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Electronic Medical Records as Evidence of Therapeutic Transactions

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Abstract

The results of the medical examination are proof of the doctor-patient relationship, which is documented in a record containing an explanation of the patient's health condition based on the results of the examination that has been carried out. Although the recording process is an obligation, there are several cases where medical records are not filled in correctly and some are not even filled in by officers. Therefore, this research is designed to find out the urgency of electronic medical records as evidence of therapeutic transactions. The problems studied in this article are: First, the juridical consequences of health workers and hospitals in making and keeping RM or RME confidential; Second, the position and strength of RM or RME as evidence according to the law of evidence. The results show that health workers or hospitals are obliged to make Medical Records or Electronic Medical Records correctly and responsibly. Regulation of the Minister of Health Number 749a/MENKES/Per/XII/1989 concerning Medical Records is the basis for the obligation to procure Medical Records, therefore it must be adhered to for every health service.

Keywords: Medical Records, Electronic Medical Records, Evidence

Abstrak

Hasil pemeriksaan kesehatan merupakan salah satu bukti adanya hubungan dokter-pasien, yang didokumentasikan ke dalam catatan berisi penjelasan kondisi kesehatan pasien berdasarkan hasil pemeriksaan yang telah dilakukan. Meski proses pencatatan itu adalah kewajiban, dijumpai beberapa kasus rekam medis tidak diisi dengan benar dan bahkan ada yang tidak diisi oleh petugas. Oleh karena itu, penelitian ini didesain untuk mengetahui urgensi rekem medis elektronik sebagai alat bukti transaksi terapeutik. Adapun permasalahan yang dikaji dalam artikel ini yakni: Pertama, konsekuensi yuridis tenaga kesehatan dan rumah sakit dalam membuat dan merahasiakan RM atau RME; Kedua, kedudukan serta kekuatan RM atau RME sebagai alat bukti menurut hukum pembuktian. Hasil penelitian menunjukkan bahwa Tenaga kesehatan atau rumah sakit wajib untuk membuat Rekam Medis atau Rekam Medis Elektronik secara benar dan bertanggung jawab. Peraturan Menteri Kesehatan Nomor 749a/MENKES/Per/XII/1989 Tentang Rekam Medis menjadi dasar adanya kewajiban pengadaan Rekam Medis, oleh karena itu harus ditaati bagi setiap pelayanan kesehatan.

Kata kunci: *Rekam Medis, Rekam Medis Elektronik, Alat Bukti*

Introduction

The practice of medicine in its implementation is a professional responsibility that must be fulfilled by a doctor, both those that have been regulated in law and those that are regulated in his agreement in seeking health. Doctors in carrying out their profession as stipulated in Law No. 29 of 2004 concerning Medical Practice have the following obligations:

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Article 51:

a. provide medical services in accordance with professional standards and standard operating procedures as well as the patient's medical needs;
b. refer the patient to another doctor or dentist who has better expertise or ability, if unable to perform an examination or treatment;
c. to keep confidential everything he/she knows about the patient, even after the patient has passed away;
d. perform emergency aid on the basis of humanity, unless he is certain that there are other people who are on duty and capable of doing so; and
e. increase knowledge and keep abreast of developments in medicine or dentistry.

One of the responsibilities of doctors in seeking the recovery of their patients is to conduct medical examinations to determine the presence / absence of disturbances in the health of their patients and find out what diseases are suffered. Doctors are required to have a scientific skill in overcoming a disease The reciprocal relationship obtained from the patient is information about what the patient complains about honestly and openly, thus creating an attitude of mutual trust and producing effective doctor-patient communication (Hapsari 2014).

The results of the health examination are proof of the doctor-patient relationship, which is documented in a record containing an explanation of the patient's health condition based on the results of the examination that has been carried out. The quality of health services needs to be improved in order to optimize health status. Adequate supporting facilities are needed to support this. The organization of medical records is one of the supporting facilities in improving the quality of health services in every health care facility in the form of examination, treatment and care. Thus, medical records are records that contain legal relationships between patients or their families with doctors and or hospitals (Marini, 2013).

Medical Records (hereinafter referred to as RM) are very important along with the development of a very dynamic society, because RM has actually been done since ancient times even though it has not become an obligation. Electronic Medical Records (hereinafter referred to as RME) is one of the technologies in the field of health services that contains data and information about health in accordance with globalization (Guwandi, 1992, Andriani, Kusnanto, and Istiono 2017).

RM or RME is a tool in therapeutic transactions between health workers and patients, therefore from a juridical point of view it is evidence of a legal relationship (Hettinger, Melnick, and Ratwani 2021; Negro-Calduch et al. 2021) (Budiyanti,

Herlambang, and Nandini 2019). Thus, the existence of RM or RME is required in health care (therapeutic) facilities, both in terms of the practical (factual) implementation of health services and from the legal (juridical) aspect (Shumilina 2022) (Hettinger, Melnick, and Ratwani 2021).

Research Problems

Based on this description, the following problem formulation is obtained:

1. What are the juridical consequences of health workers and hospitals in making and keeping RM or RME confidential?
2. What is the position and strength of RM or RME as evidence according to the law of evidence?

Research Metods

The writing of this article uses normative research methods (Asikin 2004), The main problems in this research are the juridical consequences of health workers and hospitals in making and keeping RM or RME confidential and the position and strength of RM or RME as evidence of therapeutic transactions. This research is a descriptive research that is able to provide data that is as accurate as possible about the process of legal operation of Electronic Medical Records as evidence of therapeutic transactions (Soekanto n.d.) The data is analyzed normatively-qualitatively by interpreting and constructing statements contained in documents as a policy that refers to laws and regulations. Normative because this research is based on existing regulations as positive legal norms, while qualitative means that data analysis is based on documents as case findings and documents from field searches at the research site. The approaches used in this research are statute approach and conceptual approach (Syamsudin 2021).

Discussion

1. Juridical Consequences of Health Workers and Hospitals in Making and Keeping RM or RME Secret

The Explanation of Article 46 Paragraph (1) of Law No. 29 of 2004 Concerning Medical Practice states "what is meant by medical record is a file containing records and documents about the patient's identity, examination, treatment, actions and other services that have been provided to the patient." The 21st century is characterized by information technology. The development of science and information technology affects the use of medical records, which were originally carried out conventionally through pieces of paper, to be equipped with

technological means to be more effective, efficient and facilitate health services to patients.

In accordance with the program planned by the government based on the basis of Health Development, and to realize the Vision of Healthy Indonesia 2025, the Health Development mission is set, namely to improve and utilize health resources which include health human resources, health financing, and pharmaceutical supplies and medical devices. Health resources also include mastery of health/medical science and technology, as well as data and information, which are increasingly important.

The Indonesian government through the Ministry of Health has issued Minister of Health Regulation Number 749a/MENKES/Per/XII/1989 concerning Medical Records. With the issuance of this PERMENKES, the procurement of RM became a must or has become a law that must be obeyed for every health care facility, but the regulation is still about paper-based RM (conventional). Subsequently, PERMENKES No. 269 Year 2008 on RM was issued, which explained that "RM must be made in writing, complete, and clear or electronically" (Sudra 2021).

Along with the development of information technology and electronic transactions, Permenkes No. 24 of 2022 concerning Medical Records has been issued as a replacement for Permenkes RI No. 269/MENKES/PER/ III/2008 concerning Medical Records. According to Article 1 of Permenkes Number 24 Year 2022 concerning Medical Records, what is meant by Medical Records is a document containing data on patient identity, examination, treatment, actions, and other services that have been provided to patients. Electronic Medical Record is a Medical Record made using an electronic system intended for the implementation of Medical Records.

As a compilation of facts about health conditions and diseases, a patient's RM will contain 2 important things: 1). Documentation of patient data about current and past disease states; and 2). Written documentation of treatment actions that have been, are being and will be carried out by doctors as health professionals (Handiwidjojo, 2021).

Based on the two important conditions above, in general, the information contained in a patient's RM must contain three elements, each of which is:

a. Who is the patient and Who is treating/providing medical treatment.
b. What is the patient's complaint, when did it start, why or why it happened and how did the patient receive medical treatment.
c. The result or impact (Outcome) of the medical action and treatment that the patient has received.

Data containing the three elements above must not be wrong, accurate and must not be left behind, because the data has a fatal impact on the safety of the patient's life if an error occurs (Handiwidjojo, 2021).

Every doctor or dentist in carrying out their medical practice is obliged to make a RM immediately and completed after the patient receives services that are carried out through recording and documenting the results of examinations, treatment, actions and other services that have been provided to patients. Each recording into the RM must be affixed with the name, time, and signature of the dentist or certain health workers who provide direct health services. In the event of an error in recording in the RM, corrections can be made. Corrections can only be made by crossing out without removing the corrected record and affixed with the initials of the doctor, dentist or certain health workers concerned (Handiwidjojo, 2021).

The provisions of Article 29 Paragraph (1) letter h of Law No. 44/2009 concerning Hospitals explain that, "Every hospital has the obligation: to organize RM." The explanation of the article says, "What is meant by organizing RM is that it is carried out in accordance with standards which are gradually strived to achieve international standards." Violation of this obligation is subject to administrative sanctions in the form of:

a. reprimand;
b. written reprimand; or
c. fine and revocation of Hospital license.

The provisions of Article 70 and Article 71 of Law No. 36 of 2014 concerning Health Workers explain "Every Health Worker who carries out individual health services is required to make a Health Service Recipient RM which must be completed immediately after the Health Service Recipient has finished receiving health services". Each Health Service Recipient RM must be affixed with the name, time, and signature or signature of the Health Worker who provided the service or action. The Health Service Recipient RM must be stored and kept confidential by the Health Worker and the head of the Health Service Facility. The Health Service Recipient RM belongs to the Health Service Facility. In case of need, the Health Service Recipient may request the RM resume to the Health Service Facility (Guwandi, 2004,Budiyanti, Herlambang, and Nandini 2019, Asih and Indrayadi 2023).

The RM file belongs to the health care facility while the content of the RM belongs to the patient in the form of a summary of the RM which can be given, recorded or copied by the patient or person authorized or upon written consent of the patient or the patient's family entitled to it. This is reinforced by Article 47

Paragraph (1) of the Medical Practice Act that RM documents belong to doctors, dentists, or health care facilities, while the contents of the RM belong to the patient. Based on this, the ownership of the RM is distinguished between the file and its contents, although the file and the contents are an inseparable unit. From the point of view of civil law, RM is a document in the form of paper or electronic and contains writings that contain meaning about a situation, reality or action (Putri, 2022).

The content of the RM is in the form of data that must be included in the Medical Record and is distinguished for patients examined in the outpatient, inpatient and emergency departments. Every service can make an RM whether it is in the outpatient, inpatient, emergency department, patients due to disasters, specialist services and specialist dentists, and services provided in ambulances or mass treatment (Rosyada, Lazuardi, and Kusrini 2016).

RM storage procedures are one part of the work done in connection with the storage of a document. There are two types of storage, namely storage of unfinished or still processing documents (Pending Files) and storage of documents that have been processed (Permanent Files). If detailed carefully, the steps or storage procedures are:

a. Inspection;
b. Indexing;
c. Marking;
d. Sorting first;
e. Saving

RMs of inpatients in hospitals must be kept for at least a period of 5 (five) years starting from the last date of treatment or discharge. After the 5 (five) year limit has been exceeded, RMs can be destroyed, except for discharge summaries and approval of medical actions. The discharge summary and approval of medical action must be kept for a period of 10 (ten) years from the date the summary was made. Storage of RMs and discharge summaries is carried out by officers appointed by the head of the health service facility. RMs at non-hospital health care facilities must be kept for at least 2 (two) years from the date of the patient's last treatment. After the time limit is exceeded, the RM can be destroyed (Kothari et al. 2017; Shervani, Madden, and Gleason 2021, 2021).

The content of the patient's RM has juridical consequences, namely its confidentiality, so that the RM is a file that must be kept confidential. Disclosure of the contents of the RM may only be made by the doctor or dentist treating the patient with the patient's written permission or based on statutory regulations; The head of the health service facility may explain the contents of the RM in writing or

directly to the applicant without the patient's permission based on statutory regulations (Davies et al. 2021; Kothari et al. 2017; Snowden 2020).

All information contained in the RM is confidential therefore, utilization of the contents of the RM must be with the permission of the patient, unless:

1. Legal necessity;
2. Referral to other services for the benefit of the patient/family;
3. Evaluation of services in one's own institution;
4. Research/education;
5. Contracting with service agencies or organizations

The confidentiality of the contents of the RM is not only a right for the patient, but also an obligation for health workers to keep the secret of their position. By not regulating the provisions of violations of the confidentiality of the doctor's office in the Minister of Health Regulation on RM and the Medical Practice Act as special provisions (lex specialis), then based on the principle of "lex specialis derogat lege generalis" the provisions used in the event of a violation are the Criminal Code as a general provision (lex generalis). Criminal penalties for the disclosure of official secrets are stipulated in Article 322 Paragraph (1) of the Criminal Code "anyone who intentionally discloses a secret that must be kept because of his current or former position or job, shall be punished with a maximum imprisonment of nine months or a maximum fine of six hundred rupiahs." Every doctor or dentist in practicing medicine is obliged to keep medical secrets because "the obligation to keep secrets is attached to the conditions imposed on the profession. Every person who entrusts his/her healing to a doctor, must be able to believe that what is revealed by the patient himself/herself or later known from the results of the examination which is considered to be entrusted to the doctor must be considered as a secret. If this requirement is not met, then this becomes an obstacle for patients to seek help from doctors because they are worried that their secrets will be revealed. The secret of the profession and the obligation to keep secrets lies not in an agreement or a declaration of will (such as a doctor's oath), but in the special nature of the profession itself that promises full trust and guarantees its confidentiality (Dymek et al. 2021; Goldstein et al. 2017; Vestling, Ramel, and Iwarsson 2013).

The right to medical secrets belongs to the patient, not the treating doctor. The doctor's duty of confidentiality applies to everyone, except his or her patients. There are three exceptions to this principle, namely:

a. laws and regulations;
b. the granting of permission to disclose from the patient as the one entitled to confidentiality; and

c. conflict of obligations relating to differences of interest.

Meanwhile, according to Indonesian positive law, disclosure of medical secrets can be done for:

a. In the interest of the patient's health;
b. Fulfilling the request of law enforcement officials in the context of law enforcement;
c. The patient's own request; or
d. Based on statutory provisions.

Requests for RM for this purpose must be made in writing to the head of the health care facility. Explanation of the contents of the RM may only be done by the doctor, dentist treating the patient with the patient's written permission or based on laws and regulations. The head of the health care facility may explain the contents of the RM in writing or directly to the applicant without the patient's permission based on laws and regulations (Guwandi, 2004).

Circular Letter of the Director General of Medical Services Number YM.02.04.3.5.2504 concerning Guidelines for the Rights and Obligations of Patients, Doctors and Hospitals says:" Patients have the right to "privacy" and confidentiality of the disease suffered including medical data; Patients have the right to receive information which includes: the disease suffered; what medical action is to be carried out; the possibility of disease as a result of the action and actions to overcome it; other alternative therapies; prognosis; and estimated cost of treatment.

The aforementioned provisions do not specifically and explicitly say RME, but Minister of Health Regulation No. 269/MENKES/PER/ III/2008 on Medical Records, as a replacement for PERMENKES No. 749a/MENKES/PER/XII/1989, which states "RM must be made in writing, complete and clear or electronically." This means that it gives an obligation to health workers (doctors and dentists) to make both conventional and electronic RMs. The issuance of Minister of Health Regulation Number 24 Year 2022 on Medical Records, as a replacement for the previous Permenkes, provides a statement on the obligation for every health service facility to organize Electronic Medical Records. The health service facilities referred to consist of independent practices, health centers, clinics, hospitals, pharmacies, health laboratories, centers and other health service facilities determined by the Minister.

RME is in line with Law No. 11 of 2008 concerning Electronic Information and Transactions, which has been updated with Law No. 19 of 2016 concerning Amendments to Law No. 111 of 2008 concerning Electronic Information and Transactions, as explained in Article 9: "Business actors offering products through

the Electronic System must provide complete and correct information relating to the terms of the contract, producers, and products offered"; and Article 10 Paragraph (1): "Every business actor that organizes Electronic Transactions can be certified by a Reliability Certification Body." The notion of "may" means it does not have to, so RME can be certified or not certified.

RME is the use of information technology tools for collecting, storing, processing and accessing data stored on RM patients in hospitals in a database management system that collects various sources of medical data. Even some modern hospitals have combined RME with the Hospital Management Information System (SIMRS) application which is a parent application that not only contains RME but has been added with features such as administration, billing, nursing documentation, reporting and dashboard score cards (Sudjana 2017).

RME can also be defined as an application environment composed of clinical data storage, clinical decision support systems, standardization of medical terms, computerized data entry, and medical and pharmaceutical documentation. RME is also useful for paramedics to document, monitor, and manage health services provided to patients in hospitals. Legally, the data in RME is a legal record of the services that have been provided to patients. The hospital has the right to store the data. RME is different from Electronic Health Record (RKE). RKE is a collection of patient RMEs in each hospital (health service center). RKE can be accessed and owned by the patient and the data can be used in other health care centers for subsequent treatment purposes. RKE can only be realized if there is already a standardization of RME data formats in each hospital so that these data can be integrated. To realize RKE, an integrated system is needed and agreed upon by each health service center in a certain region or even wider than that, for example national.

RM or RME has various uses. The usefulness of RM or RME can be seen from several aspects, among others:

a. Administrative aspect: the content concerns actions based on authority & responsibility for health workers.
b. Medical aspect: because the records are used as a basis for planning the treatment & care to be provided.
c. Legal aspect: because the contents concern the issue of legal certainty on the basis of justice in an effort to uphold the law and evidence to uphold justice.
d. Financial aspect: can be a material to determine the payment of health service fees.

e. Research aspect: because it contains data or information as an aspect of research & development of science in the field of health.
f. Educational aspects: because it involves information data on the chronological development of medical services to patients that can be studied.
g. Documentation aspect: because it is a source that must be documented which is used as accountability & report material.

In Indonesia, the use of RME innovation began to accelerate with the issuance of Permenkes No. 24 of 2022 concerning Medical Records, which requires RME in every health care facility. The guarantee of confidentiality and data protection by the government makes RME has advantages, namely:

a. The level of confidentiality and security of electronic documents is higher and more secure. One common form of security is that RMEs can be password-protected so that only certain people can open the original file or the copy given to the patient, making them more secure than conventional RMs;
b. The copying or printing of RMEs can also be restricted, as has been done with copyrighted multimedia files (songs or videos), so that only certain designated persons can copy or print them;
c. RME has a higher level of security in preventing loss or damage to electronic documents, as electronic documents are much easier to 'back-up' than conventional documents;
d. RME has higher capabilities than the things that have been determined by PERMENKES No 269 of 2008, for example, the storage of medical records for at least 5 years from the date of patient treatment (Article 7), RME can be stored for decades in the form of solid disk storage media (CD / DVD) with a more compact storage area than conventional RM which requires a lot of space & special care;
e. The need to use RMs for research, education, statistical calculations, and payment of health care costs is easier to do with RME because the contents of RME can be easily integrated with hospital or clinic or practice information system programs or software without neglecting confidentiality aspects. This is not easily done with conventional RM;
f. RME facilitates the search and transmission of information and makes storage more concise. Thus, data can be displayed quickly as needed;
g. RME can store data with a large capacity, so that doctors and medical staff know the track record of the patient's condition in the form of previous medical history, blood pressure, drugs that have been taken and previous actions so that further actions can be taken appropriately and potentially avoid medical errors;

h. The ITE Law has also regulated that electronic documents (including RME) are valid for use as evidentiary material in legal cases.

Some reasons why RME did not develop quickly in Indonesia include:

a. Many parties suspect that RME does not have a clear legal umbrella, especially with regard to ensuring that the stored data is protected against elements of privacy, confidentiality and information security in general. Technically, encryption technology including various biometric markers (e.g. fingerprints) will be more protective of data than a regular signature. However, the problem is not in technical matters but in legal aspects. Questions often arise such as how hospitals are able to provide protection for the security of patient data from the hands of irresponsible people, how is the validity of electronic documents, and what if there is an error in writing patient medical data? To answer all of this, clear regulations and legality are needed. But regulation-making cannot match the speed of information technology advancement. In some states in the US, hospitals only print RME if it will be used as legal evidence. Wan Fang Hospital in Taipei is the opposite. The hospital always keeps a printed RM that must be signed by the doctor as a printout of the patient's RME.
b. The next challenge is the classic reason of availability of funds. The financial aspect is an important issue because hospitals have to prepare information technology infrastructure (computers, wired and wireless networks, electricity, security systems, consultants, training, etc.). Hospitals usually have a limited budget, especially for information technology.
c. RME is not prioritized because other systems such as computerized billing system, accounting system, payroll system, etc. are preferred. Hospitals assume that all systems are prioritized because they can ensure fast, transparent and accountable hospital financial management. This is because RME also has the following disadvantages:1).Requires a larger initial investment than paper RM, for hardware, software and supporting costs (such as electricity); 2).Time required by key personnel and doctors to learn the system and redesign workflows; 3).Conversion of paper RM to RME requires time, resources, determination and leadership; 4).Risk of computer system failure; 5).Problem of limited computer usage skills of its users; 6).There is no standard RME provision from the government in the form of Electronic Medical Record Guidelines.

RM or RME is important information for patients, therefore doctors or hospitals have an obligation to inform correctly, clearly and honestly regarding the health services that have been provided to patients. Furthermore, through the RM

or RME, the patient has the right to be given guidance on the treatment that is being carried out by a doctor or hospital so that the disease heals quickly, and health services in the guidance must be carried out correctly, honestly, and non-discriminatory. Furthermore, patients also have the right to have their personal data (including their medical history) kept confidential (Astuti 2017; Nababan et al. 2020).

RM or RME is related to consumer (patient) protection, namely the provisions on consumer rights to correct information, guidance, and health services as regulated in Article 4 letters c, f, g, and i of Law No. 8 of 1999 which reads: Consumer rights are: "...c. the right to correct, clear, and honest information regarding the condition and guarantee of goods and/or services"; "...g. the right to be treated or served correctly and honestly and non-discriminatorily"; and "...i the rights stipulated in the provisions of other laws and regulations, for example the right to have their personal data (including their medical history) kept confidential". Violation of the obligation to provide correct, clear and honest information and to keep the patient's personal data (medical history) confidential is included in Article 8 letter a of the Consumer Protection Law which says "does not meet or does not comply with the required standards and provisions of laws and regulations," which can be punished under Article 62 Paragraph (1) of the Law with a maximum imprisonment of 5 (five) years or a maximum fine of Rp 2,000,000,000.00 (two billion rupiah).

The absence of RM or RME in health services has legal consequences related to (1). Responsible for RM or RME; (2). Sanctions for violations of the provisions of the RME (Wahjuni, 2012). RM or RME belongs to the hospital as the person responsible for the integrity and continuity of service as well as the hospital's evidence of all efforts in healing the patient; RM also belongs to the health worker holding the original RM file. The Hospital Director is responsible for: a. Loss, damage, or forgery of the RM; b. Use by unauthorized entities or persons; The contents of the RM belong to the patient who must be kept confidential.

The unavailability of RM or RME in health care facilities is seen as a violation in the field of administration, therefore the sanctions imposed are in the form of administrative sanctions, namely in the form of verbal warnings to revocation of licenses. In addition, violations of the RM provisions, namely not providing RM facilities, as stipulated in Article 79 letter b of the Medical Practice Act, are punishable by imprisonment for a maximum of 1 (one) year or a maximum fine of Rp. 50,000,000,- (Fifty million rupiah). The crime is an ordinary offense, so it does not require complaints from parties who feel aggrieved.

In the event of an error in recording the RM, files and records should not be removed or deleted in any way. Changes to records or errors in the RM can only be made by crossing out and initialing the officer concerned; each RM record must be affixed with the name, time, signature of the officer who provides (direct) service or action. If the RM record uses electronic information technology, the obligation to affix a signature can be replaced by using a personal identification number. Violation of these provisions can be subject to civil sanctions, as stipulated in Article 1365 of the Civil Code "every unlawful act, which causes harm to others, obliges the person who through his fault causes the loss, to compensate for the loss." The content of the Medical Record is a medical secret that must be kept confidential by every health worker, so that the unlawful disclosure of the contents of the Medical Record can cause the health worker concerned to be subject to criminal, civil or administrative sanctions.

2. Position and Strength of Medical Records or Electronic Medical Records as Evidence according to the Law of Evidence

The benefits of a clear and complete RM or RME for medical personnel are as a basis or guide for planning and analyzing diseases and planning treatment, care and medical actions that must be given to patients, as well as improving the quality of service to protect medical personnel in achieving optimal public health. While the use of RM or RME for patients, among others, is as a basis for knowing the calculation of the cost of payment for medical services that must be or have been issued and the development of disease, treatment, and medical action. Therefore, a good, correct, and complete RM or RME that is confidential is important information for patients, so that the absence or error in making it has legal consequences.

From the point of view of proving criminal law in court related to errors in the health sector: a. The process of proving a criminal case in court is to find the material truth or the real truth, meaning that proof does not only require written evidence but must be corroborated by other evidence, for example expert witnesses; b. In proving, the whole or all of the evidence must be corroborated by other evidence. In the proof, the whole or part of the information can be used as evidence to support the defense efforts for hospitals and health workers, especially doctors; c. Expert witnesses, in addition to having to provide true testimony because they are sworn, can also prove that their testimony is scientifically grounded as evidenced by the existence of the whole or part of the information in the RM of the patient concerned; d. Evidence in the form of RM and expert witness testimony. Evidence in the form of RMs and sworn expert testimony will be taken

into consideration by the judge, in deciding the case on the claim of whether or not the doctor was at fault; e. A lawsuit for criminal acts, due to the existence of fault that is reinforced by the element of intent / negligence of the doctor for not preparing everything to anticipate the risks that can occur / arise, so that the patient suffers fatal injuries even to disability or death (Sudjana 2017).

RMs that can be brought to court must meet the following requirements: 1. the RM is not written in pencil; 2. there are no erasures; 3. scribbles, corrections can only be made at that time and initialed; 4. the writing is clear and legible; 5. there is a signature and name of the officer; 6. there is a date and time of examination and action; 7. there is a medical action approval sheet. RM can be used as an evidentiary tool as regulated in Article 1866 of the Civil Code and Article 184 of the Criminal Procedure Code. The provisions of Article 1866 of the Civil Code states, Evidence includes: written evidence; witness evidence; testimony; confession; and oath. Meanwhile, Article 184 Paragraph (1) of the Criminal Procedure Code states that valid evidence in criminal law are: (1) Witness testimony; (2) Expert testimony; (3) Letters; (4) Clues; (5) Statement of the defendant (Astuti 2017).

The provisions of Article 13 Paragraph (1) letter c of the Minister of Health Regulation Number 269/MENKES/PER/III/2008 concerning Medical Records states: "Utilization of medical records can be used as evidence in the process of law enforcement, discipline of medicine and dentistry and enforcement of medical and dental ethics." RME as evidence is strengthened by Law No. 19/2016 on Amendments to Law No. 11/2008 on Electronic Information and Transactions (ITE Law) in conjunction with Minister of Health Regulation No. 269/2008. The provisions of Article 13 Paragraph (1) letter b of the PERMENKES states: the use of RM "as legal evidence in the process of law enforcement, discipline of medicine and dentistry and enforcement of medical ethics and dental ethics." The provisions of Articles 5 and 6 of the ITE Law explain:

Article 5:

1. Electronic information and/or electronic documents and/or their printouts are valid legal evidence.
2. Electronic information and/or electronic documents and/or their printouts as referred to in Paragraph (1) are an extension of legal evidence in accordance with the applicable Law of Procedure in Indonesia.
3. Electronic information and/or electronic documents are declared valid if they use an electronic system in accordance with the provisions stipulated in this Law.

Article 6:
In the event that there are other provisions other than those stipulated in Article 5 Paragraph (4) which require that information must be in written or original form, electronic information and/or electronic documents are considered valid as long as the information contained therein can be accessed, displayed, guaranteed its integrity, and can be accounted for so as to explain a situation.

The existence of Electronic Information and/or Electronic Documents is binding and recognized as valid evidence to provide legal certainty for the Implementation of Electronic Systems and Electronic Transactions, especially in proof and matters relating to legal actions carried out through Electronic Systems. Especially for Electronic Information and/or Electronic Documents in the form of interception or wiretapping results or recording which is part of wiretapping must be carried out in the context of law enforcement at the request of the police, prosecutor's office, and/or other institutions whose authority is determined based on the law.

The obstacle faced in the evidentiary process is expert testimony, which is regulated in Article 186 of the Criminal Procedure Code. The intended expert testimony can also have been given at the time of examination by the investigator or public prosecutor as outlined in a form of report and made by remembering the oath at the time of accepting the position / job. If it is not given at the time of examination by the investigator/public prosecutor, then at the time of examination by the investigator or public prosecutor in court, he/she is asked to provide information and it is recorded in the minutes of the examination. The statement is given after taking an oath or promise before the court regarding the truth of the statement as an expert witness. The oath or promise given as an expert witness must be distinguished from the oath / promise made when accepting an office / job.

The expert testimony intended by Article 186 of the Criminal Procedure Code, if it is related to the relationship between a doctor or dentist and a patient, can be in written or unwritten form. Expert testimony in written form can be in the form of RM or RME. The legal function of the RM or RME is as evidence in the event of a disagreement / demand from the patient and on the other hand as legal protection for doctors. RM or RME which is a record of certain medical actions implicitly also contains informed consent, because medical actions will not be carried out if there is no consent from the patient.

If the multifunctional RM or RME is linked to Article 184 of the Criminal Procedure Code, then the RM or RME, in addition to functioning as letter evidence,

also functions as evidence of expert testimony as outlined in the contents of the RM or RME. The contents of the RM or RME belong to the patient. The doctor is obliged to maintain its confidentiality, in the form of a summary that can be given, recorded, or copied by the patient or the person authorized or upon written consent of the patient or the patient's family who is entitled to it. Explanation of the contents of the RM or RME can be done if needed as evidence in the process of law enforcement, discipline of medicine and dentistry and enforcement of medical ethics and dental ethics. Information about identity, diagnosis, disease history, examination history and treatment history can be disclosed in the event that, among others, to fulfill the request of law enforcement officials in the context of law enforcement by court order.

Explanation of the contents of the RM or RME may only be done by the doctor or dentist treating the patient with the patient's written permission or based on statutory regulations. Meanwhile, the head of the health care facility may explain the contents of the RM or RME in writing or directly to the applicant without the patient's permission based on laws and regulations. In such cases, according to legal experts, upon court order, the doctor and/or dentist responsible for the patient's treatment or the head of the hospital can provide a photocopy of the RM in addition to the conclusion (which is his opinion), because the RM or RME functions as evidence. This means that the judge can use the RM or RME as evidence in court, but it is not binding, and still depends on the judge's judgment. Thus, the RM or RME can be used as a basis for proving the presence or absence of errors / negligence of doctors / dentists in carrying out the profession, and on the other hand the RM or RME can be used as a basis for defense / legal protection for doctors / dentists against claims / demands addressed to them.

The use of RM or RME as evidence in court is only possible if the parties, namely the doctor or dentist, the patient and the public prosecutor submit RM or RME as evidence to find the material truth, and clarify the presence or absence of errors / negligence of doctors or dentists in carrying out their profession. Thus the RM or RME is evidence that the doctor or dentist has made every effort possible through the stages of the health service effort process to arrive at the most appropriate therapeutic option in the form of certain medical actions. For patients, the RM or RME is evidence that can be used as a basis for whether certain medical actions taken by doctors or dentists against them are in accordance with professional standards. Based on that, it can be concluded that the RM or RME has a dual function as evidence, namely: (1) As evidence of expert testimony (Articles 186 and 187 of KUHAP). (2) As evidence of letters (Article 187 KUHAP). Information given directly at trial by an expert is categorized as expert testimony

evidence, while expert testimony given outside the trial indirectly (in written form) is categorized as letter evidence (Astuti 2017; Nababan et al. 2020).

Evidence similar to RM or RME in criminal cases is Visum et Repertum which can be categorized as expert testimony, letters and also instructions. RM or RME is also evidence of letters, expert testimony. However, it can also be categorized as evidence of clues, as long as the examination of the contents of the RM or RME shows that it is in accordance with other valid evidence (witness testimony, letters and testimony of the defendant). The difference between a Visum et Repertum and an RM or RME, is in the procedure for making it and its designation. Visum et Repertum must fulfill formal requirements, namely based on a written request from the investigator and its designation is as a substitute for evidence in legal (criminal) cases. RM or RME is the result of a health examination by a doctor or health facility conducted on a patient for the patient's own benefit. However, as valid evidence in criminal cases, the position of Visum et Repertum is stronger than RM or RME (Sudjana 2017).

Conclusion

Health workers or hospitals are obliged to make Medical Records or Electronic Medical Records correctly and responsibly. Therefore, the absence of Medical Records or Electronic Medical Records results in the imposition of administrative sanctions, not providing Medical Record facilities may be subject to criminal sanctions, and incompleteness in making Medical Records may be subject to civil sanctions. Meanwhile, unlawful opening of Medical Records or Electronic Medical Records has criminal, civil, and administrative legal consequences.

Regulation of the Minister of Health Number 749a/MENKES/Per/XII/1989 concerning Medical Records is the basis for the obligation to procure RM or has become a law that must be obeyed for every health service facility. Along with globalization and the need to improve the quality of health services, PERMENKES No. 269 of 2008 concerning RM was issued, which explains that "RM must be made in writing, complete, and clear or electronically".

The position of RM or RME in therapeutic transactions is evidence in the form of letters (if given outside the court), and expert testimony (if delivered in court) but does not have binding evidentiary power because the judge is free to assess the strength of the evidence.

Suggestion

Given that the procurement of RM and RME is an obligation of every health facility and has legal force as evidence and as expert testimony, it is necessary to socialize the legal umbrella of RM and RME continuously to health workers and all health facilities. Periodic RME-making training also needs to be conducted to train health workers. The government also needs to require the procurement of RME in every health facility in order to improve the quality of services at health facilities to be more effective, efficient and facilitate health services to patients.

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