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THE LEGAL DIMENSIONS OF COMMUNICATION IN HOSPITAL SETTINGS: A MEDICOLEGAL PERSPECTIVE

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Abstract

Communication in healthcare services is not merely a technical or interpersonal matter, but an integral part of the legal and ethical responsibilities of the medical profession. This article aims to examine the legal aspects of communication in hospitals through a normative and analytical approach. The discussion focuses on the classification of communication types (clinical and administrative), effective communication methods (SBAR and closed-loop), and the strategic role of medical records in documenting explanations and informed consent. By tracing the provisions of Law Number 17 of 2023 on Health, related ministerial regulations, and field practices, this paper shows that communication and documentation failures are among the main causes of medical disputes in Indonesia. It also identifies common documentation errors, such as incomplete information, undocumented explanations, or explanations delivered by unauthorized personnel. The article concludes that effective and well-documented communication not only protects patient rights but also strengthens the legal standing of medical professionals and hospitals. Reforming communication and documentation systems in healthcare facilities should be an integral part of quality improvement and legal protection strategies in medical practice.

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medical communication, medical records, informed consent, hospital, legal liability

Introduction

Communication in healthcare services is not merely a clinical skill, but rather a fundamental element in ensuring patient safety and legal certainty in medical practice. Numerous studies indicate that communication failures between healthcare professionals and patients are among the primary causes of medical errors that lead to legal disputes. An analytical report by The Joint Commission (TJC) in the United States, based on 2,455 sentinel events in 2008, revealed that over 70% of these incidents were caused by communication failures among health professionals.[1] This phenomenon also reflects the situation in Indonesia. According to the Indonesian Medical Disciplinary Honorary Council (Majelis Kehormatan Disiplin Kedokteran Indonesia, MKDKI)—now restructured as the Medical Professional Disciplinary Board (Majelis Disiplin Profesi, MDP)—most allegations of disciplinary violations in the medical field stem from inadequate communication, either in terms of delivering medical information or documenting it in the medical records.[2] The problem becomes more serious when poor communication results in medical procedures conducted without valid consent, or when important medical information is not properly conveyed to patients or their families.

From a legal standpoint, communication is not a neutral domain. Within the hospital setting, communication forms an integral part of the legal obligation of healthcare professionals to provide truthful and complete information, as stipulated in Article 45 of Law Number 29 of 2004 concerning Medical Practice, which explicitly mandates medical explanation prior to the provision of any medical action.[3] This provision has been further reinforced and expanded in Law Number 17 of 2023 on Health, particularly in Articles 293 and 294, which detail the elements of information that must be disclosed by healthcare providers to patients.

Unfortunately, in day-to-day hospital practice, communication is often perceived merely as a technical matter or soft skill. In reality,

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1 The Joint Commission, *Improving America's Hospitals: The Joint Commission's Annual Report on Quality and Safety 2008*, Illinois: JCAHO, 2008, 13.

2 Majelis Kehormatan Disiplin Kedokteran Indonesia (MKDKI), *Laporan Tahunan 2021: Statistik Pelanggaran Disiplin Profesi Dokter*, Jakarta: Konsil Kedokteran Indonesia (KKI), 2022, 27.

3 See Pasal 45 ayat (3) Undang-Undang Nomor 29 Tahun 2004 tentang Praktik Kedokteran, and Pasal 293–294 Undang-Undang Nomor 17 Tahun 2023 tentang Kesehatan.

within the framework of health law, communication functions as a legal protection mechanism not only for patients but also for the medical professionals themselves. Communication failure can be the legal basis for accusations of medical malpractice, ethical violations, disciplinary sanctions, and civil lawsuits.[4] Moreover, in the current era of national health system reform, the importance of communication is reiterated through the adoption of patient-centered care and informed consent as foundational principles of modern healthcare delivery. These approaches position the patient as an active participant in the medical decision-making process.[5] Hence, communication does not only concern *what* is conveyed but also *how* the information is delivered, understood, and documented.

Legal literature on health law in Indonesia remains relatively scarce in systematically addressing the legal dimensions of medical communication. This paper aims to fill that gap by presenting an interdisciplinary approach that integrates clinical, administrative, and legal perspectives, all of which are interconnected and mutually reinforcing. The primary objective is to construct a comprehensive legal framework to identify, analyze, and assess legal responsibilities in both medical and administrative communication within hospital settings.

However, despite its recognized urgency within various normative frameworks, regulation of communication in healthcare services in Indonesia remains fragmented and lacks systematic integration. For instance, Ministry of Health Regulation No. 290 of 2008 concerning Medical Consent only governs the technical aspects of information delivery and consent acquisition, without addressing communication methods, interaction quality, or the legal mechanisms for communication documentation.[6] This leaves gaps in actual practice, where communication is still perceived as an unmeasurable individual task, rather than as an institutional obligation that must be standardized and legally accountable. The absence of explicit legal requirements for hospitals to implement standardized communication methods—such as SBAR or closed-loop communication—indicates the legal system's weakness in supporting patient safety instruments that are based on effective communication.

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4 Sudikno Mertokusumo, *Penemuan Hukum: Sebuah Pengantar*, Yogyakarta: Liberty, 2007, 85. In the context of health law, "communication" is regarded as a form of expression or omission of will that may give rise to legal consequences.

5 Kurtz, Silverman, & Draper, *Teaching and Learning Communication Skills in Medicine*, Oxford: Radcliffe Medical Press, 2005, 11–12.

6 See Pasal 3 and 4 of Peraturan Menteri Kesehatan Nomor 290 Tahun 2008 tentang Persetujuan Tindakan Kedokteran. The regulation does not explain delivery methods, standard forms of communication, or mechanisms for verifying patient understanding.

Research Method

This study employs a normative juridical research method with a conceptual and statutory approach. The normative juridical approach focuses on analyzing legal norms that regulate communication within hospital settings, particularly as outlined in Law Number 17 of 2023 on Health and related ministerial regulations. This method is appropriate for identifying the legal basis, obligations, and responsibilities of health professionals and healthcare institutions in delivering, documenting, and managing communication as part of their services. Additionally, the conceptual approach is used to explore doctrinal interpretations of informed consent, medical records, patient rights, and legal liability in clinical communication. Several legal doctrines from both Indonesian and international health law literature are examined to build a comprehensive understanding of how communication is treated as a legal subject, not merely a professional obligation.

Data sources include primary legal materials, such as legislation, court decisions, and professional regulations, as well as secondary materials in the form of books, journal articles, and institutional reports from relevant health and legal bodies. The analysis is conducted qualitatively and descriptively to present an in-depth understanding of the legal dimensions of communication in hospitals and its relevance to the protection of patient rights and professional accountability.

Results and Discussion

A. Classification of Communication in Hospitals and Its Legal Consequences

Communication in hospitals can be classified into two major categories: clinical communication and administrative communication. These two types differ not only in terms of content and purpose but also in their legal implications. In daily observations at healthcare facilities, the failure to distinguish between these types of communication often leads to misunderstandings between medical personnel and patients, and creates complications in determining legal responsibilities when disputes arise.

Clinical communication encompasses all forms of interaction directly related to the diagnosis, therapy, and recovery process of patients. In academic classification, clinical communication is divided into two subtypes: therapeutic communication and interprofessional communication. Therapeutic communication occurs between medical personnel and patients, aiming to establish an empathetic relationship and enhance the patient's understanding of their condition and

treatment plan.[7] In contrast, interprofessional communication takes place among fellow healthcare professionals—such as physicians, nurses, and pharmacists—as they develop and implement the patient's therapeutic regimen.

On the other hand, administrative communication is not directly related to medical treatment but supports the operational functions of the hospital. This includes communication related to patient registration, physician scheduling, insurance claims, and logistical management.[8] Although non-clinical in nature, administrative communication still carries the potential for legal conflict, especially when it results in misinformation or delays in services that affect patient safety.

From a legal standpoint, clinical communication bears a heavier legal burden because it involves the patient's fundamental rights to information, consent, and safety. Law Number 17 of 2023 on Health obligates healthcare professionals to provide complete and accurate information and to obtain consent prior to any medical intervention.[9] Meanwhile, administrative communication may lead to contractual breaches, including non-performance of hospital obligations to patients or third parties such as the national health insurance agency (BPJS).

The practical implication of this classification is the need for standardized procedures tailored to each type of communication. Hospitals must establish stricter and well-documented protocols for clinical communication, while administrative communication must adhere to principles of organizational accountability. Failure to differentiate between the two may result in weak evidentiary support in court and confusion during medical audits or professional ethics investigations.

B. Standardization of Effective Communication: SBAR and Closed-Loop Communication

The high workload, frequent rotation of healthcare personnel, and the complexity of medical information make communication in hospitals highly prone to errors. Therefore, the standardization of communication has become an urgent necessity. Two communication methods that are widely recognized and increasingly adopted in many Indonesian hospitals are SBAR (Situation, Background, Assessment, Recommendation) and Closed-Loop Communication. The SBAR method allows for concise yet comprehensive communication, making

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7 Kurtz, Silverman & Draper, Teaching and Learning Communication Skills in Medicine, Oxfor d: Radcliffe, 2005, 14–16.

8 J.C. Braithwaite et al., Health Administration and Communication: Legal Perspectives, Sydney: McGraw-Hill, 2018, 88–89.

9 See Pasal 293–294 Undang-Undang Nomor 17 Tahun 2023 tentang Kesehatan.

it highly effective in emergency situations or during inter-shift handovers. Originally developed by the U.S. Navy, this method was later adopted by healthcare institutions due to its ability to structure information systematically.[10] For example, when a nurse reports a patient's declining blood pressure, the report must include the current situation (S), the patient's medical background (B), an analysis or suspected cause (A), and the recommended action (R). The use of SBAR has been shown to significantly reduce communication-related incidents in various hospital settings.[11]

Meanwhile, Closed-Loop Communication emphasizes the verbal confirmation of messages by the receiver as proof that the message has been accurately received and understood. This method is especially critical in high-risk medical situations, such as administering narcotics or performing resuscitation. In practice, a nurse must not simply respond, "Yes, Doctor," but instead repeat the instruction verbatim. This approach not only ensures accuracy but also provides a clearer communication trail for legal verification in the event of disputes.[12] From a legal perspective, the implementation of these methods should be regarded as part of the legal duty of care. In both common law and civil law systems, professional caution is often measured by adherence to generally accepted standard practices. Hence, hospitals that fail to implement communication standards may be considered to have violated their legal obligation to protect patients.[13]
Unfortunately, there is currently no positive regulation in Indonesia that explicitly mandates the use of SBAR or other standardized communication methods in hospital practice. This legal vacuum creates a potential liability gap that may harm both patients and healthcare professionals. It is therefore essential for hospitals to establish internal written policies regarding communication methods as part of their quality management and patient safety systems.

C. Legal Aspects of Medical Interview and Explanation

One of the most crucial stages in the healthcare service process is the medical interview and the delivery of medical explanation to the

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10 Institute for Healthcare Improvement (IHI), SBAR Toolkit for Effective Clinical Communication, Boston: IHI, 2006, 2.

11 J. Haig, S. Sutton, J. Whittington, "SBAR: A Shared Mental Model for Improving Communication Between Clinicians," The Joint Commission Journal on Quality and Patient Safety, Vol. 32 No. 3, 2006, 168–175.

12 AORN Journal, "Best Practices in Closed-Loop Communication," Vol. 108 No. 5, 2018, 412–414.

13 Sudikno Mertokusumo, Penemuan Hukum, Yogyakarta: Liberty, 2007, p. 91.

patient. Although often perceived as routine steps at the beginning of clinical encounters, these elements are in fact part of the legal obligations of medical professionals that directly affect the validity of medical actions and the protection of patient rights. In the context of health law, this stage is closely related to the principles of patient autonomy, the right to information, and the mechanism of consent or refusal of medical procedures. Law Number 29 of 2004 on Medical Practice—which has been formally repealed by Article 456(a) of Law Number 17 of 2023 on Health—previously stated that physicians and dentists with a valid practice registration certificate (STR) are authorized to perform medical practices, including interviewing patients, conducting physical and mental examinations, and determining further diagnostic tests.[14] The substance of this regulation has been preserved in the new Health Law, although restructured into a more comprehensive normative framework.

Furthermore, delivering a medical explanation represents the patient's right to be informed clearly about their condition, including associated risks and available alternatives. Articles 293 and 294 of Law Number 17 of 2023 on Health stipulate several essential elements that must be disclosed by healthcare providers prior to any medical intervention: the diagnosis, medical indication, type of action to be taken, risks, complications, alternatives, risks if no action is taken, prognosis, and estimated cost.[15] In principle, this explanation must be conveyed in language that is easy to understand, and in a manner that allows the patient or their family to make a well-informed decision. In fact, Ministry of Health Regulation No. 290 of 2008 on Medical Consent explicitly states that explanation must still be provided even if not requested by the patient, and must be documented in writing in the medical record.[16]

The classical view of Hippocrates also emphasizes the importance of communication in healthcare. In his teaching, it is stated: "The best physician is the one who has providence to tell to the patients according to his knowledge the present situation, what has happened before, and what is going to happen in the future."[17] This means a good doctor is not only skilled in diagnosis but also able to explain honestly

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[14] See Pasal 35 ayat (1) Undang-Undang Nomor 29 Tahun 2004 tentang Praktik Kedokteran (revoked by Pasal 456 huruf a Undang-Undang Nomor 17 Tahun 2023 tentang Kesehatan, but its substance remains normatively and historically relevant)

[15] See Pasal 293–294 Undang-Undang Nomor 17 Tahun 2023 tentang Kesehatan.

[16] See Pasal 3 Peraturan Menteri Kesehatan Nomor 290 Tahun 2008 tentang Persetujuan Tindakan Kedokteran.

[17] Hippocrates, Precepts, quoted in B. Lyons (ed.), Medical Ethics: A Comparative Study, London: Routledge, 2012, 27.

and proportionately about the patient's condition. From a contemporary perspective, patient-centered communication is considered more effective in building trust, improving compliance with therapy, and preventing conflict. According to Kurtz et al., communication that takes into account the patient's expectations, fears, and needs does not require more time than physician-centered communication styles.[18] This demonstrates that effective communication is not contradictory to service efficiency.

However, various studies indicate that communication failure during the interview and explanation stages is a major root of legal disputes in the healthcare sector. This may occur due to incomplete information, the use of medical terminology that is not understood by patients, or the lack of adequate documentation in the medical record. In such cases, the burden of proof often falls on the healthcare provider, particularly to demonstrate that the patient received sufficient information prior to giving consent.[19] Therefore, medical interviews and explanations should be understood as part of a legal consensus-building process between patient and doctor. It is not merely a matter of professional ethics, but a legal obligation with concrete juridical consequences across disciplinary, ethical, and civil dimensions.

D. Patients' Right to Consent and Refusal of Medical Treatment

The right to give consent (informed consent) is one of the principal pillars in the legal protection of patients. In the doctrine of health law, consent is not merely understood as a verbal or written expression by the patient, but rather as a manifestation of free will based on adequate information. Therefore, the validity of consent greatly depends on the quality of the information provided, as well as the patient's capacity to understand and make an autonomous decision. Normatively, the right to consent is regulated in various laws and regulations, including Article 56 paragraph (1) of Law Number 36 of 2009 on Health, which stipulates: "Everyone has the right to independently and responsibly determine the healthcare services necessary for themselves."[20]

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18 Kurtz, Silverman & Draper, Teaching and Learning Communication Skills in Medicine, Oxford: Radcliffe, 2005, 45.

19 See: Sylvia Sumarlin, "Tanggung Jawab Hukum Dokter Akibat Tidak Memberikan Informasi yang Lengkap," Jurnal Etika Kedokteran Indonesia, Vol. 5 No. 2, 2016, 134.

20 See Pasal 56 ayat (1) of Undang-Undang Nomor 36 Tahun 2009 tentang Kesehatan (revoked, but its substance remains relevant and has been adopted in Undang-Undang Nomor 17 Tahun 2023).

This provision is expanded in Articles 293 and 294 of Law Number 17 of 2023 on Health, which state that every medical action may only be carried out after the patient or their family has given consent based on adequate information.[21] Consent may be given either orally or in writing, depending on the level of risk involved in the medical procedure. Ministry of Health Regulation No. 290 of 2008 stipulates that for high-risk medical procedures, written consent is required, whereas for low-risk procedures, verbal consent is sufficient.[22] However, in practice, medical personnel often focus merely on filling out written forms, without ensuring that the information has truly been understood by the patient. This creates legal vulnerability, particularly in civil proceedings that require evidence of a mutual understanding (meeting of minds) between both parties.

Furthermore, Law Number 17 of 2023 also explicitly recognizes the patient's right to refuse part or all of the proposed medical treatment, as regulated in Article 294 paragraph (4), which states:
"Patients may refuse part or all of the healthcare services to be provided to them after receiving and understanding complete information regarding such services."[23]
This demonstrates that patient autonomy applies not only in giving consent but also in refusing or withdrawing consent previously granted. In this regard, refusal must also be documented in writing, both by the patient and the healthcare provider, as a form of legal protection for both parties.

Nevertheless, there are exceptions to the right of refusal, particularly in emergency situations or for the sake of public health. For instance, in cases of contagious disease outbreaks, mass vaccination may be carried out without individual consent, as stipulated in Article 295 of Law Number 17 of 2023, which replaces a similar provision in the 2009 Health Law.[24] In such cases, the principle of patient autonomy is overridden by the utilitarian principle of public health. From a civil law perspective, consent that is not preceded by adequate explanation may be deemed a defect of will (wilsgebreken). Several Supreme Court decisions in medical malpractice cases have affirmed that lack of relevant information prior to obtaining consent may render a medical procedure unlawful—even if the procedure was technically carried out

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21 See Pasal 293 and 294 of Undang-Undang Nomor 17 Tahun 2023 tentang Kesehatan.

22 See Pasal 4 ayat (1) and (2) of Peraturan Menteri Kesehatan (Permenkes) Nomor 290 Tahun 2008 tentang Persetujuan Tindakan Kedokteran.

23 See Pasal 295 ayat (4) of Undang-Undang Nomor 17 Tahun 2023 tentang Kesehatan.

24 See Pasal 295 of Undang-Undang Nomor 17 Tahun 2023 tentang Kesehatan.

correctly.[25] Therefore, both consent and refusal should not be treated as mere administrative formalities, but rather as legal expressions of will with substantive legal value.

Finally, it must be emphasized that the legal validity of consent and refusal is highly dependent on administrative documentation through the medical record. A medical record that fails to document the explanation chronology, signatures, or timestamps will pose a major weakness in legal proceedings. Thus, clear, complete, and honest documentation is a vital instrument in strengthening the legal position of hospitals and medical professionals in the face of potential disputes.

E. Medical Records as Legal Evidence

Medical records constitute a central form of evidence in nearly all legal disputes involving healthcare services. Among all types of communication in medical practice, documentation within medical records carries the highest evidentiary value, as it reflects the decision-making process, the patient's consent, and the professional responsibilities of healthcare providers. In civil law, medical records function as documentary evidence; in criminal or disciplinary proceedings, they serve as supporting evidence to assess the presence or absence of negligence or violations.

Law Number 17 of 2023 on Health, as the most recent regulatory framework, explicitly regulates the obligation of documentation under Pasal 738. This article states that all medical and health personnel are required to perform documentation and reporting of services provided, including in the form of medical records.[26] Furthermore, Ministry of Health Regulation Number 24 of 2022 on Medical Records affirms that medical records must include patient identity, anamnesis results, diagnosis, treatment, medical explanations provided, and patient consent or refusal.[27]

Incomplete or inaccurate documentation becomes a major source of legal vulnerability. For example, if a patient files a lawsuit on the grounds of insufficient information prior to a medical intervention, the court will first examine whether there is a record of explanation in the medical file. If such a record is absent, the burden of proof becomes

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25 Putusan Mahkamah Agung Republik Indonesia Nomor 365 K/Pdt/2010, in a civil claim concerning medical treatment conducted without adequate explanation of associated risks.

26 See Pasal 738 Undang-Undang Nomor 17 Tahun 2023 tentang Kesehatan.

27 See Pasal 5 ayat (2) Peraturan Menteri Kesehatan Nomor 24 Tahun 2022 tentang Rekam Medis.

significantly heavier for the healthcare provider.[28] In this regard, the principle "*if it is not documented, it is considered not done*" applies strongly, as commonly upheld in medical auditing systems and legal standards in various countries.[29]

On the other hand, the quality of documentation also reflects the accountability of the healthcare institution. A proper medical record not only details what was done, but also when it was done, by whom, and under what clinical circumstances. Therefore, professional practice requires that documentation be made immediately after each interaction or procedure, not retrospectively. Retroactive or backdated documentation created after a dispute arises may worsen the hospital's legal position. Specifically, documentation must include the following elements:

a. Date, time, name, and signature of both the person giving and receiving the explanation.
b. Notes regarding expanded procedures (e.g., surgeries that were extended intraoperatively beyond the initial plan).
c. Written forms of refusal or withdrawal of consent.[30]

In several Indonesian court cases, judges have ruled that the absence of documentation of medical explanations constituted a violation of the patient's rights, even when the medical procedure itself was conducted correctly. For instance, in a case before the Central Jakarta District Court, a damages claim was granted on the basis that there was no evidence the patient had been properly informed of the risks.[31]

Thus, medical record documentation is not merely an administrative formality, but a preventive legal strategy and a manifestation of professional legal and ethical accountability. The hospital, as an institution, also bears corporate liability when its documentation system is weak, unstandardized, or left unchecked without strict supervision.

F. Common Documentation Errors in Medical Communication

Based on cumulative medico-legal experience across litigation support, disciplinary review, and hospital risk management, the following six patterns of documentation error have emerged as the most

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[28] See: Sylvia Sumarlin, Tanggung Jawab Hukum Dokter Akibat Tidak Memberikan Informasi yang Lengkap, Jurnal Etika Kedokteran Indonesia, Vol. 5 No. 2, 2016, p. 134.

[29] J.C. Braithwaite et al., Health Administration and Communication: Legal Perspectives, Sydney: McGraw-Hill, 2018, p. 112.

[30] See Pasal 10 ayat (1)–(3) Peraturan Menteri Kesehatan Nomor 290 Tahun 2008 tentang Persetujuan Tindakan Kedokteran.

[31] Central Jakarta District Court Decision Number 615/Pdt.G/2019/PN.Jkt.Pst (cited in: Laporan Tahunan MKDKI 2020, p. 42).

frequent and consequential in healthcare legal disputes. These patterns are not merely theoretical but are consistently encountered in hospital practice, where communication and documentation failures often lead to misunderstandings, legal complaints, or disciplinary proceedings:

1. Information is provided completely and accurately, but not recorded in the medical record.
2. Information is provided, but it is incomplete and/or inaccurate.
3. Information is not actually provided, but it is falsely documented as if it had been explained to the patient.
4. Information is provided properly, but is recorded in vague or minimal terms, insufficient for legal or clinical verification.
5. Information is given by unauthorized personnel, i.e., not by the attending physician or responsible medical team, but by administrative staff or junior trainees.
6. Information is delivered, but the patient or family does not understand it due to medical jargon, language barriers, or communication style.

Each of these scenarios poses serious legal risks. For example, when a procedure is performed without a properly documented explanation, courts often view the absence of documentation as evidence that no valid consent was given. Similarly, delegating explanations to personnel who are not legally or professionally authorized undermines the credibility of the medical institution and may be seen as negligence or even fraud.

From a legal standpoint, communication errors are not always due to the absence of good faith, but often stem from systemic failures in standard operating procedures, training, and documentation discipline. Therefore, hospitals must not only train healthcare personnel in clinical communication techniques but also standardize how and when communication must be recorded. The introduction of documentation templates, audit trails, and supervisory validation is essential in building a legally defensible communication system.

Conclusion

Communication in hospital settings is not merely a matter of technical efficiency or interpersonal skill, but a legal construct that shapes the foundation of patient rights, professional responsibilities, and institutional accountability. The classification of communication into clinical and administrative domains, the adoption of standardized methods such as SBAR and closed-loop communication, and the emphasis on thorough documentation reflect an evolving legal expectation of precision, transparency, and ethical conduct in healthcare

services. While Indonesian health regulations have begun to incorporate legal obligations for communication and documentation, critical gaps remain in enforcement and institutional implementation. Thus, strengthening internal hospital policies and aligning them with accepted legal standards is not only a matter of best practice, but a safeguard against ethical violations, professional liability, and institutional negligence.

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