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Legal Implications of Medical Records in Trials

[1] Luluk Ulyatul, [2] Deny, [3] Damsik
[1, 2, 3] Postgraduate Program in Doctor of Law University of 17 August 1945 Semarang, Indonesia

Corresponding Author: **Deny**

Abstract
Medical records in an attempt to medical records, in particular, become crucial to health services because they are tangible pieces of evidence that detail every diagnosis, course of treatment, and medical procedure that physicians prescribe. In terms of being utilized as evidence in legal enforcement, medical ethics, and medical specialties, medical records are also very valuable.
The legal implications of medical records as evidence in the trial, namely the legal standing of medical records as evidence of medical errors that healthcare professionals have perpetrated against patients, such as when medical errors are medically insignificant and are thus overlooked, the outcomes of the medical record have been placed under the direct expert testimony of the individual at trial. Medical records in the format required by Article 164 HIR and Article 184 of the Code of Criminal Procedure, as documents contained in the proof of letters.

Keywords: Records, Medical, Legal, Implications

1. Introduction

A trusting relationship between a healer and a sufferer has existed throughout human history; this relationship is now known as a therapeutic transaction between a doctor and a patient.
Since ancient Greece, physicians and patients have had a legal relationship. A doctor is a medical professional who treats patients when necessary. Because the patient's faith in the doctor is the foundation of this relationship, it is extremely intimate. We refer to it as a healing exchange. A medical transaction is "an agreement between a doctor and a patient in the form of a legal relationship that gives birth to the rights and obligations of both parties."[1] The goal of this arrangement is to try and treat the patient's illness.
A relationship between patients or their families and doctors, either as individuals or as people in the form of legal entities (hospitals, foundations, or other institutions involved in health services), will be born out of examination, treatment, and treatment. The decision calls the medical record, which includes these tests, prescriptions, and treatments (including informed consent), the "Medical Record."
The practice of creating electronic medical records, or what are now termed medical records, in hospitals and on physician patient cards dates back thousands of years, but it is not yet required, so its adoption is not taken too seriously[2]. Medical records have become increasingly necessary and significant along with the growth of a very dynamic society, which includes the people of Indonesia. Therefore, Minister of Health Regulation Number 24 of 2022 pertaining to medical records has been published by the government through the Ministry of Health, specifically for the Unitary State of the Republic of Indonesia. Following the release of this Minister of Health Regulation, obtaining medical records has become mandatory for all health service facilities, or it is now a legal requirement.
Since health is the foundation of all facets of life and ensures that people are always healthy, the existence of Law Number 17 of 2023 concerning health is a reflection of and response to the government's duty to address health problems.

1. Endang Kusumah Astuti, Hubungan Hukum Antara Dokter Dan Pasien Dalam Upaya Pelayanan Medis. Semarang. 2003.Hlm. 3
2. J. Guwandi.1991. Dokter dan Pasien, Jakarta: Fakultas Kedokteran Universitas Indonesia, Hal. 73

1.1 Problem Formulation
What effects do medical records have on the law?

2. Discussion
2.1 Definition of Medical Records
"Legal Aspects of Medical Records," a book written by Hayt and Hayt, defines medical records as follows: "A medical record is an encyclopedia of pertinent information about a patient's condition, treatment, and life history. Broadly speaking, the medical record is an assemblage of scientific information obtained from multiple sources and accessible for diverse applications, both individual and institutional, benefiting the patients under treatment, the medical field, and the community at large."[3]
Thus, a medical record is a compilation of information about the patient's medical history, condition, care, and course of treatment, according to Hayt and Hayt. A medical record, in a more general sense, is a scientific dataset compiled from numerous sources that is organized on a single page and made available for a range of individuals, uses, and issues to benefit patients being treated, medical research, and society at large.
Moreover, medical records are a valuable instrument in the practice of medicine, according to Hayt and Hayt. They give a foundation for organizing patient care, a way to assist with the patient's care, documentary proof of the patient's disease and course of treatment, and a basis for reviewing, analyzing, and assessing the patient's medical care." This claim makes it abundantly evident that medical records are a useful instrument in the practice of medicine[4].
Furthermore, in the Minister of Health Regulation Number 24 of 2022 concerning medical records, what is meant by medical records is a document containing patient identity data, examinations, treatments, actions, and other services that have been provided to patients (Article 1, Paragraph 1).
All actions conducted within the scope of the patient-doctor relationship, also known as the therapeutic transaction relationship, will be reflected in the medical record if it is an accumulation of all written health servant activities. The patient is safeguarded in these transactions by an international agreement that includes "the right to information" and "the right to self-determination."
A well-maintained medical record will support the patient's professional treatment and offer insight about the caliber, scope, and availability of health services. One dependable method to guarantee that everyone pays correct and thorough attention to health care information is to create written records. In contemporary medical practice, the patient as a whole will be involved, necessitating the use of all the technology and abilities that physicians, nurses, and technicians have learned. Every member of the clinical team must record information precisely and accurately in order to manage patient care to the highest standard.

2.2 Implications of Medical Records
A medical record is a brief account of the illness's history as well as the method, approach, or therapy used by medical professionals (such as doctors and paramedics) to try to heal patients, all of which have been allowed by the patients through the process of "informed consent." This "informed consent" needs to be documented and kept in a medical record in order for it to be admissible as evidence in court. Of Medical Records.
Naturally, the other party that feels wronged in a therapeutic transaction will file a lawsuit if one of the parties (the patient or the doctor) fails to uphold their rights and obligations. Medical records play a significant part in this situation since they can be used to support patient claims or to disprove civil lawsuits brought against physicians, hospitals, or other healthcare facilities, as well as criminal claims based on intentional and careless errors. This implies that medical records have legal weight and can be considered a factor when judges are making decisions.
Medical records serve the following purposes in their entirety: "administrative value, legal value, financial value, research value, educational value, and documentary value." Due to the purpose of medical records, a standard for creating medical records that accurately represent the level of care or quality of medical services given to the patient by the physician has been established in major or industrialized nations. According to Article 2 of the Minister of Health Regulation Number 24 of 2022 governing medical records, medical records in Indonesia can be used for the following purposes:
1. Improve the quality of health services.
2. Provide legal certainty in the implementation and management of medical records.
3. ensure the security, confidentiality, integrity, and availability of medical record data; and
4. Realizing the implementation and management of digital-based and integrated medical records.

The quality of healthcare provided to patients is reflected in medical records completed by parties involved in therapeutic transactions. As a result, it can be observed from the literature that in order for a medical record to meet the standards, all medical services participating in the therapeutic transformation must sign it.
Health services (physicians and other medical professionals) are required to sign a medical record that includes the patient's health development history and summary for three reasons[5]:
1. The patient needs to be kept safe.
2. In the event that the matter is taken to court, the attending physician's signature is significant;
3. To keep hospitals from losing accreditation.

Medical records can serve as legal papers for the three reasons listed above: They can be used as proof of legal documents that are useful for expert witnesses, testimony, or "expert wittness" (see article 184 of the Criminal Code for criminal cases and article 164 HIR for civil cases). Therefore, the patient's signature serves as proof that the decision he makes is his own, and the actions of health professionals (such as doctors and paramedics) who provide accurate and complete information are accountable for the information's accuracy and completeness.

3. Hayt, Emanuel and Hayt, Jonathan. 1964. Legal Aspect of Medical Record. Illinois: Physician’s Record Company, Hal. 1
4. Hayt, Emanuel and Hayt, Jonathan. 1964. Legal Aspect of Medical Record. Illinois: Physician’s Record Company, Hal. 1
5. Hayt, Emanuel and Hayt, Jonathan. 1964. Legal Aspect of Medical Record. Illinois: Physician’s Record Company, Hal. 42-44

The following must be included in the contents of a modern medical record ("Contents of a Modern Medical Record") based on Article 18, Paragraph 6 in order for a medical record including informed consent to be used as evidence in court:

1. The name of the patient;
2. Address;
3. Type of disease;
4. Actions or operations; and
5. Death.

The most crucial aspect is that all information must be entered accurately, promptly, and without delay. In particular, if there are numerous patients, it is possible that the doctor will forget about the patient and the illness if the filling is delayed. The files of medical colleagues will reveal information about several aspects, including the caliber of hospital services. The adage "Medical records are witnesses whose memories never die" then surfaced.

3. Closing

In essence, a medical record is a legal document, the contents of which may be debated and taken into account during a court trial (criminal or civil), specifically as one of the forms of evidence in the form of testimony or expert witness ("expert witness"). Hence, medical records provide judges with dependable information with which to make choices.

4. References

1. Endang Kusumah Astuti. Hubungan Hukum Antara Dokter Dan Pasien Dalam Upaya Pelayanan Medis. Semarang, 2003.
2. Hayt Emanuel, Hayt Jonathan. Legal Aspect of Medical Record. Illinois: Physician’s Record Company, 1964.
3. Guwandi J. Dokter dan Pasien, Jakarta: Fakultas Kedokteran Universitas Indonesia, 1991.
4. Undang-Undang Dasar Republik Indonesia.
5. Undang-undang Nomor 17 Tahun 2023 Tentang Kesehatan
6. Kitab Undang-undang Hukum Pidana
7. Kitab Undang-undang Hukum Perdata
8. Peraturan Menteri Kesehatan Nomor 24 Tahun 2022 tentang Rekam Medis