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Legal and Ethical Arrangements for Medical Record Filling by Doctors: A Normative Study

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ABSTRACT – Medical law in Indonesia began to develop since 1981, triggered by the case of doctor Seitianingrum in Pati, which highlighted the importance of legal responsibility in medical practice. Medical records have a crucial role, both as administrative documents and legal evidence, in accordance with the Minister of Health Regulation Number 24 Year 2022. Medical records include important data related to patient identity, diagnosis, medical treatment, and other health services. However, mistakes in filling out medical records still often occur due to negligence. Although classified as minor negligence (culpa levis), these mistakes can have legal implications, both in the form of administrative, civil, and criminal sanctions. This study uses a normative approach to analyze laws and regulations, legal principles, and ethical standards that regulate the obligations of doctors in managing medical records. The results show that compliance with legal and ethical obligations is very important to protect patient rights, improve the quality of health services, and maintain the professionalism of doctors. Mistakes in completing medical records not only have an impact on legal aspects, but also violate the principles of medical ethics. Recommendations from this study include improving the competence of medical personnel through continuous training, implementing information technology in medical record management, and educating patients about their rights. These efforts are expected to strengthen legal and ethical compliance in medical practice, create better quality health services, and protect all involved sides.

Keywords: Medical of Law, Negligence, Medical Records, Legal Liability, Ethical Standard, Administrative Malpractice, Patient Right.

A. INTRODUCTION

Medical of law is an integral part of health law that specifically addresses various medical aspects, including the relationship between doctors, other medical personnel, and patients. In this context, medical of law not only includes regulations governing medical practice, but also involves legal liability that can arise from medical actions. This includes various legal dimensions, such as criminal, civil, and administrative law, all of which play a role in protecting patients' rights and ensuring that the practice of medicine is conducted in accordance with established standards.

One issue that frequently surfaces in the practice of medicine is negligence. The concept of negligence in the context of medical of law has significantly evolved (Lethy et al., 2023). In the past, negligence was generally understood as an attitude or action that lacked care, carelessness, or indifference towards others. However, in the medical world, the concept now has a more specific meaning and is frequently associated with the concept of "malpractice". Malpractice refers to medical actions that deviate from professional standards or established procedures, which may result in disadvantage or injury to the patient.

The problem of negligence in medical practice has become increasingly complex following the development of medical science and medical technology. With technological advances, doctors and other medical personnel now have access to various tools and procedures that can improve the quality of care (Arum et al., 2023). However, this also requires them to constantly update their knowledge and skills to stay in alignment with prevailing standards. The inability to keep up with these developments can potentially incite negligence, which in turn can result in malpractice.

On the other side, patients also have an important role in this context. Patients' awareness and understanding of their rights and the medical procedures they underwent greatly influence the relationship between patients and medical personnel. Patients' lack of understanding about medical procedures or associated risks can generate dissatisfaction

and lawsuits, even if the medical actions performed are in accordance with professional standards (Yulius et al., 2023). Therefore, it is important for medical personnel to not only focus on the technical aspects of care, but also to communicate effectively with patients, explain procedures, and obtain informed consent.

In a legal context, the issues of negligence and malpractice also raise challenges for the judicial system. Determining whether a medical act can be considered negligent frequently involves an in-depth analysis of the prevailing standards of medical practice. This requires specialized expertise and a deep understanding of the medical field in question. As a result, legal prosecution relating to malpractice can be complex and time-consuming, both for aggrieved patients and for medical personnel accused of negligence.

The issue of negligence in medical practice is not only a legal issue, but also reflects the complex dynamics between medical personnel, patients and the legal system. Understanding and addressing this issue requires a comprehensive approach, involving education and training for medical personnel, raising patient awareness, and developing clear and fair regulations. It is important to create a safe and responsible environment for the practice of medicine, where patients' rights are protected and medical personnel can do their job properly without fear of unfounded lawsuits.

One important aspect of medical practice is the creation and completion of medical records. Based on the Regulation of the Minister of Health of the Republic of Indonesia Number 269 Year 2008, which was updated with the Regulation of the Minister of Health of the Republic of Indonesia Number 24 Year 2022 on Medical Records, medical records are official documents that contain data on patient identity, examination, treatment, actions, and other services provided to patients. Medical records are not only administrative documents but also important evidence in legal procesution.

However, in practice, mistakes in completing medical records are frequently occuring. Lethy et al. (2023) explain that these mistakes can be in the form of negligence in recording information or recording that is not in accordance with standard operating procedures. Although classified as minor negligence (culpa levis), this mistake still has legal consequences and can create conflict between doctors and patients.

Based on this, this research is conducted to analyze the legal arrangements for the obligation to complete medical records by doctors and the responsibility of doctors for mistakes in completing medical records classified as administrative malpractice. This research is expected to provide a deeper understanding of the importance of doctors' compliance with legal obligations and professional ethics in providing health services.

B. METHOD

This research uses a normative approach, which is often referred to as library research. This approach aims to analyze relevant laws and regulations, legal documents, and scientific literature related to the responsibility of doctors in filling out medical records. Based on the views of Soekanto and Mamudji (2009), normative legal research includes analysis of legal principles, legal systematics, the level of legal synchronization vertically and horizontally, as well as historical and comparative legal studies.

The data used in this study consists of primary and secondary data. Primary data includes various laws and regulations such as Law No. 29/2004 on Medical Practice and Minister of Health Regulation No. 24/2002 on Medical Records, along with other relevant regulations. Meanwhile, secondary data is obtained from legal textbooks, scientific journals, and official publications that discuss the legal responsibilities of doctors.

Data collection techniques were conducted through a desk study that involved analyzing official documents such as laws and regulations, government regulations and ministerial decrees. In addition, materials from textbooks and scientific articles were also important sources, including the works of Syahrul (2008) and Notoatmodjo (2010). Legal journals relevant to the issues of medical records and administrative malpractice also complemented the data collection process.

The data was analyzed using a qualitative analysis method, which was carried out by identifying and reviewing relevant regulations, linking them with legal theory, and providing interpretations of their legal implications. In accordance with the views of Strauss and Corbin (1990), qualitative research produces findings that cannot be obtained through statistical procedures, but through text and narrative analysis.

A normative-juridical approach is also applied in this research. The approach refers to the applicable legal rules, including the principles of responsibility in civil law, criminal law, and administrative law relating to the filling of medical records by doctors. The analysis conducted aims to provide a comprehensive overview of the role of law in regulating the responsibilities of medical professionals.

C. RESULTS AND DISCUSSION

Legal Arrangement of the Obligation to Complete Medical Records by Doctors in Health Services

Medical records are important documents that contain the patient's identity, examination results, diagnosis, therapy, and other medical actions received by the patient during the treatment period. In a legal context, medical records have two main functions: as administrative documents and legal evidence. This function places medical records as a crucial element in efforts to maintain the quality of health services as well as a means of legal protection for doctors and patients.

Regulations concerning the obligation to complete medical records by doctors are regulated in various laws and regulations. Statute 46 of Law Number 29 Year 2004 on Medical Practice emphasized that every doctor or dentist who runs a practice is obliged to make medical records. The medical record must be completed immediately after the patient receives health services. Medical records must include the patient's identity, time of implementation, diagnosis, medical actions, and other services provided by health workers.

In addition, Statute 47 of the same law states that medical record documents belong to doctors, dentists, or health care facilities, while the contents of medical records belong to patients. The document must be stored and kept confidential in accordance with the standards of the medical profession. This was strengthened by Minister of Health Regulation Number 24 Year 2022 on Medical Records, which replaced Minister of Health Regulation Number 269 Year 2008.

Minister of Health Regulation Number 24 Year 2022 regulates in more detail the content, format, and storage of medical records. Medical records must include the patient's full identity, records of diagnosis, therapy, results of laboratory examinations, radiology, and other medical actions. Medical record documents must also be signed by medical personnel responsible for the services provided. Retention of medical record documents must be done for a minimum of 25 years since the patient's last visit, according to Statute 39 of the regulation.

The obligation to complete medical records by doctors is not only regulated in national law, but also an internationally recognized professional standard. According to Huffman (2008), medical records have three main functions: as a means of communication between medical personnel, as a basis for planning patient care, and as legal evidence in court. These functions place medical records as documents that are not only important for patients but also for the protection of medical personnel.

In the practice of medicine, incomplete or inaccurate medical records can have serious legal consequences for doctors. The obligation to compile and maintain proper and accurate medical records is an integral part of a doctor's professional responsibility. Non-compliance in complying with this obligation may result in administrative, criminal, or civil sanctions. In the context of Indonesian civil law, negligence in completing medical records can be considered as a violation of contractual obligations that have been agreed between doctors and patients, or as onrechtmatige daad, which is an unlawful act that harms other parties (Komaini et al., 2017; Abduh, 2021). In this case, inaccurate medical records can be the basis for patients to claim compensation for losses suffered due to negligence.

On the other hand, in the context of Indonesian criminal law, negligence in completing medical records can be interpreted as an act that harms patients' rights, especially in cases where medical records serve as the main evidence in legal prosecution (Utami et al., 2022). Inaccuracies or incomplete information in medical records can result in misdiagnosis or treatment that could potentially harm patients, so doctors can be subject to criminal prosecution if proven negligent in carrying out their obligations.

Medical records also have a significant ethical dimension. In the Hippocratic Oath, doctors are required to respect the patient's right to information and maintain the confidentiality of patient data. Therefore, the creation and management of medical records must not only meet legal standards, but must also be in alignment with professional ethics that prioritize the interests and rights of patients (Nurfauziah &

Fatimah, 2022). Failure to maintain the confidentiality and integrity of medical records can undermine patients' trust in medical personnel and the health system overall.

The strict regulation of medical records ensures that these documents can be optimally used for various purposes, including administration, treatment, and legal protection. A good and accurate medical record serves as an important communication tool between health workers, as well as evidence that can be accounted for in legal situations. However, the implementation of good medical record completion requires a strong commitment from health workers to always comply with professional standards and applicable regulations. This is very important to improve the quality of health services and protect patient rights (Sanjoyo, 2019; Rahayu et al., 2016).

Therefore, it is important for every medical personnel to realize that medical records are not just administrative documents, but also part of professional responsibilities that have legal and ethical implications. Efforts to improve the quality of medical record completion should be a priority in medical practice, to ensure that patients' rights are protected and health services can be provided properly and responsibly.

Doctor's Liability for Medical Record Completion Mistake as an Administrative Malpractice

Doctors have moral and legal responsibilities in every medical action, including in completing medical records. Medical records are not only a communication tool between medical personnel but also an important legal document in the context of professional responsibility. Mistakes in completing medical records, even if just administrative, can have a serious impact, both on the patient and the doctor as a health care provider.

Negligence in completing medical records is frequently caused by a lack of attention to detail or non-compliance with Standard Operating Procedures (SPO). According to Statute 46 of Law Number 29 Year 2004 on Medical Practice, every doctor is obliged to make and complete medical records immediately after the patient receives health services. Incompleteness or inaccuracies in medical records can have legal consequences for the doctor concerned.

In Indonesian civil law, negligence in completing medical records can be categorized as onrechtmatige daad (unlawful act) based on Statute 1365 of the Civil Code, which states that every act that violates the law and causes harm to others obliges the perpetrator to compensate for the loss. In this context, aggrieved patients can file a civil lawsuit against the doctor or health care facility.

Negligence in the completion of medical records can also have criminal implications, especially if the mistake causes significant harm to the patient. Article 359 of the Indonesian Penal Code states that anyone who through his negligence causes the death of another person shall be punished by a maximum imprisonment of five years or a maximum light imprisonment of one year. In the case of administrative negligence, even if it does not cause physical harm, it can still be considered an ethical or disciplinary violation that can result in criminal prosecution if an element of intent or gross negligence is found.

In the context of administrative law, mistakes in completing medical records can be subject to sanctions based on the Minister of Health Regulation Number 24 Year 2022 on Medical Records. Administrative sanctions can be in the form of disciplinary verbal, disciplinary letters, and revocation of practice licenses for doctors who are proven to have committed violations. These sanctions are meant to improve compliance with regulations and maintain the quality of health services.

Negligence in completing medical records also violates the principles of medical ethics. The Hippocratic Oath emphasized the importance of maintaining integrity and professionalism in health care. According to Hanafiah and Amir (2009), medical ethics require doctors to always act in the best of patients' interests, including in the creation of accurate and complete medical records.

In some cases, minor administrative mistakes can be categorized as gross negligence (culpa levis). The principle of de minimis non curat lex states that the law does not interfere with minor matters. However, repeated or willful mistakes may increase the seriousness of the violation.

To avoid legal consequences, doctors should always adhere to standardized procedures in completing medical records. This includes continous training, the use of technology that supports medical records, and the implementation of strict internal controls in healthcare facilities. Adherence to these standards not only protects doctors from legal risks but also increases patient trust in healthcare services.

D. CONCLUSIONS

The conclusion that can be drawn from this research shows that the completion of medical records by doctors is a legal obligation that has been regulated in various regulations. Law Number 29 Year 2004 on Medical Practice and Minister of Health Regulation Number 24 Year 2022 on Medical Records are the main legal basis for medical record management. Medical record documents not only function as administrative records, but also as legal evidence that has an important role in ensuring the quality of health services and protecting patient rights. Compliance with the obligation to complete medical records is an element that cannot be ignored by medical personnel, especially doctors.

Mistakes in completing medical records carry serious legal consequences. In the context of Indonesian civil law, such mistakes can be categorized as unlawful acts if they cause harm to patients. In Indonesian criminal law, mistakes that result in significant harm can be sanctioned under the provisions of the Criminal Code. Administrative sanctions can also be imposed on doctors who do not comply with this obligation, from reprimands to revocation of practice licenses. Medical record completion mistakes not only impact the legal aspect, but also violate the principles of medical ethics, which emphasize the importance of maintaining integrity and professionalism in health services.

The recommendations proposed to improve compliance in medical record management include several important aspects. First, improving the competency of medical personnel through continuous training is necessary to ensure adequate understanding of regulations and standard operating procedures. The use of information technology in medical record management, such as electronic medical record systems, is also recommended to reduce the risk of administrative errors. Consistent supervision and law enforcement against violations of the obligation to complete medical records need to be strengthened. Strict law enforcement will create a deterrent effect while increasing compliance among medical personnel.

Patient awareness of their rights also needs to be improved. Educating patients about their right to access medical information can empower them to actively participate in ensuring the quality of health services. Patients who understand their rights will be better able to maintain a balanced relationship with medical personnel, creating better healthcare dynamics. Collective efforts from all sides involved, including the government, health institutions, medical personnel, and patients, are needed to ensure that medical records are managed in accordance with legal and ethical standards.

With a systematic and comprehensive approach to medical record management, it is hopefully that the quality of health services can continue to be improved, the rights of patients are protected, and the professionalism of doctors is maintained. This study makes an important contribution in understanding the role of medical records as an administrative, legal, and ethical tool in medical practice.

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