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Legal Consistency of Health Personnel in Making Medical Records

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Abstrak

Introduction to The Problem: Medical record is a record or document containing patient identity, examination, treatment, action, and other services that must be made by health workers, but not 100% complete medical records. Currently, when talking about medical records, doctors always think that in the law on health workers, medical records must be made by health workers.
Purpose/Objective Study: To analyze the legal consistency of health workers in making medical records.
Design/Methodology/Approach: This research method is a normative combination of library studies with deductive research analysis.
Findings: The results of patient records carried out by the medical profession are called medical records, patient records carried out by nurses are called nursing care documentation, and patient records carried out by midwives are called midwifery care documentation. Doctors who do not make medical records can get criminal sanctions, while nurses and midwives will get administrative sanctions if they do not do documentation of care. There is a consistency of laws that require doctors, dentists, nursing, and midwives to make medical records, albeit in different terms. There has been no consistency of laws governing sanctions between doctors, dentists, nurses, and midwives. Further study is needed to evaluate the legal products governing sanctions for health workers who do not make medical records.
Paper Type: Research Article
Keywords: Legal Certainty; Medical Records; Doctors; Nurses; Midwives

Introduction

Health workers are people who devote themselves to the health sector, have the knowledge and skills obtained through education, and have certain authority to carry out health efforts. According to Law Number 36 of 2014 concerning Health Workers, health workers are medical personnel, clinical psychology staff, nursing staff,

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midwifery workers, pharmaceutical workers, public health workers, environmental health workers, nutrition workers, physical therapy personnel, medical technicians, and technical personnel, biomedicine, traditional health workers, and other health workers. The relationship between health workers and patients is equal because they have the same rights and obligations. It is proven that every health worker and client has rights and obligations (Supriyatin, 2018).

Doctors are the main element in medical services. The relationship between patients and health workers is a legal relationship that gives birth to rights and obligations between both parties. Health workers providing services to patients in an effort to cure patient diseases are legal acts so that they can be held legally accountable and demand professionalism (Said, 2016).

Legal actions between health workers can cause legal conflicts. This occurs due to patient dissatisfaction with health services, resulting in patients feeling disadvantaged. The conflict will become a dispute between the parties to resolve problems that, if not resolved properly, can disrupt the relationship between doctors and patients.

Written evidence used by investigators to uncover criminal acts in the health sector, malpractice, and civil actions in the health sector is medical records. A medical record is a file containing notes and documents about patient identity, examination, treatment, actions, and other services to patients at healthcare facilities which are evidence of what doctors or other health workers have done (Sjamsuhidajat, 2006). The concept of documentation is also used as a means of evaluating the extent to which nurses are patient-centred (Butler et al., 2022). The medical record is written evidence, which contains expert information as outlined therein, in the form of a note that aims to assist investigations in uncovering criminal acts, especially in proving medical malpractice (Ekawati et al., 2013). Medical records can show the results of extracting patient health information carried out by doctors and nurses. If the doctor and the nurse fail to receive the correct information, it will have an impact on treatment. The failure of the doctor to extract information is the responsibility of the doctor for the failure (Asadinejad, 2022).

Examples of cases where medical records are needed as evidence so that they can reveal cases in the health sector include the case of Agus Ramlan, who went blind after treatment due to a red colour meta. In that case, the hospital and the doctor were sued because the medical records that should have been used as evidence were destroyed without the patient's consent, dr. Elisabeth Susana was found guilty of malpractice after seeing the medical record that was made. Doctor Bukhari SPOG made a wrong diagnosis and did not record it in the medical record, so he could not prove whether his service was according to the procedure or not. On this basis, Dr. Bukhari SPOG was found guilty of having performed services without making medical records.

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Based on several research results, including his research that there are still 12% of doctors who do not sign in medical records (Irmawati et al., 2018). Likewise, in research conducted by (Wirajaya et al.), there are still 13.32% incomplete medical records (Wiraja & Dewi, 2019). Factors that affect incompleteness in making medical records in their research (Nurhaidah & Harijanto, 2016) are doctors, nurses, or midwives who lack discipline, and there is no evaluation (Nurhaidah & Harijanto, 2016), supported by research (Swari et al., 2019) Factors that affect incompleteness in making medical records are factors officers, procedural factors, tools, and motivation factors (Swari et al., 2019). Research conducted by Zulfita Eka (2020) found that midwives in Lubuk Buaya Padang complete documentation only on documentation that had been templated by the Health Office, but in making service documentation with SOAP (Subjective Objective Analysis and Planning), it was incomplete, completing only for the need to collect points in order to find SKP (Professional Credit Unit) (Zulfita et al., 2020). Based on research conducted by Eka Desi Purwanti that nurses at RS Haji Jakarta found that the documentation carried out by nurses was not fully in accordance with SPO (Standard Operating Procedures) for nursing care documentation (Purwanti, 2012).

Health workers' education level and work length are characteristics that affect human resources. At the same time, the infrastructure factor is the availability of facilities to be able to perform medical records, such as the existence of forms and procedures (Maharani & Setyowati, 2015). Supported by her research Wan Anita that supervision, the willingness to format, and attitude influence the creation of documentation (Anita, 2018).

An incomplete file is a reflection of incomplete care and treatment. Omitting details is a serious and common mistake in the documentation. The legal authorities for dealing with medical negligence are of the opinion that what is not recorded in the file means that it has not been done. Of course, this does not mean that everything should be recorded in the file, but important conditions, complete patient assessment data, and discharge orders should be recorded in the patient file (Organization Commission on Accreditation of Health Care, 2021). Therefore, our present study discusses the legal certainty of health workers (doctors, nurses, and midwives) in conducting medical records.

Methodology

The type of research used is normative law (normative juridical) using secondary data consisting of primary legal materials, secondary legal materials, and tertiary legal materials. The primary legal materials in this study are Law No. 36 of 2014 concerning Health Workers (Health Workers Law), Law No. 29 of 2004 concerning Medicine (UUPK), Law No. 4 of 2019 concerning Midwifery (Law on Midwifery), Law No. 38 of 20114 concerning Nursing (Nursing Law), Regulation of the Minister of Health No. 269 of 2008 concerning Medical Records and the Criminal Code Law. Secondary legal materials in this study are books and journal articles related to medical records.

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Tertiary legal materials in this study are newspapers, legal dictionaries, Indonesian language dictionaries, and websites. The research analysis in this paper is to use deductive analysis.

Results and Discussion

The obligations of health workers in making medical records are shown in table 1.

Table 1. The obligations of health workers in making medical records

Law No. 36 of 2014 concerning Health Workers		
● Article 58 point (d) Health Workers are required to make and keep records and or documents of examination, care, and actions that have been carried out. ● Article 70 paragraph (1) Every health worker, in carrying out individual health services, must make a medical record of the recipient of health services. In paragraph (2), the medical record of the recipient of health services, as referred to in paragraph (1), shall be completed immediately after the receipt of the health service has finished receiving the health service.		
Doctor	**Nurse**	**Midwife**
1. Law No. 29 of 2004 concerning the Practice of Medicine article 46 "paragraph (1) states that doctors and dentists, in carrying out the practice of medicine, are required to make medical records. 2. Regulation of the Minister of Health No. 269/MENKES/PER/III/2008 about Medical Records article 5 paragraph (1) Every doctor or dentist in carrying out medical practice is obliged to make medical records.	Law No. 38 of 2014 concerning Nursing article 37 item "(d) nurses are required to document their nursing care.	Law No. 4 of 2019 concerning Midwifery article 61 points" (e) midwives are required to document in providing services.

Based on Law No. 36 of 2014 concerning Health Workers (Law on Health Workers), every health worker has an obligation to make medical records. To improve the professionalism of doctors, nurses, and midwives, Law No. 29 of 2004 concerning the Practice of Medicine (UUPK), Law No. 38 of 2014 concerning Nursing (Nursing Law), and Law No. 4 of 2019 concerning Midwifery (Midwifery Law) have been established.

Legal Consistency the Obligation of Doctors to Make Medical Records

The obligation to make medical records for doctors has been consistent between the Health Workers Law and the UUPK. The obligation of doctors to make medical records

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is also regulated in the Regulation of the Minister of Health No. 269/MENKES/PER/III/2008 concerning Medical Records (Minister of Health Medical Records). In the Minister of Health Medical Records paragraph (2), Medical records, as referred to in paragraph (1), must be made immediately and completed after the patient receives services. In paragraph (3), the making of medical records, as referred to in paragraph (2), is carried out through recording and documenting the results of treatment examinations, actions, and other services that have been provided to patients. In paragraph (4), any recording into the medical record must be affixed with the name, time, and signature of the doctor, dentist, or certain health worker who provides health services directly. In paragraph (5), in the event of an error in recording the medical record, correction may be made. And in paragraph (6), bookkeeping, as referred to in paragraph (5), can only be done by means of cross-out without removing the corrected record and affixing it with the paraphrase of the doctor, dentist, or certain health worker concerned.

Law No. 29 of 2004 concerning the Practice of Medicine article 46 paragraph (1) states that doctors and dentists, in carrying out the practice of medicine, are required to make medical records. In paragraph (2), it is stated that the doctor or dentist in making medical records, as mentioned in paragraph (1), must be completed immediately after the patient receives services. Subsection (3) states that each medical record must be affixed with the name, time, and signature of the officer providing the service or action. Based on the regulations governing health workers, it is clearly stated that it requires a health worker to carry out medical records. However, there are doctors who lack discipline in making medical records because of a misunderstanding of the benefits and important functions of medical records (Sugiarsi & Rohmadi, 2020).

Doctors making medical records are influenced by: 1) Motivation; high motivation of doctors to maintain the quality of service affects the compliance of doctors in making medical records; 2) Good supervision provides a doctor in making good medical records (Nasution et al., 2022). 3). Support for the management of medical records prepared by the hospital is one that determines the order of the hospital (Hidayat et al., 2022).

Sanctions for doctors who do not make medical records are contained in the Law of Health Workers. Article 82 paragraph (1) stated that "any Health Worker who does not carry out the provisions of Article 47, Article 52 paragraph (1), Article 54 paragraph (1), Article "58 paragraph (1), Article 59 paragraph (1), Article 62 paragraph (1), Article 66 paragraph (1), Article 68 paragraph (1), Article 70 (1), Article 70 paragraph (2), Article 70 paragraph (3) and Article 73 paragraph (1) are subject to administrative sanctions". Based on Article 79 of UUPK, the sanctions given to doctors and dentists who do not make medical records are imprisonment for a maximum of 1 (one) year or a maximum of Rp. 50,000,000.00 (fifty million rupiahs).

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It can be interpreted that there is a consistency of regulations that require doctors and dentists to make medical records. However, it is inconsistent in sanctioning. The Law on Health Workers provides administrative sanctions, while the UUPK provides criminal sanctions.

The principle of *lex specialis derogat legi generali* is a law that specifically removes the value of a law of a general nature; special law overrides/overrides common law (Shidarta & Lakonawa, 2018). Anxifor doctors who do not make medical records correctly will get criminal witnesses in accordance with Law No. 29 of 2004 concerning the Practice of Medicine.

Legal Consistency of Nurses' Obligations to make Medical Records

In the Nursing Law, it is explained that nurses carrying out Nursing Practices have the ability to document Nursing Care in accordance with standards. Decree of the Minister of Health of the Republic of Indonesia Number HK.01.07/MENKES/425/2020 concerning Nursing Professional Standards, the record is documentation of nursing care.

The Nursing Law does not regulate the obligation of nurses to make medical records but requires nurses to make documentation of nursing care. Is medical record the same as nursing care documentation?

The definition of a medical record, according to the KBBI, is a recording regarding the patient's health or a recording regarding the treatment of the patient. According to UUPK, medical records contain records and documents about the patient's identity, examination, treatment, actions, and other services that have been provided to patients. The definition of nursing documentation is a series of activities carried out by nurses starting from the process of assessment, nursing diagnosis, action plan, nursing actions, and evaluations that are recorded both electronically and manually and can be accounted for by the nurse (Abdul , 2016).

Nursing documentation should be structured efficiently and logically. The natural three dimensions of nursing documentation are focused on structure or format, process, and content (Wang, 2011). Nursing documentation must also be accurate, reflecting the nursing process consisting of nursing review and diagnosis, nursing intervention, implementation and evaluation of nursing care, and patient responses and outcomes (Nakate et al., 2015).

The components in the nursing documentation consist of the following:

1. Assessment
   a. Documentation begins with an incoming review.
   b. Primary data is collected from clients and families.
   c. The main reason for the admission of patients should be included in the assessment.
   d. Subjective and objective data on the client's condition are documented.

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e. The actual information, when just entered, is collected as quickly as possible.
f. The assessment must be completed by the same nurse when the client enters.
g. Summary of the assessment once each shift.

2. Diagnosis of Treatment
   Treatment diagnostics are focused on things that are the main reasons for the patient's current care, and that can be completed during the treatment time.
3. Interventions/Treatment Plans
   a. A treatment plan is drawn up for each nursing diagnosis.
   b. Clients and families are involved in planning.
   c. The plan consists of the diagnosis of the treatment, what will be carried out, how to perform it, the impact of the intervention and when it is evaluated.
   d. Evaluation of plans and results is an ongoing process.
4. Implementation/Implementation
   Once the maintenance plan is completed, guidance can be used to carry out implementation.
5. Evaluation
6. A written report on the results (the client's progress towards the goals).
   a. The format was created in order to save time and provide an opportunity for a quick assessment of the client's current condition.
   b. Progress records are made in a row over time following the patient's progress (Ghafur & Olfah, 2016).

The Health Workers Law requires health workers to make medical records, but it is not explained the definition of medical records. The difference between the definition of medical records according to UUPK and the standard of nursing documentation lies in the treatment in the definition of medical records, but not in the definition of nursing documentation. Treatment is the authority of the doctor but not the authority of the nurse. The health documentation containing the results of the nurse's assessment of the patient's subjective and objective data, treatment diagnoses, treatment plans, treatment implementation, and evaluation of treatment results is a record of the patient's health. It can be concluded that the nursing documentation is the same as the patient's medical record made by the nurse.

To make it easier for nurses to do nursing documentation with electronic medical records, it is very helpful for nurses to do documentation. Electronic medical records help improve patient and community satisfaction (Ranjbar et al., 2021). Patient participation in nursing documentation will result in better adjustments to planning and documentation accuracy (De Groot et al., 2022).

Based on the Health Worker Law, nurses who do not make medical records will be subject to administrative sanctions. This is consistent with what is contained in the Law on Nursing Article 58. Sanctions for nurses who deliberately do not make nursing documentation will get administrative sanctions. The administrative sanctions in

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question are verbal reprimands, written warnings, administrative fines, and/or license revocation.

Legal Consistency of Midwife's Obligation to make Medical Records

Midwifery Documentation is evidence of recording and reporting based on accurate and complete written communication owned by midwives in carrying out midwifery care and is useful for the benefit of clients, health teams, and midwives themselves. Obstetric documentation is very important for midwives in providing midwifery care. This is because the midwifery care provided to clients requires recording and reporting that can be used as a reference to claim responsibility and responsibility for various problems that may be experienced by clients related to the services provided. Apart from being a recording and reporting system, obstetric documentation is also used as information about the patient's health status in all obstetric care activities carried out by midwives.

The principle of midwife's documentation is known as SOAP (Subjective, Objective, Assessment, and Planning) documentation. Subjective describes the documentation of the results of collecting client data through anamnesis with auto or allow anamnesis. The objective describes the documentation of the client's physical examination results, laboratory results, and other diagnostic tests formulated in the focus data to support obstetric care. The assessment describes the documentation of the results of the analysis and the interplay of subjective and objective data in an identification. Planning describes the documentation of planning, implementation, and evaluation based on assessment.

An important aspect of the documentation of obstetrics is the basic documentation and partographs. Basic documentation is used for pregnancy, childbirth, puerperium, and toddlers, while partographs are for pregnancy and childbirth (Bailey, 2015).

Similar to nursing documentation, the difference between obstetric documentation and medical records lies in treatment. Midwives do not have medical authority but have the authority to carry out obstetric actions according to authority. In the Midwifery Law article 61, midwives have an obligation to document midwifery care. But the Midwifery Law does not include sanctions for midwives who do not document midwifery care.

According to Law No. 12 of 2011 concerning the Establishment of Laws and Regulations article 5, the scope of the material in the legislation contains:

a. general provisions contain academic formulations of the meaning of terms and phrases;
b. the material to be organized;
c. sanctions provisions; and
d. transitional provisions.

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Although the Midwifery Law does not provide for sanctions for midwives who do not make obstetric documentation. The Obstetrics Law, which does not contain sanctions provisions for midwives who do not make obstetric documentation, does not mean that the Obstetrics Law is invalid, and it does not mean that midwives who do not make midwifery documentation do not get sanctions. Health Workers Law article 49 states that administrative sanctions are given in the form of verbal reprimands, written warnings, administrative fines, and/or revocation of permits for health workers who do not make medical records.

There are differences in the sanctions that doctors or dentists give to nurses and midwives. Doctors and dentists who do not make medical records are given criminal sanctions, while nurses and midwives are given administrative sanctions.

Criminal acts are classified as crimes (*misdrijf*) and violations (*overtrading*). Also formulated in the Criminal Code (KUHP) that criminal acts are divided into two forms or qualifications of criminal acts, namely in the form of crimes (located in Book II) and offences (located in Book III). Eliminating damage that is considered to be used for proof is a criminal offence. In the Criminal Code Bill, there is the elimination of violations in book III as criminal offences (Supriyadi, 2015).

Laws are made for humans, so the implementation of the law or law enforcement must provide benefits or uses for the community. Don't let it be because the law is implemented or enforced, there will be unrest in the community (Sulardi, 2015).

The framers of the Act, in determining the acts that can be punished, must pay attention to their harmony with the feelings of the law that live in society. Therefore, the act will not only be contrary to the laws and regulations but will also always be contrary to the law. In general, every criminal act is considered contrary to the law, but in special circumstances, according to concrete events, it is possible that the act is not contrary to the law. In such cases, the maker of the criminal act proves that his conduct is not contrary to the law (Ar, 2009).

Criminal law aims to protect the public interest, which is provided for in the Criminal Code. Criminal law has direct implications for society at large (general). In other words, if a criminal act is committed, it will have a bad impact on security, peace, welfare, and public order in society. Civil law is private, which focuses on regulating contact between individuals, in other words, emphasizing individual interests (Oktavira, 2022).

Doctors and dentists who do not make medical records are considered to have committed criminal acts because the implementation of medical practice is the core of the implementation of health service efforts. Not making medical records is an unlawful event that can be considered fatal, eliminating evidence and violating the patient's rights.

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Nurses and midwives who do not make documentation are not considered criminal acts. In fact, if the act of not making documentation is deliberately not made to eliminate evidence, it is a crime. Doctors, nurses, and midwives are health workers who work with codes of ethics and morals. Working in relation to human safety should not focus solely on criminal or administrative sanctions. The law should be used as a norm that must be obeyed consciously according to the purpose of the law, but in Indonesia, it has not cultivated compliance with the law. His adherence to the rule of law is out of "fear" rather than "obedience" (Edytya & Prawira, 2019).

Accurate recording of patient information by doctors and nurses will support and protect the rights of patients and also support medical staff. And it makes doctors, nurses, medical staff, and hospitals immune from possible claims by patients or their companions. In addition to recording information, documenting patient documents must also be considered because correct documentation of medical documents is one of the most basic things. Accurate and correct documentation determines the quality of care and treatment as well as treatment outcomes. Medical documents have a lot of legal value. For example, if a patient sues a legal authority for various reasons, the data recorded by doctors and nurses, as well as treatment reports and the results, are effective in the decisions of the legal authorities (Reza, 2011).

The importance of recording is also regulated in the Islamic religion Surah Al-Baqarah verse 282 "O you who have faith! When you contract a loan for a specified term, write it down. Let a writer write with honesty between you, and let not the writer refuse to write as Allah has taught him. So let him write, and let the one who incurs the debt dictate, and let him be wary of Allah, his Lord, and not diminish anything from it. But if the debtor is feeble-minded, or weak, or incapable of dictating himself, then let his guardian dictate with honesty, and take as witness two witnesses from your men, and if there are not two men, then a man and two women—from those whom you approve as witnesses—so that if one of the two defaults the other will remind her. The witnesses must not refuse when they are called and do not consider it wearisome to write it down, whether it be a big or small sum, [as a loan lent] until its term. That is more just with Allah and more upright in respect to testimony, and the likeliest way to avoid doubt, unless it is an on-the-spot deal, you transact between yourselves, in which case there is no sin upon you not to write it. Take witnesses when you make a deal, and let no harm be done to the writer or witness, and if you did that, it would be sinful of you. Be wary of Allah, and Allah will teach you, and Allah has knowledge of all things."

Conclusion

The obligation to make medical records for doctors and dentists is consistently regulated in the Law on Health Workers, UUPK, and Regulation of the Minister of Health on Medical Records, but in legal products, there are different sanctions given to doctors and dentists who do not make medical records. The obligation to make medical records and sanctions for nurses are consistently regulated in the Health

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Workers Law and the Nursing Law, even if using the term nursing documentation. The obligation to make medical records for midwives is consistently regulated in the Health Workers Law and the Obstetrics Law, even by using the term obstetric documentation. Sanctions for midwives who do not make medical records are regulated in the Health Workers Law. There is a need for further studies that evaluate the consistency of sanctions laws for health workers to realize the safety, comfort, and peace of patients.

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References

Anita, W. (2018). The implementation of documentation by midwives in Pekanbaru. *Kesmas*, *13*(1), 43–47. https://doi.org/10.21109/kesmas.v13i1.1403

Ar, S. (2009). Penentuan Sanksi Pidana dalam Suatu Undang-Undang. Legislasi Indonesia, 6, 846. https://e-jurnal.peraturan.go.id/index.php/jli/article/view/337/221

Asadinejad, S. M. (2022). The Relationship between Patients Informed Satisfaction and Medical Ethics from an Iranian Legal Perspective Review article The Relationship between Patients Informed Satisfaction and Medical Ethics from an Iranian Legal Perspective. *Pravara Med Rev*, *14*(3), 59–69. https://doi.org/10.36848/PMR/2022/70100.510250

Bailey, S. G. W. W. Y. (2015). *What factors affect documentation by midwives? A prospective study assessing relationship between length of shift, workload, and quality of note keeping*. *31*(8), 787–792. https://www.sciencedirect.com/science/article/abs/pii/S0266613815001163#:~:text=The basic note keeping and partogram documentation were, shifts may help improve the quality of documentation.

Butler, J. M., Gibson, B., Patterson, O. V, Damschroder, L. J., Halls, C. H., Denhalter, D. W., Samore, M. H., Li, H., Zhang, Y., & Duvall, S. L. (2022). Clinician documentation of patient centered care in the electronic health record. *BMC Medical Informatics and Decision Making*, *22*(1), 1–12. https://doi.org/10.1186/s12911-022-01794-w

De Groot, K., Douma, J., Paans, W., & Francke, A. L. (2022). Patient participation in electronic nursing documentation: An interview study among home-care patients. *Health Expectations*, *25*(4), 1508–1516. https://doi.org/10.1111/hex.13492

Edytya, N. P., & Prawira, R. S. (2019). Kenyataan Penegakan Hukum di Indonesia

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dalam Perspektif Hukum dan Pembangunan: Hukum Harus Ditaati atau Ditakuti? *Lex Scientia Law Review*, *3*(2), 177–190. https://doi.org/10.15294/lesrev.v3i2.35399

Ekawati, M. E., Laksono, I. S., & Sanjaya, G. Y. (2013). *Rekam Medis Eletronik Tidak Menjamin Kelengkapan Dokumentasi Kesehatan Pasien* [Udinus]. http://eprints.dinus.ac.id/2079/

Ghafur, A. & Olfah, Y. (2016). Dokumentasi Keperawatan. In *Pusdik SDM Kesehatan*. Kementrian Kesehatan Republik Indonesia.

Nasution, M. H. B., Wahyuni, S., Lubis, Y. E. P., & Nasution, A. N. (2022). Analysis Of Inpatient Medical Record Management Based on Medical Record Service Standards at Government Hospitals In Medan. *International Journal of Health and Pharmaceutical (IJHP)*, *2*(4), 692–702. https://doi.org/10.51601/ijhp.v2i4.153

Maharani, W., & Setyowati, M. (2015). Tinjauan Faktor Penyebab Ketidaklengkapan Dokumen Rekam Medis Rawat Jalan di Balai Kesehatan Paru Masyarakat (BKPM) Semarang Tahun 2015 Wahyatunnisa (Vol. 19). http://eprints.dinus.ac.id/17407/1/jurnal_16216.pdf

Hidayat, T., Turgandi, A., Anita, D., Amalia, A., Karmila, M., Sufriandi, Y., & Amelia, C. C. (2022). Filling in informed consent in the c-section operations section of Subang Regional General Hospital. *International journal of health sciences*, *6*(3), 1511–1519. https://doi.org/10.53730/ijhs.v6n3.13144

Irmawati, I., Danuri, A., Sudiyono, S., & Rahmawati, F. (2018). Quantitative Analysis of Medical Records of Inpatients in Ward Mawar Ungaran Hospital. *Jurnal Rekam Medis dan Informasi Kesehatan*, *1*(1), 11. https://doi.org/10.31983/jrmik.v1i1.3574

Mahkamah Agung. (2010). *Putusan nomor 134K/PID.SUS/2010*. Mahkamah Agung Republik Indonesia.

Mahkamah Agung. (2012). *Nomor: 281/Pdt.G/2012/PN.Bdg "Demi Keadilan Berdasarkan Ketuhanan Yang Maha Esa."* Mahkamah Agung Republik Indonesia. https://putusan3.mahkamahagung.go.id/direktori/putusan/d36e4d0d0a7b554f4c597617288e524e.html

Mahkamah Agung. (2021). *Putusan Nomor 233K/Pid.Sus/2021*. Mahkamah Agung Republik Indonesia.

Nakate, G. M., Diane, D., Pammla, P., Karen, B. D., & Ruby, D. (2015). The Nursing Documentation Dilemma in Uganda: Neglected but Necessary. A Case Study at Mulago National Referral Hospital. *Open Journal of Nursing*, *05*(12), 1063–1071. https://doi.org/10.4236/ojn.2015.512113

Nurhaidah, Tatong Harijanto, T. D. (2016). *Factors Causing Incomplete Completion of Inpatient Medical Records in Hospitals*. *29*(3), 258–264. http://jkb.ub.ac.id/index.php/jkb/article/view/1642

Oktavira, B. A. (2022). *Inti Sari Perbedaan Hukum Pidanan dan Perdata*. Hukum Online. https://www.hukumonline.com/klinik/a/intisari-perbedaan-hukum-pidana-dan-perdata-lt57f2f9bce942f/

Organization Commission On Accreditation Of Health Care. (2021). *Hospital Accreditation Standards*. https://www.hcca-info.org/. https://www.hcca-info.org/

Purwanti, E. D. (2012). *Kelengkapan Dokumentasi Asuhan Keperawatan dan Karakteristiknya Pada Pasien Rawat Inap Dewasa Non Kebidanan Di Rumah*

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Sakit Haji Jakarta. https://lib.ui.ac.id/file?file=digital/20319949-S-PDF-Eka Desi Purwanti.pdf

Ranjbar, K., Sabetsarvestani, R., Oghlaee, H., Sarvestani, P. S., Dehghan, A., & Shirazi, Z. H. (2021). Using Electronic Software for Nursing Documentation in Nursing Students. *Florence Nightingale Journal of Nursing*, *29*(2), 128–136. https://doi.org/10.5152/fnjn.2021.20077

Reza, S., Faride, K., Zahra, A., Marjan, G., Roya, S., Niloofar, M., & Roya, A. (2011). The Study of Accountability Rate of Medical Records in Referral Cases to Forensic Medicine 2000. Scientific Journal of Forensic Medicine, 17(1), 29–35. Https://Www.Sid.Ir/Paper/53386/En#Downloadbottom

Said, N. (2016). *Hubungan Hukum Antara Pasien Dan Tenaga Medis Serta Rumah Sakit* (Vol. 693). https://www.neliti.com/publications/152891/hubungan-hukum-antara-pasien-dan-tenaga-medis-serta-rumah-sakit

Shidarta; Lakonawa, P. (2018). *Lex Specialis Derogat Legi Generali: Makna Dan Penggunaannya*. Binus University Busines Law. https://business-law.binus.ac.id/2018/03/03/lex-specialis-derogat-legi-generali/

Sjamsuhidajat, S. A. (2006). Manual Rekam Medis. In *Konsil Kedokteran Indonesia*. Konsil Kedokteran Indonesia. http://www.kki.go.id/assets/data/menu/Manual_Rekam_Medis.pdf

Sugiarsi, S., & Rohmadi. (2020). Literature Review: Why Incomplete Medical Records? *Indonesian of Health Information Management Journal*, *8*(2), 45–52. https://inohim.esaunggul.ac.id/index.php/INO/article/view/212

Sulardi, Y. P. W. (2015). Legal Certainty, Purposiveness, and Justice in the Juvenile Crime Case. *Jurnal Yudisial*, *8* no *3*, 251–268.

Supriyadi. (2015). Penetapan Tindak Pidana Sebagai Kejahatan Dan. *Mimbar Hukum*, *27*(3), 389–403. https://doi.org/https://doi.org/10.22146/jmh.15878

Supriyatin, U. (2018). Legal Relations Between Patients and Medical Personnel (Doctors) In Health Services. *Jurnal Ilmiah Galuh Justisi*, *6*(2), 184. https://doi.org/10.25157/jigj.v6i2.1713

Swari, S. J., Alfiansyah, G., Wijayanti, R. A., & Kurniawati, R. D. (2019). Analysis of Completeness of Completion of Medical Record Files for Inpatients Dr. RSUP. Kariadi Semarang. *ARTERI : Jurnal Ilmu Kesehatan*, *1*(1), 50–56. https://doi.org/10.37148/arteri.v1i1.20

Wang, N. D. H. P. Y. (2011). Quality of nursing documentation and approaches to its evaluation: a mixed-method systematic review. *Journal of Advanced Nursing*, *67*(9), 1858–1875. https://doi.org/https://doi.org/10.1111/j.1365-2648.2011.05634.x

Wiraja, M. K. M., & Dewi, N. M. U. K. (2019). Analysis of Incomplete Medical Records of Inpatients at Dharma Kerti Hospital Tabanan. *Jurnal Administrasi Rumah Sakit*, *6*(1), 11–20. https://journal.fkm.ui.ac.id/arsi/article/view/3553/994

Zulfita, Z., Primasari, E. P., & Syofiah, P. N. (2020). Analisis Kelengakapan Pendokumentasian Pelayanan Kebidanan Di Wilayah Kerja Puskesmas Lubukbuaya Kota Padang. *Human Care Journal*, *5*(3), 827. https://doi.org/10.32883/hcj.v5i3.845

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