or sued together, depending on how much responsibility each has, and is responsible for the actions of medical personnel under their orders (Machmud, 2009).

Types of lawsuits or civil claims can be filed against a doctor or dentist suspected of committing medical malpractice in the form of a claim or lawsuit for default based on contractual liability and against the law onrechtmatigedaad. It means that a lawsuit or claim can be filed solely based on default or an unlawful act (alternatively), and it can also be filed simultaneously, namely in default and against the law (cumulatively). The primary basis of a claim or lawsuit, whether based on default or against the law, is the

doctor's inaccuracy (*minderzorgvulding*). Therefore, it is related to the professional standards of a doctor.

3. Criminal law enforcement

In Indonesian legislation, crime is a term that is often used. For example, Kansil (2004) formulates criminal acts as follows

a. Human actions (*hendeling*)
b. Human actions intended are not only "doing" (een doen) but also "not doing" (*nietdoen*).
c. Human actions must be against the law (*wederrechtelijk*).
d. The acts is punishable by law (*strafbaargesteld*).
e. Must be done by someone who is able to take responsibility (*toerekeningsvatbaar*).
f. The act must occur because of the perpetrator's fault (*schuld*). Mistakes can be intentional (*dolus*) or unintentional/negligent (*culpa*).

The parameter of an alleged violation of the law (criminal) if it has met the parameters as voorportal or front gate which is strict and limitative. The parameters are as follows.

a. There is accuracy *(zorgvuldigheid*)
b. Presence of diagnosis and therapy
c. Professional standards such as:
    1) Average ability
    2) Same category and condition
    3) The fulfillment of the principles of proportionality and subsidiarity in the purpose of carrying out medical action (Adji, 2005).

The health law and the medical practice law, which regulates the practice of the medical and dental professions, are substantively administrative law with administrative sanctions (berstafrecht), although there are also criminal sanctions. Administrative law enforcement is carried out due to administrative violations of the medical or dental profession, as well as violations of medical ethics.

The Indonesian Medical Discipline Honorary Council (MKDKI) receives complaints. It is authorized to examine and decide whether or not a doctor has made a mistake for violating the application of medical discipline, and MKDKI apply sanctions. If found a violation of medical ethics, the MKDKI will forward the complaint to the professional organization of the Indonesian Doctors Association (IDI). Then, IDI will take action against the doctor.

The legal protection of health workers has stated in article 27 of the Health Law that every health worker has the right to legal protection in carrying out his professional duties. The forms of legal protection are as follows.

1. Protection by health authorities based on existing regulations
2. Protection by professional organizations based on organizational rules
3. Protection by workplace facilities based on hospital rules

4. Normative protection based on the principle of propriety of legal responsibility.

The government guarantees the financing of health services sourced from the State Budget, the Regional Budget, and community assistance following statutory regulations. Article 56, paragraphs (1) and (2) of the Health Law states that people with infectious diseases have no choice but to accept or refuse the aid measures given to them. The rights of health workers have indicated in Article 57 of the Health Law, namely health workers in carrying out their practice are entitled to obtain legal protection as long as they carry out their duties following Professional Standards, Professional Service Standards, and Standard Operating Procedures; obtain complete and correct information from Health Service Recipients or their families; receive service fees; obtain protection for occupational safety and health, treatment following human dignity, morals, decency, and religious values; get the opportunity to develop their profession; reject the wishes of Health Service Recipients or other parties that are contrary to professional standards, code of ethics, service standards, Standard Operating Procedures, or provisions of laws and regulations; and obtain other rights under the conditions of laws and regulations. Meanwhile, doctors have rights that are generally regulated in Article 50 of the Medical Practice Act, namely doctors obtain legal protection as long as they carry out their duties, provide medical services according to professional standards and standard operating procedures; obtain complete and honest information from patients or their families; and receive service fees.

Then, Article 9, paragraph (1) of the Infectious Disease Outbreak Law explains that certain officers who carry out efforts to control the epidemic, as described in Article 5, paragraph (1) of the Infectious Disease Outbreak Law, can be rewarded for the risks borne in carrying out their duties. The award given can be in the form of material and other conditions. Therefore, it can conclude that health workers and doctors who also play a role in efforts to overcome Covid-19 are entitled to a material award. In addition, article 14 of the Infectious Disease Outbreak Law states that anyone who hinders the implementation of epidemic control, in this case, the patient's refusal to be isolated and refuses to carry out a PCR swab examination, is subject to criminal sanctions in accordance with article 14 paragraph (1), namely whoever deliberately obstructs the implementation of epidemic control as regulated in this Law, is threatened with imprisonment for a maximum of 1 (one) year or a maximum fine of IDR. 1,000,000 (one million rupiah), paragraph (2) whoever, due to negligence, obstructs the implementation outbreak control as regulated in this Law, is threatened with imprisonment for a maximum of 6 (six) months or a maximum fine of IDR. 500,000 and paragraph (3), the crime as referred to in paragraph (1) is a crime, and the crime as referred to in paragraph (2) is a violation.

IV. Conclusion

In conclusion, hospitals in the era of the Covid-19 pandemic function as a place for holding Covid-19 patient quarantine following the Health Quarantine Act and the Infectious Disease Outbreak Act regulations. The basic principle of handling Covid-19

rests on discovering suspected or probable cases, followed by laboratory examinations (RT-PCR). When the PCR test results are positive (confirmed for Covid-19), the next step is isolation and therapy according to the protocol. Health service facilities/hospitals treating suspected COVID-19 must report close contact monitoring for epidemiological investigations following the Decree of the Minister of Health concerning Guidelines for the Prevention and Control of Covid-19 and the Infectious Disease Outbreak Act.

Furthermore, the hospital as a legal entity (*recht* person) has risks under Article 58 (1) of the Health Law, namely compensating for errors/omissions of doctors and health workers. According to the Vicarious Liability doctrine, the hospital is legally responsible for all losses caused by its subordinates. According to the Hospital Liability doctrine, the hospital is responsible for taking over the mistakes/omissions of the hospital. With the right of regress, the hospital will ask for compensation back to the doctor who made a mistake. The Strict Liability Doctrine states that the hospital is responsible for the workhouse. The implementation of hospital legal protection has yet to be precise. Supervision and guidance by the government, including the government's authority on health, still needs to be made clear. Medical audits could have gone better. Doctors have the right to obtain legal protection as long as they carry out their duties under professional standards and standard operating procedures under Article 50 of the Medical Practice Act.

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