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Legal Protection of Patient Rights to Completeness and Confidentiality in Management of Medical Record Documents

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***Abstract*— Various problems of the lawsuit exist because the health service is not optimal, complaints about the quality of health services are also perceived. If the medical record document is filled with complete, it will be easy for health professionals to explain it if there is a lawsuit. The contents of the medical record contain medical secrets. Completeness and confidentiality are the rights of the patient and are protected by law. The purpose of this study was to understand the implementation of the arrangement of the patient's right for the confidentiality and completeness of medical record fulfillment filling and legal consequences of that. The method used a sociological juridical, the approach is analytical descriptive. The type of data is primary and secondary data. Collection of information through literature and interviews. Data analysis used a qualitative approach with thematic analysis and juridical analysis. The result is shown in the fulfillment of the right of patients for the completeness of medical record filling already contained in the legislation and poured into Standard Operating Procedures (SPO), but not implemented according to Minimum Service Standards. Confidentiality is also contained in the SPO. The existing legislation as a reference for the manufacture of SPO of the medical record is not yet complete, so the SPO is not yet complete such as the confidentiality regulation for the use of electronic medical records. The completeness definition of the medical record is not clear also, the regulatory about what needs to be revised. The confidentiality and completeness of the medical record document bring the legal effect because of not fulfilling the promise as agreed in the form of optimal service endeavors. The existing regulations necessary to revised as a form of protection of the patient's rights, with due observance of the daily implementation to fulfill the public sense of** justice.

Keywords: completeness, confidentiality, medical record document

I. INTRODUCTION

The relationship between health workers and patients is known as a therapeutic relationship. Health workers are health service providers who have the professional expertise to try their best for patient health. Hippocrates called it a "therapeutic transaction".[1]

A therapeutic transaction or therapeutic agreement in law is an engagement that was born from the agreement. The parties agreeing must fulfill the legal requirements of an agreement, as contained in Article 1320 of the Civil Code, namely the existence of the deal, the ability of the parties to agree, the existence of a particular issue and the existence of a cause that is not prohibited. In general, the engagement that is used as a legal relationship between health workers/ hospitals and patients is an engagement of endeavor oriented (inspanning verbintenis) which is as optimal an effort as possible to provide health services for patients who are hospitalized, not as an agreement that results-oriented (resultaat verbintenis).

The rights of patients as users of health services will relate to the obligations of health workers and hospitals to fulfill their rights. One of the obligations of health workers to patients is the obligation to fill outpatient medical record documents.

The data contained in the medical record documentation is a patient's data that must be kept confidential. The contents of the medical record are the property of patients who must be kept confidential.[2] This medical secret is a patient's authority that can only be opened under certain conditions.[3] The release of information in medical record documents is the delivery of medical secrecy, which is protected by legislation.

Problems in managing medical records in hospitals include problems in regulation and implementation stages. Existing regulations include the Law on Hospitals No. 44 of 2009, Law on Medical Practice No. 29 of 2004, and more technically the Minister of Health Regulation No. 129/ Menkes/Per/III/2008 concerning Medical Records, has not clearly stipulated how the management of medical records that can produce good and correct data and confidentiality is guaranteed, including there are no regulations that govern the existence of electronic medical records. The regulation has explained that a good medical record is a complete medical record, but the complete definition has not been regulated. Minister of Health Regulation No. 129/Menkes/Per/III /2008

concerning Medical Records a material test was submitted to the Supreme Court in 2011 and it was decided to be rejected with the Supreme Court's Decree No. 21 P / HUM / 2011. The Supreme Court examined and tried the case for the application of the Right to Judge Material to the Regulation of the Minister of Health R.I. 269 / Menkes / Per / III / 2008, concerning Medical Records Against Law No. 29 of 2004 Article 47 concerning Medical Practice.

Completeness of filling medical record data is very important for achieving good and correct data.[4] A good medical record is a manifestation of the usefulness and efficiency of patient care. Based on the Decree of the Minister of Health of the Republic of Indonesia No. 129/ Menkes/SK/II/2008 concerning Hospital Minimum Service Standards, mentioned in the appendix, the type of medical record service, with an indicator filling of completeness of the medical record 24 hours after completion of service with a 100% standard.

Based on the results of Eka Wilda and Andini's research[5], the highest general consent data on incomplete answers is the patient/family/responsible authentication (18%), the highest incomplete entry and exit sheet is the date of authentication (74%) at the initial assessment of the highest data the incomplete answer is pain, and the last remedy (100%). While the results of Leny Herfiyanti's[6] research showed that the greatest incompleteness was found in filling in the informed consent item for an explanation of prognosis by 54.1%, alternatives & risks by 52.5%, and complications by 50.8%. Research by Nurul and Dwi (2013), shows that 60% of nursing care documentation is incomplete.[7]

A complete medical record or health record is very important and useful in health services. The purpose of the use of the health record is to have value for administrative, legal, financial, research, education and documentation purposes, or more easily abbreviated as ALFRED. This medical record is a tool for documenting patient health data or information in health care facilities.

Health service facilities, especially hospitals, require adequate space to store medical record files. According to Minister of Health Regulation No.269 Menkes/Per/III/2008 concerning Medical Records Chapter III, Article 7 that health service facilities are required to provide the necessary facilities in the context of organizing medical records. Medical records are stored in the filing which is a place for storing medical record documents. Filing functions as a storage, provider, and protector of medical record documents. This medical record must be retained for a certain period and be reused at any time. The medical record file contains individual data that is confidential. Then each sheet of medical record file form must be protected by putting it in a folder or folder so that each folder contains data and information on the results of services obtained by individual patients (not groups or families). Things that must be considered in the medical record document storage room are temperature, filing room area, distance, safety, lighting, dust and disease vectors.[8] This certainly must be considered because officers will work continuously at the workplace, with a comfortable workplace and efficient space for officers, the performance of officers can also be optimal and minimize the occurrence of fatigue due to work.

Problems that occur in hospitals associated with storing medical record document files (filing) are insufficient space availability due to a large number of patient medical record documents, and the addition of space is not possible. The results of Oktamianiza & Sinta Andriani's[9] study stated that the condition of the medical record room did not meet the area, temperature and lighting standards. The performance of medical records officers is seen from assembling: not done well (66.7%), coding is not done well (13.3%), indexing is not done well (68.3%), filing is not done well (55, 0%) of 60 medical record files. The medical record in the form of paper does have various limitations in storage, also in annihilation. Destruction of medical record files must follow the procedures that have been determined.

The existence of electronic health records is a consideration of several hospitals, but it is still a problem in securing these types of medical records. In the United States, trends in the use of electronic medical records are slowly moving. One reason for the shift is that researchers believe electronic records may help reduce medical errors that kill up to 98,000 inpatients a year in the U.S. hospitals.[10] Some doctors, for example, are now "writing" prescriptions via computer, to avoid unreadable handwriting which can cause pharmacists and nurses to give patients the wrong medication. Electronic medical records can also be monitored and audited more easily than paper medical records.[11] But the use of electronic medical records can, of course, threaten the privacy rights of patients because of the risk of unauthorized access rights, so the legislation on this subject must be emphasized. In Indonesia, EHR (Electronic Health Records) began to be widely used in hospitals, but there are some problems in its use. Based on the results of research on the use of EHR at the UGM Academic Hospital,[12] it is generally obtained that the control/security aspect of the EHR system has the highest percentage of answers of 55.80% giving quite good answers. This control/security aspect consists of integrity and security indicators. Matters relating to the access rights of the EHR system by the requirements and applicable regulations are considered good by the users of the EHR system. However, the data security indicators in the EHR system are considered sufficient. One respondent said that the existing EHR system was unable to maintain patient privacy because it was accessible to anyone. This was expressed also by other respondents who felt the privacy of the EHR system was still lacking because each medical staff could see the desired EHR of all people even though they were not patients managed. Besides, the legality of the EHR system is felt by users of the EHR system to be lacking. In addition to the EHR system, issues related to patient and health care provider concerns, certain special requirements of medical specialties, as well as safety and confidentiality approval aspects that must be met.

Management of medical records is still experiencing problems so that legal protection is needed for the patient's

right to confidentiality and completeness in the management of medical records by the mandate of the legislation. It needs to be considered when the interests of broader public health must take precedence over the interests of individual privacy. In a court in the United States, it was decided that disclosure of medical secrets for the benefit of the general public must be based on clear reasons, unreasonable disclosures from medical records may violate the constitution.[13]

II. MATERIAL AND METHODS

A. Procedure

The method used in this research is the socio-legal research approach.[14] Sociological legal research is a study conducted on the actual situation or real conditions that occur in the community intending to find out and find the facts and data needed, after the data needed is collected then it leads to the identification of problems that ultimately lead to the resolution of problems.[15]

This research is an analytical descriptive[16] study to provide a comprehensive picture of the legal protection of patients' rights to the completeness and confidentiality of the management of Medical Record Documents in hospitals.

The following are *t*ypes of the data :

1. Primary data was obtained directly from the first source related to the problem discussed.[17]

   Determination of the informant as a sample under study using purposive sampling. Purposive sampling is a sampling technique with certain considerations.[18] Data sources were obtained directly from the field by interviewing the following informants;

   a. Chairperson of the Indonesian Doctors Association (IDI) of West Java Province
   b. Chairperson of the Association of Indonesian Medical Recorders and Health Information Professional Association (PORMIKI) of West Java Province
   c. Head of Bandung "H" Hospital Medical Record Installation
   d. Head of the "S" Hospital Medical Record Unit in Bandung
2. Secondary data as a complement to primary data sources. This study uses secondary data sources in the form of primary legal materials, secondary legal materials, and tertiary legal materials.

Collecting information to obtain data in this study, through library studies or documentation and interviews.

The study was conducted by library research in the library. Researchers also conducted interviews and observations in several places, including the "H" hospital and the "S" hospital in Bandung, the office of the West Java Province IDI secretariat and West Java PORMIKI

B. Data Analysis

The analytical method used juridical analysis, which is an analysis that bases on theories, concepts, and legislation.

III. RESULTS

A. Implementation of Arrangement of Fulfillment of Patient's Right to Confidentiality and Completeness of Completion of Medical Record Documents related to Therapeutic Agreement in Hospital

Hospital "H" and Hospital "S" in the management of medical records refer to the management of medical records from WHO (2006). The different thing in the "H" Hospital is in the management of storage of medical records using a decentralized system. There are five medical record storage rooms. Inpatients who are from outpatient and emergency care, their medical record documents can be continued and added to create an inpatient medical record. Whereas patients who were hospitalized and had previously been outpatient, but were not immediately treated, or before there were other illness conditions and were just simply being treated outpatient, did not get a continuous medical record document intact, because of the storage of medical records separately. Only previous patient data can be accessed through the SIMRS (Hospital Management Information System), but there is only a history of diagnoses and medical actions taken. In the Inpatient Storage Room, before the medical record is stored in the storage room, the data is updated first, in the form of computerized data filling consists of Diagnosis, Additional Diagnosis, Measures, How to Go Home and Hospital Entrance Hours. The data is used for hospital reporting. The results of interviews with the head of the medical record installation, that the construction of a new building is being prepared to centralize medical record documents.

Management of medical records at "S" Hospital, also refers to the management of medical records from WHO (2006). But what is different is that the analysis of the completeness of the medical record is carried out after coding, arguing that the code also has an accurate analysis at all. Analysis of the completeness of the medical record does not refer to the theory of medical record completeness in the form of a patient identity review, authentication/doctor's signature review, review of filling important reports, as well as a review of good documentation. Completeness analysis in the form of checking the presence or absence. The completeness analysis officer fills in the checklist form that must be present. The medical record document storage system has been centralized in the same place, both for inpatient, outpatient, and emergency services.

Procedures for managing medical records both inpatient, outpatient and emergency in the "H" Hospital, clearly state the completeness of the medical record documentation. The procedure in the form of a permanent procedure consists of the understanding, objectives, policies, procedures, related sections, and related documents. The complete word was written at the beginning contained in the understanding of the procedure. The definition of medical record processing is managing inpatient medical record files so that the contents

are complete, easily processed, grouped, calculated and analyzed and easily stored and retrieved if needed. In the policy section, it is clear that the inpatient medical record file returned to the medical record section must be completed. Furthermore, items 2 and 3 in the procedure emphasize the necessity of a complete medical record, appearing in the form of a statement in the following procedure;

1. Inpatient medical record files analyzed by the assembling analyzing officer examined the completeness of both patient identification, important reports, authentication, and records.
2. For incomplete medical records of inpatients, the incompleteness is recorded and then sent to a patient care room/doctor who treats for completion.

Implementation of the fulfillment of the patient's right to complete the medical record file at the "S" Hospital is outlined in several procedures. One of them is the complete medical record analysis procedure. The hospital policy deadline for fulfilling medical records is 14 days after the patient returns. There is special staff in charge of carrying out a completeness analysis and being clarified by their duties and authorities. While the security and confidentiality of medical records are also contained in a separate procedure, namely the Procedure of Maintaining the Security and Confidentiality of Medical Records. The procedure explains that the security and confidentiality of medical records for medical record files, including electronic medical records. Although the points in the procedure do not specify the ways to secure electronic medical records. Completeness of the medical record is also contained in the procedure, that the complete medical record will be stored in a special cabinet of medical record storage (filing).

The patient's rights that are clearly stated in the laws and regulations relating to the medical record are the right to obtain the contents of the medical record.[27] Fill in the medical record referred to in the form of a medical summary or medical resume.[28]

Implementation of the patient's right to obtain a medical resume at "S" Hospital is included in the Medical Records Information Giving Procedure. The procedure provides clear steps for obtaining medical information. As for medical information in the context of meeting the interests of third parties such as insurance, it is regulated in a separate procedure.

Implementation of the patient's right to obtain a medical resume at "H" Hospital is contained in the Medical Resume Service Procedure. The procedure illustrates that there is a fulfillment of the patient's right to a medical resume. The stated objectives of the procedure are to;

1. The interests of the patient's health
2. Maintaining the confidentiality of the contents of the medical record
3. Meet the requests of other interested parties
4. Prevent lawsuits.

The procedure clearly stated that medical information is only given with the consent of the patient and the Hospital Director. Thus, the confidentiality of medical information is maintained. The medical resume service procedure is accompanied by a power of attorney.

Legal protection arrangements for the fulfillment of the patient's rights to the completeness and confidentiality in the management of medical record documents at the "H" Hospital are outlined in several procedures which become internal regulations of the hospital. One procedure to maintain the confidentiality and security of medical record files. The procedure clearly emphasizes that the contents of the medical record are not read by unauthorized persons, and various efforts are made by the hospital so that any medical record file is not damaged or lost.

The hospital also has a data publication procedure to regulate the implementation of data/information publications relating to clinical outcomes and patient safety or other data at the hospital. There are several parties responsible for sorting and evaluating so that the data can be properly published to the public.

The regulation of confidentiality appears to conflict with other procedures, namely the procedure for retrieving and borrowing outpatient medical records. The procedure explains one of the stages: the officer takes the file on a storage rack and hands it to the patient or family. Then the patient or patient's family will bring the outpatient medical record file to the intended clinic. The results of an interview with one of the medical records officers, sometimes patients do not go to the polyclinic of the intended destination but he goes home, so that the medical record file which belongs to the hospital, is not kept confidential. It might be scattered on the way home, and the patient's secrets become public consumption. The officer further conveyed a large number of patients, making it difficult to do efficiency if the medical record file must be carried by the officer because it requires a large number of officers and high mobility. In some hospitals, the distribution is done by using a trolley / special rack and or can be delivered using a bicycle vehicle. Associated with the ownership rights of medical record files that belong to the hospital, the Procedure of Taking and Borrowing Outpatient Medical Record Files is a violation of ownership rights. Whereas for patients there is a violation of the right to protection of medical secrets. Furthermore, procedures related to borrowing medical records. This is possible and is included in the procedure for borrowing medical records. At point number 7 the procedure allows the medical record file to be borrowed out with a maximum period of 7 days. But it seems that there is no article relating to the protection of the patient's rights as the owner of the contents of the medical record document if the file is lost when borrowed. The procedure is also complemented with a medical record lending letter.

Completeness and confidentiality of medical record documents are already contained in legislation and operationalized in-hospital procedures. Therefore, efforts are needed to fulfill these rights as a form of justice for the community as recipients of health services.

A comprehensive understanding of officers in fulfilling medical record filling as part of alignments with justice is very important to create a good and consistent legal culture. Facts

in the field (results of observations and interviews in hospitals), compliance with filling out medical records, have not become a legal culture, running sporadically as needed, for example by the existence of accreditation activities. SPO already exists while the implementation is not going well, so as an organization based on management functions, some should be responsible for supervision and guidance so that the regulation can be carried out by what should be. Referring to the rules,[29] who responsible for fostering and supervising the management of medical records are the provincial health office, district/city health office, and professional organizations.

The results of interviews at the hospital, it appears that the function of supervision and coaching is not going well. Participant 4, who is the chairperson of professional association of medical records and health information organization in West Java province, revealed that although mandated by the law in overseeing the management of medical record documents, the professional organization could not play a large role in supervising, in addition to a large number of health workers making it difficult to supervise and supervise technicians. Eventually, this coaching function becomes difficult, the professional organization only works when there has been a case or lawsuit. The government, which in this case is carried out by the health department, also cannot play a role in supervision and guidance in the management of medical record documents. Clear regulations are needed that govern coaching techniques and appropriate tools in coaching and supervision. Thus, the patient's rights can ultimately be fulfilled. The existence of Professional Organizations and the Health Service is not effective enough to conduct supervision and evaluation because it is not directly involved. Supervision (controlling) is the last and very important function in management science. Supervision (controlling) is to measure whether the implementation of the movements of the organization is in accordance with the plan or not and determine the causes of irregularities or problems and immediately take corrective action if necessary also to oversee the use of resources in the organization so that it can be optimized effectively and efficiently to suit organizational planning. Supervision and evaluation of technical issues are carried out by parties who are part of the organization, in terms of the management of medical records can be carried out by the leadership with the hospital quality assurance department.

The results of interviews and observations in hospitals, the relationship between health workers, especially doctors and patients, have not proceeded in harmony. Doctors do not have enough time to sit listening to patient complaints and write them in the medical record. The existence of many forms that must be filled, as well as various types of forms that sometimes change, for example, due to accreditation, will the attention of health workers in filling out medical records. Likewise for hospitals that function as teaching hospitals, work rotation of residences (specialist medical education program) and other health students also require extra attention because they also use the same medical record documents for educational purposes.

Another important thing in managing medical records is the leadership commitment. Hospital leadership support and commitment have a central role. The results of the interview show that the leadership's commitment can affect the performance of employees in fulfilling the completeness of filling medical records. Leaders need to give rewards and punishment that is appropriate for health workers who complete medical record documents completely and made clear/precise rules / SPOs.

B. Legal Consequences of Non-Fulfillment of Confidentiality and Completeness in Filling Medical Record Documents (DRM) on Patients' Rights Linked to Therapeutic Agreements in Hospitals

A result of not fulfilling the filling of Medical Record Documents (DRM) at the Hospital that was raised submitted by the participants was the obstruction of payment *claims* and the absence of sufficient evidence if there were legal cases. The more complete filling of medical records means the possibility of claim is higher. Other Claims are very important issue in the era of National Health Insurance (JKN). Late submission of a claim causes late payment and will accumulate into accounts receivable to the hospital.r important thing in managing medical records is the leadership commitment.

The results of the study explained that the existence of the "H" Hospital as a teaching hospital also had implications for being used as a place of practice by health students, including by *residences* (doctors who were attending specialist education), so that *residence* changes that received official rotation schedules, contributed to the incompleteness of filling medical record document. Participants explained that because the "H" Hospital is a teaching hospital, socialization must often be made to the *residence* in how to fill out their medical records. *Residence for* each unit or each room has its rotation schedule, there are once a month there are once every two months, so if for example once a month has been socialized, the second month replaces people again. This is one of the obstacles. Participants gave an explanation that for (completeness of medical record documents) was targeted, although it was volatile because it depends on policies or forms or there was a PPDS (Specialist Medical Education Program) that had just entered or had just been rotated. Participants reiterated that one of the obstacles in fulfilling the completeness of filling medical record documents is a rotation for *residence*.

IV. DISCUSSION

A. Implementation of Arrangement of Fulfillment of Patient's Right to Confidentiality and Completeness of Completion of Medical Record Documents related to Therapeutic Agreement in Hospital

Therapeutic agreements in hospitals involve patients and health professionals as legal subjects. Health workers and patients meet at the hospital as a place of health care. The patient who came to look for health workers he knew was in the hospital. The arrival of patients to the hospital is the stage for the start of therapeutic transactions. While therapeutic agreements themselves begin to occur when there is the ability of doctors to provide health services. The therapeutic transaction between the patient and the doctor does not start from the time the patient enters the doctor's office, as many people suspect, but when the patient states his complaint and the doctor declares his ability to treat patients who are stated orally or implied statement. However, patients who come to the hospital, rarely get rejected (even the law prohibits hospitals to refuse patients), which will also be referred to, will be examined first at the hospital/place of practice.

Therapeutic agreements/relationships between health workers and patients as contained in Article 1319 of the Civil Code which states that:

"All agreements, whether they have a special name or not known by a certain name, are subject to the general rules contained in this chapter and the previous chapter".

Health care is the right of everyone guaranteed in law. Optimal health services are safe, quality, anti-discrimination and effective health services that prioritize the interests of patients by hospital service standards. Optimal health care is an achievement for health workers about patients. Achievements according to Article 1234 of the Civil Code consist of; to give something, to do something, and not to do something. In the context of optimal health services, it is said to be an achievement if a health service is performed;

1. There are medical indications, for healing efforts. If there is no medical indication, it can be classified as persecution.[19]
2. Performed according to professional standards, professional service standards, operational procedures standards and professional ethics and health needs of recipients of health services.[20]
3. There is consent/permission of the patient or family after getting information (informed consent).[21]
4. Clearly documented in medical record documents.[22]
5. Performed by competent and authorized health workers.[23]

Whereas default is an attitude where a person does not fulfill or fails to carry out the obligations as specified in the agreement. A default situation means the opposite of achievement.

Fulfillment of the patient's right to confidentiality and completeness of filling medical record documents is the patient's right arising from the agreement as a means of transformation from general objective law to more specific subjective law. The objective law is because there are legal regulations in the form of laws and regulations of the minister of health that impose obligations on providers of medical record services, both those that create medical records and those that store medical records. The existence of an agreement causes the parties to be burdened with obligations that have been grounded into subjective law. The basis for a transaction or therapeutic agreement is the right to self-determination, which gives birth to the principle of freedom of contract in an agreement. Because of the principle of freedom of contract, the parties can determine the clauses made in the agreement based on justice, practice and the law, but must fulfill the principle of balance, to carry out the agreement in good faith. The agreement also led to the birth of the rights and obligations of the parties. The fulfillment of rights is a subjective law. Subjective law is a relationship governed by objective law, based on which one has rights, another has obligations. Objective law not only regulates but also enforces. Thus, behind the subjective law, there is a force that forces the objective law. The law not only gives rights, but also the tools to carry them out. Fulfillment of rights accompanied by obligations to be fulfilled by health workers to fulfill them.

Obligations of health workers to make medical records listed in the legislation.[24] This obligation will relate to the patient's rights in the management of medical record documents. The main rights of patients in the management of medical records are;

1. The right to medical records to be equipped.
2. The right to the confidentiality of the contents of medical record documents

Obligations of health workers to medical records, listed in the Regulation of the Minister of Health RI No. 269/Menkes/ Per / III / 2008 concerning Medical Records, i.e. medical records that are made must be complete, and clear both in writing and electronically. Other obligations stated in the legislation are to maintain the confidentiality of the contents of medical record documents.[25] In jurisprudence, several doctrines underlie the emergence of confidentiality relations, including the doctrine of professional relations. Likewise, the relationship between a doctor and his patient is professional. This professional relationship creates a special confidential relationship, so it should not be opened to others or the public directly.[26] This completeness and confidentiality are the obligations of the health worker which is the patient's right to fulfill.

The scope of protection relating to health law, in this case, the legal protection for patient rights is always growing.[30] This is in line with the development of the relationship between health workers and patients. There are several laws and regulations issued by the Indonesian government as positive law. Positive law is only the embodiment of the existence of norms and to convey legal norms. Hans Kelsen said that every law is a norm. The embodiment of the norm appears as a tiered building starting from the highest positive norm to the lowest embodiment called the individual norm.[31] Protection of the patient's right to the confidentiality of medical record documents is a necessity protected by positive law. This medical secret or medical secret is a patient's authority that

can only be opened under certain conditions.[32] The principle of legal protection for the people of Indonesia, according to Philipus M. Hadjon, is based on Pancasila as the basis of ideology and the basis of state philosophy. Recognition and protection of human dignity and status are said to originate from Pancasila because recognition and protection of them are intrinsically inherent in Pancasila. Aside from being based on Pancasila, the principle of legal protection is also based on the principle of the rule of law. The formulation as a rule of law brings consequences, firstly the relationship between governing and governed is not only based on an objective norm which also binds the governing. The two objective norms, the law, must meet the requirements not only formally but materially must be good and fair. Good, because it is following what people expect from the law and fair because the basic purpose of all laws is justice.[33]

Legal protection is the government's obligation to its people. Legal protection for the people is a universal concept, which is adopted and applied by every state of law. The position of the government in legal protection in the field of civil and public law.[34]

Legal protection for patients involves various matters, namely the problem of the patient's legal relationship with health workers, the rights and obligations of the parties and their responsibilities and aspects of law enforcement.

One of the factors that influence law enforcement is the legal factor. Law in the form of a set of laws and regulations. Existing legislation, as stated by participants is already contained in hospital regulations but has not been implemented properly. Hospital regulations are legal products at the institutional level that should be implemented. The regulation was made by the institution based on the regulation above. Hans Kelsen named the highest norm as Grundnorm or Basic Norm, and Grundnorm did not change.[35]

Completeness of filling out the medical record documentation as written in Article 2 and Article 5 of Minister of Health Regulation No. 269 / Menkes / III / 2008 concerning medical records, contained in SPO (Standard Operating Procedure) and hospital service guidelines. The rules regarding completeness already exist and are listed which should be a guideline in filling out the medical record document in the hospital. But the implementation is not optimal. The results of interviews with participants said that in the service guidelines explained about medical records must be filled immediately after service, 24 hours after service and returned on time. Likewise, with completeness, minimum hospital service standards are required, completeness of filling medical record documents is 100%.[36] While the implementation in the field, it is difficult to be able to implement it. Hospital "H" and Hospital "S", which incidentally is a hospital that is a reference in the province of West Java, and has been nationally accredited that was KARS and passed the international accreditation of the Joint Joint Commission (JCI), also not able to implement the regulation. Seeing this, the existing regulations contain demands that exceed what can be done and there are discrepancies with daily implementation.

The duplicate filing of medical records is also influenced by good communication at the hospital. The results showed that communication had not gone well. The existence of a Clinical Instructure is very important to give an example of a good relationship with health workers who provide health services. Good practice advisers from academics namely lecturers and hospitals in the form of Clinical Instructure (CI) must be a good role model in providing services to patients and assisting health students in providing services to patients. The responsibility for the patient is entirely on the part of the hospital which is carried out by competent doctors and health workers who are legally employed by the hospital rather than the students of the practice. Therefore practice students including young doctors (co-ass) and specialist medical education program work under the supervision and direction of the appointed supervisor, both from the educational institution and from the hospital.

Government support is also needed in improving facilities and infrastructure in the management of health services.[37] IT-based medical record documents are expected to improve services and streamline service times, although of course they must be accompanied by manual medical records to avoid system errors or network errors. IT-based medical record documents can also save time in documenting thereby increasing the meeting time of health workers and patients who are expected to improve health services for patients thereby encouraging a comprehensive improvement in the quality of health services.

B. *Legal Consequences of Non-Fulfillment of Confidentiality and Completeness in Filling Medical Record Documents (DRM) on Patients' Rights Linked to Therapeutic Agreements in Hospitals*

A harmonious relationship and commitment to be bound in a contract is known as *Pacta Sunt Servanda*. *Pacta sunt servanda* means a commitment to keep promises made express or implied and binding. This attachment was born as a form of responsibility of the parties, and normatively is the attitude and values adopted by the majority of humans in normal circumstances. Surely patients who come to health services want healing and optimal conditions, even if necessary contrary to the law. For example, the proliferation of news on organ sales, such as kidneys, is against the laws and norms of society, but if examined further is the patient's efforts, in this case, a patient wants the kidneys to heal as before. This means that every person who comes to health services as a patient wants the optimal condition back to be obtained through health services carried out by the hospital through health workers who work in it. Likewise with health workers. Every normal healthy worker wants to be able to provide the best health services for his patients. The commitment of both parties to keep their promises is known as Pacta Sunt Servanda. The regulation of the principle of pacta sunt servanda on positive law is regulated in the Third Book Part 3 concerning Consequences of Agreement, Article 1338 Paragraphs (1), (2) and (3) of the Civil Code namely;

1. All agreements made by the law apply as the law for those who make them;
2. The agreement cannot be withdrawn other than by agreement of both parties, or for reasons determined by law.
3. Approval must be carried out in good faith

Pacta sunt servanda has an impact on the legal consequences after the agreement is implemented. The legal effect is not fulfilling the completeness of filling Medical Record Documents (DRM) on the rights of patients in the hospital, is not meeting the theories and principles of pacta sunt servanda.

Attachments to agreements or contracts are very strong, binding as they are bound to the law. What is promised is closely attached and must be fulfilled. Likewise, the parts or elements in the agreement which include essences, naturalia, and accidental forms are attached to the agreement which must also be fulfilled. Based on this, the creditor's position in terms of the relationship between health workers and patients is that the patient's position becomes more favorable. The object of health services in the form of optimal health services is carried out by health workers who must fulfill the things that have been agreed upon as well as the characteristics or parts attached to the agreement. So it can be understood that the fulfillment of the agreement is more heavily borne by health workers and hospitals. While the patient agreement in the relationship between health workers and patients is mainly just an obligation about costs that must be prepared for payment and this may also have been paid by BPJS. In addition to other obligations such as the obligation to provide clear and complete information. But providing clear information aimed at the patient himself will also benefit the patient more. Achievement in the relationship between health workers and patients is mostly done unilaterally, namely by health workers and hospitals.

According to the theory of pacta sunt servanda, that a contract or agreement results in binding the parties that make it the same as binding to the law. No matter how weak a contract is, there must be an attachment. In reality, some agreements can be canceled unilaterally as in contracts or agreements for health workers and patients. Patients can unilaterally cancel the agreed agreement. Cancellation of the agreement can be through an informed refusal form. The cancellation does not immediately terminate the patient's contract with the health worker. Except, if the patient is discharged from the hospital, and signs a form stating his desire to be discharged. Then, it automatically breaks the engagement in the contract.

Any contract or agreement made despite the principle of freedom of contract will ultimately result in an obligation to be bound to the contract agreed upon. So the contract has a force that is forced to be fulfilled. The principle of freedom of contract means that the parties are free to enter into contracts as long as they are by the legal requirements of the contract (Article 1320 of the Civil Code). So that contracts made legally according to the theory of freedom of contract, are valid as legal contracts, which bind the parties according to the theory of pacta sunt servanda.

The incompleteness of filling medical record documents, it is considered not fulfilling the promise. This contradicts the implementation of the pacta sunt servanda theory, meaning that the promise was not kept. Although in a contract or agreement there is the principle of freedom of contract. It means that before agreeing, the parties are free to arrange themselves, whatever they want to enter into the contract clause, then after entering into a contract or agreement, the parties are no longer free, but bound to what has been determined in the agreement. Attachment to what is specified in the contract is the same as the power of attachment to the law. Pacta sunt servanda has an impact on the legal consequences after the agreement is implemented. The juridical consequence is the publication of the rights and obligations of the parties to carry out what has been promised. Failure to carry out the obligations in the agreement in fulfilling the completeness of filling medical record documents can be categorized as having done a default.

Default due to negligence or intentional failure to fulfill the completeness of medical record documents, as a result of the law the therapeutic agreement does not have a direct impact on the patient. This is related to the ownership of the medical record file which belongs to the hospital and is unknown to the patient. Patients are entitled to the contents of the medical record, while the contents of the medical record cannot be known by the lay patient because each case/disease will be different, and requires different treatment. It requires a health worker who is honest and open and has enough time to be able to do a comprehensive health service and then put it in a medical record document. Government support is needed to be able to facilitate it.

As a result of the Agreement contained in Book III Civil Code Article 1338 - 1341. Article 1338 discloses that all agreements made are binding. The parties must carry out what has been agreed in good faith. It is assumed that the parties to the agreement have thought well and are ready with all the consequences of the agreement. The matters agreed in the therapeutic agreement do not take the form of specific clauses, except in the informed consent form, but what is the object of the legal agreement is optimal health services, which must meet the legal conditions of the agreement, one of which is a cause that is not prohibited , meaning it is bound to the rules. If the agreement does not meet the legal requirements in the form of a cause that is prohibited or not according to the rules, the agreement can be null and void. So that the laws and regulations are forced. Agreements may deviate from the law. Because the object of the agreement is optimal health services, health workers can violate the law, for example without informed consent in critical life-threatening situations, which is important to provide optimal services first for the best conditions of their patients.

Another thing that needs to be observed is that the agreement must fulfill the principles of justice, custom, or the law. The law clearly states the obligation to organize medical records. Completeness of filling medical records must also be 100%

contained in statutory provisions. However, the agreement must fulfill the principle of habit. The research results emerge the fact that hospitals cannot fulfill 100% filling obligations, even in hospitals that are internationally accredited namely JCI accreditation. The completion rate is still below 100%.
Medical record documents contain data that will be information. Health information can be useful for patients themselves, for the continuation of health care. With complete data, health workers will obtain complete information so that the management is likely to be appropriate and comprehensive. If the data is incomplete, health workers may obtain limited information and it is possible to manage it inappropriately. Health information will also be important data for the development of health science as health research material. Research becomes an important capital for improving health science, health supports the development of human resources (HR) which is very important to build the nation.

The government is busy with large health budgeting every year. The problem in budgeting is that budget allocations for curative and rehabilitative funds are far higher than promotive and preventive budgets, whereas promotive efforts are intended to maintain and improve healthy public health so as not to fall ill. This situation has the potential for inefficiency in health efforts. For the government, health information is very important to make health planning policy decisions that are right on target. Incorrect information will lead to wrong decisions. The problems faced in health planning include lack of adequate data and information, according to needs and on time.

Next is the incomplete filling of Medical Record Documents resulting in the absence of sufficient evidence if there is a legal case. Medical Record Documents can be legal evidence. The law requires proof, both in criminal cases and in civil cases. This evidence is important to help judges decide cases. The proof is convincing the judge of the truth of the arguments or arguments presented in a dispute. Proof requires evidence. Medical record documents are types of evidence in the form of written evidence and letters. Writing evidence in a civil case is the main evidence, while in a criminal case, the most important evidence is a testimony, but there is also written evidence in the form of letters in the proof of a criminal case.

Medical record documents as written evidence, which contains all records of patient care while in health care facilities such as hospitals. Indeed, in principle, all written evidence is detrimental or burdensome to those who have written it, damaging or damaging the creator. However, the article can be evidence that health services have been carried out by procedures. Process-oriented health services (*verbintenis inspanning*), not results. Patients returning home in good health or even death cannot be evidence of justification of the action given.
Medical records have the function as evidence of letters. The provisions regarding the evidence of the letter are regulated in Article 187 of the Criminal Procedure Code (Criminal Procedure Code).
Article 186 of the Criminal Procedure Code explains expert statements as evidence. Expert statements when connected with the relationship between health workers and patients can be written or written. Expert information in the form of writing can be in the form of a Medical Record (RM). This medical record is outlined by health experts in the form of notes and documents about the patient's identity, examinations, treatment, actions and other health services that have been provided to patients. Therefore it can be concluded that the medical record has a dual function as evidence, namely;
1. Evidence letter
2. Expert evidence evidence

The medical record is a proof for patients that health service efforts carried out by health workers are optimally provided by service standards and professional health professional standards and carried out with patient approval. As for health workers, medical records become evidence, that health workers have worked by service standards, professional standards and professional code of ethics. Therefore, the more complete the medical record, the stronger its function as evidence that provides legal protection for doctors.
Obligations of doctors and dentists in carrying out medical practice, as regulated in article 51 of Law No.29 of 2004 concerning Medical Practices is related to filling medical records that must be by professional standards and operational procedure standards and patient medical needs, maintaining medical secrets and providing services always refers to applicable medical ethics. With the existence of legal norms that regulate medical records and legal protection for hospitals and health workers according to their profession, especially doctors, the medical record has a strong position, to be used as written evidence before the law, especially in cases of lawsuits in the health sector. Therefore all or part of the information can be used as evidence that meets the requirements and therefore the medical record must be kept neat, clean and confidential. If in the future there is a claim of alleged medical malpractice against doctors and hospitals, then in the process of proving medical records and Approval of Medical Action / *Informed Consent* that is carried out responsibly can be used as evidence of justification in a court of the actions taken.
Ida Sugiarti's research (2016),[38] shows that the signing of *informed consent* is incomplete. The authentication review showed that the completeness of filling the highest *informed consent* form on the doctor/nurse signature item was 62.71% while the lowest completion completeness on the patient signature item was 91.53% incomplete. Authentication as a form of accountability for implementing health services should need to be filled in full. Republic of Indonesia Minister of Health Regulation No. 269 / Menkes / PER / III / 2008 concerning Medical Records in Article 5 Paragraph 4 emphasizes that every record in a medical record must be affixed with the name, time and signature of the doctor, dentist or certain health workers who provide services directly.

An *informed consent* form is one of two forms in a medical record document that must be kept longer, even in hospitals, to be a document that must be preserved. The point is that the *informed consent* form must not be destroyed. Completeness of filling out medical record documents must be considered, including the writing listed must be clear. The existence of medical record documents, makes patients feel safe knowing that the health services provided are continuous and according to procedures. Medical record documents provide security also for the profession of health workers because health workers have run all health services to patients clearly by competent people and according to procedures. So that if there are lawsuits in the future, medical record documents can be beneficial evidence for health workers and hospitals. The patient's condition, later on, can be known as a medical risk or medical malpractice.

As a result of not fulfilling the completeness of filling Medical Record Documents (DRM) in hospitals is very clear that is not fulfilling the rights of patients. The patient's right to health is protected by law.

As a result of incomplete medical record documents certainly, have an impact on the suboptimal fulfillment of some of the patient's rights stated above.

As a result of the non-fulfillment of the contract will make the party doing the default or those who violate the contract law must be held responsible. The legal responsibility in the therapeutic agreement is carried out by the legal subjects who carry out the agreement namely the hospital and health workers. With the implementation of the *corporate liability* doctrine, the hospital can be held responsible for all events that occur in the hospital. Law No. 44 of 2009 concerning Hospitals Article 46 explains the legal responsibilities of hospitals;

The hospital is legally responsible for all losses incurred for negligence committed by health personnel in the Hospital.

Other doctrines are *a vicarious liability* and *ostensible agency* or *apparent agency*. The doctrine of *vicarious liability* is a criminal liability imposed on someone for the actions of others (*the legal responsibility of one person for the wrongful acts of another*). The teaching of *vicarious liability is* taken from civil law which is then used in criminal law practice. The organization is responsible for employer-employee relations. While the *hospital's apparent agency* or *agency* is *vicariously* responsible for the attitude of action, the doctor's negligence when the hospital gives the public the impression that it is as if Doctor X was the hospital's doctor.

In connection with completing the fulfillment of filling medical record documents, the hospital's responsibility is to provide facilities. RI Minister of Health Regulation No. 269 / Menkes / Per / III / 2008 concerning Medical Records Article 7 explains that;

Health service facilities are required to provide the necessary facilities for the organization of medical records.

"Required facilities" contained in the above regulations do not provide a complete explanation. But in the medical record science, there are ways of organizing medical record documents that can be carried out in a hospital.

Hospitals are institutionally required to have a medical record unit/installation that specializes in managing medical records, although in general the management of medical records has begun at the place of registration of patients both outpatient, inpatient or in the emergency room. Therefore a medical record and health information (PMIK) already exists in each registration room to manage any initial information that comes in from a patient who will then issue a medical record document. After the patient is treated both outpatient and inpatient, the medical record documentation will be given to the medical record unit/installation to be managed in certain units in the room.

The hospital is responsible for fulfilling the human resources working to manage the medical record and prepare the facilities, including the required forms. Even now it is headed for the use of *electronic health records*, which of course must be prepared and facilitated by the hospital. As a result of not fulfilling human resources and medical record management facilities will complicate the management of medical records which will have an impact on the suboptimal services provided. However, it is difficult to be able to measure the existence of existing facilities, which can usually only be proven through assessment in hospital accreditation. The next important responsibility is the responsibility of health workers, especially doctors who treat, and health workers in charge also fill medical record documents such as nurses and midwives. The main responsibility for the completeness of the medical record lies with the treating doctor. The doctor has the final responsibility for the completeness and correctness of the contents of the medical record. Likewise, nurses and midwives, because there are separate forms that must be filled out by nurses and midwives.

The complete medical record document can be in the area of civil law. The discussion above is enough to explain that there are losses caused by incomplete medical record documents. Responsibility in terms of civil law is based on the provisions of Article 1365 of the Civil Code. If health workers in carrying out their duties perform actions that cause harm to patients, then these health workers can be sued by patients or their families who feel disadvantaged based on the provisions of Article 1365 of the Civil Code.

The principle of responsibility in health law is a principle-based on the presumption (*rebuttable presumption of liability principle*). In this principle, the defendant is always considered guilty unless he can prove things that can free him from mistakes. This principle is adopted in health law. Regulation of the Minister of Health of the Republic of Indonesia Number 36 of 2012 Concerning Medical Secrets Article 14 explains;

If a patient sues a health worker and/or health service facility, the health worker and/or health service facility sued has the right to reveal medical secrets in the context of his defense in a court hearing.

This means that health workers as defendants must prove things that can free them from mistakes. However, losses to

the incompleteness of filling medical record documents, do not have a clear dimension to blame. Because the impact of the incompleteness of filling medical record documents is not felt directly to bring harm. Likewise, it is difficult for patients to provide enough evidence that can make incomplete medical record documents to be sued because the medical record file belongs to the hospital while the patients are a medical summary or medical resume. The position of the medical record can only be evident if there is a lawsuit for malpractice presumption. Judges can decide cases by looking at the contents of medical record documents as evidence of letters and evidence of expert testimony. Medical record documents are valid evidence and based on the evidence the judge will make a decision. The *verbintennis inspanning* doctrine provides a limit because health service efforts are an endeavor so that doctors and health workers cannot promise a cure, therefore it cannot be directly proved as a breach or unlawful act (*onrechtmatige daad*).

Other responsibility lies with the medical records officer, who assists the doctor in fulfilling the medical record. Analysis of the completeness of the contents of the medical record is intended to look for things that are lacking and are still in doubt. To assist doctors in re-analyzing medical records, medical record personnel must carry out qualitative and quantitative analyses. So ideally this medical record officer is in each treatment room to make it easier to coordinate with the treating doctor. The implementation of Medical Recording Work is regulated in the Indonesian Minister of Health Regulation No. 55 of 2013. One of the authorities of the medical recorder regulated in the ministerial regulation is the authority to evaluate the contents of the medical record in the form of an analysis of the completeness of the medical record documentation.

Parties who have to take responsibility other than health workers in hospitals are practical students. In the Field Work Practices (PKL) or professional programs such as doctors or nurses, all students are also required to be responsible and maintain the confidentiality of the contents of the patient's medical record documents at the hospital. To maintain this confidentiality, each student promises to uphold the professional code of ethics in maintaining confidential medical information. *Co-as* and *residence* students *are* usually involved in filling out medical record documents at the hospital, so they must also be responsible for completing medical record documents.

The government regulates management in teaching hospitals through Government Regulation of the Republic of Indonesia Number 93 of 2015 concerning Teaching Hospitals. The teaching hospital has the functions of service, education, and research in the fields of medicine, dentistry, and other health. Obligations of hospitals as teaching hospitals in carrying out their functions must still pay attention to service standards and prioritize patient safety.

Discussion of the legal consequences of not fulfilling the confidentiality of Medical Record Documents is a violation of the responsibilities as a doctor or health worker. Legal responsibility as his profession. "Responsibility" in the legal sense means "attachment". In addition to the law, there are also ethical violations, because keeping medical secrets is very clear usually contained in the Code of Ethics in every health profession, especially doctors. Keeping the secrets of medicine is an obligation of health workers, and health workers are professionally bound to be responsible for these obligations.

Violations of medical secrets are easily identified because they appear from confidential patient medical news that is spread or known by unauthorized persons mandated in law. So that the criminal sanctions are quite clear. While violations due to incomplete medical record documents are not easily known because ownership of medical record files belongs to the hospital. Because of this, the discussion of legal consequences caused by not fulfilling the confidentiality and completeness of filling medical record documents on the rights of patients in the hospital, more about the legal consequences due to incompleteness of filling medical record documents (DRM).

V. CONCLUSION

1. Implementation of the regulation of fulfillment of patient rights to confidentiality and completeness of filling Medical Record Documents in hospitals if linked to therapeutic agreements, the patient's right in the form of confidentiality already exists substantially in Minister of Health Regulation No. 36 of 2012 concerning Medical Secrets and the completeness of medical record documents already in the Minister of Health Regulation No. 269/Menkes/Per/III/ 2008 concerning Medical Records, but the explanation is not yet clear so that the right of patient has not been fully fulfilled. Implementation in hospitals has not been carried out according to minimum service standards, and the structure (facilities and infrastructure) has not been fully facilitated plus the organizational legal culture that has not been properly developed.
2. Due to the legal non-fulfillment of confidentiality and completeness of filling medical record documents (DRM) associated with therapeutic agreements, then it is considered not fulfilling the promise (pacta sunt servanda), so the party that violates the promise must be responsible both civil, criminal and administrative.

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[19] *See the Criminal Code (KUHP) Article 351 -358 regarding Persecution. The absence of medical indications can be excluded by the patient's request being limited to certain cases permitted by the law, for example for cosmetics and aesthetics, for example carrying out plastic surgery or in cases of requesting Sectio Caesarea surgery without medical indication, but the nature of the engagement can shift to being oriented towards results (resultaat verbintennis), therefore health workers must be more careful in carrying out medical actions and believe that all medical risks can be ignored and the process of giving informed consent must be clearer.*

In Indonesia, in the POGI Annual Scientific Meeting (PIT) in Jakarta, July 2011 it was agreed to make changes to the POGI code of ethics which states that section Caesarea (SC) at the request of the patient is not a form of ethical violation as long as a special informed consent is made , that is, there is a letter of approval for the medical procedure for sectio Caesarea with a special format and is explained directly by the doctor who will carry out the action, accompanied by witnesses from the doctor, and witnesses from the patient, which contains: 1) Request explicitly is written that hereby the patient requests to performed Sectio Caesarea, 2) That the patient has been described by a doctor who dissected about; c sectio cesarean delivery will be done even though an examination has been done by a doctor that the patient can give birth vaginally, delivery via cesarean section is no better when compared to vaginal delivery, there are risks that can arise in the mother and fetus associated with Sectio Caesarea.

The results of research Dumilah Ayuningtyas et al, Health Ethics in Labor Through Caesarean Sectio Without Medical Indications, JOURNAL OF MKMI, Vol. 14 No. 1, March 2018 https://media.neliti.com/media/

publications/238447-secondary-health-only-birth- through-2cb2a22b.pdf, states that based on the ethical theory of consequentialism, labor through SC without medical indications can be assessed as unethical medical treatment considering the medical action is still considered to be no safer and riskier even though medical technology has developed rapidly. According to the deontological theory (obligation), labor through SC without medical indication can be said to be ethical if the doctor has performed his obligations, if he has carried out an informed consent procedure and performed SC operations by applicable medical procedures, without the slightest error.

Whereas plastic surgery or surgery is contained in Law No. 36 of 2009 concerning Health Article 69 namely; can only be done by health workers who have the expertise and authority to do so. Plastic surgery should not conflict with the norms prevailing in society and is not intended to change identity.

[20] Undang-Undang RI No. 36 Tahun 2014 tentang *Tenaga Kesehatan*, Article 58.

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[22] *See* Peraturan Menteri Kesehatan RI No. 269/Menkes/Per/III/2008 tentang *Rekam medis* dan Undang-undang RI No. 44 Tahun 2009 tentang Rumah Sakit

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[25] See Peraturan Menteri Kesehatan RI No. 269/Menkes/Per/III/2008 tentang *Rekam Medis* Article 10 dan Peraturan Menteri Kesehatan RI No. 36 Tahun 2012 tentang *Rahasia Kedokteran.*

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[28] Peraturan Menteri Kesehatan RI No. 269/Menkes/Per/III/2008 tentang *Rekam Medis* Article 12

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