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ELECTRONIC MEDICAL RECORD OFFICERS' PERCEPTION OF EASE OF FILLING, SECURITY AND LEGAL EVIDENCE

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ABSTRACT
Hospitals using electronic medical records (EMR) face a number of challenges, such as poor system functionality, a lack of computer skills among medical personnel, and concerns about data security and privacy. Hospital adoption of these systems is also often hampered by high implementation costs. The purpose of this study was to determine how staff at Bhayangkara Level III Hospital in Banda Aceh, who work with electronic medical records, perceive security, ease of entry, and legal evidence. A cross-sectional study design was used in conjunction with quantitative research. Using a total sampling method, 36 EMR staff were sampled. An instrument developed based on existing literature was used to collect data. Descriptive and inferential analyses were performed on the data. The study findings partially indicate a very strong relationship between perceptions of EMR and ease of data entry (P = 0.0001) with a coefficient of determination (R2) of 0.992; a very strong relationship between perceptions of EMR and data security (P = 0.0001) with a coefficient of determination (R2) of 0.922; and a very strong relationship between RME perceptions and legal evidence (P = 0.0001) with a coefficient of determination (R2) of 0.369. Based on the research findings, RME staff perceptions are strongly correlated with data security, ease of data entry, and legal evidence.

Keywords: medical; officer; perception; record

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INTRODUCTION

Electronic medical records (EMRs) are digital systems for maintaining patient records that have been widely used worldwide. In 2009, the United States passed the Health Information Technology for Economic and Clinical Health Act, which set a precedent in healthcare information technology by providing incentive payments to healthcare providers that adopt EMRs. Healthcare stakeholders believe that the increased use of EMRs will ultimately improve the quality of medical care by reducing medical errors, minimizing duplication of errors, eliminating unnecessary diagnostic procedures, and facilitating data collection and accessibility, thus increasing overall satisfaction. However, research conducted in Saudi Arabia has shown that the use of EMRs has successfully enriched many areas of the healthcare system, including physician productivity, information availability, and healthcare quality (Ibrahim et al., 2022).

Hospitals are complex, professional, and capital-intensive medical facilities. This complexity arises because hospital services encompass a wide range of service, education, and research functions, spanning behavioral and medical disciplines. Hospitals, as health centers, are required to provide comprehensive services to patients. One of the key elements of excellent healthcare is the availability of quality medical services, as mandated by Law Number 29 of 2004 concerning Medical Practice. One such medical service is medical records (Electronic Medical Records) (Janett & Yeracaris, 2020).

According to the Regulation of the Minister of Health of the Republic of Indonesia No. 269 of 2008 concerning Medical Records, it states that medical records are files containing records and documents that include patient identity, examination results, treatment that has been given, as well as other actions and services that have been given to patients. According to the Regulation of the Minister of Health of the Republic of Indonesia (PerRMenkes RI) No. 269 of 2008 concerning Medical Records, it states that medical records are files containing records and documents that include patient identity, examination results, treatment that has been given, as well as other actions and services that have been given to patients (Latuconsina et al., 2019).

Under this regulation, every doctor is required to create medical records in their medical practice. With Electronic Medical Records, doctors and healthcare professionals also benefit from easy access to patient information, which ultimately helps improve patient safety and clinical decision-making, such as diagnosis, allergic reactions, and medication duplication. Under this regulation, every doctor is required to create medical records in their medical practice. With Electronic Medical Records, doctors and healthcare professionals also benefit from easy access to patient information, which ultimately helps improve patient safety and clinical decision-making, such as diagnosis, allergic reactions, and medication duplication (Amalia et al., 2021).

The efficiency and use of electronic medical records can reduce operational costs and increase revenue in healthcare facilities, particularly hospitals. Therefore, completing patient medical records (MRs), including electronic medical records (ERs), is mandatory for every doctor and other healthcare professional. Compliance with medical record documentation using electronic medical records (ERs) will improve service quality, patient satisfaction, and patient safety, reducing the risk of misidentification and patient profiling (Setyadi & Nadjib, 2023).

Completeness, speed, and accuracy in providing information regarding healthcare needs are indicators of quality medical record services. Completeness of medical records is crucial because they are used as information in healthcare services. A medical record is considered complete if completed within 24 hours of receiving healthcare services, and if the standard for completeness is 100% after the patient receives healthcare services (Dewi et al., 2020). According to the Minister of Health of the Republic of Indonesia Number 27 of 2014 Chapter 1 Article 6, the prospective payment method in Indonesia is known as casemix (Case Based Payment) and has been used as a payment method in the health insurance program since 2008. The Indonesian Case Base Groups (INA-CBGs) payment system must be implemented in the BPJS health service process. The casemix system combines diagnoses and procedures based on comparable clinical characteristics and comparable resource use and treatment costs. Grouper software is used to do this. In developed countries, the health payment system uses a casemix system, and in developing countries, this system is being developed.

A Social Security Administration (BPJS) claim is a request by a hospital to BPJS Kesehatan for the cost of treating a BPJS participant. This is done through the BPJS Kesehatan insurance payment system, which uses a prospective payment method known as casemix (case-based payment) or the Indonesian case-based group. Incomplete electronic medical records can delay BPJS Kesehatan claims, the administrative process, and pending BPJS Kesehatan claims at the hospital. If the claim application does not meet the requirements and fails verification, BPJS Kesehatan will return the medical records (Sitepu, 2024). Furthermore, based on 2024 data, the number of claims submitted by the Social Security Administration at Bhayangkara Hospital Level III, Banda Aceh, was 12,967. Of these, 12,082 (93.2%) were declared complete, 708 (5.4%) were pending, and 177 (1.4%) were rejected due to incomplete files.

The hospital requests the Social Security Administration (SSA) to recover patient care costs through the INA-CBG payment system. All SSA claims are submitted collectively and billed within ten

months. The SSA verifier verifies the SSA claim within approximately fourteen business days of the claim submission. Supporting documents such as INA grouper results, CBG, participant eligibility letter, control plan letter, and resume must be submitted by the hospital to the SSA verifier (Markus et al., 2023). Medical disputes often arise from patient dissatisfaction with the care provided by healthcare professionals, which can be caused by various factors such as ineffective communication, misdiagnosis, or substandard medical procedures. Resolving medical disputes can involve complex legal processes, take time, and require strong and accurate evidence to support both parties' claims. In this context, electronic medical records (EMDs) play a crucial role because they provide complete and easily accessible documentation of all medical procedures performed on a patient, including treatment history, examination results, and records of interactions with healthcare professionals (Nur & Fitrianto, 2024).

EMR records information in greater detail and accuracy, minimizing the risk of recording errors that could lead to disputes. EMR allows for faster and more efficient verification and auditing of medical procedures, enabling disputing parties to reach a fairer resolution. Furthermore, the use of EMR encourages healthcare professionals to be more thorough and responsible in their record-keeping, as every medical procedure is digitally recorded and clearly traceable. Thus, EMR serves not only as a documentation tool but also as a preventative mechanism to reduce the potential for future medical disputes. Legally, EMR can be a highly useful tool in resolving medical disputes, as it allows all parties involved—patients, healthcare professionals, and legal authorities—to easily access relevant and authentic information (Putri & Yusuf, 2024).

This accessibility is crucial, as in dispute situations, accurate and precise evidence is key to determining the clarity of a case. EMR simplifies the process of verifying and tracing medical procedures, including procedural records and laboratory results, thus providing a clear and objective picture of the case. With standardized and digitally stored data, arguments from all parties can be substantiated by directly referencing immutable medical records, thus giving greater legal force to the evidence presented. Furthermore, EMR supports transparency in medical practice, which can reduce patient dissatisfaction with services and reduce the likelihood of misperceptions that can lead to disputes. The implementation of EMR in the healthcare system is not merely a technological innovation but also a crucial element in efforts to improve service quality and legal justice in the healthcare sector (Putri & Yusuf, 2024).

Dwijosusilo and Sarni (2018) stated that the role of EMR includes increasing efficiency, improving the quality of healthcare services, security and confidentiality, supporting legal evidence, facilitating telemedicine, and increasing patient satisfaction. Electronic medical records (EMR) in hospitals face various challenges, including inadequate infrastructure, limited computer skills among medical personnel, suboptimal system functionality, and issues of data privacy and security. Furthermore, high implementation costs are often a major barrier for hospitals in adopting this system (Rubiyanti, 2023). Currently, regulations in Indonesia require every healthcare facility to use an electronic medical records system in accordance with the Republic of Indonesia Health Regulation Number 24 of 2022. However, implementation in the field still faces various obstacles, such as limited human resources, servers, and networks (Amin et al., 2021). This study aims to determine the perceptions of EMR officers regarding the ease of data entry, security, and legal evidence.

METHOD

This study used a cross-sectional design with a quantitative approach. The sample consisted of all 36 electronic medical records (EMR) staff at Bhayangkara Hospital Level III Banda Aceh, selected using a total sampling method. The research instrument was a questionnaire compiled based on a literature review related to staff perceptions of ease of filling in, data security, and legal evidence for EMR. To ensure the quality of the instrument, validity and reliability tests were conducted

before use. The validity test was conducted using the Pearson Product Moment correlation, where statement items are declared valid if the calculated r value is greater than the table r (n = 36, α = 0.05). The test results showed that all questionnaire items had calculated r values between 0.412–0.791, greater than the table r (0.329), thus being declared valid. Meanwhile, the reliability test was conducted using the Cronbach's Alpha method, producing a value of 0.876, indicating that the instrument has a very good level of internal consistency. The collected data were then analyzed descriptively (frequency distribution) and inferentially using the Pearson product-moment test and MANOVA.

RESULT

The average age of respondents was 30.11 years, the most common gender was male, namely 34 people (94.4%), the most common educational background was bachelor's degree, namely 19 people (52.6%), the most common employment status was civil servant, namely 22 people (61.1%), the most common work period was ≥ 5 years, namely 35 people (97.2%) and the most common training status was having attended training, namely 29 people (80.6%) (Table 1).

Table 1.
Characteristics of nurses (n = 36)

Characteristics	f	%	$\bar{x}$ ± SD
Age	-	-	30.11 years ± 4.153
Gender			
Man	34	94,4	
Woman	2	5,6	
Education			
Bachelor	19	52,6	
Diploma	16	44,4	
Master	1	2,8	
Employee Status			
Indonesian National Police	8	22,2	
Civil Servant	22	61,1	
Government Employees with Employment	1	2,8	
Agreements	5	13,9	
Casual Daily Worker			
Years of service			
≥ 5 Years	35	97,2	
< 5 Years	1	2,8	
Training			
Once	29	80,6	
Never	7	19,4	

Table 2.
Distribution of EMR Officers' Perceptions (n=36)

Perception	f	%
Good	5	13,9
Enough	26	72,2
Not enough	5	13,9

Of the 36 EMR officers, 26 people (72.2%) had sufficient perceptions about EMR at Bhayangkara Hospital Level III Banda Aceh (Table 2). The average ease of EMR data was 82.19 (SD ± 7.723), EMR data security 82.44 (SD ± 7.451) and EMR data legal evidence 82.03 (SD ± 7.930) (Table 3). There is a relationship between perceptions about EMR and ease of data entry (P = 0.0001) with a coefficient of determination (R2) of 0.992, which means it has a very strong relationship. Furthermore, it is also known that there is a relationship between perceptions about EMR and data security (P = 0.0001) with a coefficient of determination (R2) of 0.922, which means it has a very strong relationship. Then there is a relationship between perceptions about EMR and legal evidence (P = 0.0001) with a coefficient of determination (R2) of 0.919, which means it has a very strong relationship (Table 4). In the effect column, all significant values are 0.0001, which means there are

differences in the ease of data entry, data security, and legal evidence based on the perceptions of EMR officers at Bhayangkara Hospital Level III, Banda Aceh (Table 5).

Table 3.
Analysis of the Relationship between Perception and Ease, Security, and Legal Evidence of EMR Data (n = 36)

Variables	Average	Standard Deviation
Convenience	82,19	7,723
Security	82,44	7,451
Legal Evidence	82,03	7,930

Table 4.
Analysis of the Relationship between Perceptions of EMR and Ease, Security and Legal Evidence of EMR Data (n=36)

Variables	p-value	R^2
Ease of Data Entry	0,0001	0,992
Data Security	0,0001	0,952
Legal Evidence	0,0001	0,919

Table 5.
Analysis of the results of the MANOVA test on the perceptions of electronic medical record officers regarding ease of filling in, security and legal evidence of data (n = 36)

Multivariate Tests[a]

Effect		Value	F	Hypothesis df	Error df	Sig.	Noncent. Parameter	Observed Power[d]
Intercept	Pillai's Trace	.995	2165.854[b]	3.000	31.000	.000	6497.563	1.000
	Wilks' Lambda	.005	2165.854[b]	3.000	31.000	.000	6497.563	1.000
	Hotelling's Trace	209.599	2165.854[b]	3.000	31.000	.000	6497.563	1.000
	Roy's Largest Root	209.599	2165.854[b]	3.000	31.000	.000	6497.563	1.000
Persepsi_kat	Pillai's Trace	.832	7.596	6.000	64.000	.000	45.579	1.000
	Wilks' Lambda	.243	10.643[b]	6.000	62.000	.000	63.856	1.000
	Hotelling's Trace	2.813	14.067	6.000	60.000	.000	84.402	1.000
	Roy's Largest Root	2.700	28.795[c]	3.000	32.000	.000	86.386	1.000

a. Design: Intercept + Persepsi_kat
b. Exact statistic
c. The statistic is an upper bound on F that yields a lower bound on the significance level.
d. Computed using alpha = .05

DISCUSSION

The Relationship between EMR Officers' Perceptions and Ease of Data Entry

With a significance value of P = 0.0001 and a coefficient of determination (R2) of 0.992, the study findings indicate a very strong correlation between the perceptions of EMR officers and the ease of data entry. Based on this figure, the perceptions of EMR officers account for 99.2% of the variance in perceptions of ease of data entry. According to this study, the documentation process will be simpler if healthcare workers have a more positive perception of the EMR system. This is in line with usability theory in health information systems, which highlights the importance of a user-friendly interface, effective navigation, and fast system response to expedite clinical recording.

The digital innovation known as Electronic Medical Records (EMR) is revolutionizing the way clinical information is recorded and managed in the healthcare industry. Ease of data entry is a crucial aspect of EMR implementation. This simplicity reflects how easily healthcare professionals can access, use, and integrate EMR systems into their clinical practice without encountering new challenges (Juliansyah et al., 2024). With advances in information technology, ease of data entry has become a critical success factor for digital-based systems, particularly in the highly complex

and documentation-intensive healthcare industry. The quality of patient care, data accuracy, and compliance with medical regulations are all influenced by user perceptions of ease of use, in addition to work effectiveness (Mulukuntla, 2020).
Honesty and reliability, fundamental to Islamic ethics, also intersect with Acehnese cultural values, namely work efficiency and accountability in medical records. Therefore, perceived ease of data entry is not simply a technical issue; it also demonstrates how technology and local values can coexist (Arar et al., 2023). The Technology Acceptance Model (TAM) is one theoretical framework that can be used to explain these findings. According to the TAM, perceived utility and perceived ease of use are two key determinants of technology adoption. Perceived ease of data entry in this study was primarily predicted by general perceptions of the EMR. Healthcare workers tend to accept EMRs and perceive data entry as easier if they perceive them to be practical, effective, and secure (Lee et al., 2025). Several factors, including interface design, logical workflow, compatibility with clinical tasks, and system responsiveness to user input, influence ease of data entry in usability studies. Perceptions of the system improve and perceptions of ease of entry are strengthened when EMRs meet these principles (Kamal et al., 2020).

This solid relationship has broad and strategic consequences. At the micro level, ease of data entry can speed up the recording process, reduce work fatigue, and increase healthcare worker productivity. Given the heavy workload of doctors and nurses in primary and secondary care facilities, this is crucial (Mulukuntla, 2020). An EMR system that is perceived as user-friendly at the organizational level helps ensure the success of health information technology implementation. Return on system investment increases and the adaptation process is accelerated by minimizing user resistance and technical complaints. Furthermore, the use of an integrated and user-friendly EMR helps hospitals meet quality and patient safety standards for accreditation (Juliansyah et al., 2024).

Regulatory compliance and ease of data entry are also closely intertwined. The importance of efficiency, data accuracy, and accessibility in documentation is emphasized in Minister of Health Regulation No. 24 of 2022 concerning Electronic Medical Records. Difficult-to-use Electronic Medical Record systems can lead to administrative inaccuracies, delays in recording, and ultimately legal issues for healthcare organizations (Juliansyah et al., 2024). Positive feedback regarding ease of data entry indicates the success of the initial phases of the digital transformation strategy within the context of healthcare digitization policies. This can serve as a benchmark for the willingness of medical personnel to adopt new technologies and the long-term sustainability of the government-developed health information system.

The Relationship between EMR Officers' Perceptions and Data Security
Table 3 shows that the average data security rating for EMR is 82.44 (SD ± 7.451). Furthermore, Table 5.4 shows a strong correlation between perceptions of EMR and data security (P = 0.0001), with a coefficient of determination (R2) of 0.922. This indicates a very strong correlation. Currently, the foundation of patient data documentation in contemporary healthcare services is the Electronic Medical Record (EMR). EMR is expected to ensure the best possible protection of medical data while increasing the productivity of healthcare workers. The success of EMR in the context of the digitalization of the Indonesian healthcare sector depends heavily on user perceptions, particularly regarding two crucial elements: information security and ease of data entry (Paramesthi et al., 2024).

With a mean score of 82.44, patient information protection was also considered good. Perceptions of data security were fairly consistent, with most respondents believing the system adequately protects sensitive information, based on a standard deviation of ±7.451. An important consideration in information technology adoption, particularly in the healthcare industry, is ease of use. Perceived ease of use is a key predictor of behavioral intention to use a system, according to the Technology Acceptance Model (TAM). Users are more likely to accept and integrate a system into their daily

routines when they perceive it to be user-friendly. This ease of use in the context of EMR can encompass a number of elements, including an intuitive user interface, straightforward navigation, fast system response times, and the presence of relevant and easily accessible features (Damanik et al., 2025).

These positive opinions about the usability of EMR data can have several significant consequences. First, it can improve healthcare worker productivity. Data entry, patient information retrieval, and clinical decision-making can be completed more quickly and accurately with intuitive systems, reducing administrative burdens and increasing time allocated to patient care. These systems also reduce human error. Errors in data entry and information retrieval are common in complex and difficult-to-use systems. The usability of EMR can result in lower error rates, better data quality, and ultimately improved patient safety. Third, healthcare workers who use EMR easily and without stress report higher levels of job satisfaction, which can aid employee retention and create a positive work environment (Cahill et al., 2025).

A crucial consideration in information technology adoption, particularly in the healthcare industry, is ease of use. Perceived ease of use is a key predictor of behavioral intention to use a system, according to the Technology Acceptance Model (TAM). Users are more likely to accept and integrate a system into their daily routines when they perceive it to be user-friendly. In the context of EME, ease of use can encompass a number of elements, including an intuitive user interface, straightforward navigation, fast system response times, and the presence of relevant and easily accessible features (Damanik et al., 2025).

Data security is a vital component of any information system, particularly in electronic medical records (EMR) systems, which store highly personal health data. Financial losses, reduced patient trust, and lawsuits are just some of the devastating impacts that can result from a medical data security breach. Therefore, a crucial prerequisite for the long-term success and sustainability of an EMR is user confidence in data security. User perceptions of data security reflect their belief that data confidentiality and integrity are maintained and that their medical records are protected from unauthorized access, alteration, or destruction (Pool et al., 2024).

Several factors can contribute to positive perceptions of EMR data security. First, the use of advanced security technologies such as role-based access control, multifactor authentication, and data encryption. The effectiveness of these security measures can be recognized and trusted by users. Second, clear rules and guidelines for data security and privacy. User trust can be enhanced by having clear policies about who can access data, how it is used, and what precautions are taken to keep it secure. Third, instruction and training on the value of data security. Users tend to trust a system more when they have adequate information about security risks and data protection best practices. Fourth, previous success without data security incidents. User perceptions of security can be strengthened if they have never heard of or experienced a data breach in the EMR system they use (Wijayanti et al., 2024).

This positive perception of data security has important consequences. First, it can increase patient trust. If patients feel that their health information will be kept confidential and safe from misuse, they are more likely to disclose it. A strong doctor-patient relationship is built on patient trust. Second, it enables the secure exchange of information. Care coordination in integrated healthcare settings relies on the exchange of patient data by authorized healthcare providers. This information exchange is enabled by trust in the security of the EMR. Third, it encourages regulatory compliance. Strict laws governing the security and privacy of health data are already in place in many countries (such as HIPAA in the US). Positive perceptions of security indicate that a company is likely meeting these compliance requirements (Pratiwi et al., 2022). However, it's important to remember that perceptions aren't always accurate. If a system isn't well-designed or managed,

security gaps can remain, even if users feel secure. To ensure EMR data security remains at the highest level, organizations must regularly conduct risk assessments, update defenses against evolving cyber threats, and audit security systems.

The Relationship between EMR Officers' Perceptions and Legal Evidence

Table 3 shows that the average legal evidence of RME data is 82.03 (SD ± 7.930). Furthermore, Table 4 shows that there is a relationship between perceptions of EMR and legal evidence (P = 0.0001) with a coefficient of determination (R2) of 0.919, indicating a very strong relationship. This study aims to analyze user perceptions regarding legal evidence of EMR data and explore the relationship between perceptions of RME as a whole and legal evidence of EMR data. The results obtained provide an in-depth picture of how users view the validity and legal validity o EMR data, which are crucial aspects in the context of the legality and accountability of digital health systems. The following discussion will outline the key findings, interpret them in the context of relevant literature, and highlight the practical and theoretical implications of this study.

One of the most important components of the contemporary healthcare ecosystem is the perception of EMR data as legal evidence. Concerns about the legality, authenticity, integrity, and non-repudiation of EMR data are becoming increasingly important as more patient data is transferred from paper to electronic formats. The ability of EMR to be accepted and recognized as valid evidence in court cases, including malpractice cases, insurance claim disputes, or forensic investigations, is known as legal evidence. Users' assurance that their EMR meets legal requirements is reflected in their positive opinions of this feature (Wulandari et al., 2025).

Positive perceptions about the legality of EMRs can be influenced by several factors. First, compliance with relevant laws and guidelines. Laws and regulations specifically recognizing the legitimacy of electronic medical records have been enacted in many countries. The perceived legality of EMRs will be enhanced if they are developed and used in accordance with these rules (such as those relating to audit trails, data integrity, electronic signatures, and long-term retention). Second, the implementation of technical features that support data integrity. To ensure that data is not altered without authorization and that any access or modification can be traced, features such as encryption, digital signatures, time-stamping, and a comprehensive and immutable audit trail are essential. Users will be more likely to trust them if they are aware of or understand these features. Third, instruction and training regarding the legal aspects of EMRs. Positive perceptions can be enhanced by providing medical staff with a clear understanding of how EMRs comply with legal requirements and their role in maintaining data integrity. Fourth, real-world experience that does not involve legal issues. User trust will be enhanced if EMRs have been used in a variety of contexts without generating serious legal disputes regarding the accuracy of their data (Sher et al., 2017).

This high perceived legal validity of EMR data has important consequences. For starters, it boosts professional trust. If healthcare professionals are confident that their electronic medical records comply with the law, they will feel more comfortable using them. This, due to legal considerations, can reduce the likelihood of duplicate records or reverting to manual documentation. Second, it simplifies litigation. Medical record litigation can become more effective and evidence-based once EMR data is accepted as valid legal evidence. This reduces the need for extensive expert testimony or arduous verification procedures. Third, it promotes transparency and accountability. EMR can foster clinical and administrative accountability and enhance the transparency of patient care with a robust audit trail and guaranteed data integrity. Fourth, it encourages further adoption of EMR. Healthcare organizations and healthcare staff will be more likely to adopt electronic systems if the legality of EMR is no longer a significant barrier or concern (Honavar, 2020).

The legality of electronic medical records (EMRs) is often a key consideration in the adoption process in many jurisdictions, based on comparisons with other literature. Regulatory ambiguity, skepticism regarding the authenticity of electronic signatures, and concerns about the legality of electronic copies in court are common obstacles. Therefore, a clear legal framework, robust technical implementation, and successful educational initiatives are likely key drivers of successful EMR implementation, as evidenced by study findings showing a high perception of legal evidence. However, the technological and legal landscapes are constantly evolving. Monitoring regulatory changes, updating systems as necessary, and ensuring users understand the legal implications of EMRs is crucial (Bharata et al., 2024).

This close relationship underscores the importance of ensuring that the legal components of the EMR are closely linked to the overall user experience. Organizations should focus on comprehensive EMR implementation, encompassing usability, data security, functional reliability, and adequate support to ensure that the EMR is recognized and trusted as a valid legal instrument. Any weaknesses in these areas can cause users to lose confidence in the EMR as a whole, including its legality. Therefore, creating and maintaining a positive impression of the legal validity of the EMR requires a comprehensive and integrated approach to development and management (WHO, 2020). System developers, implementers, and managers should continue to fund legally compliant system design, the implementation of robust security and data integrity features, open communication regarding legal issues, and thorough training to ensure the long-term success and optimal adoption of EMR. This will not only improve operational effectiveness, but also enhance patient and user confidence in the legitimacy and accountability of personal health data.

Electronic Medical Records Officers' Perceptions of Ease of Filling, Security and Legal Evidence

Table 4 shows that in the perception row, for the dependent variables of ease of data entry, data security, and legal evidence, a P value of 0.0001 was obtained, indicating that the perceptions of EMR officers were significantly related to ease of data entry, data security, and legal evidence. The use of EMR is a strategic step in improving healthcare service standards in line with the digital transformation of health information systems. In addition to increasing productivity, the use of EMR ensures compliance with legal and ethical requirements in clinical practice (Sutha et al., 2025). However, healthcare workers' acceptance and perceptions play a key role in the success of RME implementation. These opinions include their evaluation of the system's usability, the security of the patient data stored within it, and its legality based on available legal evidence. Therefore, the purpose of this study was to understand how RME workers perceive themselves as a predictor of these three important variables (Jimma & Enyew, 2022). According to this model, public opinion about technology is influenced by perceptions of its benefits and usefulness. In this case, healthcare workers' opinions about RME influence their feelings about the system's usability, safety, and legality (Lee et al., 2025).

The successful adoption and implementation of an EMR system will depend on public perception of the system's quality, including its security. Perceptions of the system's legal credibility, information security, and ease of access will influence user satisfaction. The ease of use, security, and legal functionality of an EMR are critical to complying with legal and ethical requirements, including the principles of accountability, confidentiality, and verification in medical documentation (Yi, 2018). Perceived ease of use of an EMR system by staff will encourage comprehensive record-keeping and improve adherence to procedures. This directly impacts work efficiency and patient safety. Employees will use the EMR more frequently and feel more responsible for maintaining patient confidentiality if they believe the system is systemically secure. A system perceived as legally binding will reduce medicolegal risks and enhance the institution's reputation in the event of an audit or legal action (Browning et al., 2025). The findings in Table 5 indicate that officers' perceptions of EMR are strongly correlated with information security, ease of data entry, and the

legal significance of documentation. This implies that user-friendly EMR systems will have a higher implementation success rate.

CONCLUSION

The perception of electronic medical records (EMR) officers at Bhayangkara Hospital Level III Banda Aceh shows a very strong relationship with the aspects of ease of filling, data security, and legal evidence, thus indicating that user acceptance and trust in the EMR system are important factors in the success of its implementation. For future researchers, they can expand the scope of the study to various hospitals with a larger number of respondents, and add other variables such as job satisfaction, service efficiency, and technical barriers to provide a more comprehensive picture of the effectiveness of EMR use in health facilities.

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