

Legal Aspect of Patient's Medical Record

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ABSTRACT

Activities related to health services between patients / patients or their families and doctors as individuals or in hospitals will be recorded in the medical service record folder called the Medical Record. In various cases of health service disputes, medical record have a very important role in the aspect as evidence in court. The better the medical record, the more legal protection will be given to patients, doctors and hospitals. Medical record are often used as a basis for defense / legal protection for doctors. Medical record are files containing record and documents about patients identities, examination result, treatment program and other medical measures in health care facilities. Legal problems often arise that are directly related to the management / treatment of their Medical Record.

The value of Medical Record are called as "**ALFRED VALUES**" which is interpreted: Administrative value, Legal value, Financial value. Research value, Education value and Documentation value.

Medical record can function as a legal document, namely as a valuable evidence as an expert witness but its depend on judge decision. Sometimes, Medical Record can be use as a key witness to dispute resolution in health services both in hospitals and in individual clinics. Medical record can be used as a basic data to prove the presence or absence of errors As evidence at the trial.

The position of the medical record is very dependent on the judge's judgment. The judge greatly determines the relevance and position of the medical record at the trial. Medical record are also very important for evaluating health services and evaluating staff performance in order to reduce morbidity and prevent mortality.

Keywords: *medical record, medical disputes*

1. INTRODUCTION

The hospital as a public health service is expected to provide complete and holistic health services, starting from emergency care, outpatient installation services, providing inpatient services, as well as supporting installations that are of high quality and affordable by the community. The hospital has the task of prioritizing healing and recovery efforts for its patients (Law No. 44 of 2009).

Aside from being a labor intensive and labor intensive institution, the hospital is a very complex organization because it is capital intensive, technology intensive, system intensive, and quality-intensive and risky so that incidences are not expected in hospitals. A series of activities related to health services between patients / patients or their families and doctors as individuals or in hospitals will be recorded in the medical service record folder called the Medical Record.

Medical record are very important folder and very needed. The Indonesia Ministry of Health has issued Minister of Health Regulation Number 749a / Menkes / Per / XII /

1989 concerning medical record where the management / existence of a medical record becomes a necessity or obligation that must be carried out by each health service facility.

In various cases of health service disputes, medical record have a very important role in the aspect as evidence in court. The better the medical record, the more legal protection will be given to patients, doctors and hospitals. The medical record is a series of record of patient health services that can be used as evidence for both patients and hospitals and doctors in front of the court, because the medical record contains about who, when, how, the medical action took place.

Thus, a medical record guarantees legal certainty on the basis of justice in order to uphold the law and provide evidence to uphold justice.

2.BACKGROUND

Medical record are sometimes a key witness to dispute resolution in health services both in hospitals and in individual clinics. Medical record can be used as a basis to prove the presence or absence of errors / omissions of the

doctor / dentist in carrying out the profession according to the established SOP. On the other hand medical record are often used as a basis for defense / legal protection for doctors / dentists against claims / demands directed at him. In addition to legal disputes about medical service activities, sometimes legal problems often arise that are directly related to the management / treatment of their Medical Record . Some of the problems that often arise related to medical record in court are:

- a. Issues of authority / ownership of medical record data
- b. Loss / damage or falsification of medical record.
- c. Use by unauthorized bodies / people.

In the field there often arises friction about the level of authority of the medical record, especially between doctors as the medical record takers, medical record officers as those who maintain medical record and also with patients who have data in medical record.

3. DISCUSSION

3.1. Definition of Medical Record

A good and complete medical record is a benchmark for professional health services, in addition to providing an overview of the quality and quality of health services in these health facilities. The quality of the medical record will greatly provide confidence to patients and their families, especially guarantees about the accuracy of the actions and completeness of information on health services carried out.

Some references about the definition of Medical Record Notes / "Medical Record":

- a. **Medical Practice Law No. 29 of 2004 Article 46 paragraph (1):** medical record are files that contain record and documents about patient identity, examination, treatment, actions and other services that have been given to patients.
- b. **Regulation of the Minister of Health Number 749a / Menkes / Per XII / 1989** concerning Medical Record: Medical record are files containing record, documents about patient identity, examination, treatment, actions and other shipping to patients at health care facilities (Article 1 letter a) The medical record record is a collection of data about who, what, where and how to care for the patient while in the hospital.
 - 1) **According to Articles 15 and 16:** The contents of the medical record for outpatients can be made at least containing: identity, amnese, diagnosis, and action / treatment. While the contents of the medical record for patients treated at least contain:
 - a) patient identity
 - b) anamnese;
 - c) history of the disease
 - d) results of laboratory examinations;

- e) diagnosis
- f) approval of medical action
- g) action / treatment
- h) nurse record
- i) clinical observation record and treatment results; and
- j) final resume and treatment evaluation.

- c. **Indonesia Minister of Health Regulation Number 269 / MenKes / Per / III / 2008**

concerning medical record: medical record are files containing record and documents about patients containing identities, examinations, treatment, other medical measures in health care facilities for outpatient care, care stay both government and private.

- d. **Hayt and Hayt** in his book entitled "**Legal Aspect of Medical Record**"

defines the medical record as follows: "A Medical record is the most important fact of the patient's life history, his illness, and treatment. In a larger sense medical record is a compilation of scientifically derived data from many and various uses, personal and impersonal, to serve the patient's treatment, the science of medicine, and society as a whole.[1]

"The medical record is a collection of facts relating to the history / life history of the patient, his illness, the nurse / his treatment".

- e. **Gemala R. Hatta** formulates medical record as a collection of all activities carried out by health care workers who are written, described, on activities for patients [2]

3.2. Management of Medical Record

Management of medical record in hospitals is usually carried out by medical record management. The management of medical record in a hospital must be carried out correctly, because in the medical record contains various vital values. These values are called "**ALFRED VALUES**" which is interpreted as follows (Directorate General of Medical Services, 1997):

1. **Administration Value.** A file of medical record has administrative value, because the contents involve actions based on authority and responsibility as medical personnel and paramedics in achieving health service goals.
2. **Legal Value.** A file of medical record has legal value, because the content concerns the issue of guaranteeing legal certainty on the basis of justice, in the context of efforts to uphold the law and provide evidence to uphold justice.
3. **Financial Value.** Each examination, both a physical examination by a doctor, a medical examination (laboratory, radiology and medical rehabilitation), the diagnostic treatment is all worth the cost (cost) that must be issued as well as the services provided are the rights attached to the doctor. Supporting the financing and payment

are financial values in the medical record document.

4. **Research Value.** A file of medical record has the value of research, because the content concerns data / information that can be used as material for research and development in the field of health. Various studies originating from medical record documents can be carried out from various fields of administration, law, medicine, nursing, finance, nutrition and others.
5. **Education Value.** Understanding the value of education is closely related to research because of the results of research to educate to make changes or also improvements towards improving quality services. The result of the completion of the system for filling in medical record that immediately educates doctors to carry out compliance to fill in medical record on time.
6. **Documentation Value.** Documentation of medical record is a source of memory that is always needed. Documentation of medical record must be good and appropriate so that they are easily retrieved if needed.

4. FUNCTIONS AND BENEFITS OF MEDICAL RECORD.

4.1. Function of Medical Record.

Medical record have legal force as an element of evidence in the decision making process by a judge.

If there is a medical dispute between the doctor / hospital and the patient, often the medical record has a huge role in helping decision making in both criminal and civil cases.

All data / transactions / record in the medical record file must be agreed / known / signed by 3 parties related to health service activities, namely doctors, patients and paramedics. This is to create openness about what, when, how, where and by whom medical services are carried out ("There is no lie between us").

So the medical record can function as a legal document, namely as a valuable evidence as an expert witness / expert witt (Article 164 RIB for civil matters, and article 184 of the Criminal Code for criminal cases).

The function of medical record in Indonesia can be seen in Article 14 of the Minister of Health Regulation Number 749a / Menkes / Per / XII / 1989, which can be used to:

1. the basis for maintaining health and treating patients,
2. material evidence in legal cases,
3. materials for research and education purposes
4. basic payment of health care costs; and
5. ingredients for preparing health statistics.

4.2. Benefits of Medical Record

In accordance with Indonesia Minister of Health Regulation Number 269 / MenKes / Per / III / 2008, the benefits of medical record are:

1. **Record of medical history.** Medical record contain identity, informed consent, patient treatment data data, diagnostic enforcement steps and patient care and treatment planning programs.
2. **Supervision of Service Quality.** Medical record are also used as quality control to improve service quality.
3. **Education and Research.** Medical record can be used for information material for the development of teaching and research in the fields of the medical and dental professions (training and R & D).
4. **Financing.** The medical record file also contains details of funding in health services at health facilities.
5. **Statistics.** Health Medical record can be used as data material for making health statistics.
6. **Legal evidence.** Medical record can be used as the main written / witness evidence, so that it is useful in resolving legal, disciplinary and ethical issues involving medical personnel, patients and hospitals.

5. LEGAL STRENGTHS OF MEDICAL RECORD.

In addition to monitoring the protocol for patient treatment (starting diagnostic to therapy / action plans), medical record are also very important for evaluating health services and evaluating staff performance in order to reduce morbidity and prevent mortality. In criminal procedural law, the medical record has a position as proof of trial because the making of medical record meets the provisions as contained in **KUHAP Article 187**. This is also in accordance with **Article 13 paragraph (1) letter c Regulation of the Minister of Health No. 269 / MENKES / PER / III / 2008 concerning medical record stating:**

"Medical record can be used as evidence in the process of law enforcement, medical and dental disciplines and the enforcement of medical and dental ethics."

A complete & careful medical record is an absolute requirement for evidence in medicolegal cases.

Legal aspects of medical record can be explained as follows:

- a. Ownership.** Physically, the Medical Record Note belongs to the Health Center (Hospital), while the contents belong to the patient. The contents of medical record must be kept confidential to protect patient confidentiality. Hospitals must protect the physical record of medical record as archives.

According to Article 47 (1) of Law no.29 / 2004: "The medical record document as referred to in Article 46 (1) Law no.29 / 2004 is owned by doctors, dentists or health care facilities, while the record of medic record belong to pasien "Management of medical record (activities, recording & storage) is regulated in Law No. 29/2004, Minister of Health Regulation No.269 / 2008, & SOPs made by health service facilities, also in accordance with Indonesian medical ethics.

- b. Storage.** Medical record can be categorized as vital record and are confidential, therefore the treatment and storage must be in accordance with the specified SOP.
- c. Secret.** The medical record unit officer is demanded as much as possible to maintain confidentiality and secure the medical record file. The original medical record cannot be taken out of the hospital, except if it is at the request of the court (permission of the hospital manager).

Legal Basis for Organizing Medical Record:

- a. Law 29 of 2004 concerning Medical Practice.
- b. Law 11 of 2008 concerning Information and Electronic Transactions.
- c. Law 14 of 2008 concerning Public Information Openness.
- d. Health Law Number 36 of 2009, Regarding Health.
- e. Law No. 43/2009 concerning Archives.
- f. Law No. 44 of 2009 concerning Hospitals.
- g. Regulation of the Minister of Health of the Republic of Indonesia no. 269 / MENKES / PER / III / 2008 concerning medical record.
- h. Regulation of the Minister of Health No. 377 / Menkes / XII / 2007 concerning Professional Recorder Medical Standards and Health Information.

As evidence at the trial, the position of the medical record is very dependent on the judge's judgment. The judge is free to judge and not bound to him. The judge greatly determines the relevance and position of the medical record at the trial, whether the record can be alleviating, burdensome or even meaningless.

Technically, the procedures for administering medical record in Indonesia starting from the procedure for filling

them up to their deletion are regulated in Regulation of the Minister of Health No. 749a / Menkes / Per / XII / 1989.

The filling of medical record data must be carried out as soon as possible, in full, direct and not postponed - delay to maintain the validity of the data contained therein.

In addition to filling out the medical record, the most important thing is the treatment / management / system for administering medical record.

In the implementation of the medical record, both its activities, recording and storage are regulated in Law no. 29/2004, Minister of Health Regulation no. 269/2008, & SOP in the Hospital. So, it is clear that medical record cannot be discharged from health care facilities / hospitals. As for other parties / families, if you want to get a medical record there are special procedures that must be met.

Inpatient medical record must be kept for at least 5 (five) years. After 5 (five) years, medical record can be destroyed, except the summary home and approval of medical action. A summary of the return and approval of medical treatment are kept for a period of 10 (ten) years.

6. CONCLUSION

The Medical Record is essentially a collection of documents / folders, the contents of which can be considered as evidence in a court proceeding (civil or criminal), which is one proof in the form of an expert witness ("Expert witness").

The medical record document is owned by the health service facility, while the contents of the medical record are owned by the patient. Record of medical record must be kept & kept confidential.

Judges' judgments determine the position and role of Medical Record in front of the trial.

The contents of the medical record can only be known by the patient or his parents (in this case if the patient is not yet an adult). Other parties (including families, patient attorneys, companies, or health insurance) can find out the contents of the medical record if the patient permits it in writing & is aware of the risk of being known to himself by others.

If the patient has died, then the medical record & contents cannot be given to anyone, including the heirs.

REFERENCES

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