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Confidentiality of Doctors Handling Patients in Hazardous Communicable Disease Programs, Jambi City

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Abstract

This study examines the implementation of doctors' professional confidentiality in the care of patients with hazardous communicable diseases at Community Health Centers in Jambi City. It focuses on the legal and ethical tension between mandatory disease reporting and patient privacy. The research employs a non-doctrinal legal research design with a qualitative approach. Data were collected through in-depth interviews with doctors and infectious disease officers, field observations, and analysis of relevant health laws, regulations, and professional codes of ethics. Participants were selected using purposive sampling. The findings show that confidentiality is generally maintained in accordance with health legislation and medical ethical standards through restricted access to patient information, separation of sensitive data, and controlled use of electronic medical records. However, three major challenges were identified: pressure to disclose patient identities, patient reluctance to cooperate due to stigma and fear of discrimination, and vulnerabilities in digital data management systems. These conditions place doctors in a dilemma between maintaining confidentiality and fulfilling public health reporting obligations. The study concludes that effective protection of medical confidentiality requires ethical commitment, clear operational procedures, and stronger data security measures to protect patient rights while supporting communicable disease control.

Keywords Confidentiality of Doctor's Office; Hazardous Communicable Diseases; Community Health Centers of Jambi City

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1. INTRODUCTION

Hazardous communicable diseases remain a major challenge within public health systems due to their rapid transmission, potential to cause outbreaks, and significant mortality rates (World Health Organization, 2022). In response, the Indonesian government has established comprehensive disease control policies encompassing prevention, early detection, treatment (Gostin et al., 2019), and surveillance mechanisms (Holijah et al., 2023). At the primary care level, Community Health Centers (*Puskesmas*) play a pivotal role in implementing programs to eradicate hazardous communicable

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diseases, particularly through epidemiological surveillance, case management, and mandatory reporting to health authorities. (Ri, 2018; Heywood & Harahap, 2009)

Doctors occupy a strategic position within this framework, as they are responsible not only for diagnosing and treating patients but also for ensuring compliance with disease reporting obligations (Upshur, 2002). This dual role places doctors at the intersection of individual patient rights and collective public health interests (Beauchamp & Childress, 2019). Medical confidentiality, as an ethical and legal obligation, requires doctors to protect patients' personal and medical information, thereby fostering trust within the doctor–patient relationship (Agustin et al., 2020). However, this obligation is not absolute and may be limited under specific legal conditions, particularly in the context of infectious disease control. (Annas, 2003; Childress et al., 2002)

Law Number 17 of 2023 concerning Health explicitly mandates health workers to maintain confidentiality of patient information while simultaneously allowing exceptions for public health purposes (Ransom & Valladares, 2021), including infectious disease surveillance and outbreak control (Isibor, 2024). This obligation is further operationalized through derivative regulations, such as the Minister of Health Regulation Number 6 of 2024, which establishes minimum technical service standards for the reporting and management of communicable diseases such as tuberculosis and HIV (Sander, 2025; Kumar, 2025). Additionally, the Minister of Health Regulation Number 45 of 2014 on health surveillance requires rapid, accurate, and systematic reporting of infectious disease cases to prevent wider transmission. (Darmawan, 202; Patria et al., 2024)

Despite the clarity of the regulatory framework, its implementation at the primary health care level presents practical and ethical challenges. Doctors at *Puskesmas* often face resistance from patients who fear social stigma, discrimination, or breaches of privacy when their disease status is reported (Link & Phelan, 2001; Nyblade et al., 2019). Cases involving tuberculosis patients who refuse to report illustrate the tension between maintaining medical confidentiality and fulfilling statutory reporting obligations. This situation highlights unresolved issues regarding the legal limits of confidentiality, the scope of doctors' authority, and the mechanisms for protecting patient rights without undermining disease control efforts.

From a theoretical perspective, this study is grounded in Medical Confidentiality Theory, which emphasizes confidentiality as a core principle of medical ethics (Rahardjo, 2006; Rahardjo, 2017) and professional responsibility, and Legal Protection Theory, which views law as a means to safeguard individual rights while balancing broader societal interests (Montgomery, 2003). These frameworks are essential for analyzing how legal norms regulate doctors' actions and protect patients within public health programs involving hazardous communicable diseases. (Gostin et al., 2019; Epstein, 2003)

Based on these considerations, the central problem of this study lies in the lack of clarity and consistency in the practical application of confidentiality obligations amid mandatory disease reporting requirements at Community Health Centers. This gap necessitates legal analysis to ensure both effective disease eradication and adequate protection of patients’ rights.

Accordingly, this study aims to address the following research questions: How is the legal position of doctors regarding medical confidentiality in handling patients under the hazardous communicable diseases eradication program at Community Health Centers in Jambi City? What legal limitations and exceptions apply to medical confidentiality in the context of mandatory reporting of hazardous communicable diseases? How can patient rights to confidentiality be protected without compromising the effectiveness of infectious disease control programs?.

Based on identified gaps between the normative legal framework and its practical implementation at Community Health Centers, this study focuses on clarifying the legal position of doctors regarding the maintenance of medical confidentiality in hazardous communicable disease eradication programs. Specifically, this research aims to analyze the legal boundaries of doctors' confidentiality obligations when confronted with mandatory reporting requirements, to examine the forms of legal protection afforded to patients' personal and medical data, and to identify appropriate legal and procedural mechanisms that balance patient privacy rights with the effectiveness of public health surveillance and infectious disease control in Jambi City.

2. METHOD

This study employs non-doctrinal (empirical) legal research, which examines law not merely as written norms but as a social reality manifested in practice. This approach analyzes how legal provisions on doctors' confidentiality obligations are implemented in the context of hazardous communicable disease eradication programs at Community Health Centers (*Puskesmas*) in Jambi City. The research emphasizes the interaction among legal norms, medical ethics, and public health practices, examining the challenges doctors face in balancing patient confidentiality with mandatory reporting obligations. (Widodo, 2020)

A qualitative research approach was adopted to explore the meanings, experiences, and interpretations of medical personnel regarding the application of confidentiality rules within infectious disease control programs. The research was conducted at several Community Health Centers in Jambi City that actively implement tuberculosis and HIV control programs. Participants were selected using purposive sampling, based on their direct involvement in disease diagnosis, treatment, and reporting. The research informants consisted of six doctors, four tuberculosis program officers, two HIV program officers, and three patients who were undergoing treatment for hazardous communicable diseases. This sampling strategy was chosen to obtain in-depth and relevant information aligned with the research objectives. (Sugiyono, 20); (Sugiyono, 20;)(Sugiyono, 2014)

Data were collected through in-depth interviews, non-participant observations, and document analysis. The interview guide was semi-structured and covered key themes, including: understanding of medical confidentiality; experiences in reporting infectious disease cases; perceived legal and ethical dilemmas; patient responses to reporting procedures; and institutional policies related to data protection. Field observations were conducted to examine reporting workflows, communication practices, and confidentiality safeguards within the health centers. Documentation analysis included laws and regulations, ministerial decrees, standard operating procedures, and medical codes of ethics relevant to confidentiality and infectious disease surveillance. (L. J. Moleong, 2017; J. A. Moleong, 2003; L. J. Moleong, 1989)

Data analysis was conducted using a thematic analysis. Interview transcripts and field notes were first subjected to open coding to identify relevant concepts, followed by axial coding to connect legal norms with empirical findings, and selective coding to formulate overarching themes related to confidentiality limits, legal compliance, and patient protection. The results were then interpreted through the lenses of Medical Confidentiality Theory and Legal Protection Theory to ensure coherence between empirical data and legal analysis.

To ensure data credibility and research rigor, data were triangulated by comparing interview results, observations, and documentary evidence. Member checking was conducted by confirming key findings with selected informants to minimize misinterpretation. An audit trail was maintained throughout the research process to document analytical decisions and enhance transparency. All participants provided informed consent, and anonymity was ensured through the use of pseudonyms and the omission of identifiable information. Data were used solely for academic purposes and handled in accordance with applicable data protection regulations.

3. FINDINGS AND DISCUSSION

3.1. Findings

Table 1. Implementation of Doctors' Confidentiality in Handling Hazardous Communicable Disease Patients

No	Theme	Description of Implementation	Interview/Field Quotation	Legal/Ethical Basis
1	Restriction of Data Access	Access to TB and HIV patient data is strictly limited. Sensitive information is	"For HIV cases, we do not include the data in the general electronic	Legal Protection Theory; Article 274 of Law No. 17 of

		stored separately from general medical records. Only authorized officers may access the files. Physical records are kept in restricted rooms, and digital systems require personal login credentials.	medical record. Only specific officers can access it." (Doctor, Simpang Kawat Health Center)	2023 on Health
2	Patient Consent as a Core Principle	Disclosure of medical information, including to family members, is conducted only after obtaining explicit patient consent. Patient autonomy is treated as a central ethical value in practice.	"Even to family members, we cannot disclose the illness without the patient's consent." (Doctor, Payo Selincah Health Center)	Medical Confidentiality Theory; Medical Code of Ethics; Article 274 of Law No. 17 of 2023
3	Use of Digital Reporting Systems	Digital applications such as SITB and electronic medical records are protected through password-based systems and role-based authorization. Login credentials are personal and monitored to prevent misuse.	(Field observation) Login credentials were individual and periodically monitored by the health facility administrator.	Ministry of Health technical regulations; Data Security Principles
4	Confidential Cross-Sector Coordination	During coordination with village officials or community health cadres, only aggregated or non-identifiable data are shared. Patient names are never disclosed.	"We only share regional data, never patient names, even during cross-sector coordination." (TB Program Officer, Tahtul Yemen Health Center)	Article 274 of Law No. 17 of 2023: Principle of balancing public health and privacy protection

Table 2. Obstacles in Maintaining Medical Confidentiality

No	Obstacle	Risk Level	Description of the Challenge	Empirical Evidence / Quotation
1	Social Stigma	High	TB and HIV patients fear discrimination, leading to reluctance in treatment adherence and reporting.	Field observations showed that officers minimized visible medical attributes during home visits to avoid drawing community attention.
2	External Pressure for Data Disclosure	Medium	Requests from village officials, health cadres, or community members for patient identities create ethical and legal dilemmas for doctors.	Doctors reported consistently refusing such requests despite repeated external pressure.
3	Digital Data Vulnerability	Medium	Multiple system users increase the potential risk of data leakage if internal discipline weakens.	Informants acknowledged that although systems are secure, risks remain if internal controls are not strictly maintained.
4	Internal Stigma among Health Workers	Low–Medium	Informal discussions among staff regarding patient conditions pose a latent risk to confidentiality.	Identified through interviews and observation of internal staff interactions.

Table 3. Strategies to Overcome Confidentiality Challenges

No	Strategy	Practical Implementation	Supporting Evidence / Field Findings	Effectiveness Indicators
1	Strengthening Ethical Commitment	Regular internal discussions, peer reminders, and reinforcement of professional ethics	Ethical reinforcement practices are conducted informally but continuously within each health center.	No reported data breaches; strengthened professional awareness.

		within health facilities.		
2	Enhancement of Data Security	Password rotation, limited document ownership, and restricted access authorization mechanisms.	Personal login systems and administrative monitoring were observed in practice.	Controlled and documented access systems.
3	Patient-Centered Communication	Empathetic and repeated counseling to encourage voluntary disclosure when necessary for disease control purposes.	Doctors emphasized persuasive communication to ensure patients understand limited disclosure for public health needs.	Sustained patient trust and continued treatment participation.
4	Institutional Regulation and Oversight	Official decrees from the Health Office designating authorized officers and centralizing decisions regarding data disclosure.	Disclosure decisions are made institutionally rather than individually.	No reported confidentiality violations; structured cross-sector coordination.

3.2. Discussion

The findings of this study demonstrate that the implementation of doctors' professional confidentiality in handling patients within the hazardous communicable diseases eradication program at Community Health Centers (Puskesmas) in Jambi City has generally been conducted in accordance with the prevailing legal framework. Empirical data obtained from interviews and field observations reveal that health workers apply strict limitations on access to patient information, particularly for patients diagnosed with infectious diseases such as tuberculosis and HIV. Patient data are stored in separate administrative systems, both physically and electronically, and access is granted only to authorized personnel directly involved in medical treatment and reporting obligations. This practice reflects an institutional effort to prevent misuse of sensitive information that could expose patients to stigma, discrimination, or social exclusion. (Parker & Aggleton, 2003)

The study also finds that patient health information is disclosed selectively and cautiously. Doctors and health workers consistently emphasize that information related to a patient's identity may be discloseonly d wittheipatient's explicit consent or when required by law for public health purposes, such as mandatory reporting to higher health authorities. In interactions with community representatives or village officials, medical personnel limit information sharing to aggregate or anonymized data without revealing patient identities. This empirical reality indicates that doctors are actively negotiating the boundaries between confidentiality obligations and public health responsibilities in their daily professional practice.

Nevertheless, the findings also reveal several challenges that complicate the consistent application of confidentiality principles. Social pressure from communities and local stakeholders often arises during infectious disease surveillance and contact tracing activities. Community leaders or neighborhood authorities may request access to patient identities to prevent disease transmission. Such requests place doctors in a difficult ethical and legal position, as fulfilling them could violate medical secrecy, while refusing them may generate social tension or mistrust (Childress et al., 2002). Additionally, patients’ fear of stigma frequently leads to reluctance in providing complete information, thereby complicating disease control efforts and requiring health workers to employ persuasive and empathetic communication strategies. (Courtwright & Turner, 2010)

From a theoretical perspective, these findings can be analyzed through the lens of Legal Protection Theory, which views law as a mechanism for safeguarding individual rights while maintaining social order. In the context of health services, medical confidentiality serves as a legal protection that prevents the arbitrary disclosure of patients' personal and medical data. Law Number 17 of 2023 concerning Health reinforces this protection by obligating health information system operators to guarantee the security and confidentiality of individual health data. The empirical practices observed at the Puskesmas in Jambi City reflect the operationalization of this theory, as doctors and health workers consciously apply data restrictions and procedural safeguards to protect patients’ rights.

At the same time, Medical Confidentiality Theory emphasizes that confidentiality is not merely a legal obligation but also an ethical foundation of the doctor–patient relationship. Trust emerges as a central element, as patients are more likely to disclose accurate and complete information when they believe their privacy will be respected (Hall et al., 2001) (Montgomery, 2003). The study's findings support this theoretical assumption, as doctors report that maintaining confidentiality helps build patient trust, encourages treatment adherence, and ultimately supports the effectiveness of infectious disease control programs. The consistent emphasis on confidentiality, even after a patient's death, further demonstrates adherence to the professional ethical standards outlined in the Indonesian Medical Code of Ethics.

The balance between individual rights and collective interests can also be examined through Legal Purpose Theory, which seeks to harmonize justice, legal certainty, and utility. In public health emergencies, the utility of disease surveillance and reporting becomes critical, yet it must not negate the principle of justice that protects individual dignity and privacy. The findings indicate that doctors at the Puskesmas attempt to achieve this balance by disclosing only the minimum necessary information required by law, while avoiding unnecessary exposure of patient identities. This approach illustrates a practical interpretation of proportionality, where public health objectives are pursued without excessive infringement on personal rights. (Upshur, 2002; Kass, 2001)

Compared with previous studies, this research largely affirms existing scholarly conclusions. Pomantow et al. (2024) emphasize that medical confidentiality remains a fundamental obligation even in the context of infectious disease management, provided that data disclosure follows legal procedures and ethical considerations (Pomantow et al., 2024). Similarly, Indina (2024) highlights that respect for patient autonomy and confidentiality strengthens trust and professionalism in health services. The practices observed in Jambi City align with these conclusions, particularly in terms of limiting access to patient data and prioritizing patient consent. (Indina, 2024)

Research by Supraba et al. (2025) further underscores the importance of internal supervision and accountability mechanisms in ensuring compliance with confidentiality obligations (Supraba et al., 2025). This study corroborates that assertion, as regular supervision, evaluation, and internal coordination were found to be integral components of confidentiality implementation at the Puskesmas. Continuous education and training for health workers, as noted by Bahri et al. (2022), also play a crucial role in minimizing unintentional violations of medical secrecy. The present findings confirm that such educational strategies enhance awareness of ethical boundaries and legal responsibilities among medical personnel. (Bahri et al., 2022)

However, this study also presents critical insights that extend and, in some respects, challenge previous research. While many earlier studies focus on normative compliance and regulatory adequacy, the findings here reveal practical vulnerabilities, particularly in the use of electronic medical records. Weak access control, shared passwords, and limited digital security infrastructure increase the risk of data leakage. This observation introduces an antithetical perspective to studies that assume technological adoption inherently improves confidentiality. Instead, the findings suggest that digitalization without robust security protocols may exacerbate confidentiality risks rather than mitigate them. (Cohen & Mello, 2019; Rumbold & Pierscionek, 2017)

Furthermore, the study highlights the persistent influence of social stigma on patients with infectious diseases, which remains insufficiently addressed in some prior research. Although existing literature acknowledges stigma as a barrier to treatment, the findings here demonstrate its direct impact on confidentiality practices. Patients' fear of discrimination not only limits information disclosure but also intensifies demands for privacy, thereby increasing the ethical burden on doctors. This condition challenges simplistic assumptions that legal norms alone can ensure confidentiality, emphasizing the need for broader social interventions.

The role of cross-sector coordination also emerges as a complex issue. While collaboration with local authorities is necessary for effective disease control, it simultaneously creates opportunities for confidentiality breaches if not carefully managed. Previous studies tend to frame coordination as a positive mechanism for public health governance. In contrast, this study offers a more nuanced view by showing that clear ethical guidelines and role boundaries must accompany coordination to prevent unauthorized disclosure of patient information. (Kickbusch & Gleicher, 2012)

In light of these comparisons, the study affirms the central argument of prior research that medical confidentiality is a non-negotiable ethical and legal obligation, even in the context of infectious disease eradication. However, it also makes an antithetical contribution by demonstrating that the effectiveness of confidentiality protection depends on technical capacity, institutional discipline, and societal understanding. Legal provisions and ethical codes, while necessary, are insufficient in isolation without supportive infrastructure and public education.

The strategies employed by doctors at the Puskesmas, such as personalized communication, trust-building approaches, and controlled information sharing, reflect an applied understanding of Health Emergency Theory. This theory emphasizes prompt and effective intervention during health crises while maintaining respect for fundamental rights. By prioritizing patient trust and confidentiality, doctors contribute not only to individual well-being but also to the broader goal oprotecting f public health. The alignment of these strategies with Legal Protection Theory further reinforces the moral and legal justification for maintaining strict confidentiality standards.

Ultimately, this study contributes to the discourse on medical confidentiality by demonstrating that the balance between patient privacy and public health imperatives is both dynamic and context-dependent. The findings affirm existing theoretical and empirical perspectives while simultaneously critiquing their limitations in addressing practical challenges. By integrating empirical data, legal theory, and comparative analysis with previous research, this discussion underscores the need for a holistic approach that combines legal regulation, ethical commitment, technological security, and social education. Such an approach is essential to ensure that medical confidentiality remains protected while supporting effective infectious disease control in Community Health Centers.

4. CONCLUSION

This study concludes that the implementation of doctors' professional confidentiality at the Community Health Centers of Jambi City generally complies with legal provisions and medical ethical standards. Confidentiality is maintained through restricted access to patient data, separation of sensitive infectious disease information, careful communication practices, and controlled electronic medical records. These mechanisms confirm that medical confidentiality plays a crucial role in protecting patient rights, strengthening trust in health services, and enhancing the effectiveness of programs to eradicate hazardous communicable diseases.

The findings contribute to theory by affirming Medical Confidentiality Theory and Legal Protection Theory, demonstrating that confidentiality serves as a proportional safeguard that balances individual privacy rights with public health interests. In practice, however, this balance is challenged by social pressure, administrative reporting obligations, patient resistance due to stigma, and vulnerabilities in digital data management. This indicates that confidentiality cannot rely solely on individual ethical commitment but requires strong institutional support.

Based on these findings, several practical implications are proposed. Community Health Centers should strengthen electronic medical record security by implementing individual user access controls, password management, and periodic audits; conduct regular training on confidentiality and data protection for all health workers; establish internal mechanisms for confidentiality audits; and develop a clear cross-sector coordination protocol to limit identity disclosure. Public education to reduce stigma toward patients with infectious diseases is also essential to support ethical and effective disease control.

This study is limited by its qualitative approach and restricted geographic scope in Jambi City, which may limit generalizability. Future research should involve broader regional comparisons and technical evaluations of health information systems to enhance the protection of medical confidentiality in public health services.

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