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LEGAL ASPECTS OF DOCTORS' RESPONSIBILITIES IN FILLING IN MEDICAL RECORDS ON LEGAL CERTAINTY PERSPECTIVE

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Abstract: *Medical records have an important role in the world of health, besides that they can also be used as evidence in evidence in court. Medical records must be managed properly and filling in medical records must be in accordance with existing procedures, but sometimes the filling is not appropriate or the person writing is not at capacity. The medical records in it contain a legal relationship between hospitals and health workers. The problem is how the responsibility of doctors for writing the wrong diagnosis in filling out medical records and responsibility for delegating their duties to other health workers. The method used in this study, normative juridical, looks at the existing rules, on the work of doctors as the person responsible for filling in medical records. The data used is secondary data, Law No. 17 of 2023 concerning Health, Permenkes No. 24 of 2022 concerning Medical Records and other laws and regulations related to medical records. This study results that medical records must be made by the person in charge. medical records, doctors or other health workers. Filling in the wrong diagnosis and delegating the filling to other health workers, the doctor must be responsible for his actions on the patient if there is a lawsuit. the filling is handed over to another person, becoming a risk liability (risico aanspraklijkheid) based on Article 1367 paragraph (3) B.W. by the doctor. Since there is no lawsuit, this liability becomes an administrative liability.*

Keywords: medical records; rights; obligations; responsibilities; liabilities

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I. INTRODUCTION

The improvement of health services is aimed at increasing awareness, comfort and the ability to live a healthy life for every citizen in order to realize an optimal degree of health as one of the elements of general welfare as mandated in the preamble to the Constitution of the Republic of Indonesia in 1945. (Ulil Kholili, 2011: 25).

In the health sector, the interaction between health service providers and recipients or patients is close and can also be sustainable. Therefore, to improve the quality of health services to be provided and to monitor a person's medical history, every safety service provider is required to make a medical record.

Basically, medical records are one of the important parts of health services in hospitals. The quality of medical records in hospitals also determines the quality of service. This is because medical records are one of the standards that must be met by agencies or hospitals to get accreditation titles. (zaenal Sugiyanto; 2005; 2)

In the implementation of medical records, doctors are not fully aware of the benefits and usefulness of medical records, both in health service facilities and in individual practices, as a result of which medical records are made incomplete, or incorrect in filling, unclear and untimely. (Indonesian Medical Council; 2006; 1) In fact, the completeness and accuracy of the contents of medical records are very useful, both for the treatment and treatment of patients, legal evidence for hospitals and doctors, as well as for the interests of medical and administrative research.

Medical record officers or health information management professionals are obliged to make efforts to ensure that documentation is done properly, coding is done correctly, conveying health information only with legal procedures, processing medical record data properly, utilizing medical record data for the purpose of quality control of health services, and realizing that computerization of medical records is very helpful for all management efforts but has a more open impact So that the aspect of confidentiality becomes orderly. (Diana Salowong; 2013; 7)

For example, a case like the research that has been conducted previously by Ni Luh Putu Dhevy, and Ika Setya Purwanti who stated that the completeness of the medical records of hospitalization for dengue cases at Wangaya Hospital as a whole consists of 4 (four) criteria included in the incomplete group, which is as much as 90%. (Nih Luh Putu Dhevy and Ika Setya Purwanti; 2022; 24) This proves the need for innovation and renewal in the medical record filling service system. The proportion of filling in medical records as a whole includes completeness of identification, completeness of recording, completeness of reporting and authentication. Medical records of inpatients are classified as incomplete at 85.78% (Karma et al., 2019). The proportion of incompleteness in filling in identity data was also 15.17%, the average incompleteness of filling in clinical data was 15.17%, medical was carried out at Patut Patuh Patju Gerung Hospital (Maliki & Purnama, 2018)

As quoted from tempo.co on September 3, 2021, it was reported that the public was shocked by the alleged leak of 1.3 million personal data of *electronic Health Alert Card* (eHAC) users. Then also data on a number of participants of the Social Security Administration Agency (BPJS) was sold on Raid Forums for 0.15 Bitcoin. (tempo; accessed June 20, 2024)

Recording medical records is mandatory for doctors and dentists who perform medical procedures on patients in accordance with the rules so there is no reason for doctors not to make such medical records. With the Regulation of the Minister of Health of the Republic of Indonesia Number 24 of 2022 concerning Electronic Medical Records, it provides a legal basis for the implementation of electronic medical records, but there are still mistakes made by doctors.

At the government hospital x in Tegal Regency, doctors in filling out medical records still incorrectly write the patient's diagnosis in filling out medical records and the filling is handed

over to other health workers, such as nurses and midwives. The problem is what is the responsibility of the doctor and the scope of the doctor's liability.

From a legal point of view, a Medical Record is a document that contains writing that contains meaning about a situation, reality or deed. A document certainly cannot be separated from its contents. (Soepardjo Sujadi; 2016; 62) If the content is incorrect, then the person responsible for filling in the medical record must be responsible.

The medical record must contain detailed data so that other doctors can know how the treatment and treatment and actions given to the patient and the consular officer can give an appropriate opinion after examining it or the doctor concerned can re-estimate the patient's future condition from the procedure that has been performed. However, if there are still blank medical records, they are filled in incorrectly. This will result in the mistakes of other doctors in providing therapy and further treatment. Therefore, it is necessary to implement significant responsibilities accompanied by liability, so that there are no errors in the provision of services, especially in filling in medical records.

The concept of legal responsibility is related to the concept of legal obligation, where a person is legally responsible or liable for a certain act. That is, there is someone who is responsible for sanctions if the action is inconsistent or violating. Legal liability can be divided into individual responsibility and collective responsibility. Personal responsibility is understood as individual responsibility for crimes committed by oneself, whereas collective responsibility is understood as individual responsibility for crimes committed by others.

The concept of legal responsibility is essentially related to the concept of legal responsibility. Obligation is related to this, but it is not synonymous with this. A person has a legal obligation to act in a certain way if the act is a prerequisite for the use of coercive action. However, these law enforcement actions do not need to be carried out against those who are considered "violators", but can also be carried out against other people who are in contact with the first person in the manner described above. (Quarterly Point and Shinta; 2010; 48)

The theory of responsibility emphasizes more on the meaning of responsibility born from the provisions of laws and regulations so that the theory of responsibility is interpreted in the sense *of liability*, (Busyra Azhery; 2011; 54) as a concept related to the legal obligation of a person who is legally responsible for a certain act that he can be subject to a sanction in case his act is contrary to the law.

Regarding the theory of liability, Peter Mahmud Marzuki, the meaning *of liability* as liability (aansprakelijkheid) which is a specific form of responsibility. Liability refers to the position of a person or legal entity that is considered to have to pay a form of compensation or compensation after a legal event or legal action. Meanwhile, according to J.H. Nieuwenhuis, it is said that the conditions of liability according to article 1365 BW are that a person is responsible for the losses of others, if: (Djasadin Saragih, 1985; 118)

a. Acts that cause losses are unlawful (unlawful acts)
b. The loss arises as a result of the act (causal relationship)
c. The perpetrator is guilty (mistake) and
d. The violated norm has "*strekking*" to avoid incurring losses (*relativity*).

II. RESEARCH METHODS

The type of qualitative research with the research approach method used by Doctrinal, namely the normative juridical method, by analyzing the duties and obligations of medical personnel in filling in medical records, legal principles and referring to legal norms contained in existing laws and regulations in Indonesia and using secondary data types from literature materials, such as books, journals, theses and others. (Soerjono Soekanto; 1998; 92)

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III. DISCUSSION

Medical records are mandatory documents in health services that contain comprehensive information about the patient's identity, health history, examination results, diagnosis, therapy, medical procedures, and the development of the patient's health condition during treatment. Medical records have the function of providing health information for all health workers involved in providing health services to a patient. Indicators of quality medical record services include completeness, speed and accuracy, in providing information for health service needs. Good medical record management not only supports the clinical process and patient care, but also has significant legal implications.

In relation to the management of medical records, government hospitals issue their operational standards in filling in the medical records, namely:

1. Filling by the medical record executor
   a. The officer asked for the patient's identity including name, age, address, status; ....
   b. The officer writes the patient's identity according to the medical record form on each sheet;
   c. The officer fills in the registration number;
   d. Officers fill in the types of services needed;
   e. The officer takes notes in the patient's register book;
2. Charging by a doctor
   a. The doctor writes the results of the anamnesis, the results of the examination, and the dignosis;
   b. The doctor writes a service plan; administration of drugs, action reports;
   c. The doctor writes his name.
   d. The doctor writes down the hours and dates of the service.
   e. Doctors sign medical record documents
3. Charging by nurses.
   a. Nurses fill out nursing diagnoses;
   b. Nurses create nursing care plans;
   c. The nurse records the nursing care action;
   d. The nurse records the action in order to follow up on the instructions from the doctor;
   e. The nurse records the hours and dates of the service;
   f. The nurse added a paraphrase.

If you look at the existing SOPs, it turns out that filling in medical records can be done by medical record implementers, doctors or nurses, but they have their own duties and responsibilities. What happened at government hospital X in Tegal Regency, was related to filling in medical records carried out by doctors. Where that the filling in of examination results and diagnoses is filled in by medical record officers, not by doctors. from the results obtained in the field, it shows that doctors who work at Government-owned hospitals are found to still write incorrect diagnoses and have also delegated the filling of medical records to other health workers such as nurses and midwives, and so far there has never been a lawsuit related to incorrect filling in the medical records. This means that doctors at Government-owned hospitals still do not fully carry out their responsibilities in filling in medical records, because there are still doctors who delegate filling in medical records to other health workers.

By writing the wrong diagnosis, of course, it will result in the health of the patient, the treatment and treatment given to the patient can be different and wrong, instead of getting better, it will get worse. Diagnosis is a procedure carried out by doctors in determining the patient's condition. Diagnosis is carried out by paying attention to several indicators, namely physical examinations, laboratory tests or the like, as well as the use of computer technology through several stages of examination.

The authority of doctors in carrying out this stage is contained in Article 35 paragraph (1) number 4 of Law Number 29 of 2009 concerning Medical Practice, namely:

"4. Read out the patient's diagnosis;"

Meanwhile, in carrying out a diagnosis, there are several stages that need to be known, namely:

1. Anamnes
2. Body or physical examination,
3. Supporting Examination.
4. Diagnosa

So if there is an incorrect writing in the medical record regarding the diagnosis, there can be a diagnostic error. Misdiagnosis is a medical error that occurs after an intensive diagnostic procedure and examination performed on a patient by a doctor. If a doctor makes a misdiagnosis, the responsibility is closely attached to him.

The responsibility of a doctor is an attachment of a doctor to the provisions of the law in carrying out his profession. As a natural legal subject, in carrying out health services, doctors are bound and must be responsible for all things that arise as a result of the implementation of their legal status as bearers of rights and obligations.

In this context, the legal responsibility of doctors for medical records plays an important role in establishing legal certainty. Legal certainty is urgently needed to protect the rights of patients, doctors, and health institutions, and to ensure that the health system functions fairly and efficiently.

The responsibility of a doctor is an attachment of a doctor to the provisions of the law in carrying out his profession. As a natural legal subject, in carrying out health services, doctors are bound and must be responsible for all things that arise as a result of the implementation of their legal status as bearers of rights and obligations.

The responsibilities of doctors are related to the obligations that must be carried out by doctors as stated in Article 296 of Law No.1 7 of 2023 concerning Health, the obligations of the doctor are affirmed as follows:

1. Every medical and health worker who provides individual health services is required to make a medical record.
2. Medical records must be completed immediately after the patient receives health services.
3. Each medical record must be affixed with the name, time and signature of the officer who provided the service or action.

The medical record made by the doctor must of course be in accordance with what is diagnosed and completed after the patient is examined, medical records that write incorrect diagnoses can have legal consequences and become the legal responsibility of the doctor who wrote them. It was said earlier that in filling in medical records at government hospitals x, there was still filling in the wrong diagnosis and filling was not done by the doctor because his duties and authority in filling in the medical records were clear. When the medical record becomes the doctor's task, it should not be delegated or filled in by others. This shows that the health secrets of the patient can be known by other people, namely the person who wrote the medical record.

Both Article 274 of Law No. 17 of 2023 concerning Health and Article 32 of the Regulation of the Minister of Health No. 24 of 2022 concerning Medical Records:

> "(1) The contents of the Medical Record must be kept confidential by all parties involved in health services at the Health Service Facility even if the patient has passed away.
>
> Meanwhile, in Article 26, it is stated that:
>
> "The Medical Record as referred to in paragraph (2) must be made by the person in charge of the service."

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This means that filling in medical records should be filled in by doctors.

Doctors in carrying out their obligations understand the principles that exist in providing health, namely: The principle *of non-maleficence.* Doctors are guided by *primum non nocere (first of all do no harm),* do not take unnecessary actions, and prioritize actions that do not harm patients, and strive to minimize physical, psychological, and social risks due to these actions. Filling in medical records at government hospitals x is the legal responsibility of doctors as well as filling in by other people is the responsibility of doctors because what is done by these doctors is already against the law.

According to Abdulkadir Muhammad, the theory of responsibility in tort *liability* is divided into several theories, (Abdulkadir Muhammad; 2010; 5030) however, regarding the case that occurred at Government Hospital X, it is included in the Absolute Responsibility due to unlawful acts without questioning fault (*strick liability*), based on his actions either intentionally or unintentionally, meaning that even though it is not his fault, he is still responsible for the losses arising from his actions. The principle of liability *based on fault* The principle of liability based on fault is a fairly common principle that applies in criminal and civil law. In the Civil Code, especially articles 1365, 1366, and 1367, this principle is firmly held. This principle states that a person can only be held legally responsible if there is an element of wrongdoing by him. (Shidarta; 2000; 59).

In article 1365 of the Civil Code, commonly known as the article on unlawful acts, it requires the fulfillment of four main elements, namely:

a. The existence of deeds;
b. There is an element of error;
c. Losses received;
d. There is a causal relationship between mistakes and losses.

Although there has been no lawsuit related to the error of filling in medical records, this practice shows the potential legal risks and uncertainties that can harm both patients and health workers. With the enactment of Permenkes No. 24 of 2022 concerning Medical Records, it is hoped that doctors will be more aware and responsible for filling out medical records. The implementation of electronic medical records, which require unique identification of the doctor, will help ensure that the filling of medical records is done correctly and cannot be delegated to others. This will improve accuracy, clarity, and trust in medical record systems, while ensuring compliance with applicable laws.

In addition, the hospital, in giving sanctions, was given a reprimand by calling the doctor concerned and other health workers who received orders to fill out medical records, so it was only *an administrative liability*.

IV. CONCLUSION

The filling in of medical records at Government Hospital X has made a mistake by writing down the wrong diagnosis and filling in medical records is left to other health workers, midwives and nurses who are not their responsibility. The sanctions given are only reprimands (*liability administration)* so that the filling is corrected and the filling of medical records must be those responsible in accordance with the procedures that have been set by the Hospital.

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