Normative Legal Study of Medical Records in Indonesia

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ABSTRACT

This study aims to understand and analyze the normative aspects of medical in Indonesia. This study uses a normative legal approach with library study techniques. The secondary data used were analyzed qualitatively and presented descriptively. The urgency of medical records was initially only related to the business in health services. Currently, medical records are not only limited to the study of health sciences but have also become part of the health law.

Keywords**:** Medical Records and Indonesia

A. Introduction

One form of health effort is to seek health services. Health services are consist of promotive, preventive, curative, and rehabilitative activities. Promotive health service is an activity and/or a series of health service activities that prioritize health promotion. Preventive health service is an activity to prevent a health problem/disease. Curative health service is a treatment activity aimed at curing disease, reducing suffering due to disease, controlling disease, or controlling disability to maintain patient's quality as optimally as possible. Rehabilitation health services are activities and/or a series of activities to return former sufferers to the community to function again as community members for the benefit of themselves and the community as much as possible according to their abilities (Article 1 points 12, 13, 14 and 15 of Law Number 36 of 2009).

Curative health services can be done with traditional medicine and modern medicine. In Law No. 36 of 2009, the regulation on traditional medicine is not as complete as the regulation on modern medicine. With this consideration, the study of health services in this paper only focuses on health services with modern medicine.

Curative services will intersect with health workers. In curative services, it includes health workers, medicine, and patients. These interactions are summarized in the medical record. The focal point of curative health services is health workers which are summarized in the Medical Record.

Thus, the problems that will be discussed and explained in this paper are How is the normative study of medical records in Indonesia

B. Research Objectives

The purpose of this research is to find out and analyze normative policies of the legislation regarding medical record.

C. Research Method

1. Approach Method

In this study, the law is conceptualized as statutory regulation. The approach in this study is research with a normative legal approach. According to Zaenuddin Ali, normative legal research is a type of research to answer academic questions as empirical research.

2. Type of Research/Specification of Research

Based on the analysis, this research is categorized as qualitative research. Qualitative research is research that refers to the legal norms contained in legislation, court decisions, and norms that live in society[1].

3. Types and Sources of Data

In normative legal research, the data used is secondary data, in the form of laws and books related to the research topik.

4. Data Analysis

In this study, the analysis is descriptive-analytical who is only limited to describing/descriptive about the normative aspects of the medical record. According to Zaenuddin Ali, descriptive-analytical legal research uses a qualitative approach to primary data and secondary data in its data analysis.[2]

D. Research Results and Discussion

In curative services, several aspects to be considered are health workers, medicine, and patients. The Law provides the following definition of health workers, medicine, patients, and medical records::

1. A health worker is any person who devotes oneself to the health sector and has the knowledge and/or skills through education in the health sector which for certain types requires the authority to carry out health efforts (Article 1 Point 6 of Law Number 36 of 2009 concerning Health);
2. Medicines are materials or combinations of materials, including biological products that are used to influence or investigate physiological systems or pathological conditions in the context of establishing a diagnosis, prevention, healing, recovery, health improvement, and contraception for humans (Article 1 Point 8 of Law Number 36 of 2009 about health).
3. A patient is any person who consults on their health problems to obtain the necessary health services, either directly or indirectly at the hospital (Article 1 Point 4 of Law Number 44 of 2009 concerning Hospitals).
4. Medical records according to article 1 point 1 of the Indonesian Minister of Health Regulation Number: 269/MENKES/PER/III/2008 concerning Medical Records are files containing records and documents regarding patient identity, examination, treatment, actions, and other services that have been provided to the patient.

From a historical perspective, knowledge of medical records is begun with the discovery of paintings about medical practices, including amputation of fingers. The

painting is plastered on the walls of a rock cave in Spain and is presumed to be 25,000 years old. These findings are considered by experts as evidence of medical records that have been carried out since ancient times. Several types of records in the form of carvings, paintings on the walls of pyramids, bones, trees, dry leaves in ancient Egypt are also considered to have shown an increase in the development of medicinal practices.[3]

Medical records were originally developed as business records for individual services (especially hospitals and doctors). Currently, medical records are documents that provide vital information for the continuity of care whose existence is subjected to state regulations. The regulation regarding medical records in the Law gives patients ownership to their health information. This explanation can be seen in the writings of William H. Roach, Jr et al. as follows: *"Although the medical record originally developed as a business record of individual healthcare providers (primarily hospitals and physicians), it is now a document that supplies health information critical to continuity of care, is subjected to state and federal regulation, and is "owned" as much, if not more, by the patient as by the provider"*.[4]

Medical records were also useful in medical training, certification and accreditation, and control of health services in the late 1900s. William H. Roach, Jr. et al. stated: *"Several forces contributed to this transition, including increased emphasis on the importance of documentation in medical training; medical records standards incorporated in accreditation and certification requirements, and the development of formal utilization controls for healthcare services, culminating in the managed care revolution of tha late 1990s[5]*

Medical records have existed since the colonial era and have undergone several improvements. The Decree of the Minister of Health of the Republic of Indonesia Number 031/Birhub/1972 requires all hospitals to perform medical recording and reporting as well as hospital statistics. It is then followed by the Decree of the Minister of Health of the Republic of Indonesia No.034/Birhup/1972 concerning Hospital Planning and Maintenance. Chapter 1 Article 3 of the Decree emphasizes that to support the implementation of a good master plan, every hospital is required to have and maintain up-to-date statistics and to make medical records based on established provisions.[6]

The Decree of the Minister of Health of the Republic of Indonesia Number: 134/MenKes/SK/VI/1978 also states, to regulate the implementation of hospital medical records, it is necessary to establish a sub-section of medical registration. Meanwhile, the Indonesian Doctors Association (IDI) in 1988 issued a statement regarding medical/health records through the appendix of IDI SKPB No. 315/PB/A.4/88 as follows:[7]

1. Medical/health records are records in written form or descriptions of service activities provided by medical/health service providers to patients;
2. Medical/health records include the patient's complete identity, records about the disease (diagnosis, observation of medical history), third party records, examination results, laboratories, X-rays, ultrasound, and a summary;
3. Medical/health records must be made immediately and completed no later than 48 hours after the patient returns home or dies;
4. If the doctor gives an order by telephone to the nurse, the senior nurse who is entitled to receive the order must re-read the notes on the order. If there is an error, the doctor must correct it and within 24 hours, the doctor who gave the order must sign the note;
5. Any changes to medical records must be made in a special sheet that must be combined with documents for other medical records;
6. Medical records must exist to maintain a high quality of professional service, for the benefit of a substitute doctor who continues patient care, for future reference, and to fulfill patient rights;

7. Medical records must exist in hospitals, health centers, as well as private/individual doctor practices or group practices;
8. The owner of the medical record is the patient. Therefore, if the patient demands it, the doctor must grant it to the patient either orally or in writing;
9. The presentation of the medical record contents may only be carried out by a doctor who is responsible for the patients served.
10. Disclosure of the contents of medical records may only be made for the patient concerned, health consumers such as insurance, and for court purposes.
11. The duration of the mediation record is five years.
12. With the issuance of Regulation of the Minister of Health of the Republic of Indonesia Number 749a/Men.Kes/Per/XII/1989 concerning Medical Records, thus, normatively, medical records have binding legal force.

According to [8], the reform of medical records in Indonesia began in 1972, which was marked by the issuance of the Decree of the Minister of Health of the Republic of Indonesia Number: 031/Birhup/1972. In the decision, it was emphasized that all hospitals were required to perform medical recording and reporting, as well as hospital statistics. It was further stated that the decision was followed by the issuance of the Decree of the Minister of Health of the Republic of Indonesia Number 034/Birhup/1972 concerning Hospital Planning and Maintenance. One of the decrees stated that to support the implementation of a good master plan, every hospital is required to have and maintain up-to-date statistics and to make medical records based on established provisions.

Moreover, M. Jusuf Hanafiah and Amri Amir also stated that the policy was followed by the issuance of the Decree of the Minister of Health of the Republic of Indonesia Number 134/Menkes/SK/IV/78 concerning the Organizational Structure and Working Procedures of Hospitals. In the decree, it is stated that one of the tasks of the Medical Registration Sub-Section is in charge of regulating and performing medical recording activities. From then on, medical records whose previously known as “patient status”, “medical records” or “medical documents” began to be considered and addressed. Furthermore, it was explained that the improvement of medical records was better after the issuance of Minister of Health Regulation No. 749a of 1989 concerning Medical Records. The Minister of Health regulation aims to improve the quality of health services which regulates procedures for administering medical records, ownership and utilization of medical records, contents of medical records, organization, and sanctions for procedure’s violations. In Article 46 Paragraph (1) of Law Number 29 of 2004 concerning Medical Practice, it is stated that every doctor and dentist in performing medical practice is obliged to make a medical record. Moreover, the Indonesian Medical Council (KKI) also produced a Book for the Implementation of Good Medical Practices in Indonesia, compiled a quality manual for Medical Records published in 2006 as well as in Medical Action Approval Manual[9].

M. Jusuf Hanafiah and Amri Amir also stated that to adjust medical records in health services, the Ministry of Health issued a replacement for the Minister of Health of the Republic of Indonesia Regulation Number 749a of 1989 with the Minister of Health of the Republic of Indonesia Regulation Number 269 of 2008 concerning Medical Records. Both of them also emphasized that the Indonesian Doctors Association (IDI) from the beginning had stated that to support improving the quality and role of Medical Records in health services as stated in the Fatwa IDI Decree No. 315/PB/A/.4/88 concerning Medical Records, the practice of the medical profession must carry out medical records that apply to those who work in hospitals or private practice.[9]

In medical practice, making medical records is an obligation for doctors or dentists.[10] The Medical Practice Act has categorized doctors or dentists who do not make medical records as a crime. Article 79 letter b of Law Number 29 of 2004 states: ”Sentenced to a maximum imprisonment of 1 (one) year or a maximum fine of

Rp. 50,000,000,- (fifty million rupiah) for every doctor or dentist who intentionally does not make a medical record as referred to in Article 46 paragraph (1)."

The obligation of doctors to maintain medical secrets with all the consequences is not only expressed by Indonesian law; the legal theory whose object is health services also concur. Traditionally, patients expect doctors to keep the confidentiality of their secrets. If the doctor violates this, then he/she will be faced with an authorized institution and can be determined as a defendant. Such an arrangement, of course, will have consequences for patients and doctors. In this medical secret dispute resolution, the medical record becomes prominent. Jean V. McHale writes: *"Patients have traditionally expected doctors to keep their secrets and to maintain silence regarding their confidential information. If doctors break that obligation, they may be disciplined by the professional body, the general medical council, and find themselves defendants in an action in a court of law for breach of confidence. In the light of such an expectation, many patients and doctors are surprised to be told that doctor can be forced to give evidence in the countroom about the patient's confidential information. That surprise borders on incredulity when they find that special rules of evidence protect lawyer-client information from disclosure. Why does this anomaly exist, and what is so important about confidential information anyway?*"[11]

In addition, if the doctor does not make a medical record, which then results in an unfavorable outcome for the patient, it will be difficult for the doctor to state that the action is in accordance with the procedure. Doctors or dentists in making medical records must refer to the standards that have been determined by laws and regulations; each of which has a different description/content in respective patient treatment. In general, the types and contents of medical records consist of records for outpatients, medical records for inpatients and one-day care, medical records for emergency patients, and medical records in a disaster situation.

The contents of medical records for outpatients at healthcare facilities must contain at least: a. patient identity; b. date and time; c. anamnesis results, including at least complaints and disease history; d. results of physical examination and medical support; e. diagnosis; f. management plan; g. treatment and/or action; h. other services that have been provided to the patient; i. odontogram for patients with dental cases; and j. action approval if necessary (Article 3 Paragraph (1) 1 of the Indonesian Minister of Health Regulation Number: 269/MENKES/PER/III/2008 concerning Medical Records).

The contents of medical records for inpatients and one-day care at least: a. patient identity; b. date and time; c. anamnesis results, including complaints and a disease history; d. results of physical examination and medical support; e. diagnosis; f. management plan; g. treatment and/or action; h. action approval if necessary; i. records of clinical observations and treatment outcomes; j. discharge summary; k. name and signature of the doctor, dentist, or health worker who provides healthcare; l. other services performed by certain health personnel; and m. for dental cases, patients are equipped with ondontogram (article 3 paragraph 2 of Indonesian Minister of Health Regulation Number: 269/MENKES/PER/III/2008 concerning Medical Records).

The contents of the medical record for emergency patients must contain at least: a. patient identity; b. conditions when the patient is treated in healthcare facilities; c. patient identity; d. date and time; e. anamnesis results, including complaints and a disease history; f. results of physical examination and medical support; g. diagnosis; h. treatment and/or action; i. summary of the patient's condition before leaving the emergency service and follow-up plan; j. name and signature of a doctor, dentist or health worker who provides healthcare (Article 3 paragraph (3) of the Indonesian Minister of Health Regulation Number: 269/MENKES/PER/III/2008 concerning Medical Records).

The contents of the patient's medical record in a disaster situation, in addition to complying with article 3 paragraph (3) also added with the type of disaster and the location of the patient found, the emergency category and the patient in a mass disaster number, and the identity of the person who found the patient (Article 3 paragraph (4) of the Indonesian Minister of Health Regulation Number: 269/MENKES/PER/III/2008 concerning Medical Records).

In addition, for specialist doctors, the contents of medical records can be developed according to their needs. For emergency patients who are not referred for treatment (returning home), the doctor or dentist must make a discharge summary which includes the patient's identity, admission diagnosis and indications of outpatients, a summary of the results of the physical examination, support, final diagnosis, treatment and follow-up, as well as the name and signature of the doctor or dentist providing health services.[12]

Judging from the process of creation, content and recipients, medical records based on Law No. 43 of 2009 are categorized as archives. Article 1 number 2 of Law Number 43 concerning Archives emphasizes that archives are recordings of activities or events in various forms and media in accordance with the development of information and communication technology made and accepted by state institutions, regional governments, educational institutions, companies, political organizations, community organizations, and individuals in the life of society, nation and state.

E. CONCLUSION

The term medical record, which is normatively applicable to Indonesia, has a long history. Initially, medical records served as business records in health services between doctors and hospitals. Several laws and regulations that become the forerunner and regulate medical records are: (1) Decree of the Minister of Health of the Republic of Indonesia Number 031/Birhub/1972 which requires hospitals to perform medical recording and reporting as well as hospital statistics; (2) Decree of the Minister of Health of the Republic of Indonesia No. 034/Birhup/1972 which emphasizes that to have a good master plan, hospitals are required to have and maintain good statistics and foster medical records based on the provisions of the legislation; (3) Decree of the Minister of Health of the Republic of Indonesia Number 134/Menkes/SK/VI/1978 which requires hospitals to have a sub-section of medical records; (4) Attachment of SKPB IDI No. 315/PB/A.4/88 regarding the statement of medical record/health/medical record; (5) IDI Fatwa Decree No. 315/PB/A/4/1988 concerning Medical Records, (6) Regulation of the Minister of Health of the Republic of Indonesia No. 749a/Menkes/Per/XII/1989 concerning Medical Records; (6) Indoesian Minister of Health Regulation No. 269/PER/III/ of 2008 as a replacement for the Regulation of the Minister of Health of the Republic of Indonesia Number 749a/Menkes/Per/XII/1989 concerning Medical Records; (7) Law Number 29 of 2004 concerning Medical Practice which stipulates that a doctor or dentist who intentionally does not make a record will be subject to criminal sanctions; (8) Regulation of the Minister of Health of the Republic of Indonesia No. 36 of 2012 concerning Medical Secrets.

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