

Constitutional Protection of Patients in Telemedicine: Informed Consent as a Right to Health

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Abstract

This article examines constitutional protection of patients in telemedicine, focusing on platform-based chat teleconsultation between doctors and patients. While telemedicine can expand access to healthcare, chat-based consultation limits clinical verification beyond text-based history taking, increasing the risks of misinterpretation, misdiagnosis, and delayed referral. These risks require meaningful informed consent rather than merely formal acceptance of platform terms. This study employs an implementation-oriented legal education approach within a community engagement framework to translate patient protection and informed consent principles into practical guidance for telemedicine users, health workers, and digital health providers. The methodology comprises four stages: identifying practical challenges in chat teleconsultation, developing accessible legal education materials, constructing a practical e-informed consent model, and assessing its applicability to promote safer and more accountable teleconsultation practices. The findings indicate that Indonesian positive law recognizes telemedicine and requires consent following adequate explanation but has not established specific and auditable e-informed consent standards for direct-to-consumer chat teleconsultation. This gap may lead to the conflation of general platform or data consent with specific clinical informed consent at points of clinical decision-making, including therapy recommendations, prescriptions, clinical instructions, and referrals. The study proposes a rights-based and risk-based e-informed consent model built on four pillars: structured minimum disclosure emphasizing chat limitations; verification of patient understanding through teach-back or closed-loop communication; trigger-based, just-in-time separation of platform consent from specific clinical consent; and an audit trail compatible with electronic medical records. The model strengthens patients' rights to health and information while enhancing accountability in digital health services and supporting Sustainable Development Goal (SDG) 3 on Good Health and Well-being.

KEYWORDS *Telemedicine, Teleconsultation Chat, Informed Consent, Right to Health, e-Informed Consent.*

Introduction

The right to health within Indonesia's constitutional framework is not merely a policy goal, but a binding fundamental right that gives rise to the state's positive obligations. Article 28H paragraph (1) of the 1945 Constitution of the Republic of Indonesia (UUD NRI 1945) affirms every person's right¹ to obtain health services, and Article 34 paragraph (3) reinforces the state's role in providing health service facilities² as part of the responsibility of the welfare state.³ At the same time, the right to health cannot be separated from the right to information as referred to in Article 28F of the 1945 Constitution of the Republic of Indonesia,⁴ because autonomous medical decision-making is possible only when patients receive information that is adequate, understandable, and verifiable for comprehension.⁵ Thus, informed consent should not be understood merely as an administrative procedure or a consent form, but as a mechanism for protecting fundamental rights, namely the right to health⁶ and the right to information, both of which are constitutionally guaranteed and must be implemented by the state in the design of health services,⁷ including when those services migrate to the digital sphere or telemedicine. Legal reform needs to be directed toward clarifying authority,

¹ Uche Nnawulezi et al., "Evaluating the Right to Life: Lessons from Nigeria, the African Charter, and Indonesian Regulations," *Jurnal Hukum Novelty* 16, no. 1 (2025), <https://doi.org/10.26555/jhn.v16i1.29985>.

² Majelis Permusyawaratan Rakyat, "UUD Negara RI Tahun 1945," 2000, 1–28.

³ Budi Setiyono, *Model Dan Desain Negara Kesejahteraan* (Bandung: Nuansa Cendekia, 2018).

⁴ Majelis Permusyawaratan Rakyat, "UUD Negara RI Tahun 1945."

⁵ Evelien De Sutter et al., "Testing and Practical Implementation of a User-Friendly Personalized and Long-Term Electronic Informed Consent Prototype in Clinical Research: Mixed Methods Study," *Journal of Medical Internet Research* 25, no. 1 (2023), <https://doi.org/10.2196/46306>.

⁶ Zahara Nampewo, Jennifer Heaven Mike, and Jonathan Wolff, "Respecting, Protecting and Fulfilling the Human Right to Health," *International Journal for Equity in Health* 21, no. 1 (2022), <https://doi.org/10.1186/s12939-022-01634-3>.

⁷ Ibid.

accountability, and rights protection in the administration of public affairs⁸.

The urgency of equitable access to health services in Indonesia becomes increasingly evident when placed in the context of public policy in an archipelagic state. Data from the Geospatial Information Agency (BIG) in 2024 recorded that Indonesia has 17,380 islands,⁹ which has implications for challenges of connectivity, population distribution, and unequal access to health service facilities, especially in remote, border, and island areas. The scale of this problem is reinforced by data from Statistics Indonesia (BPS), which projects Indonesia's population in 2025 at approximately 284,438,800 people (mid-year projection)¹⁰, thereby requiring a large and evenly distributed health service capacity. Barriers to equity have become more pronounced due to limitations and unequal distribution of health human resources: in 2024, the number of medical personnel (general practitioners and specialist doctors) was recorded at 202,967 people, with a ratio of approximately 0.72 per 1,000 population. A comparison with the ratio of 1 doctor per 1,000 population,¹¹ which is often used as a comparative indicator, shows a gap in service capacity; within that calculation framework, Indonesia is estimated to need an additional approximately 78,663 doctors. On the other hand, the concentration of specialist doctors in major cities¹² and the inadequacy of health facilities and infrastructure further widen service gaps, so that the needs of the community as recipients of health services have not been fully met.¹³

⁸ Muhammad Mutawalli Mukhlis et al., "Regional Government According to the 1945 Constitution: Ideas Refinements and Law Reform," *Journal of Law and Legal Reform* 5, no. 2 (2024): 485–530.

⁹ Adi Wikanto, "Badan Geospasial, Ini Jumlah Pulau Di Seluruh Indonesia Tahun 2024," 2024.

¹⁰ Rosy Dewi Arianti Saptoyo, Bayu Galih, "Jumlah Penduduk Indonesia 2025," 2025.

¹¹ Dinas Kesehatan Provinsi Papua, "Krisis Dokter Di Indonesia: Upaya Pemerintah Dan Tantangan Mendesak," 2024.

¹² Marniati Desy Kartika Ningsi, Nurul Hidayah, Hetty Panggabean, Firna Novi Anggoro, Dony Novaliendry, Elies Fitriani, Zeni Zaenal Mutaqin, *Hitam Putih Telemedicine Dalam Pelayanan Kesehatan* (Yogyakarta: Deepublish, 2022).

¹³ Mohammad Hilman Mursalat, Efa Laela Fakhriah, and Tri Handayani, "Yuridis Juridical Problems And Legal Protection Principles In Remote Health Services Using

Within the framework of the welfare state, which emphasizes the fulfillment of citizens' fundamental rights, telemedicine may be viewed as a logical policy instrument for reducing barriers of distance, transportation, and cost, while also accelerating the digital transformation of health services.¹⁴ Welfare state-based public services require readiness in digital services, coherent service standards, and clear accountability mechanisms so that the fulfillment of citizens' rights does not stop merely at expanding access¹⁵. Telemedicine, namely remote health services that utilize information and communication technology for clinical communication between doctors and patients through an electronic platform system, therefore requires a design of risk governance, safety standards, and consent mechanisms that is compatible with patient rights.¹⁶

However, when telemedicine, particularly platform-based chat teleconsultation between doctors and patients, is positioned as a solution for expanding access, a fundamental problem arises that is both clinical and juridical, namely the limitations of examination.¹⁷ In medical practice, establishing a diagnosis should ideally be carried out through a series of stages consisting of history taking, physical examination, supporting examinations, and diagnosis determination, whereas platform-based chat teleconsultation between doctors and patients tends to be dominated by history taking without direct verification through physical or supporting examinations. This condition increases the risk of diagnostic inaccuracy,

Information And Communication Kondisi Geografis Tersebut Menyebabkan Persebaran Penduduk Di Indonesia Tidak Merata Sehingga Masih Banyaknya Penduduk Yang Kesulitan ,” no. 42 (2022): 94–111.

¹⁴ Desy Kartika Ningsi, Nurul Hidayah, Hetty Panggabean, Firna Novi Anggoro, Dony Novaliendry, Elies Fitriani, Zeni Zaenal Mutaqin, *Hitam Putih Telemedicine Dalam Pelayanan Kesehatan*.

¹⁵ Muhammad Mutawalli Mukhlis et al., “Toward Welfare-Driven Regional Autonomy: Strengthening Public Services in Indonesia,” *LITIGASI* 27, no. 1 (2026), <https://doi.org/https://doi.org/10.23969/litigasi.v27i1.39515>.

¹⁶ Kementerian Kesehatan Republik Indonesia, *Petunjuk Teknis Pelayanan Telemedicine*, 2019.

¹⁷ Desy Kartika Ningsi, Nurul Hidayah, Hetty Panggabean, Firna Novi Anggoro, Dony Novaliendry, Elies Fitriani, Zeni Zaenal Mutaqin, *Hitam Putih Telemedicine Dalam Pelayanan Kesehatan*.

including the possibility of misdiagnosis.¹⁸ The findings of Salsabila and Sari's 2021 study show that 35% of telemedicine users reported inaccurate diagnosis as the main problem;¹⁹ this risk becomes more serious when consultation leads to drug recommendations or prescriptions, considering the potential side effects and allergic reactions that may arise. From the perspective of patient rights protection, this vulnerability requires the application of meaningful informed consent, not merely formal consent by clicking 'agree', but consent based on the patient's understanding of service limitations, limitations in establishing diagnosis, potential risks, alternative options such as face-to-face referral, and the consequences of therapeutic recommendations, for example side effects or allergies.²⁰ Thus, the problem of telemedicine does not stop at service quality, but also concerns the accountability of the state and service providers to ensure that patients' fundamental rights remain protected in the design of digital health services.

At the regulatory level, Indonesia has in fact had a normative framework that recognizes telemedicine while also regulating consent to medical procedures. Telemedicine is recognized in Law Number 17 of 2023 concerning Health (Law Number 17 of 2023) together with its implementing regulations, including Government Regulation of the Republic of Indonesia Number 28 of 2024 concerning the Implementing Regulation of Law 17 of 2023 (Government Regulation Number 28 of 2024), while the implementation of telemedicine between health service facilities is regulated through Minister of Health Regulation of the Republic of Indonesia Number 20 of 2019 concerning the Implementation of Telemedicine Services Between Health Service Facilities (Minister of Health Regulation Number 20 of 2019). With regard to informed consent,

¹⁸ Yussi Adelina Mannas dan Siska Elvandari, *Aspek Hukum Telemedicine Di Indonesia* (Depok: Rajawali Pers, 2022).

¹⁹ Isna Mutiara Salsabila and Kurnia Sari, "Analysis of Factors Related To Intention-To-Use Telemedicine Services (Teleconsultation) in Jabodetabek Residents During the Covid-19 Pandemic in 2021," *Journal of Indonesian Health Policy and Administration* 7, no. 3 (2022): 262, <https://doi.org/10.7454/ihpa.v7i3.6090>.

²⁰ E Sulaiman, T Handayani, and A Mulyana, "Kajian Yuridis Layanan Konsultasi Telemedisin Di Indonesia," *Jurnal SOEPRA Jurnal Hukum Kesehatan* 7, no. 2 (2022): 259–74.

Minister of Health Regulation of the Republic of Indonesia Number 290 of 2008 concerning Consent to Medical Procedures (Minister of Health Regulation Number 290 of 2008) establishes the minimum elements of explanation that must be conveyed, including diagnosis, procedure and purpose of the action, alternatives along with risks, complications, prognosis, and financing, and emphasizes the use of language that is easy to understand²¹ as a prerequisite for valid consent, in line with the principle of patient self-determination. Law Number 17 of 2023 also affirms that patient consent to individual health service actions must be given after receiving adequate explanation. However, the main problem lies in the gap between regulation and practice: the existing set of rules has not provided specific operational standards for informed consent in telemedicine in the form of platform-based chat teleconsultation between doctors and patients, so its application in the field is not uniform. Normative ambiguity can weaken certainty in governance and accountability; therefore, telemedicine standards should not be left to depend on the platform's internal practices²².

In platform practice, users are generally asked to agree to terms/conditions and privacy policies, which are more appropriately understood as general consent to use the service, not consent to a specific medical procedure (specific informed consent). As a result, at the crucial point when platform-based chat teleconsultation between doctors and patients develops into therapeutic recommendations or drug prescriptions, patients may not receive the protection that should be guaranteed through the informed consent mechanism. Consent for the processing of specific personal data under Law Number 27 of 2022 concerning Personal Data Protection (Law Number 27 of 2022) cannot be treated as a substitute for consent to medical procedures, because the object is different (data

²¹ Toto Surianto Subu et al., "Addressing Legal Uncertainty in Delayed Informed Consent: Protecting Health Workers in Indonesian Hospitals," *Volksgeist: Jurnal Ilmu Hukum Dan Konstitusi* 8, no. 2 (2025): 329–44, <https://doi.org/10.24090/volksgeist.v8i2.13089>. Hlm.334

²² Muhammad Mutawalli Mukhlis et al., "Legal Ambiguities Surrounding the Role of Regional House of Representatives in Indonesia's Regional Autonomy Framework," *Legality: Jurnal Ilmiah Hukum* 33, no. 2 (2025): 334–360, <https://doi.org/https://doi.org/10.22219/ljih.v33i2.38409>.

processing versus clinical decisions), the function is different (legal basis for processing versus protection of clinical autonomy), and the timing is different (platform onboarding versus the moment of material clinical decision-making).

In terms of the state of the art, the previous studies that have been described provide an important foundation while also revealing the space for this research's contribution. Hidayat in 2024²³ examined the reconstruction of telemedicine patient protection regulations based on the value of justice and showed that the existing regulatory framework still focuses on telemedicine between health service facilities, so the direct relationship between doctors and patients has not been adequately regulated; although amendments have been proposed, the aspect of informed consent as an obligation prior to medical procedures has not been placed as the main focus. Meanwhile, Masyuri in 2024²⁴ highlighted the tendency of formalistic consent and proposed reconstruction, including recognition of digital consent, but the discussion remains dominant in conventional services and has not specifically answered the distinctive characteristics of telemedicine in the form of platform-based chat teleconsultation between doctors and patients, such as e-informed consent mechanisms, validation of patient understanding in remote services, and the distinction between general consent and informed consent. Starting from that gap, the position of this research can be affirmed: this research does not merely add to the list of studies on 'legal protection in telemedicine', but directs the focus to a more fundamental agenda, namely the constitutionalization of patient protection in telemedicine in the form of platform-based chat teleconsultation between doctors and patients by positioning telemedicine informed consent as an instrument for realizing the fundamental rights to information and health.

²³ Mohammad Syarif Hidayat, "Rekonstruksi Regulasi Perlindungan Hukum Bagi Pasien Telemedicine Yang Berbasis Nilai Keadilan" (Semarang: Disertasi, Fakultas Hukum Universitas Islam Sultan Agung (UNISSULA), 2024).

²⁴ Rohmad Imam Masyuri, "Rekonstruksi Regulasi Informed Consent Pada Pelayanan Kesehatan Berbasis Nilai Keadilan" (Semarang: Disertasi, Fakultas Hukum Universitas Islam Sultan Agung (UNISSULA), 2024).

The novelty of this article needs to be emphasized in two mutually complementary domains. First, in the conceptual-constitutional domain, informed consent in telemedicine, particularly platform-based chat teleconsultation between doctors and patients, is positioned as a fundamental right rooted in Article 28H paragraph (1) of the 1945 Constitution concerning the right to health and Article 28F of the 1945 Constitution concerning the right to information, and aligned with the principle of the welfare state, which requires the state to actively design public services that are safe, fair, and accountable. Second, in the operational domain, this article offers an applicable design of e-informed consent standards in platform-based chat teleconsultation between doctors and patients, not merely an abstract norm, by establishing minimum information elements, including limitations of examination, risk of misdiagnosis, referral criteria, drug/side-effect risks, question-and-answer mechanisms and validation of patient understanding, as well as digital audit trails, so that consent becomes accountable and verifiable. In line with international ethical principles of telemedicine that emphasize the maintenance of professionalism and patient safety in remote services, standardization of consent should not be viewed as an administrative burden, but as a prerequisite for the protection of patient rights.

Four indicators of meaningful consent, namely disclosure of relevant information, verified comprehension, voluntariness, and documentation that enables verification and audit, are used in this article as normative and operational parameters to assess the adequacy of the *ius constitutum* and to design the *ius constituendum*, especially to concretize the element of 'understanding' in the patient's right to accept or refuse an action. What is meant by 'the point of clinical decision-making that has direct implications for action or therapy' in platform-based chat teleconsultation between doctors and patients is the output of consultation that directly determines health service actions, including drug recommendations, prescriptions, specific clinical instructions, or referral decisions. Therefore, at that point, specific clinical informed consent is required after disclosure of relevant information.

Based on the foregoing description, this article is directed toward examining three main focuses. First, it analyzes the constitutional

construction of the protection of patients' rights to health and information in the implementation of telemedicine in the form of platform-based chat teleconsultation between doctors and patients, as well as its implications for the position of informed consent as a mechanism for fulfilling fundamental rights. Second, it identifies and evaluates the location of normative or standard gaps in informed consent under positive law, particularly in platform-based chat teleconsultation services between doctors and patients, and their impact on patient protection. Third, it formulates a reconstruction of e-informed consent standards that are operational, accountable, and verifiable as meaningful consent, including through a clear distinction between general platform consent and consent to specific medical procedures. Thus, this article does not only position informed consent as an administrative procedure in digital health services, but also as a constitutional instrument to ensure the fulfillment of the right to health, the right to information, patient safety, and accountability in telemedicine administration.

Methods

This community engagement program employed an implementation-oriented legal education approach to translate the principles of patient protection and informed consent in platform-based chat teleconsultation into practical guidance that can be understood and applied by the community. The beneficiaries addressed by the program consisted of telemedicine users, health workers, digital health service providers, and other stakeholders involved in communication and decision-making during online health consultations. The method did not position legislation as an object of doctrinal examination, but used relevant health and digital-service regulations as supporting materials for developing practical and community-oriented guidance.

The program was implemented through four interrelated stages. The first stage was problem identification, which focused on practical difficulties commonly encountered in chat teleconsultation, including the

limitations of text-based clinical assessment, the possibility of misinterpretation or inaccurate diagnosis, delayed referral, insufficient explanation of medication risks, and the tendency to equate agreement to platform terms with consent to a specific clinical decision. This stage was intended to determine the information that community members need before accepting medical recommendations, prescriptions, clinical instructions, or referral decisions through a digital platform.

The second stage involved preparing legal education materials in accessible and non-technical language. The materials covered the limitations of chat teleconsultation, patients' right to receive understandable information, the distinction between general platform consent, consent to personal-data processing, and specific clinical informed consent, as well as the circumstances in which patients should be advised to obtain direct medical examination. Legal provisions and relevant scientific literature were used as references for ensuring the accuracy of the educational content, rather than being analyzed through statutory, constitutional, or conceptual legal-research approaches.

The third stage consisted of developing a practical e-informed consent model that could be used as educational guidance by telemedicine users and as an implementation reference for service providers. The model was organized around four main components: structured disclosure of essential information, verification of patient understanding through a comprehension check or teach-back mechanism, separation between general platform consent and specific clinical consent, and documentation of consent through a traceable digital audit trail. These components were arranged into an operational workflow covering the stages before consultation, during clinical communication, at the point of a clinical decision, and after consent was provided.

The final stage was an applicability assessment of the proposed model. The assessment examined whether the guidance was capable of helping users recognize the limitations and risks of chat teleconsultation, understand the information provided by health workers, distinguish different forms of digital consent, identify the need for direct examination or referral, and retain evidence of the consent process. The outcome of the program was a practical e-informed consent framework and operational

workflow intended to support safer, more transparent, understandable, and accountable telemedicine services for the community.

Results and Discussion

A. Constitutional Construction of Patient Protection in Telemedicine in the Form of Platform-Based Chat Teleconsultation and the Position of Informed Consent

1. The Right to Health as a Fundamental Right and the State's Positive Obligation (Welfare State)

The right to health guaranteed by Article 28H paragraph (1) of the 1945 Constitution of the Republic of Indonesia and reinforced by Article 34 paragraph (3) of the 1945 Constitution of the Republic of Indonesia places the state as the duty bearer to ensure that health services are available, safe, high-quality, and accountable. In line with that principle, the state is required to take immediate steps to fulfill the right to health and is prohibited from taking regressive measures that may reduce the level of fulfillment and protection of that right.²⁵ This obligation does not diminish when health services are provided through telemedicine, because telemedicine remains part of the design of public services within the framework of the welfare state, which requires prevention and control of foreseeable risks. The recognition of telemedicine in Law Number 17 of 2023 and Government Regulation Number 28 of 2024 confirms that technology-based services are within the normative framework of health services subject to safety and governance standards. In the context of telemedicine in the form of

²⁵ Lisa Montel et al., "How Should Implementation of the Human Right to Health Be Assessed? A Scoping Review of the Public Health Literature from 2000 to 2021," *International Journal for Equity in Health* 21, no. 1 (2022): 1–12, <https://doi.org/10.1186/s12939-022-01742-0>.

patient-doctor chat teleconsultation via a platform, the consequence is that the positive obligations of the state and service providers include the design of measurable clinical communication procedures, clear triage-referral mechanisms,²⁶ and consent that truly protects patients, because the limitations of clinical verification in chat teleconsultation are an inherent risk characteristic and therefore must not be left without standards.²⁷ Therefore, the state and providers of platform-based chat teleconsultation between doctors and patients must ensure that clinical communication procedures and consent are designed as instruments for controlling foreseeable risks, and are not left solely to the platform's internal practices.

Constitutional protection in this context cannot be reduced to the existence of a consent procedure. Article 28I paragraph (4) of the 1945 Constitution places responsibility for the protection, advancement, enforcement, and fulfilment of human rights upon the state, while Article 28D paragraph (1) guarantees fair legal certainty and equal protection before the law. When these provisions are read together with Article 28H paragraph (1), Article 28F, Article 28G paragraph (1), and Article 34 paragraph (3), telemedicine governance must protect not only patient autonomy, but also equitable access, clinical safety and quality, personal and data protection, regulatory accountability, and effective remedies. Therefore, e-informed consent constitutes only one safeguard within a broader constitutional system of patient protection. It cannot substitute for the state's obligations to regulate and supervise providers, prevent foreseeable harm, clarify the allocation of responsibility, and ensure access to appropriate face-to-face care whenever remote consultation is clinically inadequate.

²⁶ Tomáš Holčápek, Martin Šolc, and Petr Šustek, "Telemedicine and the Standard of Care: A Call for a New Approach?," *Frontiers in Public Health* 11 (2023), <https://doi.org/10.3389/fpubh.2023.1184971>.

²⁷ Ricardo Almeida-Magana et al., "E-Consent—a Guide to Maintain Recruitment in Clinical Trials during the COVID-19 Pandemic," *Trials* 23, no. 1 (2022): 1–8, <https://doi.org/10.1186/s13063-022-06333-6>.

2. The Right to Information as a Prerequisite for Patient Autonomy in Medical Decisions

The right to obtain information as guaranteed by Article 28F of the 1945 Constitution of the Republic of Indonesia serves as the foundation for autonomous medical decision-making, because patient choice is meaningful only when supported by adequate and understandable material information. Within that framework, the main requirement from the patient's side requires the availability of clear and easy-to-understand information, including information concerning the use and protection of data in the provision of health services.²⁸ This principle is consistent with the regulation of consent to medical procedures in Minister of Health Regulation Number 290 of 2008, which requires minimum explanations regarding diagnosis, purpose of the procedure, alternatives and risks, complications, prognosis, and financing as prerequisites for valid consent. In platform-based chat teleconsultation between doctors and patients, fulfillment of the right to information is not sufficiently achieved through general explanations,²⁹ because text-based communication has vulnerabilities that may result in incomplete delivery, misinterpretation, and false reassurance; therefore, the quality of information must be adapted to the character of chat teleconsultation³⁰ so that patients understand service limitations, risks of inaccuracy, alternative options, and the clinical consequences of the recommendations given.³¹

²⁸ Mascha Goldschmitt et al., "Digitalizing Informed Consent in Healthcare: A Scoping Review," *BMC Health Services Research* 25, no. 1 (2025), <https://doi.org/10.1186/s12913-025-12964-7>.

²⁹ Iman Kassam et al., "Patient Perspectives and Preferences for Consent in the Digital Health Context: State-of-the-Art Literature Review," *Journal of Medical Internet Research* 25 (2023): 1–18, <https://doi.org/10.2196/42507>.

³⁰ Amy D. Nguyen et al., "Communication during Telemedicine Consultations in General Practice: Perspectives from General Practitioners and Their Patients," *BMC Primary Care* 25, no. 1 (2024): 1–9, <https://doi.org/10.1186/s12875-024-02576-1>.

³¹ Kea Turner Oliver T Nguyen, Amir Alishahi Tabriz, Jinhai Huo, Karim Hanna, Christopher M Shea, "The Impact of Asynchronous E-Visits on Clinical Outcomes

This argument is strengthened by findings that the feasibility of digital consent technology differs depending on the medical procedure and patient characteristics, thereby emphasizing the need for a transparent and individualized consent process, especially when telemedicine is intended for high-risk patients and is expected to reduce travel barriers and time limitations.³² The implication is that informed consent in telemedicine in the form of platform-based chat teleconsultation between doctors and patients must contain material information relevant to the limitations of that communication format, and must not stop at general disclosure without a mechanism ensuring that the information is truly understood.

The constitutional right to information also contains an accessibility and equality dimension. Information is not constitutionally adequate merely because it is displayed on a digital interface; it must be accessible and understandable to patients with different levels of literacy, language proficiency, disability, age, technological experience, and internet connectivity. A digital-only service design may indirectly exclude patients who lack suitable devices, reliable internet access, digital skills, or assistance in navigating the platform³³. Constitutional protection therefore requires plain-language and disability-sensitive communication, reasonable user support, alternative communication channels, and the continued availability of face-to-face services. These measures are necessary to prevent the expansion of telemedicine from creating a new form of inequality between patients who can effectively use digital services and those who cannot.

and Healthcare Delivery: A Systematic Review,” *Infection Control and Hospital Epidemiology* 42, no. 5 (2021): 530–48, <https://doi.org/10.1017/ice.2020.1229>.

³² Goldschmitt et al., “Digitalizing Informed Consent in Healthcare: A Scoping Review.”

³³ Anu-Marja Kaihlanen et al., “Owads Digital Health Equity—A Qualitative Study of the Challenges Experienced by Vulnerable Groups in Using Digital Health Services in the COVID-19 Era,” *BMC Health Services Research* 22, no. 188 (2022), <https://doi.org/https://doi.org/10.1186/s12913-022-07584-4>.

3. Informed Consent as a Mechanism for Protecting Fundamental Rights (Not an Administrative Formality)

Consent after adequate explanation should not be understood as an administrative formality, but as a rights-protection mechanism that integrates the right to health and the right to information while safeguarding patient self-determination.³⁴ In telemedicine services in the form of platform-based chat teleconsultation between doctors and patients, consent that is reduced to clicking 'agree' to platform terms and conditions risks emptying that protective function because consent to use a service is not identical to consent to a specific clinical action or decision. This problem is closely related to legal uncertainty concerning access and consent, especially when disclosure of information regarding data use is often hidden in lengthy privacy policies, thereby raising ethical concerns regarding data privacy, autonomy, and digital justice.³⁵ At the same time, chat teleconsultation processes health data classified as specific personal data, so consent governance must also be compatible with the principles of accountability and purpose limitation in data processing under Law Number 27 of 2022. However, the need for this compatibility is often reduced in practice when consent is expressed through a clickwrap mechanism: when someone clicks 'I agree' without reading or understanding the terms, the mechanism can create a pseudo-consent and place users as if they are in a 'no choice' situation created by the service design itself. This situation becomes even more problematic given the sensitivity of health data in general.³⁶ Therefore, the minimum consent standard that protects patient rights in chat teleconsultation must fulfill meaningful consent marked by four indicators: disclosure of material information, verified comprehension, voluntariness, and documentation that enables verification and audit. The success of legal protection is not sufficiently measured by the fulfillment of formal

³⁴ Celia Brightwell et al., "Trust and Inclusion in Digital Health: The Need to Transform Consent," *Digital Society* 3, no. 3 (2024): 1–12, <https://doi.org/10.1007/s44206-024-00135-w>.

³⁵ Ibid.

³⁶ Ibid.

procedures, but must be seen from the extent to which protected subjects truly obtain substantive recovery and protection³⁷.

In digital health services, fulfillment of these indicators can be facilitated through electronic consent (e-Consent), namely the use of digital technology to conduct the consent process in a more structured and traceable manner. The components of e-Consent may include multimedia to complement text-based content, interactive features (for example, to accommodate questions, explain terms, test understanding, and allow patients to continue from the last point), capture of electronic signatures, status dashboards, and version control. Its main purpose is to improve patient understanding and engagement with clinical information, while also strengthening the administrative integrity of consent through clearer and more auditable recording trails, which in practice often become a weak point when consent is treated merely as a formality. However, the effectiveness of e-Consent still depends on the quality of the substance of the information: good technology will have no meaning if the consent content is poor, in line with the analogy of 'garbage in, garbage out', because ultimately valid consent requires genuine understanding of what is agreed to, including its purpose, risks, alternatives, and clinical consequences.³⁸ Thus, platform-based chat teleconsultation between doctors and patients must separate general platform consent from specific clinical informed consent, and must require mechanisms for verifying understanding and auditable documentation so that consent does not become formalistic.

4. Constitutional Consequences in Chat Teleconsultation

Chat teleconsultation relies on text-based history taking with limitations in direct verification through physical and supporting

³⁷ Muhammad Mutawalli Mukhlis et al., "Psychological Recovery of Crime Victims within Contemporary Restorative Justice: An Islamic Legal Perspective," *MILRev: Metro Islamic Law Review* 4, no. 2 (2025): 1098–1127, <https://doi.org/https://doi.org/10.32332/milrev.v4i2.11184>.

³⁸ Edwin Cohen et al., "Comparative Effectiveness of EConsent: Systematic Review," *Journal of Medical Internet Research* 25, no. 1 (2023), <https://doi.org/10.2196/43883>.

examinations, thereby increasing the risk of misinterpreting symptoms, misdiagnosis, false reassurance, and delayed referral, especially when consultation results in therapeutic recommendations or drug prescriptions. This vulnerability cannot be separated from the fact that certain symptoms and conditions indeed require physical examination, laboratory tests, medical imaging, or certain procedures;³⁹ therefore, telemedicine should not be used in severe or unstable conditions, or when direct examination by a doctor is needed.⁴⁰ In addition to limitations in clinical verification, the use of technology also reduces opportunities for direct face-to-face interaction and informal communication regarding safe medication use, which in turn may increase the risk of medication safety incidents.⁴¹ These risks increase the degree of the information obligation: the more limited the clinical verification and the greater the consequences of the decision, the higher the quality of informed consent that must be fulfilled so that patient autonomy and safety are protected. Therefore, at the moment of material clinical decision-making in platform-based chat teleconsultation between doctors and patients, the standard of informed consent must increase: structured disclosure, comprehension check, alternative/referral options, and an audit trail compatible with medical records.

The constitutional consequences of these clinical limitations extend beyond a heightened duty of disclosure⁴². First, the right to health

³⁹ Jenny J. Lin, Carol R. Horowitz, and Jessica S. Ancker, "An Urgent Need for Guidelines for Telemedicine Use," *Journal of General Internal Medicine* 38, no. 4 (2023): 1061–62, <https://doi.org/10.1007/s11606-022-07905-7>.

⁴⁰ Magdalena Kludacz-Alessandri et al., "The Impact of Medical Teleconsultations on General Practitioner-Patient Communication during COVID- 19: A Case Study from Poland," *PLoS ONE* 16, no. 7 July (2021): 4–6, <https://doi.org/10.1371/journal.pone.0254960>.

⁴¹ Laura L. Gleeson et al., "Medication Safety Incidents Associated with the Remote Delivery of Primary Care: A Rapid Review," *International Journal of Pharmacy Practice* 30, no. 6 (2022): 495–506, <https://doi.org/10.1093/ijpp/riac087>.

⁴² Samuel Petrie et al., "Quality Measures of Virtual Care in Ambulatory Healthcare Environments: A Scoping Review," *BMJ Open* 14, no. 4 (2024), <https://doi.org/https://doi.org/10.1136/bmjopen-2023-078214>.

requires service standards capable of preventing avoidable harm, defining the permissible scope of remote consultation, and directing patients to in-person care when clinical verification cannot be adequately performed through chat. Second, equal legal protection requires the state to prevent differences in service quality and accessibility between patients who possess adequate digital resources and those who experience technological, economic, linguistic, or disability-related barriers. Third, the rights to information and personal protection require transparent clinical communication and secure governance of health data. Fourth, constitutional protection must include regulatory supervision, identifiable responsibility, accessible complaint mechanisms, and remedial pathways when a platform, healthcare provider, or health professional fails to comply with the applicable standard. The constitutional benchmark is therefore whether the telemedicine system as a whole provides accessible, safe, non-discriminatory, transparent, and accountable healthcare, rather than merely whether an electronic consent record exists.

B. Evaluation of Ius Constitutum: Regulatory Map, Standard Gaps, and Their Impact on Patient Protection

1. Mapping of Regulations Related to Telemedicine and Informed Consent

The following mapping of the *ius constitutum* is presented vertically, namely from the constitution, statutes, government regulations, to ministerial regulations, and horizontally, namely by examining the regulatory framework for consent to medical procedures or informed consent, the regulatory framework for telemedicine, the regulatory framework for medical records, and the regulatory framework for data protection, in order to assess regulatory alignment and identify points of standard gaps in telemedicine services in the form of platform-based chat teleconsultation between doctors and patients.

Hierarchically, the normative basis of telemedicine and informed consent in Indonesian positive law forms a continuous chain of norms, from constitutional guarantees to the operational needs of digital services. The 1945 Constitution of the Republic of Indonesia affirms the right to health services (Article 28H paragraph (1)), the right to obtain information (Article 28F), and protection of one's personal self (Article 28G paragraph (1)).⁴³ Although it does not explicitly mention telemedicine services in the form of platform-based chat teleconsultation between doctors and patients, these constitutional norms require the design of digital health services to continue guaranteeing access, proper and understandable information, and privacy protection as prerequisites for patient safety.

To assess the constitutional adequacy of the *ius constitutum*, this article employs five interrelated parameters of patient protection⁴⁴. The first is accessibility and equality, including whether the regulatory framework prevents digital exclusion and preserves alternative service channels for patients who cannot effectively use digital platforms. The second is clinical safety and quality, including standards concerning the permissible scope of remote services, professional competence, triage, red flags, referral, and continuity of care. The third is information and patient autonomy, within which meaningful informed consent is situated. The fourth is privacy and secure governance of medical and personal data. The fifth is accountability and remedy, including regulatory supervision, traceable allocation of responsibility, complaint mechanisms, and access to correction or redress when patient rights are impaired. These parameters allow the constitutional analysis to examine the entire structure of patient protection rather than limiting regulatory adequacy to the validity of consent.

At the statutory level, Law Number 17 of 2023 regulates consent to medical procedures as a general framework, including the obligation of medical personnel to obtain consent (Article 293 paragraph (1)), the

⁴³ Majelis Permusyawaratan Rakyat, "UUD Negara RI Tahun 1945."

⁴⁴ Sumit Kane, "Leveraging Digital Health Initiatives to Enhance the Effectiveness, Equity and Responsiveness of Health Systems," *BMJ Global Health* 9, no. 8 (2024), <https://doi.org/10.1136/bmjgh-2023-014626>.

patient's right to accept or refuse after receiving and understanding information (Article 4 paragraph (1) letter h), the minimum components of explanation before consent (Article 293 paragraph (3)), and exceptions in emergency situations (Article 293 paragraphs (9) to (11)).⁴⁵ This regulation is supported by the medical record framework, including the obligation to create medical records (Article 296 paragraph (1)) and provisions related to access to and security of medical record data (Article 297 paragraphs (2) and (3)). In the context of technology-based services, this law also recognizes the use of information and communication technology through telehealth and telemedicine (Article 25), as well as telemedicine between health service facilities and the community that may involve registered electronic system providers (Article 172).⁴⁶

Government Regulation Number 28 of 2024 regulates telemedicine, which includes services between health service facilities and services between health service facilities and the community, and may be implemented independently or in cooperation with registered electronic system providers (Article 558 paragraphs (1) and (4)). Types of telemedicine services include teleconsultation, namely remote clinical consultation services to assist in establishing a diagnosis and/or provide considerations or suggestions for management (Article 561 paragraph (1) letter a and paragraph (2)).⁴⁷ Regarding consent to procedures, this Government Regulation requires Medical Personnel and Health Workers to obtain consent from patients or their families for the action to be provided (Article 735 paragraph (1) letter b), and affirms that consent or refusal of action is carried out after the patient receives and understands complete and adequate information and is recorded in the medical record (Article 737 paragraph (1) letter d and paragraph (5)). Medical records also include consent to health service actions, and the obligation of electronic medical records applies to Health Service Facilities that provide telemedicine services (Article 778 paragraph (3)

⁴⁵ Indonesia, "Undang-Undang Nomor 17 Tahun 2023 Tentang Kesehatan," 2023.

⁴⁶ Ibid.

⁴⁷ Pemerintah Indonesia, "Peraturan Pemerintah (PP) Nomor 28 Tahun 2024 Tentang Peraturan Pelaksanaan Undang-Undang Nomor 17 Tahun 2023 Tentang Kesehatan," *Kemenkes RI*, no. 226975 (2024): 656.

and Article 781 paragraph (2)).⁴⁸ However, this Government Regulation has not formulated specific and auditable digital informed consent standards for telemedicine in the form of platform-based chat teleconsultation between doctors and patients, for example mechanisms for verifying patient understanding and proving digital consent attached to the conversation flow, so accountability control may shift to the platform's internal SOP.

This gap becomes increasingly evident because Minister of Health Regulation Number 20 of 2019 focuses on telemedicine between health service facilities, so it does not answer the model of implementing platform-based chat teleconsultation between doctors and patients, and therefore does not directly answer the model of platform-based chat teleconsultation between doctors and patients. In practice and in the discourse of health law in Indonesia, this condition gives rise to a crucial issue in the form of the absence of specific regulation on teleconsultation, which affects the unclear legality of services, the construction of the therapeutic relationship between doctors and patients, and guarantees of confidentiality and security of patient health data.⁴⁹

For the aspect of consent to actions or informed consent, the main operational reference still relies on Minister of Health Regulation Number 290 of 2008. This Regulation affirms that all medical actions to be performed on patients must obtain consent, and that consent may be given in writing or orally after the patient receives the necessary explanation (Article 2 paragraphs (1) to (3)). The explanation must be given directly to the patient and/or closest family and must at least include the diagnosis and procedure, purpose, alternatives and their risks, risks and complications, prognosis, and estimated financing (Article 7 paragraphs (1) and (3)). The explanation must be delivered completely in language that is easy to understand, and must be recorded and documented in the medical record by including the date, time, names,

⁴⁸ Ibid.

⁴⁹ Penggalih Mahardika Herlambang Rani Tiyas Budiyaniti, "Perlindungan Hukum Pasien Dalam Layanan Konsultasi Kesehatan Online," *Jurnal Hukum Kesehatan Indonesia* 1, no. 1 (2023): 1–10, <https://doi.org/10.53337/jhki.v3i02.99>.

and signatures of the person giving and the person receiving the explanation (Article 9 paragraphs (1) and (2)). In the context of telemedicine based on chat teleconsultation on a platform (DTC), these provisions may be read as a normative basis that consent can be expressed through written communication in a conversation; however, this Regulation has not established specific auditable standards for digital consent attached to the chat flow, for example verification of patient understanding, verification of the identity of the person giving consent, or mechanisms for proving high-risk written consent that require special forms and signatures, so the gap in operational standards for the platform model remains visible. This gap becomes more problematic because in digital practice, user agreements/terms of use tend to be long and rarely read. As a result, platform-based consent becomes less reliable for ensuring users' awareness and/or understanding of the consequences of data processing and service risks.⁵⁰

On the other hand, Law Number 27 of 2022 strengthens protection through the classification of health data as specific personal data (Article 4 paragraph (2) letter a), but this framework regulates consent to data processing and does not replace clinical informed consent, so consent to terms of service and privacy policies cannot be equated with consent to medical procedures at the point of clinical decision-making. In line with this, studies on health data governance emphasize the need for a framework that enables the use of data for health interests while ensuring privacy and security protection. This balance requires clear mechanisms of identification, authorization, and accountability. These mechanisms are relevant as a basis for audit trails and proof of accountability in platform-based teleconsultation.⁵¹

The juridical implication is not limited to the risk of formalistic consent. Although the existing legal framework recognizes telemedicine, consent to medical procedures, medical records, and personal-data protection, these components have not yet been integrated into a

⁵⁰ Luke Gelinas, Walker Morrell, and Barbara E. Bierer, "Terms and Conditions Apply: An Ethical Analysis of Mobile Health User Agreements in Research," *Journal of Law and the Biosciences* 10, no. 2 (2023): 1–16, <https://doi.org/10.1093/jlb/lsad021>.

⁵¹ Ibid.

comprehensive constitutional protection standard for direct-to-consumer chat teleconsultation⁵². The regulatory gap concerns at least five areas: unequal access and digital exclusion; the absence of uniform standards for clinical quality, triage, referral, and continuity of care; inadequate guarantees of understandable information and autonomous decision-making; fragmented responsibilities for privacy and health-data governance; and unclear mechanisms for supervision, liability, complaints, and remedies. Consequently, the realization of the rights to health, information, personal protection, and fair legal certainty may depend excessively on internal platform policies. E-informed consent may address the information and autonomy dimension, but it cannot by itself remedy deficiencies in accessibility, clinical safety, regulatory supervision, or patient redress.

2. Gaps/Inadequacy of Telemedicine Informed Consent Standards (Especially Chat Teleconsultation)

The gap or inadequacy of telemedicine informed consent standards, especially in platform-based chat teleconsultation between doctors and patients, lies in the fact that the norms of consent and telemedicine already exist and are clear at the level of principle, but have not been clearly translated into operational standards that are both compliance-able and audit-able in text-based conversation channels.⁵³ This standard gap implies that consent in the chat channel can easily shift into formalism and makes it difficult to verify patient understanding. In line with this, the medical ethics framework emphasizes that informed

⁵² Rachael Hinton, Ulla Jasper, and Siddhartha Jha, "Moving beyond Tokenism in Our Approach to Human Rights in Digital Health," *The BMJ* 375, no. 2873 (2021), <https://doi.org/https://doi.org/10.1136/bmj.n2873>.

⁵³ Nivedita Saksena et al., "Rebooting Consent in the Digital Age: A Governance Framework for Health Data Exchange," *BMJ Global Health* 6 (2021), <https://doi.org/10.1136/bmjgh-2021-005057>.

consent requires good communication and assurance of patient understanding, not merely the existence of a consent form.⁵⁴

The health regulatory framework indeed contains general provisions, namely the patient's right to accept or refuse after receiving and understanding information (Law Number 17 of 2023 Article 4 paragraph (1) letter h), the obligation of medical personnel to obtain consent except in emergencies (Article 274 letter b), minimum disclosure standards (Article 293 paragraph (3)), recognition of oral or written forms of consent and the obligation of written consent for invasive or high-risk actions (Article 293 paragraphs (4) and (5)), and exceptions in emergency situations (Article 293 paragraphs (9) to (11)). Government Regulation Number 28 of 2024 defines telemedicine as the provision and facilitation of clinical services through telecommunications and digital communication technology (Article 1 number 28) and regulates the implementation of telemedicine (between facilities and facility-community), including the possibility of cooperation with registered electronic system providers (Article 558). However, this recognition has not locked in the parameters of meaningful consent in chat teleconsultation, even though teleconsultation is recognized as one type of telemedicine service (Article 561). Meanwhile, Minister of Health Regulation Number 20 of 2019 focuses on telemedicine between health service facilities, so it does not answer the model of direct service delivery to patients through platforms. This gap appears in four points. First, there is no additional minimum information standard that must be conveyed specifically for chat teleconsultation (for example, limitations of remote assessment, risk of misinterpretation or misdiagnosis or false reassurance, recommendations or prescriptions, and referral criteria or warning signs (red flags)) and/or safety-netting as a risk mitigation mechanism).⁵⁵ Second, there is no explicit provision regarding

⁵⁴ World Medical Association, *Ethics Governing Medical Negligence in Clinical Practice, Journal of Clinical Research & Bioethics*, vol. 05, 2015, <https://doi.org/10.4172/2155-9627.1000187>.

⁵⁵ Olivia Lounsbury et al., "Patient Safety of Virtual Primary Care: A Qualitative Study Examining Risks and Mitigation Strategies," *Health Policy and Technology* 14, no. 1 (2025): 100966, <https://doi.org/10.1016/j.hlpt.2024.100966>.

verification of understanding that distinguishes disclosure of information from proof of understanding, even though the element of 'understanding' is the core burden of patient rights protection. In line with the medical ethics framework, doctors are required to ensure that patients understand management options, so consent does not stop at formality. This ethical standard reinforces the need for a structured and auditable comprehension-check mechanism in the chat channel.⁵⁶ Third, there is no clear operational distinction between general platform consent or consent to data processing and specific clinical consent. Although Law Number 27 of 2022 classifies health data as specific personal data (Article 4 paragraph (2) letter a), its object is consent to data processing, not clinical consent.

Therefore, consent to terms of service and privacy policies cannot be assumed to constitute meaningful consent for clinical actions or decisions.⁵⁷ In line with informed consent theory, a form or signature is an instrument of administrative proof, while the substance of consent is an autonomous process of communication and authorization. This distinction needs to be translated operationally into chat teleconsultation.⁵⁸ Fourth, there is no uniform standard for documentation and digital consent audit trails, even though the obligation to maintain medical records and to preserve their security, integrity, and confidentiality has been affirmed (Law Number 17 of 2023 Article 296 paragraph (1) and Article 297 paragraph (3), as well as the patient's right of access in Article 297 paragraph (2)). The juridical implication is that consent in platform-based chat teleconsultation between doctors and patients is vulnerable to shifting into formalistic consent that is difficult to verify, creating risks of evidentiary disputes and uneven accountability, so the protection of patients' right to information as a prerequisite for decision autonomy may weaken. Ultimately, the fulfillment of the right to health and the right to

⁵⁶ Association, *Ethics Governing Medical Negligence in Clinical Practice*.

⁵⁷ Gelinas, Morrell, and Bierer, "Terms and Conditions Apply: An Ethical Analysis of Mobile Health User Agreements in Research."

⁵⁸ Tom L Beauchamp and Ruth R Faden, "Meaning and Elements of Informed Consent," *Encyclopedia of Bioethics* 1682, no. c (1995): 1238–41.

information (1945 Constitution of the Republic of Indonesia Article 28H paragraph (1) and Article 28F) risks depending on the internal SOP of providers or platforms, rather than on explicit normative standards.

3. General Platform Consent Is Not the Same as Specific Informed Consent for Medical Actions/Decisions

Consent to terms of service and privacy policies on a platform is essentially general platform consent, especially for access/use of services and as a basis for data processing, whereas consent to clinical actions or decisions is specific clinical informed consent that must attach to the stage of medical decision-making with direct impact after relevant clinical explanation. This distinction is important because user agreements are generally long and complex and are rarely read in practice, so click-based consent (clickwrap) is vulnerable to being reduced to administrative acceptance, rather than autonomous authorization of clinical risks and consequences.⁵⁹ In line with criticism of consent fatigue and routinisation in digital consent, consent merely to access services does not necessarily amount to meaningful consent to the risks of specific medical decisions.⁶⁰

This distinction is consistent with the logic of the regulatory framework for consent to medical procedures. Law Number 17 of 2023 places consent as an obligation of medical personnel (Article 274 letter b) and requires minimum information disclosure in the form of diagnosis, indication, procedure and purpose of the action, risks or complications, alternatives, risks if not performed, and prognosis (Article 293 paragraph (3)) as prerequisites for valid consent. This Law also affirms the patient's right to accept or refuse actions after receiving and understanding information (Article 4 paragraph (1) letter h). This principle is consistent with the regulatory framework for Consent to Medical Procedures in Minister of Health Regulation Number 290 of

⁵⁹ Gelinas, Morrell, and Bierer, "Terms and Conditions Apply: An Ethical Analysis of Mobile Health User Agreements in Research."

⁶⁰ Saksena et al., "Rebooting Consent in the Digital Age: A Governance Framework for Health Data Exchange."

2008, which links consent to decisions on actions after explanation. Ethically, informed consent requires effective communication and efforts to ensure patient understanding, so the consent process is not identical with a document or a mere click of agreement.⁶¹ Therefore, equating general platform consent with specific clinical informed consent risks reducing the right to information. Patients are deemed to have agreed to clinical risks from the beginning of access to the service, whereas clinical risks and consequences must be explained specifically at the moment of clinical decision-making (for example, providing therapy/drug recommendations, prescribing, or referral decisions). In line with literature on the digitalization of informed consent, merely conveying information does not guarantee understanding, so a process design that truly facilitates understanding is needed, not merely transferring consent into digital format.⁶²

In platform-based chat teleconsultation between doctors and patients, such equivalence also obscures the evidentiary trail of consent because the point of specific explanation and consent should be traceable through clinical documentation. This is related to the obligation to maintain medical records (Law Number 17 of 2023 Article 296 paragraph (1)) and the obligation to maintain the security, integrity, confidentiality, and availability of medical record data (Article 297 paragraph (3)). Furthermore, mixing clinical consent with consent to data processing may weaken accountability in health data governance, which is classified as specific personal data under Law Number 27 of 2022 (Article 4 paragraph (2) letter a), because the objects of consent are different. Even in data protection discourse, there is a principle that services should not be made dependent on consent to processing that is not relevant to the purpose of the service, so the need to separate types of consent based on their objects and purposes becomes stronger.⁶³ Consent to medical actions/decisions (clinical informed consent) is not

⁶¹ Association, *Ethics Governing Medical Negligence in Clinical Practice*.

⁶² Goldschmitt et al., "Digitalizing Informed Consent in Healthcare: A Scoping Review."

⁶³ Saksena et al., "Rebooting Consent in the Digital Age: A Governance Framework for Health Data Exchange."

identical to consent to the processing of health data. Thus, an adequate compliance design in platform-based chat teleconsultation between doctors and patients requires a clear operational separation between general consent for service use and/or data processing and specific clinical informed consent for particular medical actions or decisions after relevant clinical explanation. This separation is necessary so that patients' right to information, accountability for clinical decisions, and protection of health data remain maintained, and so that the audit trail of clinical consent in the chat flow can be traced accountably through the medical record.

4. Impact of Standard Gaps on Patient Protection

The absence of an integrated constitutional protection standard for platform-based chat teleconsultation has consequences that extend beyond informed consent. The existing norms remain fragmented across health-service regulation, professional obligations, medical-record governance, electronic-system administration, and personal-data protection. This fragmentation makes it difficult to determine whether telemedicine providers have fulfilled the constitutional requirements of equitable access, safe and quality healthcare, understandable information, personal protection, accountable decision-making, and effective remedies. Law Number 17 of 2023 guarantees the patient's right to accept or refuse actions after receiving and understanding information (Article 4 paragraph (1) letter h), requires medical personnel to obtain consent (Article 274 letter b), and establishes the minimum content of explanation before consent (Article 293 paragraph (3)). However, because these provisions are not formulated specifically for chat channels, in practice patients may receive non-uniform information depending on the provider's SOP and communication style. This vulnerability is in line with findings in studies of patient safety in synchronous telehealth showing recurring risks, including gaps in user knowledge and the absence of safety criteria in evaluation protocols. These findings show that without clear evaluation criteria or standards, the quality of patient protection tends to depend on variations in service

implementation.⁶⁴ In chat teleconsultation, patient autonomy is also weakened because the element of 'understanding' is not verified in a standardized manner, and the risk of clinical decisions increases when the limits of chat teleconsultation services, referral criteria, and warning signs (red flags) are not explained consistently, even though the remote context increases the risk of misinterpretation and false reassurance. This gap also hampers verification of whether consent is truly informed because documentation and audit trails of digital consent are not standardized, even though clinical accountability normatively rests on medical records, including the obligation to create medical records (Article 296 paragraph (1)) and the obligation to maintain the security, integrity, confidentiality, and availability of medical record data (Article 297 paragraph (3)). As a result, assessing compliance with consent obligations and fulfillment of the patient's right to information becomes difficult. This condition weakens patient protection and accountability of platform-based chat teleconsultation services between doctors and patients, especially because medical communication processes health data that constitutes specific personal data under Law Number 27 of 2022 (Article 4 paragraph (2) letter a). At the level of digital health governance, global policy documents emphasize that digital transformation must take place ethically, safely, and securely, and must respect privacy, security, and confidentiality, accompanied by mechanisms for monitoring and evaluating strategy effectiveness. At the DTC service level, these principles point to the need for measurable and auditable operational standards⁶⁵, including a clear separation between general platform consent/consent to data processing and specific clinical informed consent, as well as an audit trail that can be traced in medical records. Without such separation and audit trail, consent in chat teleconsultation risks shifting into formalistic consent that is difficult to verify and increases the risk of evidentiary disputes. This formalistic tendency is also

⁶⁴ Juliana Salomão Rocha de Oliveira et al., "Patient Safety Risk Associated with Synchronous Telehealth: A Scoping Review," *PloS One* 20, no. 12 (2025): e0336992, <https://doi.org/10.1371/journal.pone.0336992>.

⁶⁵ World Health Organization, "Global Strategy on Digital Health 2020–2025," 2020, 1–36.

in line with criticism in Indonesian informed consent literature that practice often focuses merely on signatures.⁶⁶ At the same time, global ethical guidelines emphasize that the use of health data for secondary purposes should rest on free and informed consent at critical points. Thus, the separation of data consent and clinical consent, accompanied by an audit trail mechanism, is a prerequisite for accountability in the platform-based chat teleconsultation ecosystem.⁶⁷

C. Constitutional Reconstruction of Patient Protection in Platform-Based Chat Teleconsultation

The reconstruction of patient protection in platform-based chat teleconsultation should not be centred solely on the digital form and procedure of informed consent. Constitutional protection concerns the entire structure through which patients obtain access to healthcare, receive safe and appropriate clinical services, exercise autonomy, retain control over their health information, and seek remedies when their rights are impaired. Therefore, e-informed consent must be placed as one component within a broader constitutional protection framework rather than being treated as the sole answer to the legal risks of telemedicine.

The proposed reconstruction is based on the combined interpretation of Article 28D paragraph (1), Article 28F, Article 28G paragraph (1), Article 28H paragraph (1), Article 28I paragraph (4), and Article 34 paragraph (3) of the 1945 Constitution of the Republic of Indonesia. These provisions establish constitutional protection through the rights to fair legal certainty, information, personal protection, healthcare, and the state's responsibility for the protection and fulfilment of human rights. Within this framework, patient protection in chat teleconsultation consists of five

⁶⁶ Erwin Dyha Ayu Masita Dewi, "Information Disclosure Sebagai Dasar Pertimbangan Keputusan Pasien Dalam Informed Consent," *Fakultas Kedokteran Universitas Surabaya*, no. 2018 (2022): 6.

⁶⁷ Organization, "Global Strategy on Digital Health 2020–2025."

interrelated pillars: equitable and non-discriminatory access; clinical safety and quality; information and patient autonomy; privacy and secure health-data governance; and accountability accompanied by effective remedies.

This broader reconstruction is necessary because Indonesian studies have identified legal issues in telemedicine extending beyond consent. Sulaiman et al.⁶⁸ find that legal uncertainty also concerns medical records, data accuracy, medical responsibility, and the absence of clear operational regulation. These findings demonstrate that improving e-informed consent alone cannot resolve all dimensions of constitutional patient protection.

1. Constitutional Parameters and Allocation of Responsibilities

The *ius constituendum* should reconstruct patient protection through a constitutional rather than consent-centred architecture. This reconstruction consists of five mutually dependent pillars⁶⁹: (1) equitable and non-discriminatory access, including digital assistance and the availability of non-digital or face-to-face alternatives; (2) safe and quality-assured clinical services, including limitations on the scope of chat consultation, professional competence, triage, red flags, referral, and continuity of care; (3) information and patient autonomy, including meaningful e-informed consent at material clinical decision points; (4) privacy and secure governance of health and personal data; and (5) public and private accountability, including supervision, transparent allocation of responsibility, complaint handling, and effective remedies. These pillars derive from the combined constitutional guarantees of the right to health, the right to information, personal protection, equal legal protection, and the state's responsibility for the fulfilment and enforcement of human rights.

Within this structure, the state remains the principal constitutional duty bearer. However, health facilities, health professionals, and digital

⁶⁸ Eman Sulaiman, Trini Handayani, and Aji Mulyana, "Juridical Study of Telemedicine Consulting Services in Indonesia," *Soepra* 7, no. 2 (2021), <https://doi.org/https://doi.org/10.24167/shk.v7i2.4035>.

⁶⁹ Kathleen Leslie, "Protecting the Public Interest While Regulating Health Professionals Providing Virtual Care: A Scoping Review," *PLOS Digital Health* 2, no. 4 (2023), <https://doi.org/https://doi.org/10.1371/journal.pdig.0000163>.

platform operators also exercise functions that directly affect the enjoyment of patients' constitutional rights⁷⁰. The state's duty to protect therefore requires constitutional guarantees to be translated into binding statutory, licensing, professional, technical, and contractual obligations for these private actors. Regulation must clarify the responsibility of each actor for service accessibility, clinical decision-making, referral, data security, documentation, complaint handling, and remedial action. This allocation of responsibility prevents constitutional protection from depending solely on voluntary platform policies or on the existence of a digital consent record.

2. Equitable and Non-Discriminatory Access to Telemedicine

Telemedicine can reduce geographical and temporal barriers, but constitutional access cannot be measured solely by whether a platform is technically available. Access is meaningful only when patients can use the service, understand its interface, communicate their health conditions, and obtain appropriate follow-up care. Therefore, digital availability that excludes patients because of limited connectivity, devices, language, literacy, age, disability, or technological competence does not fully satisfy the constitutional right to health.

Hati et al.⁷¹ identify several barriers to digital health use, including limited technological literacy, inadequate digital infrastructure, additional access costs, language barriers, visual limitations, poor application design, system failure, privacy concerns, and the inability to conduct complete physical examinations. These barriers show that a uniform digital interface may produce unequal effects among different groups of patients.

⁷⁰ Ardiansah, "Responsibility of Public Health Service Based on the Constitution of Indonesia," *Diponegoro Law Review* 5, no. 1 (2026): 51–66, <https://doi.org/10.14710/dilrev.5.1.2020.51-66>.

⁷¹ A. K. Hati et al., "Diabetic's Patient Perspectives about Barriers to Using Digital Health Technology: A Qualitative Systematic Review," *Indonesian Journal of Pharmacy*, 2024, <https://doi.org/https://doi.org/10.22146/ijp.8016>.

A constitutionally compliant platform should consequently apply an inclusive design. Important information must be written in plain language and presented in stages rather than through lengthy legal documents. The platform should provide adjustable text, accessible formats for persons with disabilities, low-bandwidth options, language assistance, and channels through which patients can obtain human support. Assistance must also be available for older persons and patients with limited digital literacy without compromising the confidentiality of their health information.

The state must ensure that telemedicine complements rather than replaces conventional health services. Patients who cannot effectively use digital platforms or whose conditions require direct examination must retain access to telephone assistance, primary healthcare facilities, hospitals, and face-to-face consultations. A patient's inability to use digital technology must not result in a lower standard of healthcare or the denial of necessary treatment.

The implementation study conducted by Farhany et al.⁷² found that telemedicine services could improve access and provide a useful alternative, but their operation was constrained by fragmented platforms, inadequate system integration, and the absence of specific standard operating procedures. This finding confirms that access depends not only on the existence of an application but also on institutional readiness, integrated systems, competent personnel, and clear service procedures.

Accordingly, the *ius constituendum* must establish minimum accessibility requirements for platform-based teleconsultation. These requirements should include user assistance, inclusive interface standards, information concerning alternative service channels, transparent costs, referral access, and procedures for continuing treatment when the digital system is unavailable. Platforms should also

⁷² F. F. Farhany, L. Lazuardi, and D. Ratmasari, "Evaluasi Penggunaan Telemedisin Pada Pelayanan Rawat Jalan Di Rumah Sakit Akademik UGM Saat Pandemi COVID-19 Dengan Metode HOT-Fit," *Jurnal Manajemen Pelayanan Kesehatan* 25, no. 4 (2022), <https://doi.org/https://doi.org/10.22146/jmpk.v25i4.6111>.

be periodically evaluated to identify groups that are underrepresented or experience higher failure rates in obtaining services.

3. Clinical Safety, Quality, Triage, and Referral

The constitutional right to health encompasses the right to receive safe and professionally accountable healthcare. The expansion of access through chat teleconsultation must not be achieved by transferring the risks created by limited clinical verification to patients. Because chat communication generally relies on written history taking, it cannot always replace physical examination, laboratory testing, diagnostic imaging, or direct clinical observation.

Rosady et al.⁷³ find that compliance with ethical principles, legal norms, and medical discipline is necessary to ensure patient safety in clinical teleconsultation. Their study confirms that teleconsultation must remain a form of medical practice governed by professional standards rather than being treated merely as an exchange of information through an application.

The *ius constituendum* should therefore clearly define the clinical scope of platform-based chat teleconsultation. Regulation should identify conditions that may generally be handled remotely, conditions requiring audiovisual assessment, and conditions that require direct examination. The platform must also provide structured screening for emergency symptoms, rapidly deteriorating conditions, and other warning signs that make continued chat consultation clinically inappropriate.

Initial triage should not be treated as an automated disclaimer that merely instructs patients to visit a hospital in an emergency. The triage process must enable the doctor to assess the urgency of the complaint based on the available information and must provide patients with specific, understandable, and actionable instructions. When the information is insufficient, the appropriate response is not to continue

⁷³ D. S. Rosady, L. Lazuardi, and S. Sastrowijoto, "Telekonsultasi Klinis: Etika, Disiplin, Dan Hukum Kedokteran," *Jurnal Hukum Kesehatan Indonesia* 2, no. 1 (2022): 1–23, <https://doi.org/https://doi.org/10.53337/jhki.v2i01.17>.

making assumptions but to seek additional information, change the communication method, or recommend direct examination.

Clinical safety also requires identity verification and adequate patient-history verification. Before prescribing medicine or issuing specific clinical instructions, the doctor should have sufficient information concerning the patient's identity, age, current symptoms, medical history, allergies, pregnancy status when relevant, medicines currently being used, and other material factors. The platform must facilitate rather than obstruct this information-gathering process.

The limitations of chat communication require a stronger *safety-netting* mechanism. At the end of the consultation, the patient should receive information concerning expected developments, symptoms that require urgent assistance, the period within which the condition should improve, and where further care may be obtained. Referral must be accompanied by reasons, the level of urgency, and directions concerning the appropriate healthcare facility. It should not consist merely of a generic recommendation to obtain face-to-face treatment.

Continuity of care must also form part of constitutional protection. Consultation records, prescriptions, referral advice, and follow-up information should be available to authorised healthcare personnel when necessary for subsequent care. Farhany et al.⁷⁴ demonstrate that fragmented service platforms and inadequate integration can impair the sustainability of telemedicine services. Therefore, interoperability with electronic medical-record systems is relevant not only for administrative efficiency but also for clinical safety.

Quality assessment should include measurable indicators covering the accuracy and completeness of documentation, waiting time, failed consultations, inappropriate prescriptions, referral compliance, repeated consultations for the same complaint, adverse incidents, patient complaints, and continuity of care. These indicators enable the government and providers to determine whether telemedicine genuinely

⁷⁴ Farhany, Lazuardi, and Ratmasari, "Evaluasi Penggunaan Telemedisin Pada Pelayanan Rawat Jalan Di Rumah Sakit Akademik UGM Saat Pandemi COVID-19 Dengan Metode HOT-Fit."

improves the fulfilment of the right to health rather than merely increasing the number of consultations.

4. Information and Patient Autonomy: The Position of E-Informed Consent

Within the broader constitutional framework, e-informed consent functions primarily as an instrument for protecting the right to information and patient autonomy. It is necessary but not sufficient for comprehensive constitutional protection. A valid electronic record of consent cannot legalise a service that is clinically inappropriate, inaccessible, discriminatory, insecure, or conducted by an unauthorised person.

Kurniawan et al.⁷⁵ position informed consent under Law Number 17 of 2023 as both a patient's right and a professional obligation requiring comprehensive information. This construction supports the view that consent should be treated as a communication and decision-making process rather than merely as electronic evidence that the patient clicked an agreement button.

The content of specific clinical consent must be distinguished from general platform consent. Consent to terms of service concerns the general use of the application, while consent to personal-data processing provides a legal basis for particular data-processing activities. Neither form of consent automatically constitutes authorisation for a clinical recommendation, prescription, medical procedure, or referral decision. Specific clinical informed consent must arise at the moment when the consultation produces a material decision affecting the patient's health.

The information provided should correspond to the elements regulated in Article 293 paragraph (3) of Law Number 17 of 2023, including the diagnosis or suspected condition, indication, purpose and nature of the proposed action, relevant risks and complications,

⁷⁵ F. Kurniawan and & Andoko Aspan, H., "A Juridical Review of Informed Consent Based on Law Number 17 of 2023 Concerning Health as a Replacement for Law Number 36 of 2009," *Bengkoelen Justice: Jurnal Ilmu Hukum* 14, no. 1 (2024): 85–100, <https://doi.org/https://doi.org/10.33369/jbengkoelenjust.v14i1.33564>.

reasonable alternatives, consequences of refusing the proposed action, and prognosis. In chat teleconsultation, the explanation must additionally address the limitations of remote examination, uncertainty resulting from incomplete clinical verification, circumstances requiring face-to-face assessment, and relevant medication risks.

The obligation to provide information is not fulfilled merely by displaying a standard text. The explanation must be adjusted to the patient's condition and the material clinical decision being considered. When a recommendation has relatively minor implications, a concise explanation may be proportionate. When the decision involves prescription medicine, significant side effects, diagnostic uncertainty, or delayed referral risk, the disclosure and verification requirements should be strengthened.

The element of understanding under Article 4 paragraph (1) letter h of Law Number 17 of 2023 should be operationalised through a comprehension check. Instead of asking only whether the patient understands, the doctor or system should request confirmation of critical information, such as the principal risk, the alternative of direct examination, and the action to be taken if symptoms worsen. This process may use a short *teach-back* or closed-loop communication method and should be proportionate to the risk of the decision.

The operational sequence of e-informed consent may be structured into six stages. First, platform onboarding should contain only general service and data-processing consent, accompanied by an explicit notice that it is not clinical consent. Second, the doctor conducts history taking and initial risk screening. Third, when the conversation reaches a material clinical decision, the system activates specific disclosure. Fourth, the patient's understanding of essential information is verified. Fifth, the patient's agreement or refusal and the communication process are documented in an electronic medical record. Sixth, the doctor ends or redirects the remote service when the condition requires urgent or face-to-face care.

This sequence must preserve voluntariness. The platform should not design the interface so that accepting the recommendation is significantly easier than refusing it, asking questions, or selecting an

alternative. Patients must have an opportunity to seek clarification, refuse the proposed recommendation, and request a direct consultation without losing access to relevant information.

Sukertayasa and Arjawa⁷⁶ examine legal protection for patients who suffer losses through online health consultation and highlight the importance of mechanisms for resolving disputes between patients and providers. Therefore, documentation of consent should be designed not merely to protect providers from claims but also to preserve reliable evidence for patients when they need to challenge the adequacy of the explanation or the service.

5. Privacy and Secure Health-Data Governance

The protection of health data is connected to the constitutional protection of the individual under Article 28G paragraph (1) and the right to information under Article 28F of the 1945 Constitution. Patients must be able to understand how their data are collected, used, stored, accessed, transferred, corrected, and deleted where legally permissible. Because health data are classified as specific personal data under Law Number 27 of 2022, their processing requires stronger protection than ordinary administrative data.

Consent to data processing must remain separate from informed consent for clinical decisions. Patients may agree to the processing necessary for providing telemedicine services without necessarily agreeing to secondary uses such as marketing, profiling, research, or sharing with third parties. The platform must specify the purpose and legal basis for each materially different processing activity rather than combining all purposes in a single general agreement.

Mulyani et al.⁷⁷ explain that electronic medical records must satisfy the principles of confidentiality, integrity, and availability. Their research

⁷⁶ I. M. A. Sukertayasa and A. A. G. P. Arjawa, "Perlindungan Hukum Pasien Dalam Layanan Konsultasi Kesehatan Online," *Jurnal Hukum Kesehatan Indonesia* 3, no. 2 (2023): 81–90, <https://doi.org/https://doi.org/10.53337/jhki.v3i02.99>.

⁷⁷ W. Mulyani, D. L. S. Kurniasih, and A Sukawan, "Hak Akses Pelepasan Informasi Rekam Medis Elektronik Untuk Kepentingan Penelitian Di RSUP Dr. Hasan

also indicates that temporary or inadequately restricted access can create risks of misuse. This finding supports the use of role-based access, limited authorisation periods, identifiable user accounts, and audit records that show who accessed data, when access occurred, and for what purpose.

An e-informed consent audit trail should therefore be integrated with electronic medical-record governance rather than stored only as an ordinary platform log. The record should include the identities of the parties, time of communication, information provided, patient questions, comprehension verification, the patient's decision, and the version of the information displayed. However, the creation of an extensive audit trail must not justify unlimited collection or retention of data.

The principles of purpose limitation and data minimisation require the platform to collect only information relevant to healthcare delivery, legal compliance, and legitimate service evaluation. Access to consultation records must be limited according to professional and organisational roles. Commercial personnel, advertisers, or unrelated business partners should not obtain access merely because they are affiliated with the platform operator.

Manela et al.⁷⁸ observe that electronic medical records will increasingly become important evidence in determining medical responsibility. This reinforces the need to preserve the authenticity, integrity, and traceability of records while preventing unauthorised alteration.

Patients should also receive effective access to their own consultation records, prescriptions, referral instructions, and other relevant information. Recent Indonesian research by Magdalena et al.⁷⁹

Sadikin Bandung," *Jurnal Kebijakan Kesehatan Indonesia* 12, no. 3 (2023): 154–159, <https://doi.org/https://doi.org/10.22146/jkki.86892>.

⁷⁸ C. Manela, R Sawitri, and E. Prawestiningtyas, "Analisis Tanggung Jawab Medis Era Rekam Medis Elektronik Di Indonesia," *Soepra Jurnal Hukum Kesehatan* 10, no. 2 (2024): 301–310, <https://doi.org/https://doi.org/10.24167/sjkh.v10i2.11411>.

⁷⁹ M. Magdalena, Y. B. Sarwo, and D. B. Wibowo, "Perlindungan Hukum Bagi Pasien Terhadap Hak Akses Rekam Medis Elektronik Di Rumah Sakit Paska Permenkes Nomor 24 Tahun 2022 Tentang Rekam Medis Elektronik," *Soepra Jurnal Hukum*

shows that the implementation of patient access to electronic medical records may differ among healthcare units when technical standards are left to internal institutional policies. Such inconsistencies demonstrate the need for uniform minimum procedures governing patient requests, identity verification, response periods, correction of inaccurate information, and refusal accompanied by legally valid reasons.

Data protection must be supported by technical and organisational safeguards, including encryption, secure authentication, access control, periodic security evaluation, incident logging, and procedures for responding to data breaches. The platform should inform affected patients when a security incident creates a material risk to their rights, while the government must possess sufficient supervisory and enforcement authority to ensure that data-protection obligations are not reduced to voluntary corporate policies.

6. Regulatory Accountability, Complaints, and Effective Remedies

Constitutional protection is incomplete when patients possess formal rights but cannot determine who is responsible or where a complaint should be submitted. The availability of an e-informed consent record does not eliminate the possibility of diagnostic error, inappropriate prescribing, delayed referral, unauthorised data access, system failure, or misleading commercial representation. Therefore, the *ius constituendum* must provide both preventive and corrective protection.

Kartika and Andika⁸⁰ distinguish preventive legal protection from repressive protection in telemedicine. Preventive protection includes professional training and measures intended to avoid disputes, while

Kesehatan 12, no. 1 (2026), <https://doi.org/https://doi.org/10.24167/sjhc.v12i1.13422>.

⁸⁰ K. Kartika and A. Andika, "The Legal Protection for Independent Practicing Doctors in Providing Telemedicine Services to Patients," *Oepra Jurnal Hukum Kesehatan* 10, no. 2 (2024): 335–350, <https://doi.org/https://doi.org/10.24167/sjhc.v10i2.12569>.

repressive protection concerns the resolution of disputes after harm has occurred. Although their study focuses on protection for doctors, the distinction is also relevant to patient protection because constitutional safeguards must operate before and after a violation.

Preventive accountability should include provider licensing, professional credential verification, standard operating procedures, clinical audits, system-security assessments, and periodic reporting of adverse incidents. Platforms should display the identity, qualifications, and registration status of doctors in a manner that can be verified by users. Healthcare facilities and platforms must also establish clear procedures for supervising prescriptions, referrals, consultation documentation, and complaints concerning professional conduct.

Corrective accountability requires an accessible complaint mechanism within the platform. The mechanism should allow patients to complain about clinical services, payments, data processing, accessibility, discriminatory treatment, or technological failures. Complaints should be acknowledged within a defined period, investigated by an appropriately independent unit, and resolved through a reasoned response rather than an automated message.

The complaint mechanism must not become the only available avenue. Patients should retain access to healthcare-facility procedures, professional disciplinary mechanisms, personal-data supervision, consumer protection, mediation, and judicial remedies according to the nature of the violation. Sukertayasa and Arjawa⁸¹ emphasise the relevance of legal protection and dispute resolution for patients suffering losses in online consultation. This supports the establishment of pathways that are understandable even to patients who do not know whether the source of their loss is clinical, contractual, or technological.

The allocation of responsibility should be transparent. Doctors are accountable for professional clinical decisions within their authority, healthcare facilities are accountable for clinical governance and continuity of care, and platform operators are accountable for the

⁸¹ Sukertayasa and Arjawa, "Perlindungan Hukum Pasien Dalam Layanan Konsultasi Kesehatan Online."

operation and security of electronic systems under their control. When harm results from interconnected failures, the regulatory framework should permit responsibility to be assessed jointly rather than requiring patients to prove the internal division of tasks before obtaining protection.

Effective remedies should be proportionate to the violation. They may include correction of records, renewed clinical assessment, immediate referral, cancellation or refund of charges, deletion or restriction of unlawfully processed data, restoration of account access, compensation, professional sanctions, administrative sanctions, and other remedies provided by law. A provider's terms of service should not exclude responsibility for negligence, unlawful data processing, or the denial of statutory patient rights.

Auditability should consequently extend beyond consent. The evidentiary record should include the clinical conversation, identity verification, triage result, prescription, referral, system notification, access to health records, and handling of complaints. Such documentation allows regulators and adjudicators to determine whether the entire service fulfilled constitutional standards rather than examining only whether the patient clicked an agreement box.

7. Policy Implications and Integrated Operational Standards

The proposed constitutional reconstruction requires an integrated implementing instrument rather than a regulation limited to e-informed consent. The instrument may take the form of a Minister of Health Regulation, technical guideline, or mandatory national standard governing direct-to-consumer platform-based teleconsultation. Its content must cover the entire cycle of service, from platform registration to clinical follow-up and complaint resolution.

The first component should regulate access and inclusion. It must require accessible interface design, user assistance, transparent pricing, language and disability accommodation, low-bandwidth alternatives, and continued access to non-digital or face-to-face services. The second component should establish clinical standards concerning professional

competence, service scope, identity verification, history taking, red-flag screening, prescribing, referral, *safety-netting*, and continuity of care.

The third component should regulate information and autonomy. It should distinguish platform consent, data-processing consent, and specific clinical informed consent; determine when specific consent must be activated; establish minimum disclosure; and require proportionate verification of understanding. The operational e-informed consent sequence described above should be included as one module within this component rather than treated as the entire regulatory framework.

The fourth component should establish health-data governance standards, including purpose limitation, data minimisation, access control, retention, patient access, record correction, interoperability, audit trails, and data-breach response. The fifth component should clarify institutional responsibility, supervision, adverse-incident reporting, complaint handling, dispute resolution, and remedies.

Farhany et al.⁸² recommend the preparation of standard operating procedures, service roadmaps, and integration with existing hospital information systems after identifying operational fragmentation in telemedicine implementation. Their findings demonstrate that constitutional principles must be translated into institutional processes capable of being used in daily practice.

Implementation should be supported by periodic monitoring and evaluation. Evaluation should not rely solely on the number of registered users or completed consultations. It should examine whether different population groups can access the service, whether clinical incidents and delayed referrals occur, whether patients understand material information, whether data-access rules are followed, and whether complaints result in timely and effective remedies.

The government should also require providers to submit periodic reports concerning service quality, accessibility, security incidents,

⁸² Farhany, Lazuardi, and Ratmasari, "Evaluasi Penggunaan Telemedisin Pada Pelayanan Rawat Jalan Di Rumah Sakit Akademik UGM Saat Pandemi COVID-19 Dengan Metode HOT-Fit."

patient complaints, referrals, and adverse clinical outcomes. Reporting requirements must protect patient confidentiality while providing regulators with sufficient information to detect systemic risks. Regulatory supervision should be risk-based, with more intensive monitoring for services involving prescriptions, vulnerable patients, high consultation volumes, or repeated safety incidents.

Accordingly, the proposed *ius constituendum* does not eliminate or diminish the importance of e-informed consent. Instead, it places e-informed consent in its proper constitutional position as an instrument for protecting information and patient autonomy. Comprehensive constitutional protection is achieved only when meaningful consent operates together with equitable access, clinical safety, secure data governance, clear responsibility, effective supervision, and accessible remedies.

Conclusion

This article concludes that patient protection in platform-based chat teleconsultation constitutes a constitutional obligation derived from the rights to health and information and the state's positive obligations under the 1945 Constitution of the Republic of Indonesia. Although Indonesian law recognizes telemedicine, informed consent, electronic medical records, and health-data protection, these norms have not been translated into specific, enforceable, and auditable standards for chat-based clinical interactions. The theoretical contribution of this article lies in the constitutionalization of informed consent by positioning it not merely as an administrative requirement or electronic acceptance, but as a mechanism for realizing patient autonomy and the constitutional rights to health and information. Accordingly, valid consent must ensure that patients receive and understand material information concerning the limitations of chat-based examinations, clinical risks, available alternatives, referrals, and the consequences of therapeutic decisions.

The normative contribution of this article is the reconstruction of existing legal obligations into a rights-based and risk-based e-informed consent standard comprising structured disclosure, verification of patient understanding, trigger-based separation of platform, data-processing, and specific clinical consent, and auditable documentation integrated with electronic medical records. Practically, this model provides guidance for regulators to establish binding operational standards, supervision, complaint mechanisms, and remedies, while requiring telemedicine platforms to activate specific consent before prescriptions, therapeutic recommendations, clinical instructions, or referrals are issued and to maintain traceable consent records. Thus, the proposed model strengthens patient understanding and platform accountability, while remaining part of a broader constitutional framework that includes equitable access, clinical safety, secure data governance, clear responsibility, effective supervision, and accessible remedies.

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