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Legal Analysis of the Doctor's Responsibility Towards the Completeness of Patient Medical Records in the Framework of Fulfilling Patient Rights in the Hospital

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Abstract
Doctors have a legal responsibility to ensure that patient medical records are complete and accurate. A legal analysis of the doctor's responsibility for the completeness of patient medical records in order to fulfill patient rights in hospitals is an important study to ensure that patient rights are fulfilled in accordance with the standards set by applicable laws and regulations. A comprehensive analysis of the doctor's responsibility and the importance of complete medical records is expected to create a better health care system that respects and fulfills patient rights optimally. This study uses a normative legal method. The conclusions of this study are: 1) The doctor's legal responsibility for fulfilling the patient's right to obtain complete Medical Records as a form of the patient's right to information in health services. This right is protected and regulated in a number of legal regulations. Fulfillment of the method of obtaining the contents of Medical Records to patients must also pay attention to and follow the procedures as stipulated in the laws and regulations. 2) The legal consequences of the doctor's legal responsibility if they violate the fulfillment of the patient's right to complete Medical Records, including: 1) criminal sanctions, namely imprisonment for a maximum of 1 (one) year and a maximum fine of Rp. 50,000,000.00 (fifty million rupiah) (Article 79 point b of the Medical Practice Law Law No. 29 of 2004), 2) civil sanctions in the form of compensation by the Hospital or the doctor to the patient (Article 1365 of the Civil Code) and 3) administrative sanctions in the form of written warnings and/or recommendations for revocation or revocation of accreditation status. (Minister of Health Regulation 24 of 2022 concerning Medical Records).

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Introduction

Legal analysis of the doctor's responsibility for the completeness of the patient's medical records in order to fulfill the patient's rights in the hospital is an important study to ensure that the patient's rights are fulfilled in accordance with the standards set by applicable laws and regulations. A comprehensive analysis of the doctor's responsibility and the importance of the completeness of medical records is expected to create a better health service system that respects and fulfills patient rights optimally.

Health, which is everyone's dream, is more valuable than property, gold and jewels. Although it is often not realized, but when someone is sick, only then can he feel the pleasure of health which is everything in life. The right to health is one of the basic rights owned by every citizen. Obtaining access to quality and affordable health services is one manifestation of the right to health. Providing access to health services with decent quality is basically the main task of the government which in its implementation can be supported by community participation. Minister of Health Regulation 4 of 2018 concerning the obligations of hospitals and patients, states that the forms of health services that can be obtained by the community include health services consisting of promotive, preventive, curative, and rehabilitative efforts. So that its implementation takes place in an orderly manner and ensures the fulfillment of the interests of each party, the law of course also needs to intervene in regulating the implementation of health services in the community.

The relationship between patients and health care providers can be philosophically viewed as a form of relationship between

dignified human beings [1]. Based on this understanding, every human being should have an equal position before the law. Therefore, the relationship between patients and health service providers can also be viewed as a form of legal relationship. The legal relationship formed in health services results in the emergence of rights and obligations between the parties.

One of the real manifestations of the consequences caused by legal relations in health services is the obligation for health service providers to organize medical records. The obligation to implement the organization of medical records is not only imposed on health workers but also on health service facilities (fasyankes). Regulations related to these obligations can be found in the following laws and regulations:

1. Article 46 paragraph 1 of Law Number 29 of 2004 concerning Medical Practice states that recording in medical records is mandatory for every doctor or dentist who carries out medical or dental practice.
2. Article 29 paragraph 1 letter h of Law Number 44 of 2009 concerning Hospitals in conjunction with Article 2 paragraph 1 letter h of the Minister of Health Regulation Number 4 of 2018 concerning Hospital Obligations and Patient Obligations stipulates that the provision of medical record services must be carried out by every hospital.
3. Article 7 letter f of Law Number 75 of 2014 concerning Community Health Centers stipulates that Community Health Centers (Puskesmas) have the authority to carry out the organization of medical records.

Medical Records as explained in the Minister of Health Regulation No. 269 of 2018 concerning Medical Records which was later updated by the Minister of Health Regulation 24 of 2022 concerning Medical Records are records and documents containing the patient's personal identity, examination results, treatment that has been carried out on the patient, and other actions and services that have been carried out on the patient. The data contained in the medical record includes the patient's identity, the reason for the patient's visit, the patient's history and background (anamnesis, physical examination, current symptoms), examination results, treatment, documentation time, results of treatment that has been carried out, a summary of discharge after hospitalization (discharge letter), and the identity of the person who made the notes in the medical record. Anamnesis contains information obtained by the doctor based on the complaints and symptoms conveyed by the patient. Based on the anamnesis that has been carried out, the doctor will then conduct a clinical examination of the symptoms that have been conveyed by the patient.

Based on patient information and examination results, doctors can diagnose the disease and determine the name of the disease and which part of the body is affected by the disease. Meanwhile, patient data contained in the medical records of inpatients consists of daily medical records containing the patient's condition and the progress of the treatment that has been given to the patient. Documentation of patient data is also carried out by nurses who provide daily care to patients. In adition, there is also a discharge summary (discharge letter) containing a summary of the entire series of treatments that have been received by the patient while in the hospital for a certain period and contains follow-up instructions that must be carried out by the patient after returning home from the hospital [2].

The quality of health services certainly cannot be separated from the quality of the implementation of medical records in a health facility. Efforts to improve the quality of services in hospitals require support from various factors. One of these supporting factors is the implementation of medical records which in turn influences the assessment of the quality of health services. The implementation of medical records in question starts from patient registration to the management of medical record data and information which is then presented in the form of a report. The process that takes place in the implementation of medical records is a series of units that must be carried out in an orderly manner in order to produce accurate and accountable information [3].

There are several objectives that form the basis for organizing medical records in health services. Some of these objectives, one of which, is intended to fulfill interests related to patient services. The existence of medical records containing patient identity, health services that have been provided by health workers, and the amount of medical costs, can be used as a means to confirm the truth that the patient has received health services. The information documented in the medical records is also useful for facilitating communication between health workers who treat the same patient. Ultimately, this will of course help in determining treatment efforts for patients. If the health services provided to patients are not in accordance with what is expected to the point of causing a legal dispute, then medical records can also be used as valid legal evidence [4].

The provision of medical records in health services is also intended to fulfill the patient's personal interests, one of which is related to the release of the contents of medical records which is carried out at the patient's request. Based on the provisions in Permenkes 24 of 2022 concerning Medical Records, it can be understood that the release of medical record information in relation to the patient's interests can be carried out at the request and/or through the patient's consent. There are several interests that are the basis for the reasons for patients wanting to know and even wanting to obtain information related to the contents of their medical records, including:

1. Financial interest in knowing the amount of medical costs that must be paid by the patient or that will be covered by the insurance company.
2. The legal interest is that the disputing parties should have an equal opportunity to access the contents of medical records so that they have strong supporting data to file a claim or defense in court.
3. The interest in treatment when the patient wishes to continue treatment efforts for himself at another health facility based on the patient's medical data that has been obtained from previous health services.
4. Interests related to the protection of patients' personal

[1]Anggraeni Endah Kusumaningrum. (2019). Legal and Ethical Struggles Against Euthanasia in Hospitals. Journal of Law Spectrum, Vol. 16/No. 1/April 2019
[2]Dalianis, H. (2018). Clinical Text Mining (Secondary Use Of Electronic Patient Records). Switzerland: Springer International Publishing
[3]Apriyantini, D. (2016). Analysis of the Relationship between Completeness of Medical Resume Compliance and Ina-Cbg's Tariff Standards. Journal of Hospital Administration (ARSI), 2(3), 195.
[4]Magentang, & Retno, F. (2015). Completeness of Medical Resume and Appropriateness of Writing Diagnosis Based on ICD-10 Before and After JKN at Bahteramas Hospital. Journal of Hospital Administration (ARSI), 1(3), 161-162

data [5].

It should also be understood that patients have the right to information in health services. The patient's right to information is not only manifested in the form of the patient's right to receive an explanation regarding the medical actions that will be performed on him. However, this right is also manifested in the form of the authority for patients to be able to access and even obtain the contents of their medical records. The existence of the patient's right to access the contents of the medical records is one of the reasons underlying why quality medical record services need to be carried out in health services.

The patient's right of access to the contents of medical records in fulfilling their health services needs to receive strict legal protection. This is because at the technical level of health service provision, violations of the patient's rights often occur. There are several forms of violations of the patient's right of access to the contents of medical records. One of them is a phenomenon found in a study in a hospital that found that health workers were reluctant to show and explain the contents of medical records to patients [6].

Other forms of violations can also arise because health workers who provide direct health services to patients do not document the health services that have been provided to patients clearly, completely and accurately. This condition was found in a study at a Community Health Center which showed that in the analysis of incompleteness of the contents of medical records, patient identities and diagnoses were found to be incomplete in 3 out of 30 (10%) medical record files [7]. The existence of incomplete information related to patient identity certainly has the potential to cause obstacles in the process of granting access rights to the contents of medical records to patients. In adition, incomplete information related to the diagnosis of the disease also has the potential to cause patients to access inaccurate information about their health condition.

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Health provider obliged to obtain approval (permission) from the patient for anything that will be done in providing medical services. *Actions without permission are an unlawful act that can be sued* or prosecuted civilly and/or criminally due to losses experienced by the patient. The main cause of media conflict in health services is to minimize the medical conflict, so it must be realized early on that a new chapter has occurred, namely health services that are not only in the form of a moral relationship and medical relationship, but have shifted towards that health services provided by health providers have legal relationships that can have legal consequences. Changes in the paradigm of health services as an initial step to prevent conflicts between doctors and patients.

The implications of administrative law in the legal relationship between a hospital and a patient are related to policies or provisions that are administrative requirements for health services that must be met in order to provide quality health services. These policies or provisions of administrative law regulate the procedures for providing proper and appropriate health services in accordance with hospital service standards, operational standards and professional standards. Violations of policies or provisions of administrative law can result in administrative legal sanctions which can be in the form of revocation of business licenses or revocation of legal entity status for hospitals, while for doctors and other health workers it can be in the form of verbal or written warnings, revocation of practice permits, delays in periodic salaries or promotions to a higher level.

A. Problem

The problem of this research is how is the legal analysis of the doctor's responsibility for the completeness of the patient's medical records in order to fulfill patient rights in hospitals?

B. Research Methods

The research method used in this study is normative juridical. Normative juridical legal research is a method used to study various applicable legal rules, whether in the form of laws, regulations, or legal doctrines, with the aim of understanding and explaining the legal phenomena being studied.

C. Discussion

1. Legal Responsibilities of Doctors for Fulfilling Patients' Rights to Complete Medical Records

Variousdthings that cause the relationship between the patient anddoctor, that relationshipdhappened because of severaldbecause, betweendanother isdbecause of the patient himselfdwho came to the doctordto ask for helpdtreat the illnessdsuffered. Another reason that causesdemergence of relationshipdlaw between patientsdand the doctor isdue to the patient's conditiondvery urgent todget it soondhelp from a doctor, for example because of a traffic accidentdcrossing, natural disasters occur, or due to other situations that causedpatient conditiondit's already critical, sodvery difficultdfor doctorsdwho handles to knowdwith certainty the patient's wishes.

Connection doctor inpatients, in general law occurs through Dan agreement or contract. Instar with a question answer (anamnesis) between doctor with patient, then followed By physical examination, the doctor finally establishes a diagnosis. Diagnosis this can beda working diagnosis or provisional diagnosis can also be a diagnosis that definitive. The relationship formed between a doctor and a patient is a form of agreement known as a therapeutic agreement. Therapeutic agreements have different characteristics from agreements in general that are formed in society. The differentiating factor lies in the object of the agreement. The patient's recovery is not the object agreed upon in a therapeutic agreement, but rather the best treatment efforts

[5] https://www.jogloabang.com/kesehatan/permenkes-24-2022-rekam-medis. Accessed on July 21, 2024, 07.20 WIB

[6] Ampera, A. (2018). Hospital Responsibilities Towards Patients in the Implementation of Health Services. Al Ishlah Journal: Scientific Journal of Law, 21(2), 71

[7] Khusnawati, T. (2021). The Relationship between Completeness of Filling in General Patient Medical Records and the Quality of Medical Records at the Kebumen Health Center UPTD. Tambusai Education Journal, 5(3), 6057

that can be made to cure the patient's illness [8].

Therapeutic agreements are generally based on two types of human rights, namely the right to self-determination and the right to information [9]. The right to information in health services is often associated with the patient's right to obtain information related to the risks of medical actions that will be carried out on him/her by first knowing clearly the condition of the disease he/she is suffering from. Through the information that has been obtained, the patient can then determine whether or not to give consent to the medical actions that will be carried out for the sake of healing his/her disease [10].

Legal protection for the fulfilment of patient rights in health services is not based on the promise that the doctor will definitely provide results in the form of healing to the patient. However, the guarantee of protection of patient rights is carried out based on three standard instruments in the implementation of health services, namely:

1. Legislation relating to the implementation of medical practice;
2. Professional ethics are manifested in the form of a medical code of ethics;
3. The discipline of medical science as a standard used in the practice of the medical profession and Standard Operating Procedures in the implementation of health services [11].

Meanwhile, the legal responsibility of doctors to fulfill patients' rights to complete medical records is the foundation in organizing medical services. Regulation of the Minister of Health of the Republic of Indonesia Number 24 of 2022 concerning medical records seeks to provide a legal basis or legality for organizing medical records. Electronic medical. Indian general, there are three new things that are regulated Indian the Ministerial Regulation Republic Health Indonesia Number 24 Yearsd2022, namely the system electronic medical records electronics, organizing activities medical records electronics, security and data protection medical records electronic.

Electronic medical record management activities include: Patient Registration, Distribution of Electronic Medical Record Data, Completion of Clinical Information, Processing of Electronic Medical Record Information, Data Input for Financing Claims, Storage of Electronic Medical Records, Guarantees Quality of Medical Records Electronic, Content Transfer Medical records Electronics. In registration process patient, patient data is an essential matter. This patient data includes data patient identity (minimum consists of: number medical records, patient name, and Population Identification Number) and patient social data (consisting of at least from: religion, work, education, and marital status). While distribution of recorded data electronic medical is the activity of sending electronic medical record data from one service unit to another service unit.dat service facilities health.

2. Legal consequences of doctors' legal responsibilities for fulfilling patients' rights to complete medical records

There are several principles that should be used as a basis for achieving goals in health development. The principles referred to in this context include the principle of humanity, the principle of balance, the principle of benefit, the principle of protection, the principle of respect, the principle of gender justice and the principle of religious rules. All of these principles should not just be used as mere principles, but should be used as benchmarks for health development in Indonesia [12]. The implementation of the principle of protection in health development can be done, one of which is marked by the presence of laws to protect the interests of patients in health services. Legal protection is all efforts made to realize protection and fulfillment of both rights and including providing a sense of security for witnesses and/or victims. The form of legal protection can be done through the provision of compensation, the provision of medical services, and the provision of legal assistance [13].

Violation of the fulfillment of patient rights to complete medical records should not only be viewed as a form of violation of laws and regulations but also as a form of violation of morality that injures the natural rights of patients as human beings. When viewed from a civil aspect, then the violation of patient rights is an Unlawful Act (PMH) or Onrechtmatige Daad. PMH in its development is not narrowly limited as a form of violation of obligations regulated in legal regulations alone. However, the scope of PMH also includes violations of the rights inherent in a person, moral norms that apply in society, or even propriety [14].

If the violation causes a loss, the patient can file a lawsuit for Unlawful Acts (PMH) which refers to the provisions in Article 1365 of the Civil Code (BW). Article 1365 BW regulates the obligation in the form of compensation for losses by anyone who commits an unlawful act that causes loss to another person. The principle of liability based on fault applies in Article 1365 BW. This principle is regulated in Article 1865 BW which explains that anyone who claims to have a right, or points to an event to confirm that right or to deny the rights of another person, is required to prove the existence of that right or the event stated [15]. In other words, the burden of proof in a lawsuit for Unlawful Acts (PMH) related to the violation of incomplete patient medical records is entirely borne by the patient as the plaintiff.

Referring to the provisions in Article 1866 BW, patients can use various pieces of evidence to prove that their right to access the contents of their medical records has been violated. The types of evidence as intended in Article 1866 BW include written evidence, evidence stated by witnesses, allegations, confessions and even oaths. Patients with the evidence they have must be able to prove the losses they have experienced by fulfilling the four elements of Unlawful Acts

[8]Mannas, AY (2018). Relationship octor's Law And Patients And Responsibilities of Internal Medicine Physicians Service Provision Health. Cita Journal Law, 6(1), 168

[9]Sugandi, MW (2017). Medical Law. Bandung: Alfabeta

[10]Jacobus, R. (2014). Rights Patients Get Service Risk Information Medical. Private Law, 2(1), 172

[11]Ariwibowo, BN, Nurhayati, BR, & Dahlan, S. (2017). Perception Patients About Aspects Law of Undertaking Contract (Inspanning Verbintenis) In Therapeutic Transactions Between Doctors With Patients In Salatiga City Hospital. SOEPRA Journal Law Health, 3(1), 53-54

[12]Marom, AA (2015). Criminal Law Politics of Medical Records as Evidence in Criminal Evidence Law. Al-Mazāhib, 3(1), 125-126

[13]Simamora, TP, Batubara, SA, & Efrianto, IS (2020). Protection Law Against Patient In Medical Services At home General Illness. Journal Al'Adl, 12(2), 272

[14]Muhammad, AK (2014). Law Indonesian Civil Code. Bandung: PT. Citra Aditya evotion

[15]Heriani, I. (2018). Legal Protection for Health Consumers in Cases of Malpractice. Jurnal Al' Adl, 10(2), 201

(PMH), which include:

a) There was an error that resulted in the patient's medical records being incomplete.
b) Patients experience losses, either material or immaterial, caused by violations of the patient's right to access the contents of medical records.
c) Violations of the completeness of patient medical records are carried out by health workers and/or health facilities where patients receive health services.
d) There is a causal relationship between the actions of health workers and/or health facilities and patient losses due to violations of the patient's right to access the contents of medical records.

Record Medical is a document that contains patient identity data, examinations, treatment, actions, and other services which has been given to the patient. While the Record Electronic Medical is a Record Medical made with using the electronic system intended for the implementation of Recording Medical. Presence medical record from the practical side medicine is very important, both for service facilities home health hospital, clinic, health center, hall treatment, as well as doctor's practice. This medical record is real evidence that scribe the diagnosis, actions treatment, care, therapy, costs and all procedures proper medical given by doctor. As ad valid evidence, if seen from a formal perspective and material, then this medical record evidence must comply with the provisions of the Medical Record Book Procedural Law Law Criminal Procedure Code (KUHAP) must also comply with operational standards standard procedure that applicable in general in the field medical.

Tidbits function from a legal perspective, this medical record can be used as evidence in the process of law enforcement, medical ethics and medical discipline. Especially in-law enforcement process, then this medical record can be accepted as evidenced in the process settlement of a cased law, namely to determine whether or not a doctor is guilty in a legal conflict. The legal conflict that occurred between the doctor and the patient, in general often used by the community malpractice term medical.

Asdan obligation that must be implemented as mentioned in Medical Practice Law Law No. 29 of 2004 Article 46 paragraph (1), then if doctor in action medical practiced not making a record medical can be subject to sanctions based on Article 79 point medical Practice Act UUdNo. 29 of 2014d2004:

a) Sanctions regarding the failure to make medical records, it is in accordance with Article 79 pointed Medical Practice Law No. 29 of 2009d2004 in the form of a threat maximum imprisonmentd1 (one) year and the most finesdRp. 50,000,000.00 (five hundred thousand rupiahs) dtens of millions of rupiah)
b) Sanctions regarding the making of the record medical that is not din accordance with the provisions contained in din the Minister of Health Regulation 24 of 2022 concerning Electronic Medical Records din the form of a warning verbal, reprimand written up to revocation of permit.

3. Hospital Efforts to Overcome Incomplete Medical Records as Fulfillment of Patient Rights

Incompleteness Medical record filed become one of the problems because medical records frequently times is one of the notes that can provided detailed information about what has been occurs during the patient hospitalized. This results in internal and external impact because of the results Data processing is the basis for making good reports Internal Hospital as well as ford external parties [16]. Based on the research results, it can be concluded that the Hospital's efforts to overcome incomplete Medical Records as a fulfillment of patient rights include:

a) Socialization to DPJP (Doctors in Charge of Services) regarding regulations regarding the completeness of medical records in this case Electronic Medical Records (EMR)
b) The process of assisting in filling out the EMR by the PPJA (Nurse in Charge of Care) and the IT (Information Technology) Team
c) The completeness check is carried out again by the PPJA, Case Manager and Karu when the patient is going home.
d) Re-checking is carried out by the Casemix Team and the Medical Records Installation for the purpose of claiming BPJS financing.
e) Periodic evaluation every 3 months by reviewing Medical Records
f) Evaluation meeting for the completeness of filling out the RM with the medical committee and nursing committee
g) Multi-level verification starting from Karu, MPP, Medical Records Installation and Medical Records Committee.

The monitoring and evaluation system also affects the incompleteness of filling in the Medical Record. The absence of a monitoring and evaluation system for incomplete Medical Records causes no control over the completeness of the contents of the Medical Record. So it is appropriate to have an evaluation meeting for filling in the RM with the medical committee and nursing committee. Then continued with tiered verification starting from Karu, MPP, Medical Record Installation and Medical Record Committee as an effort by the Hospital to overcome incomplete Medical Records as a fulfillment of patient rights.

In accordance with Law Number 29 of 2004 concerning Medical Practice, Articles 50 and 51, the Rights and Obligations of Patients are as follows:

a) Get full explanation about the plan medical action that will be done doctor
b) Candask a doctor for an opinion other (second opinion)
c) Get medical services din accordance with the need
d) Can refuse medical action to be carried out by a doctor if there is any doubt
e) Can get Medical Record information.

[16]Mirza, A., & Lusita, MD (2021). Development System Using Codeigniter Framework on the System Patient File Management Hospital PELNI. Journal of Artificial Intelligence and Innovative Applications (JOAIIA), 2(4), 278-284

D. Closing

The conclusion of this paper is as follows:

1. The legal responsibility of doctors to fulfill the patient's right to obtain complete Medical Records as a form of patient rights to information in health services. These rights are protected and regulated in a number of legal regulations. Fulfillment of the method of obtaining the contents of Medical Records to patients must also pay attention to and follow the procedures as regulated in laws and regulations.
2. The legal consequences of a doctor's legal responsibility if they violate the fulfillment of the patient's rights to complete Medical Records, include: 1) criminal sanctions, namely imprisonment for a maximum of 1 (one) year and a maximum fine of Rp. 50,000,000.00 (fifty million rupiah) (Article 79 point b of the Medical Practice Law Law No. 29 of 2004), 2) civil sanctions in the form of compensation by the Hospital or the doctor to the patient (Article 1365 of the Civil Code) and 3)administrative sanctions in the form of written warnings and/or recommendations for revocation or cancellation of accreditation status.(Minister of Health Regulation 24 of 2022 concerning Medical Records).
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    b) The process of assisting in filling out the RME by the PPJA (Nurse in Charge of Care) and the IT Team*(Information Technology)*
    c) PPJA re-checks the completeness,*Case Manager*and Karu when the patient is going home.
    d) Re-checking is carried out by the Casemix Team and the Medical Records Installation for the purpose of claiming BPJS financing.
    e) Periodic evaluation every 3 months by reviewing Medical Records
    f) Evaluation meeting for the completeness of filling out the Medical Records with the Medical Committee and Nursing Committee
    g) Multi-level verification starting from Karu – MPP – Medical Records Installation and Medical Records Committee.

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