

Ownership of Medical Records in Indonesia: Discourse on Legal Certainty and Justice

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Abstract

Medical disputes between patients and health workers place medical records as a vital document for evidentiary in a court proceeding. The existing law and regulations in Indonesia determine that the medical record file is owned by the health service facility, while the patient receives a summary of the medical record. This study aims to analyze medical record ownership in Indonesia from perspectives of legal certainty and justice. This article reflects normative juridical research that explores relevant primary and secondary legal materials to be analyzed deductively. This article concluded that the obligation of health workers to make medical records in proving that they have delivered properly a health service as stipulated in the law and regulations reflects a legal certainty. However, laws and regulations governing the ownership of medical records seem not to fully reflect the principle of justice since medical record files are owned by doctors, dentists, or health service facilities. Even though patients/health service recipients are entitled to requesting the files from health care facilities, the sense of justice for the patients would be in the form of easy procedures for obtaining medical records.

Keywords: Certainty; Health Law; Indonesia; Justice; Medical Records.

1. INTRODUCTION

The number of medical malpractice cases in Indonesia in recent years has gradually raised the awareness of society regarding the importance of medical records. To prevent such malpractice cases, some people ask health workers and health service facilities to deliver their medical records. These medical records are usually kept for their document, while some others transmit the information contained in the records to their relatives and friends for a “second opinion.”¹

Determining whether a medical action meets the element of malpractice is not an easy task. The allegation of medical malpractice must be examined by collecting facts and evidence to be further assessed for its compliance with standard operating procedures, health workers’ code of ethics, and

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¹ Term ‘second opinion’ is commonly used in Indonesia, refers to a non-binding opinion delivered by health workers who are asked for opinion and advice. See also Decision of the Supreme Court No. 21P/HUM/2011 (Judicial Review on Regulation of Minister of Health No. 269 /Menkes/III/2008 concerning Medical Records), 13.

regulations. The regulations on health and health professionals seem to indicate that health workers and health care facilities are, on one hand, easily touchable by the law, but on the other hand, potentially forgiven by the law.² In case a doctor is suspected of committing malpractice, he/she cannot be held responsible for civil, public, and criminal responsibility if according to medical standards, his/her medical actions were proper, even though the consequences may cause harm.³

In Indonesia, the term ‘medical malpractice’ refers to medical negligence or professional negligence.⁴ In medical malpractice cases, the doctrine *res ipsa* which means siding with the victim *loquitur* is often used. This doctrine accepts a kind of circumstantial evidence, which is evidence about a fact that can be used to draw conclusions. The evidentiary process in civil procedural law determines that the victim of an unlawful act in the form of negligence does not need to prove the existence of the element of negligence, as they can only show the facts. The goal is to achieve justice.⁵

The dissatisfaction or harm suffered by the patient after receiving health services that are allegedly caused by medical malpractice may lead to legal matters. In general, health workers and patients are encouraged to settle the problem by deliberation, mediation, or any other non-judicial mechanism.⁶ However, some cases showed that they are settled before the court. Generally, malpractice is classified as a civil case, where the patient as the plaintiff filed a lawsuit before the court. As long as the regulations do not require it, providers may not wish to risk recording information that could later be used to show or imply negligence.⁷ However, if a health worker’s professional care falls below standards of negligence and reaches recklessness or intentional misconduct, there is a potential for criminal liability.⁸

In this context, the medical record has its relevance as it can be used as one written piece of evidence in court.⁹ In a civil judiciary proceeding, the medical record becomes a primary document to prove the elements of negligence. In criminal judiciary proceedings, it plays a vital role as it assists investigators in discovering crimes in case of criminal allegation as a

² Sandra Dini Febri Aristya, “Pembuktian Perdata Dalam Kasus Malpraktik di Yogyakarta,” *Mimbar Hukum*, special edition (2011): 181.

³ *Ibid.*

⁴ Bambang Heryanto, “Malpraktik Dokter Dalam Perspektif Hukum,” *Jurnal Dinamika Hukum* 10, no. 2 (2010): 184-185.

⁵ *Ibid.*, 187.

⁶ See Public Relations Universitas Gadjah Mada /Agung, “Konflik Dokter dan Pasien Wajib Gunakan Mediasi,” 2015. <https://ugm.ac.id/id/berita/10262-konflik-dokter-dan-pasien-wajib-gunakan-mediasi>.

⁷ Yuju Wu, *et.al.*, “Using standardised patients to assess the quality of medical records: an application and evidence from rural China,” *BMJ Quality & Safety* 29, no.6 (2020): 496.

⁸ Jack Bernstein, Injury Attorneys, “Is Medical Malpractice a Civil Case or a Criminal Case?,” 2021. <https://bernsteininjurylaw.com/blog/medical-malpractice-civil-case-vs-criminal-case/>.

⁹ Medical Record Manual of the Indonesian Medical Council of 2006, Chapter III.F

medical record is classified as documentary evidence.¹⁰ The fact is, the patient usually receives a resume of the medical treatment because the complete information belongs to health care facilities confidentially. Therefore, the patient does not have strong evidence to be presented before the court proceeding.

Method of documentation of all medical treatment becomes more and more important. As an example, documentation of Patient Centered Care (PCC) involves treating the patient as a whole person and engaging the patient in their care. The PCC, among others, influences satisfaction with treatment, greater satisfaction with the provider and clinic, and less decisional conflict for patients.¹¹

A medical recorder has competencies, one of which is the management of health data and information, utilization of data and information to support health services, and use of health information systems in health data management.¹² Since 1989, medical recorders in Indonesia established the Indonesian Association of Medical Record Professionals and Health Information (*Perhimpunan Profesional Perekam Medis dan Informasi Kesehatan Indonesia*).¹³ This association has a strategic position because its recommendations are required in applying for a medical recorder work permit.¹⁴ In addition, this association is involved by the Central and Regional Governments in conducting guidance and supervision of the Work of Medical Recorders.¹⁵ These guidance and supervision works include the authority of imposing administrative sanctions on medical recorders who violate the provisions on the implementation of medical recorder work, in the form of verbal warnings, written warnings, and/or revocation of medical recorder work permit.¹⁶

Research conducted by Irmawati, *et.al.* reveals that some 12% of doctors in Indonesia do not sign their medical records,¹⁷ while Wirajaya *et.al.* discover that 85,78% of doctors in Indonesia do not complete medical records.¹⁸ Studies suggested that factors influencing incompleteness in making medical records are the lack of discipline of doctors, nurses, or

¹⁰ Rachmad Abduh, "Kajian Hukum Rekam Medis Sebagai Alat Bukti Malapraktik Medis," *De Lega Lata* 6, no. 1 (2020): 223.

¹¹ Jorie M. Butler, *et.al.*, "Clinician Documentation of Patient-Centered Care in the Electronic Health Record," *BMC Medical Informatics and Decision Making* 22, no. 1 (2022): 2.

¹² Decree of Minister of Health No. HK.01.07/MENKES/312/2020 concerning Professional Standards for Medical Recorders and Health Information," Attachment, Chapter III, 16.

¹³ Indonesian Association of Medical Record Professionals and Health Information, "Sejarah Pormiki", <https://pormiki.or.id/sejarah-terbentuknya-pormiki/>.

¹⁴ Regulation of Minister of Health No. 55 of 2013 Concerning the Implementation of Medical Recorder Work, Art. 7 (1)(g).

¹⁵ *Ibid.*, Art. 19 (1).

¹⁶ *Ibid.*, Art. 21.

¹⁷ Irmawati Irmawati, *et.al.*, "Quantitative Analysis of Medical Records of Inpatients in Ward Mawar Ungaran Hospital," *Jurnal Rekam Medis Dan Informasi Kesehatan* 1, no. 1 (2018): 11.

¹⁸ Made Karma Maha Wiraja and Ni Made Umi Kartika Dewi, "Analisis Ketidaklengkapan Rekam Medis Pasien Rawat Inap di Rumah Sakit Dharma Kerti Tabanan," *Jurnal Administrasi Rumah Sakit* 6, no. 1 (2019): 18.

midwives, lack of evaluation, human resources, procedural aspects, tools, and motivation.¹⁹ Research by Bambang Heryanto suggested that doctors can be held accountable for malpractice cases that harm patients because of unlawful acts, namely contrary to the legal obligations of the perpetrator; against the subjective rights of others; or against the rules of decency (morality); or contrary to propriety, thoroughness, and prudence.²⁰

The use of medical records as an evidentiary document in legal proceedings entails that the ownership of medical records then becomes a central issue. The applicable law and regulations in Indonesia determine that the file of medical record belongs to the health care facility, while the patient is given a summary of the medical record.²¹

A legal system is a set of components that work together to achieve a common goal (systems are made up of sets of components that work together for the overall objective of the whole).²² In general, the law aims to achieve justice, certainty, and utility.²³ Therefore, this article aims to analyze the ownership of medical records in Indonesia from the perspective of legal certainty and justice.

This article applies juridical normative research that uses secondary data which consists of primary and secondary legal materials. Primary legal materials used in this research are Indonesian law and regulations; international legal documents; and manuals and guidelines from health organizations/associations. Secondary legal materials refer to books, journal articles, and other sources related to legal science, health law, and medical record. Those legal materials are analyzed using the deductive method.

2. RESULT AND ANALYSIS

2.1. International Concern on Medical Records

The right and access to medical records have already become an international concern. The World Health Organization (WHO), a United Nations specialized agency,²⁴ adopted some documents related to medical

¹⁹ See for example Nurhaidah, Thontowi Djauhari and Tatong Harijanto, "Faktor-Faktor Penyebab Ketidaklengkapan Pengisian Rekam Medis Rawat Inap di Rumah Sakit Universitas Muhammadiyah Malang," *Jurnal Kedokteran Brawijaya* 29, no. 3 (2016): 260; Selvia Juwita Swari, *et.al.*, "Analisis Kelengkapan Pengisian Berkas Rekam Medis Pasien Rawat Inap RSUP Dr. Kariadi Semarang," *Arteri: Jurnal Ilmu Kesehatan* 1, no. 1 (2019): 50.

²⁰ Heryanto, *op.cit.*, 186, 191.

²¹ Regulation of Minister of Health No. 269 of 2008 Concerning Medical Records, Art.12 (1-3).

²² See explanation of C. West Churman in Mustafa Bachsan, *Integrated Indonesian Legal System* II. Bandung: Citra Aditya Bakti, 2016, 41.

²³ Judicial Commission of the Republic of Indonesia, Eka Putra and Festy, "Penegakan Hukum Wujudkan Keadilan, Kepastian, dan Kemanfaatan Hukum," 2017. https://www.komisiyudisial.go.id/frontend/news_detail/514/penegakan-hukum-wujudkan-keadilan-kepastian-dan-kemanfaatan-hukum.

²⁴ Constitution of the World Health Organization, Preamble. Available in Basic documents: forty-ninth edition (including amendments adopted up to 31 May 2019). Geneva: World Health Organization, 2020.

records. In 1980, it released a document titled “Guidelines for medical record practice.” The guidelines admit that medical records are an essential component in the effective management of a patient's health care that contains the information needed to plan, provide, and evaluate the care given to the individual. The guidelines was created to serve as a tool for communicating information to all the health personnel who deal with the patient, and it contributes to the continuity of patient care.²⁵

In 2002, the WHO issued a Medical Records Manual A Guide for Developing Countries that aims to help medical/health record workers, particularly clerical staff with a basic understanding of medical/health record procedures, in developing countries in developing and managing the medical record/health information service in an effective and efficient manner.²⁶

Recently, the WHO adopted a Global Patient Safety Action Plan 2021–2030: Towards Eliminating Avoidable Harm in Health Care, that covers the issue of medical records. The Action Plan expected three partners, namely the government, health care facilities and services, and stakeholders to take action Towards Eliminating Avoidable Harm in Health Care. Actions expected from those three partners can be described in Table 1.

Table 1 Expected Actions from Partners regarding Medical Record Towards Eliminating Avoidable Harm in Health Care²⁷

Partners in Action	Actions
Government	<ol style="list-style-type: none"> 1. Develop national guidelines for patient access to their medical records. 2. Strengthen synergies and data-sharing channels between sources of patient safety information for timely action and intervention, such as malpractice claims and medical record reviews. 3. Promote and support the digitization of health care processes such as medical records, electronic prescribing, and clinical decision support systems with due consideration to interoperability of digital solutions.
Health care facilities and services	<ol style="list-style-type: none"> 1. Promote transparency with patients; ensure that patients have access to their medical records. 2. Standardize formats for patient records in primary and ambulatory care, supported by electronic health records. 3. Develop procedures around the provisions of the national charter or bill, including access to medical records and full disclosure of adverse events. 4. Develop institutional policies for patient access to their medical records.
Stakeholders ²⁸	Raise awareness about the right to access medical records.

²⁵ World Health Organization. Division of Epidemiological Surveillance and Health Situation and Trend Assessment. “Guidelines for medical record practice.” World Health Organization, 1980, <https://apps.who.int/iris/handle/10665/59341>, 7.

²⁶ The World Health Organization, “Medical Records Manual: A Guide for Developing Countries, revised and update version, (Manila: Western Pacific Region, 2006), 1.

²⁷ World Health Organization, “Global Patient Safety Action Plan 2021–2030: Towards Eliminating Avoidable Harm in Health Care.” Geneva: World Health Organization, 2021, 26-61.

Table 1 describes expected actions from government, health care facilities and services, and stakeholders regarding medical records as laid down in the WHO Global Patient Safety Action Plan 2021–2030. The Action Plan emphasizes all three partners take action on the issue of patients' access to their medical records. It also encourages both government and health care facilities and services to work on digitization of health care processes and EMR.

The international concern on rights and access to medical records may also be analyzed from human rights perspectives. The Committee on Economic, Social, and Cultural Rights issued General Comment No. 14 which elaborates on information accessibility. It emphasizes that “accessibility includes the right to seek, receive and impart information and ideas concerning health issues. However, accessibility of information should not impair the right to have personal health data treated with confidentiality.”²⁹ The relationship between patient and provider rights is critical. It is difficult for providers to provide high-quality treatment if their rights are not respected and if they cannot work in proper conditions with professional independence. There are many examples of health providers who have been punished for providing evidence-based health care to their patients, ordered to destroy medical records, or disclose confidential health information to the state.³⁰ There are two common types of human rights violations that may relate to medical information. First, limiting or denying information related to an individual medical treatment to effectuate the policy or practice of the state or other third party; second, disclosing confidential information of a patient to state authorities or other third parties in circumstances that violate human rights.³¹

2.2. Obligations of Health Workers to Make Medical Records Reflect Legal Certainty

It is a constitutional guarantee for all Indonesian citizens to enjoy an equitable legal certainty.³² Legal certainty refers to a clear, consistent, and decisive situation that is recognized under the legal rules.³³ Certainty may also be understood as a court decision in a specific case.³⁴ The medical

²⁸ Stakeholders comprises of nongovernmental organizations, patients and patient organizations, professional bodies and scientific associations and societies, academic and research institutions, and civil society organizations. See *Ibid.*, v and 6.

²⁹ Committee on Economic, Social, and Cultural Rights, General Comment No. 14: The Right to the Highest Attainable Standard of Health (Art. 12) Adopted at the Twenty-second Session of the Committee on Economic, Social and Cultural Rights, on 11 August 2000 (Contained in Document E/C.12/2000/4), para. 12.b.

³⁰ Jonathan Cohen and Tamar Ezer, “Human Rights in Patient Care: A Theoretical and Practical Framework,” *Health and Human Rights* 15, no. 2 (2013): 8.

³¹ *Ibid.*, 9.

³² The 1945 Constitution of the Republic of Indonesia, Art. 28 D(1).

³³ See Wicaksono, *op.cit.*, 10.

³⁴ See for example, Richard Huxtable and Giles Birchley, “Seeking Certainty? Judicial Approaches To The (Non-) Treatment of Minimally Conscious Patients,” *Medical Law Review* 25, no. 3 (2017): 434-435.

record represents a minimum service standard in the health sector,³⁵ and therefore becomes an instrument in ensuring legal certainty for patients in receiving health services delivered by health workers.

The Medical Record Manual issued by the Indonesian Medical Council in 2006 admits two definitions of a medical record. On one hand, the explanation of Article 46 (1) of the Medical Practice Law defines it as a file containing notes and documents about patient identity, examination, treatment, action, and other services provided to patients. On the other hand, Regulation of Minister of Health No. 269/Menkes/Per/III/2008 concerning Medical Records (Minister of Health Regulation on Medical Records) defines it as a file containing records and documents about the patient's identity, examination, treatment, action, and other services to patients in health care facilities. From these definitions, it shows definition in Medical Practice Law has a broader meaning as medical record applies both to health facilities and outside health facilities while the definition given by the Minister of Health only emphasizes medical record in health service facilities.³⁶

The medical record includes both notes and documents. Note, is a description of the patient's identity, examination patients, diagnosis, treatment, action, and other services are well performed by doctors and dentists as well as health workers others according to their competence. The document is the completeness of the note, including X-rays, laboratory results and other information in accordance with scientific competence.³⁷ Medical records can be distinguished into conventional medical records and electronic medical records (EMR).³⁸ The Manual specifically determines that the medical record of outpatient must contain at least the patient's identity, physical examination, diagnosis/problem, action/treatment, and other services that have been provided to the patient.³⁹ These contents similarly apply to inpatients, but in addition, they must include approval of medical action (if needed).⁴⁰ In principle, doctors and dentists make/fill out medical records. However, other health workers who provide direct services to patients can carry out these duties as long as they are given a written delegation from the doctors and dentists.⁴¹ In the legal context, one of the benefits of medical records is that they can be used as the main written evidence in resolving legal, disciplinary, and ethical issues.⁴²

Law and regulations in Indonesia underline the obligation of health workers to make medical records. Law No. 29 of 2004 concerning Medical Practice (Medical Practice Law) determines that every doctor or dentist is

³⁵ See Elucidation, Regulation of Minister of Health No. 4 of 2019 Concerning Technical Standards for the Fulfillment of Basic Services Quality in Minimal Service Standards in Health Sector, 38, 45, 123.

³⁶ Medical Record Manual of the Indonesian Medical Council of 2016, Chapter II.A.

³⁷ *Ibid.*, Chapter II.B.

³⁸ *Ibid.*, Chapter II.C.

³⁹ *Ibid.*, Chapter IV.A.

⁴⁰ *Ibid.*, Chapter IV.B.

⁴¹ *Ibid.*, Chapter IV.C.

⁴² *Ibid.*, Chapter III.F.

obliged to make a medical record that must be completed immediately after the patient has finished receiving health services. Such a medical record must be affixed with the name, time, and signature of the officer providing the service or action.⁴³ In addition, this law covers criminal punishment. Article 79 of Medical Practice Law mentions that a doctor or a dentist who intentionally does not make medical records may be sentenced to a maximum imprisonment of 1 (one) year or a maximum fine of IDR 50,000,000.00 (fifty million rupiah). However, the Medical Practice Law does not regulate a sanction for doctor or dentist who does not make an incomplete medical record.

Reiterating the wordings of the provisions contained in Medical Practice Law, the later Law No. 36 of 2014 concerning Health Workers (Health Worker Law) also obliged health workers to make a medical record that must be completed immediately after the patient has finished receiving health services, which includes the name, time, and signature of the officer providing the service or action.⁴⁴ The Health Worker Law makes clear that medical records must be kept confidential by Health Workers and Head of Health Service Facilities.⁴⁵

Both nurses and midwives are capable of making documentation for their nursing and midwife activities.⁴⁶ Law No. 38 of 2014 concerning Nursing (Nursing Law) requires nurses to carry out nursing documentation in accordance with standards.⁴⁷ As a measuring tool and a guide to the ability of nurses, one of them is to carry out nursing documentation contained in the nursing profession standards.⁴⁸ The nurse's obligation to do documentation is strengthened by the patient's right to receive services in accordance with the code of ethics, nursing service standards, professional standards, standard operating procedures, and provisions of laws and regulations.⁴⁹

In Midwifery Practice, Law No. 4 of 2019 concerning Midwifery (Midwifery Law) determines that a client has the right to obtain correct and clear information about his/her health. If needed, the information may include a resume of the contents of the medical record, which is a summary of information containing records of midwifery care and midwifery services that have been provided by the midwife to the client.⁵⁰

⁴³ Law No. 29 of 2004 concerning Medical Practice, Art 46 (1-3).

⁴⁴ Law No. 36 of 2014 concerning Health Workers, Art. 70 (1), (2), and (3).

⁴⁵ *Ibid.*, Art. 70 (4).

⁴⁶ Ministry of Health Republic of Indonesia, *Nursing Professional Standards*, 2013, 17 and Decree of Ministry of Health No. HK.01.07/Menkes/320/2020 concerning Midwife Professional Standards, 3.

⁴⁷ *Ibid.*, Art 37 (d).

⁴⁸ Decree of Minister of Health No HK.01.07/MENKES/425/2020 concerning Nurse Professional Standard, 17.

⁴⁹ Law No. 38 of 2014 concerning Nursing, Art. 38 (c).

⁵⁰ Law No. 4 of 2019 concerning Midwifery, Art. 62 (b) and its explanation.

Minister of Health Regulation on Medical Records indirectly regulates the patient's rights to the contents of the medical record, even though it is in the form of a summary of the medical record.⁵¹

There are different sanctions given to health workers who do not make medical records. The Law on Health Workers states that the sanctions imposed on health workers who do not make medical records or make medical records but are incomplete will receive an administrative sanction.⁵² The Medical Law provides criminal sanctions and fines for doctors or dentists who do not make complete medical records.⁵³ In contrast to the Nursing Act and the Midwifery Act, it does not impose sanctions on nurses or midwives who do not do documentation.

The Health Workers Law regulates more general aspects of health workers, rather than regulating specific aspects. Therefore, Health Workers Law is considered more general than the Medical Practice Law, Nursing Law, and Midwifery Law. To deal with the different sanctions for health workers who do not make correct medical records as stipulated in those laws, the principle of *lex specialis derogat legi generali* applies.⁵⁴ According to Bagir Manan, several aspects must be taken into consideration in applying this principle. First, the provisions of general laws rules remain in effect, except those specifically regulated in special law; second, the general law and the specific law must be in the same degree; and third, the general law and the specific law must be in the same legal regime/field.⁵⁵ Therefore, considering the Medical Practice Law, the Nursing Law, and the Midwifery Law are special laws, then the sanctions should refer to each of these laws, rather than Health Worker Law.⁵⁶

2.3. Medical Record Ownership in Indonesia: Perspective of Justice

Article 8 Law No. 36 of 2009 concerning Health uses the generic term 'data' rather than 'medical record'. It determines that everyone has the right to obtain information about his/her own health data including actions and treatments that have been received or will be received from health workers.

The explicit and specific rules regarding the ownership of medical records generally can be found in some other law and regulations. The Health Worker Law makes clear that medical records are the property of the health service facility,⁵⁷ however, health service recipients may request a

⁵¹ Regulation of Minister of Health No. 269 of 2008 concerning Medical Records, Art. 14 (2-3).

⁵² Law No. 36 of 2014 concerning Health Workers, Art. 82. (1).

⁵³ *Ibid.*, Art. 79 (b).

⁵⁴ Harif Fadhilah, Endang Wahyati, and Budi Sarwo, "Pengaturan Tentang Tenaga Kesehatan dalam Peraturan Perundang-Undangan dan Azas Kepastian Hukum," *Soepra Jurnal Hukum Kesehatan* 5, no. 1 (2019): 147.

⁵⁵ Bagir Manan. *Hukum Positif Indonesia: Suatu Kajian Teoritik*. Yogyakarta: FH UII Press, 2004, 56.

⁵⁶ For this analysis, see Decision of the Constitutional Court No. 82/PUU-XIII/2015, para 2.5.

⁵⁷ Law No. 36 of 2014 concerning Health Workers, Art. 71 (1).

resume of medical records from that facility.⁵⁸ Medical Practice Law regulates that medical record documents belong to doctors, dentists, or health care facilities, while the contents of the records belong to the patient.⁵⁹ The law emphasizes that medical records must be kept confidential by doctors or dentists and leaders of health service facilities.⁶⁰

Further, Article 12 (1) of the Minister of Health Regulation on Medical Records determines that medical record files are the property of health service facilities. Paragraph (2) of that article explicitly mentions that the 'content of the medical record belongs to the patient. Paragraph (3) then makes clear that the 'content of the medical record' is in form of a medical record summary (medical resume). Lastly, Article 12 (4) specifies that a medical record summary can be given, noted, or copied by the patient or person who is authorized or with the written consent of the patient or patient's family who is entitled to it.⁶¹ The provisions regarding the ownership of medical records in this ministerial regulation have been judicially reviewed before the Indonesian Supreme Court.⁶² The petitioner argued that Article 12 (3) and (4) of the Minister of Health Regulation on Medical Records must be declared null and void.⁶³ Against this petition, the Minister of Health, as respondent, replied that the petitioner's request to revoke those provisions is counterproductive and eliminates the patient's right to obtain medical records.⁶⁴ Besides, the minister clarified that the term 'summary/resume' should not be interpreted as limiting and reducing the patient's rights because if the patient needs it, his/her right to access the entire contents of the medical record documentation from the beginning to the end of the health service process is fully guaranteed.⁶⁵ Further, the Minister explained that the term 'summary/resume' implies simplification of the language of the contents of medical record documents to ease the understanding for patients and their families because if medical language is used, it will be relatively difficult for ordinary patients to understand.⁶⁶ Finally, the Indonesian Supreme Court rejected the judicial review petition, considering that the ministerial regulation provisions being reviewed before this court are further explanations of Article 47 of the Medical Practice Law.⁶⁷

As previously discussed in Section 2.3, the right to keep the medical record files belongs to the health care facility, but health workers and health service facilities are obliged to keep the confidential information contained in

⁵⁸ *Ibid.*, Art. 1 (18) and Art. 71 (2).

⁵⁹ Law No. 29 of 2004 concerning Medical Practice, Art. 47 (1).

⁶⁰ *Ibid.*, Art. 47 (2).

⁶¹ Regulation of Minister of Health No. 269 of 2008 Concerning Medical Records, Art. 12.

⁶² One out of four authorities of the Constitutional Court is to examine, at the first and final level, the judicial review a law against the 1945 Constitution of the Republic of Indonesia. See Luthfi Widagdo Eddyono, "The Constitutional Court and Consolidation of Democracy in Indonesia," *Jurnal Konstitusi* 15, no. 1 (2018): 5.

⁶³ Decision of the Supreme Court No. 21P/HUM/2011, *op.cit.*, 4.

⁶⁴ *Ibid.*, 13, 14.

⁶⁵ *Ibid.*, 13.

⁶⁶ *Ibid.*

⁶⁷ *Ibid.*, 17, 18.

the medical record.⁶⁸ The contents of the patient mean that the contents of the medical record are the rights of the patient. The content of medical records only refers to its summary creating the perception that this regulation only favors doctors.⁶⁹ The health care provider is sworn to keep the confidentiality of the data of the patient unless asked by the court to discover it.

This means that the content of the medical record is something that is written in the medical record. Based on this, the patient should get all of the contents of the medical record.

The patient is a dignified human being so he has autonomy over himself. On the basis of their right to autonomy, only the patient can determine what is best for him. This includes determining when it is appropriate to disclose personal and sensitive health information, to whom the information will be provided, and how much information will be provided to the desired party.⁷⁰ By being given a special password to be able to access electronic medical records, patients will be able to view medical records without having to change them. Patients have the right to determine what is best for themselves, and when and with whom to disclose their medical secrets.

From a philosophical perspective, John Rawls argues justice has two main interests, namely to guarantee the stability of human life and to balance private life and public life. The ideal structure of a just society is the basic structure of the original society, where basic rights, freedoms, power, authority, opportunities, income, and welfare are fulfilled.⁷¹ Plato reveals that a problem requires regulation with laws that reflect justice. The law is not only to maintain order and the stability of the country but also must be able to guide people to become good citizens.⁷² Legislation which is a manifestation of legal norms essentially has a legal purpose for the sake of justice. The loss of a norm in the formation of legal products will allow the loss of a citizen's constitution. For this reason, the law must be made or formulated fairly so that there are legal products containing the value of social justice that fulfill the basic rights of citizens.⁷³ Social justice has become the nation's constitution as stated in the fifth precept of social justice for all Indonesian people. The characteristics of Pancasila-based

⁶⁸ See Law No. 36 of 2014 concerning Health Workers, Art. 70 (4); Law No. 38 of 2014 concerning Nursing, Art. 38 (e); Law No. 4 of 2019 concerning Midwifery, Art. 61 (f).

⁶⁹ Regulation of Minister of Health No. 269 of 2008 concerning Medical Records, Art. 12 (3).

⁷⁰ Anggra Yudha Ramadianto, "Aspek Filosofis Moral Dan Hukum Kewajiban Menyimpan Rahasia Medis Pasien Sebagai Objek Perikatan (Prestasi) Dalam Kontrak Terapeutik," *Simbur Cahaya* 22, no. 3 (2017): 4906.

⁷¹ Muchamad Ali Safa'at, "Pemikiran Keadilan (Plato, Aristoteles, John Rawls)," <http://www.safaat.lecture.ub.ac.id/files/2011/12/keadilan.pdf>

⁷² Bahder Johan Nasution, "Kajian Filosofis Tentang Konsep Keadilan Dari Pemikiran Klasik Sampai Pemikiran Modern," *Yustisia Jurnal Hukum* 3, no. 2 (2014): 7.

⁷³ Rudiansyah Putra Sinaga, "The Urgency of Legal Policy to Fulfill The Constitutional Rights to Employment Social Security for Vulnerable Workers in The National Social Security System," *Jurnal Hukumtora: Hukum Untuk Mengatur dan Melindungi Masyarakat* 7, no. 3 (2021): 489.

justice, namely humanizing humans in a fair and civilized manner according to their human rights.⁷⁴

Fairness will be achieved when there is a balance of rights and obligations between health workers and patients. To achieve this aim, there are some issues to be taken into consideration. On one hand, health workers and health care facilities should adopt and implement strict mechanisms and procedures that ensure the confidentiality of patients' medical records. In particular, health workers should carry out health services with a high level of integrity, according to what have they sworn, and comply with procedures and professional standards. This is expected to build the trust of the patients. On the other hand, patients or their legal representatives are provided with the disclosure of medical records before the patient's discharge, given the fact that the entire contents of the medical record are patients' property even though what is given is only its summary.

Justice, as one of the goals of the creation of law, cannot be easily defined. While it is considered to differ from equalizing or getting an equal share, justice may be described as a mutual feeling that is related amongst human beings and may be reflected in the expression of the ideals of society.⁷⁵ The principle of justice has traditionally been understood as the fair distribution of burdens and benefits,⁷⁶ while it was further developed into some concepts, *e.g.* restorative justice,⁷⁷ which will be further elaborated in Section 2.4.

The current regulation states that medical records are the property of health facilities, doctors, or dentists, while patients only get a summary of medical records which does not reflect justice. Patients do not have the right to obtain complete health data, even though health workers or health service facilities will keep patient data confidential. For patients, the meaning of justice is not only the guarantee of the confidentiality of their medical records but also the easy procedures of obtaining such records. This easy procedure would enable patients to choose further medical treatment, including, for example, seeking a second opinion or continuing medical treatment at different medical care services.

2.4. The Upcoming Future of Telemedicine-Based Medical Record and Method for Resolving a Medical Dispute

In the current digitalization era, medical records in electronic form seem to be promising. Electronic Medical Record (EMR) is an electronic

⁷⁴ Ferry Irawan Febriansyah, "Keadilan Berdasarkan Pancasila Sebagai Dasar Filosofis Dan Ideologis Bangsa," *DiH Jurnal Ilmu Hukum* 13, no. 25 (2017): 9.

⁷⁵ See Raden Mas Try Ananto Djoko Wicaksono, "Reviewing Legal Justice, Certainty, and Legal Expediency in Government Regulation Number 24 of 2018 Concerning Electronically Integrated Business Services," *Lex Scientia Law Review* 5, no. 1 (2021): 5-6.

⁷⁶ Bridget Pratt, *et.al.*, "Justice: A Key Consideration in Health Policy and Systems Research Ethics," *BMJ Global Health* 5, no.4 (2020): 1-2.

⁷⁷ See for example Markus Y. Hage and Panggih Kusuma Ningrum, "Corrective Justice and Its Significance on the Private Law," *Journal of Indonesian Legal Studies* 7 no.1 (2022): 6-16.

version of patients' health records that can be used for input, storage, display, retrieval, and sharing of information.⁷⁸ In other countries like the United States (US), an EMR has been developed that can be used to reduce the risk of error and minimize the risk of prosecution.⁷⁹ The use of EMR provides advantages, *i.e.* providing certainty of health information when requiring separate health services and responding to the challenges of changing clinical and administrative processes.⁸⁰ EMR prevents the possibility of lost documents, changes in data, and falsification of patient treatment history. With regard to access to information, EMR enables patients to access their medical records with a special password without being able to change the information contained.

The medical record becomes one of the issues in the current trend of telemedicine, a remote health service provided by a healthcare professional that uses information and communication technology.⁸¹ The Corona Virus Disease 2019 (Covid-19) makes telemedicine becomes more important. Responding to this global matter, both Minister of Health and the Indonesian Medicine Council issued documents on the same day 29 April 2020. The Minister of Health issued a circular letter to be used as a reference in providing health services through telemedicine. Regarding medical records used for telemedicine, this circular letter determines that the results of telemedicine services are recorded in digital or manual records served as medical record documents.⁸² These documents are the doctor's responsibility, must be kept confidential, and used in accordance with the provisions of laws and regulations.⁸³ In addition, the circular also determines that copies of electronic prescriptions must be kept in printed and/or electronic form as part of the medical record document.⁸⁴ In line with the Minister of Health's circular letter, the Indonesian Medical Council also issued a regulation that requires doctors and dentists who practice telemedicine to make medical records, which can be in the form of manual medical records in written form or electronic medical records in the form of

⁷⁸ Michelle Helena van Velthoven, *et.al.*, "Feasibility of extracting data from electronic medical records for research: an international comparative study," *BMC Medical Informatics and Decision Making* 16 (2016): 1.

⁷⁹ Venkataraman Palabindala, Amalawari Pamarthy, and Nageshwar Reddy Jonnalagadda, "Adoption of Electronic Health Records and Barriers," *Journal of Community Hospital Internal Medicine Perspectives* 6, no. 5 (2016): 3.

⁸⁰ Brent A. Williams, *et.al.*, "Establishing a National Cardiovascular Disease Surveillance System in the United States Using Electronic Health Record Data: Key Strengths and Limitations," *Journal of the American Heart Association* 11, no. 8 (2022): 1.

⁸¹ Regulation of Minister of Health No. 20 of 2019 concerning the Implementation of Telemedicine Services between Health Service Facilities in Indonesia, Art. 1 (1).

⁸² Circular Letter of Minister of Health No. HK.02.01/MENKES/303/2020 concerning the Implementation of Health Services through the Utilization of Information and Communication Technology to Prevent the Spreading of Corona Virus 2019 Disease, 4.

⁸³ *Ibid.*

⁸⁴ *Ibid.*, 6.

transcripts for each patient, to be further filed in health service facilities in accordance with the statutory provisions.⁸⁵

The Presidential Staff Officer assessed some loopholes in the implementation of telemedicine as regulated in the Minister of Health's regulation and decree, such as guarantees for private data protection, the confidentiality of integrated medical records between health facilities, and legal protection, especially for medical personnel who provide services. The government plans to adopt smart regulations to keep pace with the rapid development of technology and innovation, especially with regard to health services through telemedicine, which are basically internet-based. The government is also concerned that the need for legal protection will increase along with the use of telemedicine, thus it is necessary to be prepared to deal with cases of ethics, malpractice, fraud, and moral hazard both from the side of the patient and the doctor.⁸⁶

As previously discussed in Section 1 and Section 2.3, medical records are generally used as an evidentiary document for medical disputes that are settled before the court. Referring to Law No. 11 of 2008 concerning Information and Electronic Transactions, medical records that are part of electronic information and/or electronic documents and/or the printout version of a medical record may be classified as, in an extension meaning, legitimate legal evidence according to the applicable procedural law in Indonesia.⁸⁷ Even though a court must be regarded as the ultimate institution to ensure justice for all disputed parties, not everyone can sense justice from the court's decision.⁸⁸ In this context, it would be relevant to consider the idea of Edward Omar Sharif Hiariej, Vice Minister of Law and Human Rights, who proposes the need to bring restorative justice in medical disputes. He explained that restorative justice is a form of approach to resolve cases according to criminal law by involving criminals, victims, families of victims or perpetrators, and other related parties. Hiariej explains five reasons why restorative justice needs to be applied in medical disputes. First, restorative justice is an out-of-court settlement that prioritizes the recovery of victims and not punishment. Second, the emergence of disputes in medical practice and medical actions are mostly not intentional, but rather on negligence, it can even be a pure accident. Third, the nature of criminal law is an *ultimum remedium*. Fourth, restorative justice represents the paradigm of modern criminal law. Fifth, investigations into malpractice

⁸⁵ Regulation of Indonesian Medical Council No. 74 of 2020 concerning the Clinical Authority and Medical Practice through Telemedicine during the Corona Virus 2019 (COVID-19) Pandemic in Indonesia, Art. 7 (1) and (2).

⁸⁶ VOI, "Cegah Malpraktik, Pelanggaran Etik Pasien dan Dokter, KSP Sebut Pemerintah Siapkan Payung Hukum Bagi Telemedisin," <https://voi.id/berita/134483/cegah-malpraktik-pelanggaran-etik-pasien-dan-dokter-ksp-sebut-pemerintah-siapkan-payung-hukum-bagi-telemedisin>.

⁸⁷ Law No. 11 of 2008 concerning Information and Electronic Transactions, Art. 5.

⁸⁸ For example, a patient expressed disappointment to the Makassar District Court Panel of Judges who awarded an acquittal to a doctor suspected of committing malpractice. See Abdul Hadi, "Dokter Malpraktik Elisabeth Divonis Bebas, Korban Laporkan Hakim ke KY," <https://www.antvklik.com/headline/dokter-malpraktik-elisabeth-divonis-bebas-korban-laporkan-hakim-ke-ky>.

acts are not intended to punish doctors or medical professionals, but to prevent similar cases from occurring in the future.⁸⁹ Law scholars argue that restorative justice emphasizes human rights and the need to recognize the impact of social injustice and restore the parties to their original condition.⁹⁰

3. CONCLUSION

Medical record, undeniably, plays a vital role in legal matters related to tension, or even dispute, between patient and health worker as it becomes a primary document to prove the elements of negligence. While right and access to medical records has already become international concerns, Indonesian law and regulations repeatedly emphasize their importance.

There are two concerns with regard to medical records. On one hand, the humanitarian activities of health workers should be respected, and therefore, legal consequences should not make them worry to carry out their medical work. As long as medical records show that health workers comply to rule, ethics, and procedural standards and that health care facilities keep the medical records confidentially and in a proper means, there must be a legal certainty to ensure that both health workers and health care facilities are protected by law. On the other hand, improper and unprofessional work of health workers that may cause harm to patients who need or request medical treatment must be dealt with properly.

The obligation of health workers to make medical records as stated in Health Worker Law, Medical Practice Law, Nursing Law, Midwifery Law and some Minister of Health regulations reflects a legal certainty. These laws and regulations require a medical record to be made to prove a health service has been delivered by the health workers.

The sense of justice regarding the ownership of medical records may be realized if there is a balance between the rights and obligations of health workers and patients. On the side health workers, they are guaranteed legal protection as long as carrying out their duties, including keeping the confidentiality of patients' data, according to standards and procedures. The regulations governing the existence of medical records seem do not to reflect the principle of justice since medical record files are owned by doctors, dentists, or health service facilities, even though such files must be disclosed in a legal proceeding before the court. For patients, the meaning of justice is not only the guarantee of the confidentiality of their medical records but also the easy procedures of obtaining such records. This easy procedure would enable patients to choose further medical treatment,

⁸⁹ Faculty of Medicine, Public Health, and Nursing Universitas Gadjah Mada, "Dinamika Sengketa Medis di Indonesia," <https://fkkmk.ugm.ac.id/dinamika-sengketa-medis-di-indonesia/>.

⁹⁰ See Ahmad Syaafi, Diana Haiti, and Mursidah, "Application of Restorative Justice Values in Settling Medical Malpractice Cases," *International Journal of Criminology and Sociology* 10, (2021): 109.

including, for example, seeking a second opinion or continuing medical treatment at different medical care services.

It might happen in the future that conventional forms of the medical record seem to be less attractive compared to electronic medical records. Therefore, that situation requires adaptable laws and regulations. With regards to dispute settlement, the application of restorative justice to resolve medical disputes seem to place medical record as the sole and the most valuable document.

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