MEDICAL RECORD IN MEDICAL PRACTICE

Aidil Akbar
Emir Syarif Fatahilla Pakpahan
Ramon Nofrial

ABSTRACT

Obligations of doctors regarding medical practice, health, information, and Electronic Transactions and medical records are regulated in Laws and Ministerial Regulations Health (Permenkes). The obligation that is carried out and charged to doctors is making medical records. Medical record recording includes manual medical records and electronic medical records based on the industrial revolution (cyber medicine). The legal responsibility of doctors who do not record medical records can be subject to sanctions, namely being punished or as administrative sanctions.

Keywords: Doctors, Medical Records, and Legal Liability.

1. INTRODUCTION

Health is a human right and it regulated everything in Pancasila and the 1945 Constitution of the Republic of Indonesia. [1] Every activity to maintain and improve the highest degree of public health is carried out based on non-discriminatory, participatory, and sustainable principles. The series of activities carried out by doctors and dentists for patients in the context of health services is called medical practice, which has been regulated by several laws and regulations and regulating the Minister of Health (Permenkes). Doctors in implementing health efforts to do so with the noble profession, ethics, morals, and expertise in carrying out the medical practice. Medical practice is carried out based on Pancasila and is based on scientific values, benefits, justice, humanity, balance, and patient protection and safety. Practice settings in medicine will provide protection to patients, improve the quality of medical services and provide legal certainty to the public, doctors, and dentists.

To carry out effective health efforts, it is necessary the existence of an integrated health information system that can produce complete, accurate, relevant, and timely data or information. (Hafid Hutama dan Erwin Santosa, 2016)

So important is the existence of medical records in health services so that doctors/dentists who do not make medical records based on the law are subject to criminal sanctions or fines. The role of medical records is very important in the quality management of hospital services. The contents of the medical record are a source of patient information so that incomplete medical records can have a terrible impact on the health service process to patients, which can later impact the quality of service. (Hafid Hutama dan Erwin Santosa, 2016)

More provisions on medical records regulated in the Permenkes. In medical/health services by doctors in hospitals and private practice, the role of recording medical records is very important. With medical records, doctors can remember or recognize the patient's condition when examined, making it easier to continue their treatment and care strategies. (Muhammad Jusuf Hanafiah dan Amri Amir, 2016). Good records reflect the health services provided, which must be supported by implementing a quality medical record system so that patients feel safe and comfortable. On services and management of their health data. (Yasnimar Ilyas, Sri Suwarti dan Abdul Rahman, 2012).

By legislation, every health service facility, both hospital and private practice must make and have a medical record. Because later this medical record file will be written evidence of health service actions to patients if in the future there is a legal dispute regarding medical practice, especially regarding medical records.

Based on the description in the introduction, the formulation of the problem in this study is:

1. How to record medical records in medical practice?
2. What is the doctor's legal responsibility for the obligation to record medical records?

This research is juridical, normative, and empirical. They took an approach to legal principles, legal norms, and legal behavior to describe the implementation and legal responsibilities of doctors for recording medical records in industrial revolution-based medical practice (*Cyber Medicine*).

2. DISCUSSIONS

2.1. Medical Record in Medical Practice.

Experts agree that they have carried medical records out since ancient times. Various types of records as sculptures, paintings on pyramid walls, bones, trees, leaves which are thought to be relics since the time of ancient Egypt show the procedures for medical practice that go hand in hand with the development of human civilization. They defined medical records as a written statement of identity, history taking, physical examination, laboratory, diagnosis, and all medical services and actions to patients, and treatment, both inpatient, outpatient, and emergency services. (Departemen Kesehatan Republik Indonesia, 2006)

According to Huffman in medical record management, the medical record is the who, where, and how of patient care during hospitalization. It must contain sufficient information to identify the patient, justify the diagnosis and treatment, and record the result. (Indar, *Etika dan Hukum Kesehatan*, 2010.

So the core of the medical record is a file that contains records and documents about information on disease and treatment or other services that have been provided to patients aimed at maintaining and improving a health service.

The medical record is a compendium (overview), containing information on the patient's condition during treatment of the diseases or in health care. (Ta'adi, *Hukum Kesehatan:Pengantar Menuju Perawat Profesional*, 2010). We can use these medical records as educational, research, or accreditation materials. The contents of the medical record are a source of patient information so that the incompleteness of the medical record can have a terrible impact on the health service process to patients, which can later impact the quality of service. Well-maintained medical records are very important for the health care system and the interests of patients. According to Permenkes Number 269 of 2008, medical records must contain at least outpatient, inpatient, and emergency care.

Table 1. Outpatient, inpatient, and emergency medical record data.

Outpatient	Inpatient	Emergency
Patient identity, date and time, results of history taking, including complaints and medical history, results of physical examination and medical support, diagnosis, management plan, treatment and action, other services that have been provided to patients, Doctor's name and signature, for dental cases equipped with clinical odontogram and approval of action when necessary	Patient identity, date and time, history includes complaints and medical history, results of physical examination and medical support, diagnosis, management plan, treatment and action, approval of action when needed, observation notes clinical and treatment outcomes, discharge summary, name and the signature of the doctor or dentist or staff certain health care providers.	Patient identity, a condition when arriving at health services, the identity of introduction, date and time, results of anamnesis at least complaints and disease history, results in physical examination and medical support, diagnosis, treatment and action, condition summary patient before leaving the emergency room, name and signature of the doctor or doctor dentist or certain health workers who provide health services, means of transportation used patients who will be transferred to the service other health and other services provided to patients.

The patient's identity in the medical record includes personal identity and social identity.

Table 2. Data on personal identity and social identity in medical records**.**

Personal identity	Social identity
Name, place of birth date, age, gender, address, marital status and patient's medical record number.	Social status, economic status, religion, education, occupation, and the identity of the person in charge of the patient.

A complete Medical Record contains 4 (four) kinds of data, namely (J Guwandi, 2005)

Table 3. Personal data (personal), financial data, social data, and medical data

Personal data	Financial data	Social data	Medical data
Name, Identity Card number, place and date of birth, gender, marital status, current address, closest family, occupation, doctor's name, and other information required for identification.	Name/address of employer/company, the insurance company that covers, type of insurance, policy number, and so on.	Nationality/nationality, family relationship, religion, livelihoods, community activities, and other data regarding the patient's social position.	The clinical record of the patient, record the history of continuous treatment given to the patient during hospitalization. This data contains the results of a physical examination, medical history, treatment given, treatment progress reports, doctor's instructions, clinical laboratory reports, consultation reports, anesthesia, surgery, informed consent forms, nurse notes, and other reports/records that occurred and were given during the patient's care.

Medical records meet the elements of accreditation, namely: (Bastian, dan Suryono, 2011)

Table 4. Data on accreditation elements and contents of medical records.

Accreditation aspect	Medical records
Administrative, legal, financial, research, education, and documentation.	Medical records have an identity, complete patient medical history, physical examination reports, diagnostic and therapeutic instructions with signatures and bright names of authorized health workers, observation reports including consultation reports, action reports, and findings, including those from medical support, namely laboratories, radiology, operative reports, and patient consent forms.

Of the several obligations of doctors for medical records of patients in inpatient care, there is one thing that must be considered, namely making a final resume or evaluation of treatment. This resume was made immediately after we discharged the patient. The purpose of this resume is to: (Muhammad Jusuf Hanafiah)

Table 5. Contents of medical resume and Purpose of medical resume

Medical resume	Purpose of medical resume
The medical resume must be brief, explaining important information about the disease, the examinations performed, and treatment. The medical resume can explain why the patient was admitted to the hospital, the important results of the diagnostic physical examination, laboratories, x-rays, treatment and actions carried out, the condition of the patient when he was discharged (need to seek treatment). walking, able to work, etc.), recommendations for treatment and care (name of drug and dosage, other treatment measures, where to be referred, appointment to come again, etc.).	1. Ensure the continuity of medical services with high quality and as a useful material for doctors when patients are hospitalized again; 2. Hospital medical staff assessment materials; 3. To meet official bodies or individuals, for example, Insurance; 4. As information material for doctors on duty, doctors who send and doctor consultants. 5. For patients who died, a report of the cause of death was made.

This medical record is a means used by medical personnel to record information about patients. Medical records have the following benefits and values: (Bastian, dan Suryono)

Table 6. The benefits of medical records and the values of medical records

The benefit of Medical Records	Values of Medical Records
1. Patient treatment Medical records are useful as a basis and guide for planning and analyzing diseases and planning treatment, care, and medical actions that must be given to patients. 2. Improved service quality Creating clear and complete medical records for medical practitioners will improve the quality of services to protect medical personnel and to achieve optimal public health. 3. Education and research Medical records are information on the chronological development of diseases, medical services, treatment, and medical actions, useful as information material for the development of teaching and research in the medical and dental professions. 4. Financing Medical records can be used as instructions, materials, and the basis for determining to finance health services at health facilities. Records can be used as evidence of financing to patients. 5. Health statistics Medical records can be used as material for health statistics, especially studying the development of public health and determining the number of sufferers of certain diseases.	1. Administrative value: Medical records are data records Health service administration; 2. Legal value: Medical records can be used as evidence in court; 3. Financial value: Medical records can be used as the basis for the breakdown of health care costs that must be paid by the patient; 4. Research value: Medical record data can be used as research material in the fields of medicine, nursing, and health; 5. Education value: The data in medical records can be used as a teaching and educational materials for medical, nursing students As well as other health workers; 6. Documentation Value: Medical records are a means of storing various documents related to patient health; 7. Referral system value: Communication between health workers in the care of the patient concerned.

6. Proof of legal, disciplinary, and ethical issues Medical records are the main written evidence for all service actions, disease progression, and treatment while the patient is being treated, so that it is useful in solving problems, law, discipline, and ethics, as well as providing legal protection for patients, hospitals, and health workers. 7. As a communication tool between health workers 8. Become a source of memory that must be documented, accounted for, and reported.	

Organizing medical records in health services is one indicator of the quality of health services. Based on medical record data, it can be assessed whether health services are of good quality or not, whether according to standards or not. For this reason, the government, in this case, the Ministry of Health, feels the need to regulate the procedures for administering medical records in the Permenkes so that it can run well according to the provisions.

Table 7. Permenkes Number 269/Menkes/Per/III/2008

Permenkes Number 269/Menkes/Per/III/2008
1. Procedures for Organizing Medical Records. According to Article 46 paragraph (1) of Law Number 29 of 2004, doctors and dentists are required to make medical records in carrying out the medical practice. After providing medical practice services to patients, doctors and dentists must immediately complete medical records by filling out or writing down all services performed. If in recording medical records using electronic information technology, the obligation to sign can be replaced with a personal identification number (PIN). If an error occurs while recording the medical record, the file record may not be deleted or deleted in any way. Changes in notes for errors in the medical record can only be made by deleting and then affixing the initials of the officer concerned
2. Medical Record Ownership Under Article 47 paragraph (1) of Law Number 29 of 2004, medical record files become the property of doctors, dentists, or health service facilities, while the contents of medical records and document attachments belong to patients. medical records belonging to health care facilities and the contents of the medical record are the property of the patient, the contents of the medical record are in the form of a summary of the medical record then a summary of the medical record can be provided by recording, copying by the patient or authorized person with the written consent of the patient or the entitled family. Hospitals or health workers are responsible for the integrity and continuity of services, must have medical records as evidence of the hospital for all efforts to cure patients. The Hospital Director is responsible for the loss, destruction, or falsification of medical records, and the use of patient medical records by unauthorized bodies or persons. Patients have legal and moral rights to the contents of medical records.
3. Storage of Medical Records. According to Article 47 paragraph (2) of Law No. 29 of 2004, medical records must be kept and kept confidential by doctors, dentists, and leaders of health facilities. According to Permenkes No. 269/2008, the storage time limit is a maximum of 5 (five) years and a medical resume is at least 10 years. All medical record information contained in medical records is confidential, exposure of medical record contents must be with the patient's permission, except for legal purposes, referrals to other services for the benefit of patients or their families, evaluation of services at their institutions, research or education, and agency or organizational contracts service.
4. Organizing Medical Records. The existence of a medical record installation in the organizational structure of a health care institution depends on the class of the hospital. The medical record sub-committee is responsible to the medical records committee consisting of doctors or dentists or other health workers involved in health services to assist the medical committee in implementing quality medical records directly under the medical records committee. The doctor's responsibility, in this case, the medical record, can be carried out in the medical record committee. The duties of the medical record committee are: a. Provide advice and consideration in the storage of medical records and ensure that all information is properly recorded and ensure the availability of data needed to assess the services provided by doctors to patients; b. Ensuring that the procedures for storing, borrowing medical records, issuing, making disease codes, filling out medical records, managing and presenting data for the reporting process at the agency have been running well; c. Submit a proposal to the Director of the Hospital if there is a change in the filling procedure or the management of medical records that are adapted to the situation and condition of the hospital. The membership of the medical record committee consists of the head of the medical record installation, a doctor or dentist, and other health workers who are involved in filling out medical records. The membership of the committee is determined by the Decree of the Director of the Hospital for a period of 3 years. Given the importance of the medical record committee and sub-committee of medical records to help smooth service to patients, every hospital is obliged to make a medical record committee.
5. Guidance and Supervision. For guidance, control, and supervision of medical records by Article 16 of the Minister of Health Number 269 of 2008 namely by the Head of the Provincial Health Office, Head of the Regency/City Health Office, and related organizations according to their respective duties and functions.

At this time the recording of medical records in addition to the manual has developed recording of records is done electronically through the hospital management information system (SIMRS). To improve efficiency and integrated care and health services, patient medical records can be made electronically so that all patient medical records for life can be in electronic format. Everything about a person's health information is written by health workers in an integrated manner.

According to Shortliffe, electronic medical records (computer-based medical records) are an electronic repository of information about the health status and health services obtained by patients throughout their lives, stored in such a way that they can serve various legitimate medical record users. (Shorthliffe, H. Edward, 2001). The obligation of doctors in health services to make medical records a responsibility, either manually or electronically.

Table 8. Electronic medical records.

Electronic medical records
1. Electronic Medical Record Clinical Data System. a. Medical record of each patient b. Summary of clinical data. c. Disease registration. d. Specific Data Units. e. Medical library system and clinical decision support. f. Health passport (patient-carried records).
2. Electronic Medical Record Concept. The basic concept in the electronic medical record system is to add information management to be able to produce the following: a. Clinical alerts and reminders. b. Relationship with sources of knowledge for health-care decision support. c. Aggregate data analysis. d. Doctor's orders via computer (CPOE; computerized physician order entry) e. Automatic data capture of biological signals).
3. Electronic Medical Record Components. (Sabarguna, Boys, 2005) a. Important components that refer to needs b. Important Components of the Use of Medical Records on Individuals c. Use of Medical Records by Institutions
4. Regulations Regarding Electronic Medical Records. a. Law Number 29 of 2004 concerning Medical Practice Article 46 and Article 47. b. Law Number 11 of 2008 concerning Information and Electronic Transactions Article 6, Article 11 and Article 16. c. Minister of Health Regulation No. 269 of 2008.

`The legislation has regulated the implementation of medical records, both manual and electronic, although for electronics there is no special arrangement, thus if there are problems that arise from the implementation of electronic medical records in health care facilities, the existing law can protect patients in the event of a loss. because the existing arrangements are clear enough. This also applies to electronic medical records which are a form of medical record activities. Electronic medical record data has the same position as manual medical records.

2.2. Physician's Legal Liability for Medical Record Recording Obligations.

Responsibility is the state of being obliged to bear everything (if there is something, it can be prosecuted, blamed, sued, and so on). (Ridwan H R, 2011)

The doctor's attachment to legal provisions in carrying out his profession includes responsibilities in the fields of civil, criminal, and administrative law.

Liabilities physicians in making health care are the responsibility of the medical records, the meaning of responsibility is not to be evasive when asked explanation for the act. (Effendi Erdianto, 2011). In making medical records to provide the benefits of medical records, the medical personnel must comply with the rules of the manufacture of medical records, including the completeness of the contents, validity, and confidentiality. (dr. Yulvi Derosa). As for the legal responsibilities of doctors in the implementation of medical records, namely:

1. Responsibility for Confidentiality of Medical Records

   From a legal point of view, errors or omissions are related to the unlawful nature of an act committed by a person who is capable of being responsible. (Syahrul Machmud, 2012)

   Medical records are one of the elements of the medical secret trilogy. The data in the medical record is confidential. Because the doctor-patient relationship is personal and special, everything that is entrusted by the patient to the doctor must be protected against further disclosure (J, Guwandi,2004). Every recording of the medical record is the

confidentiality of the medical value of the results of examination, diagnosis, treatment, observation, or anamnesis of the patient. (dr. Elvira Muthia Sungkar, M. Ked (OG), Sp OG.) All record files medical records are stored in a safe place and if there is a medical record issuance there must be written evidence in the borrower's form.

Table 9. Confidentiality of Medical Records

Law and Regulation of the Minister of Health of Confidentiality of Medical Records
Article 48 paragraph (1) of Law Number 29 of 2004 states that every doctor or dentist in carrying out medical practice is obliged to keep medical secrets. Paragraph (2) Medical secrets may be disclosed only for the benefit of the patient's health, fulfilling the request of law enforcement officials in the context of law enforcement, the patient's request, or based on the provisions of the legislation.
In Article 47 paragraph (2) of Law Number 29 of 2004, it is stated: Medical records must be kept and kept confidential by doctors or dentists and leaders of health service facilities after the patient dies.
Article 57 paragraph (1) of Law Number 36 the Year 2009 states: Everyone has the right to on the secret of his health condition that has been disclosed to the health service provider; paragraph (2): Provisions regarding the right to secret personal health conditions as referred to in paragraph (1) do not apply in the case of statutory orders; court orders; relevant permits; public interest; or the interests of the person
In Article 10 of the Minister of Health Number 269 of 2008, it is stated that information about identity, diagnosis, disease history, examination history, patient medical history must be kept confidential by doctors or dentists, certain health workers, management officers, and leaders of health facilities.

The medical record is a collection of patient health records and all medical actions must be recorded in the medical record because it is directly related to the examination and therapy of patients. Confidentiality of medical records is an important factor that must be held by doctors, and it is the duty of doctors to maintain them because it is mandated by law. (drg. Melva Triasbela). The contents of a medical record can be intentionally opened by a doctor by conveying it directly to other people, but a doctor can also open it accidentally, namely when he discusses the patient's condition with other health workers.

In carrying out the medical record file, it is the medical record officer or nurse who works at the health facility. It is not allowed to bring medical records with the patient's family or close people to be delivered directly to the doctor concerned when going for a consultation.

If this happens, the medical record has the potential to leak medical secrets by irresponsible people, and if it happens, the doctors and hospitals are responsible for this because doctors and hospitals as institutions are considered to have failed to maintain the confidentiality of medical records.

Table 10. Sanctions for leaking medical records

Criminal sanction	Civil sanction	Administrative sanction
In the event of disclosure of secrets without the patient's consent, and they consider it detrimental, those deemed to be leaking secrets can be subject to Article 332 of the Criminal Code, namely: 1. Whoever discloses a secret which must be kept because of his current or former position or occupation, shall be punished with a maximum imprisonment of nine months or a maximum fine of nine thousand rupiahs. 2. If the crime is committed against a certain person, then the act can only be prosecuted on the complaint of that person. This article applies to people who divulge job secrets or job secrets, both current and past because they have changed jobs or have retired. Paragraph (2) is a complaint offense, where the case cannot be investigated without a complaint from the person who was harmed. The complaint can be	If the disclosure of confidential information about a patient's illness, including medical data, results in a loss to the patient, the doctor or hospital, where the leak occurs, can be sued civilly for compensation for being negligent in maintaining patient confidentiality, and the person who leaked it can be sued for compensation. Article 58 of Law Number 36 of 2009 states: Everyone has the right to claim compensation for someone, health workers, and or health providers who cause losses due to errors or omissions in the health services they receive. Article 1365 of the Criminal Code: Every act of violating the law that results in harm to another person, obliges the person who because of his fault that resulted in the loss, compensates for the loss. Article 1366 of the Criminal Code: Everyone is responsible not only for losses due to their actions but also for losses caused	Administrative sanctions for health workers in connection with regulations regarding medical records are regulated in Article 17 of the Minister of Health Number 269 of 2008. Administrative actions can be carried out by the Minister, Head of Provincial and Regency / City Health Offices in the context of fostering and monitoring and the sanctions are in the form of verbal warnings, written warnings to revocation permission. Although it is regulated regarding the confidentiality of medical records, it is also regulated about the obligation to disclose secrets contained in; a. Article 48 paragraph (2) of Law Number 29 of 2004 states that medical secrets can be opened, namely for the benefit of patients, fulfilling requests from law enforcement on court orders, patient requests, and statutory provisions.

withdrawn again, as long as it has not been submitted to the court. However, Article 4 of the Elucidation of Government Regulation Number 10 of 1966 states: In the public interest, the Minister of Health may act against the leaking of medical secrets, even though there is no complaint. For example, a medical officer repeatedly talks in front of a crowd about the condition and behavior of the patient he is treating. By doing so he has demeaned the medical office and reduced people's trust in medical officials.	by negligence or carelessness. Then Article 1367 of the Criminal Code: A person is not only responsible for losses caused by his actions, but also for losses caused by the actions of people who are his dependents or caused by goods under his control. The purpose of Article 1367 of the Criminal Code is that if a subordinate makes a mistake, the person being sued is his superior. This is called the responsibility of the superior, while the crime is borne by the person concerned.	b. Article 10 paragraph (2) of the Minister of Health Number 269 of 2008 concerning identity, diagnosis, history of the disease, and treatment can be opened if; for the benefit of health, requests from law enforcement on court orders, patient requests/approvals, education, and research and medical audits but without mentioning identity and paragraph (3) must be made in writing to the head of health facilities. c. Article 11 Permenkes 269 In 2008 it was stated that an explanation of the contents of a medical record may only be made by a doctor or dentist who treats a patient with the patient's written permission based on the legislation. laws and regulations. d. Third parties, such as family, attorney, insurance, and police, the court must show a power of attorney (written) from the patient if you want to have a medical record. Confidentiality is not absolute, in certain situations, it can be done through: a. Patient consent The person who has the most rights regarding the preservation of medical secrets is the patient. Patients have the right to determine whether or not the contents of their medical records are disclosed. The consent given by the patient can be given expressly or tacitly but must reflect it. Secret consent is considered to have been given to a patient whose health condition and other knowledge about himself are discussed in certain circles in secret, for example in a team, and also applies when informing the patient's condition to the closest family. b. Legislation requires disclosure that information. The provisions of the law cut the obligation to keep secrets by ordering the announcement of medical conditions and events such as death statements, birth reports, reporting of infectious diseases, and others. Obligations are stated in the law because they are involved in big interests. c. Information can be provided to the closest member if in the opinion of the doctor on medical considerations it is not wise to directly provide the information to his patient. d. Obligations to the public interest. Article 11 Law Number 6 of 1963 concerning Health Workers states that without reducing the provisions in the Criminal Code and other laws and regulations, administrative actions may be taken against health workers in the following cases:

		a. Neglect of obligations; b. Doing something that should not be done by a health worker, either remembering his oath of office or remembering his oath as a health worker. c. Violate a provision under or under this law

2. Legal Consequences for Absence of Medical Records.

Doctors and dentists are required to make medical records as an obligation as Article 46 paragraph (1) of Law Number 29 of 2004, if a doctor in carrying out medical practice does not make medical records, may be subject to sanctions based on Article 79 b Law No. 29 of 2004, namely being punished or fined.

Violation of the provisions of Permenkes Number 269 of 2008 in the form of administrative actions in the form of verbal warnings, written warnings to revocation of permits. So the current sanctions are more severe.

The provisions of the criminal law are imperative and cruel, which can backfire on medical personnel. Criminal sanctions in the form of imprisonment for a maximum of one year or a fine of fifty million rupiahs against perpetrators of medical record violations are quite severe. At a minimum, even if it is declared a criminal act, the formulation of the provision is declared as a complaint offense, so as long as no parties are harmed by the unavailability of medical records, then the medical personnel cannot be prosecuted.

This is very useful for doctors so that they can get used to making medical records according to the desired standards in Articles 3 and 5 of the Minister of Health Number 269 of 2008 must meet the minimum requirements specified both outpatient, inpatient, and Emergency Unit and immediately make medical records after providing services, carried out by recording and documenting starting examinations, treatment and other necessary actions by affixing a signature, time and name on each record and if one makes corrections by crossing out and initialing. [2] The habit of making standard medical records will protect doctors from criminal threats. based on Article 79 b of Law Number 29 of 2009, which is much more severe, namely not making it as Article 46 paragraph (1). Article 14 of the Minister of Health states that the head of health service facilities is responsible for the loss, damage, or falsification of medical records; and Use by persons/entities who are not entitled to medical records. Medical record files as property of health care facilities must be maintained, and it is the responsibility of the leadership of health service facilities to maintain the confidentiality of the medical record information contained therein.

According to Article 17 of the Minister of Health, the unavailability of medical records at health service facilities is seen as a violation of the administrative field, the sanctions imposed are the form of administrative sanctions, namely in the form of verbal warnings to revocation of licenses.

The function of medical records in the legal field can be used as evidence in legal cases. In the civil sector, medical records can be used as a basis of evidence in the event of a claim for compensation against health workers on suspicion of medical malpractice.

3. EPILOGUE

3.1. Conclusion

One of the obligations of doctors is to make medical records as regulated in Law No. 29 of 2004 concerning Medical Practice, Law No. 36 of 2004. While in the year of 2009 concerning Health, Law Number 11 of 2008 concerning Information and Electronic Transactions and Permenkes Number 269 of 2008 concerning Medical Records. The implementation of medical record recording in medical practice includes manual medical records and electronic medical records based on the industrial revolution (cyber medicine). The legal responsibility of doctors who do not record medical records can be subject to sanctions based on Article 79 b of Law Number 29 of 2004, namely being punished with imprisonment or a fine. Meanwhile, Permenkes Number 269/Menkes/Per/III/2008 states that violations of the provisions in the Minister of Health are in the form of administrative actions in the form of verbal warnings, written warnings to licensing revocation.

3.2. Recommendations

Doctors and related health workers must implement the provisions of medical records, and maintain full confidentiality of medical records, and avoid defaults and acts against the law in therapeutic transactions.

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Aidil Akbar
Fakultas Hukum, Universitas Prima Indonesia
Email: aidilabr@gmail.com

Emir Syarif Fatahilla Pakpahan
Fakultas Hukum, Universitas Prima Indonesia
Email: emirsyariffatahillapakpahan@unprimdn.ac.id

Ramon Nofrial
Email: ramonnofrial@yahoo.com