

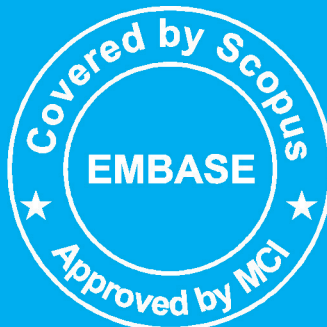
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Legal Protection of Medical Records for Hospital Patients

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Abstract

Providing Medical Records in a health service facility is one indicator of service quality at the institution. Based on the data in the Medical Record, it can be assessed whether the services provided are good enough or not, and whether they are in accordance with standards or not. Therefore in medical partners is a picture of the process of health care for every patient who goes to the hospital. Based on Article 1 of the Republic of Indonesia's Minister of Health Regulation No. 269 / MENKES / PER / III / 2008, that medical record is a file containing records and documents about patient identity, examination, treatment, actions and other services provided to patients. This means that the medical record is a systematic procedure given to the patient and the hospital patient's right to know.

Keywords: *Legal Protection, Medical Records and Hospitals*

Introduction

Good hospital services cannot be separated from the patient's medical record, where the medical record is written and recorded information about the identity, history, physical determination, laboratory, diagnosis and medical action given to patients whether hospitalized, outpatient or receiving emergency services. Medical records have a very broad understanding, not just recording activities, but also have an understanding as a system of organizing medical records that starts recording as long as patients receive medical services, followed by handling medical record files which include organizing storage and releasing files from storage for serving requests or borrowing from patients or for other purposes. Medical records are part of the archive that describes all activities by an agency within a certain period. The hospital must have a medical record as a standard of service in the health sector that is useful for improving quality in providing optimal services to all clients. The existence of records plays a significant role in determining policies and work guidelines for achieving the vision and mission of an agency. Medical records

have an important role to support the achievement of orderly administration in efforts to improve health services in hospitals and must be managed properly that is beneficial for patients, doctors and hospitals. Problems in the medical record will be seen as insignificant, but will greatly affect health services, as argued by Nugraheni.¹ Therefore, the existence of a medical record can provide health services according to standards based on the objective condition of the patient through his medical history.

Providing Medical Records in a health service facility is one indicator of service quality at the institution. Based on the data in the Medical Record, it can be assessed whether the services provided are good enough or not and whether they are in accordance with standards or not. For this reason, the government, in this case the Ministry of Health, felt that it was necessary to regulate the procedure for organizing Medical Records in a Minister of Health regulation to make it clear. Broadly speaking, the implementation of the Medical Record in the Minister of Health Regulation is regulated as follows (RI Minister of Health Number 269 / MENKES / PER / III / 2008):

1. The Medical Record must be immediately made and fully completed after the patient receives the service (article 4). This is so that the data recorded is original and nothing is forgotten because of the grace period.

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2. Every record of Medical Records must be affixed with the name and signature of the health service officer. This is needed to facilitate the system of accountability for the recording (Article 5), as opined by Nurani.²

Medical records recorded by the hospital must be known by patients as a form of patient rights.

Research Methodology

In research, the method is a means to measure the validity of research conducted by researchers. Therefore in this study related to “Legal Protection of Medical Records for Hospital Patients”, focus on the object of the medical record and the rights of hospital patient by conducting qualitative research and normative juridical approaches.

Findings and Discussion

Indonesia’s national goal is to advance public welfare, to educate the nation’s life, and to participate in maintaining world order as stated in the Preamble to the 1945 Constitution of the Republic of Indonesia. Public welfare itself means security, order, the fulfillment of needs and health. In order for a human being to live productively and be active, health is needed. In realizing health, surely efforts are needed such as promotive, preventive, curative and rehabilitative. Bambang Poernomo mentioned about health efforts in the health law that “health efforts are activities to maintain and improve health carried out by the government and or by the public by using the services of health workers,” as argued by Poernomo³ which is based on professional standards and services.

The hospital is an institution that plays a role in health care. Soekidjo Notoatmojo said that the organization of hospitals prioritized social functions that were intended:⁴

- a. Facilitate community access to health services.
- b. Provide protection for patient safety, the community, the hospital environment and human resources at the hospital.
- c. Improve quality and maintain hospital service standards.
- d. Provide legal certainty to patients, the community, hospital human resources, and hospitals itself.

According to Permenkes No.82 of 2013 concerning

SIMRS is a communication information technology system that processes and integrates the entire flow of hospital services in the form of a network of coordination, reporting and administrative procedures to obtain information precisely and accurately and is part of the Health Information System. SIMRS management must be able to improve and support the process of health services in hospitals including speed, accuracy, integration, service improvement, efficiency improvement, ease of reporting in operational implementation, as argued by Novia.⁵

The medical record is one of the most important pillars, so the organization of medical records must be managed with professional personnel. The role of medical records is needed to manage evidence of health services safely, comfortably, efficiently, effectively and confidentially. The medical record unit is one of the units in the hospital that plays an important role in providing patient data and information related to health services received by patients. The quality of health data and information is important to consider. Quality data and information obtained from the performance of good medical records officers, as opined by Utami.⁶

The hospital as an individual health service facility is part of the health resources that are indispensable in supporting the implementation of health efforts. The delivery of health services in hospitals has very complex characteristics. In the era of globalization, hospitals need to prepare themselves to compete. The rapid development of science and technology (science and technology) has led to increasing public demands for hospitals to provide fast and professional health services to the needs of medical information. Hospitals must run medical records properly. In a complete and correct medical record, information can be obtained that can be used for various purposes. These requirements include evidence for court, education and training, and can be used for analysis and evaluation of hospital service quality. Given the many uses of medical records, it is necessary to control the filling out of medical record forms, according to Winarti.⁷

Medical record document storage system is one very important factor in providing services in hospitals. Medical record document storage system provides data availability about all services that have been provided to patients. Therefore, medical record document storage must be managed properly to be able to provide optimal service to patients. According to Permenkes 269 of 2008

concerning medical records, medical record document storage space can be used to accommodate active medical record documents for five years, whereas according to the Director-General of Medical Services Development in 2006 storing medical record documents is recommended or recommended to use the system centralized storage with the alignment of the final number system, as argued by Kusnadi.⁸ So that the patient's patient record will always be maintained, to find out the patient's history.

Improved health services are intended to increase awareness, comfort and ability to live healthy for every citizen in order to realize optimal health status as one of the elements of the general welfare as mandated in the opening of the 1945 Constitution of the Republic of Indonesia. Health Personnel as one of one main component of health service providers to the community has a very important role because it is directly related to the quality of service. Implementation of health efforts must be carried out by doctors and dentists who have high ethics and morals, justice and authority that must be continuously improved. One of the main elements in a prime health care system is the availability of medical services by doctors and dentists whose quality is maintained in accordance with the mandate of Law Number 29 of 2004 concerning Medical Practices. In the implementation of medical practice, every doctor and dentist must refer to the applicable standards, guidelines and procedures so that the community can obtain professional and safe medical services. By providing good services, it will lead to public confidence in hospitals and doctors.

In order to realize optimal health status for the whole community, it is necessary to improve the quality of health services which must be accompanied by adequate supporting facilities, among others through the implementation of Medical Records (hereinafter referred to as RM) in each health care facility in the form of examinations, treatment and care. Examination, treatment and care give birth to a legal relationship between the patient or his family with a doctor and / or hospital, which is recorded in the "Medical Record", according to Sudjana.⁹

According to Regulation of the Minister of Health No. 269/MENKES/PER/III/2008, the requirements for quality medical records are: related to the completeness of the contents of the medical record; accuracy; the accuracy of medical record records; punctuality; and fulfilment of legal aspects requirements. Meanwhile,

if referring to the hospital's minimum service standard (SPM) guidelines, there are four quality target indicators, one of which is the timely delivery of medical record documents, according to Winarti.⁷

In the implementation of health services, each hospital is required to provide quality services is the implementation of medical records. The role of the medical record is very important and is very attached to the service activities because such records are useful for recording the patient's condition, examination results and the actions given at that time. Today, the rapid development of technology has penetrated various sectors including health. In this case the researcher wants to examine developments in the medical record section, where the medical record is very influential in the implementation of patient services. Medical records will be a reference in the handling of patients let alone returning to treatment so that doctors can be easier, faster and more precise in the examination and treatment of patients. The medical record is an asset to ensure the smooth running of health services, therefore an electronic-based medical record (medical records information system) is needed that is easy to use and useful to help the doctor's performance inpatient care. Basically an electronic medical record is the use of electronic methods for the collection, storage, processing and accessing of medical records of patients in hospitals that have been stored in a multimedia data basis management system that collects various sources of medical data, as opined by Dharmawan.¹⁰

Realizing the application of electronic medical records, previously required the process of migrating paper medical records to electronic medical records, namely a series of processes that began with the introduction of electronic medical records and their benefits¹¹ and they were able to use them when providing services to patients¹².

Conclusion

Medical records are hospital actions performed on patients related to identity and related to the history of treatment given by doctors and hospitals to patients. With the existence of a medical record is an effort to provide the service standards needed for hospital patients. Medical records are regulated in 1 Regulation of the Minister of Health of the Republic of Indonesia Number 269 / MENKES / PER / III / 2008. Medical records are an effort to occur in the practice mall in the

field of health services for patients.

Ethical Clearance: Yes

Conflict of Interest: No

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