

ANALYSIS OF LEGAL REVIEW OF MEDICAL INFORMATION RELEASE TO ENSURE THE CONFIDENTIALITY OF PATIENT IDENTITY

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Abstract

Assessment of health service can be viewed from the recording on the file of medical record, which can provide information about the patient's social identity, diagnosis of disease, disease history, examination and treatment which must be kept confidential by doctors, nurses, health workers and manager of the healthcare facility. This study aimed to describe legal review of the medical information release in ensuring patient confidentiality. The research used normative-judicial approach through literature study which examines secondary data in the form of primary and secondary legal materials. The results of the study showed that health care facilities are responsible for protecting health information contained in medical records against possible loss, damage, falsification and unauthorized access. Maintaining information security, accuracy of information and ease of access to information are demanded to health service organizations and health practitioners as well as authorized third parties. Meanwhile, parties who need information must always respect patient privacy. Healthcare facilities are obliged to maintain the confidentiality of the information contained in the medical record and are not allowed to release it to irresponsible people/institutions. Requests for medical information must go through the established procedures to protect patient privacy and avoid lawsuits.

Keywords: confidentiality of patient identity, medical information, legal

INTRODUCTION

There are various types of health services that have been developing in Indonesia, including hospitals, health centers, private practice doctors, medical centers, 24-hour clinics, and family doctors. Health service facilities have the obligation to provide healthcare according to their respective major objectives. Hospital is a health service institution that provides complete individual health services that provide inpatient, outpatient, and emergency services (Law Number 44 of 2009).

Medical records provide information both written and recorded concerning identity, anamnesis results, physical examination, laboratory, diagnosis, and all medical services and actions provided to patients, and treatment for inpatients, outpatients and emergency services (Ministry of Health the Republic of Indonesia, 2006). The explanation of the content of a medical record may only be made by the doctor or dentist who treats the patient with the patient's written permission or based on the applicable regulations (Permenkes RI 2008). Medical records must provide accurate and complete information about the process of medical and health services in hospitals, both past, present and that expected to occur in the future (Muninjaya AAG, 2016).

According to Law no. 36 of 2009 article 1 paragraph 11, health service is any or a series of actions performed in an integrated and sustainable manner to maintain and improve the degree of health, treatment and disease as well as health recovery by the government or the community. Health service is the subsystem of service that aims to improve health status. Health service contains a medical record unit that supports the health service process i.e. managing data and then processing it into a document that can be used as the basis for very important information aspects by external and internal parties. In providing health services, the hospital must document every action and treatment that has been given to the patient in a medical record document. The Minister of Health Regulation number 269/MENKES/PER/III/2008 rules the issue of confidentiality of information concerning patient medical information in article 10 stating that medical records are files that must be kept confidential and article 13 paragraph 1 which states that the use of medical records can be used as: (a) Health care and patient treatment; (b) Evidence of the law enforcement process; (c) Educational needs; (d) Funding basis for health services; (e) Health statistics data. The release of information to other parties (secondary release) has often emerged since the era of computerization of health information. A valid request can be processed for payment of a claim bill but does not guarantee security in the future. The first requester can forward information to another party without the patient's authorization (Hatta, 2013).

The use of this medical information relates to the release of medical information for internal and external purposes of the hospital. For internal purposes, the information is used for the patient's benefit and health insurance. Meanwhile, for external purposes, the information is used for education/research, courts/police and the Health Service. Therefore, fixed procedures are required for releasing medical record documents and returning medical record documents in purposes of anticipating the loss of medical record documents and misuse of medical record documents by irresponsible parties and avoiding difficulties in retrieval, storage and arrangement of medical record documents on storage rack.

The release of medical record information must be regulated through special regulation and agreement between the patient and the hospital. If performed causally, it will have an impact on the hospital or the health workers-in-charge. Based on the description above, the research is entitled "Analysis of Legal Review of Medical Information Release to Ensure the Confidentiality of Patient Identity"..

RESEARCH METHOD

This paper used normative-judicial approach. The steps taken were through library research which examined secondary data from primary legal materials and secondary legal materials.

1. Primary Legal Materials are binding legal materials such as Law of the Republic of Indonesia Number 44 of 2009 concerning Hospitals, Health Laws, Law of the Republic of Indonesia Number 29 of 2004 on the practice of medicine, Minister of Health regulations as well as other legal documents.
2. Secondary Legal Materials are legal materials obtained through the review of research reports, books, scientific journals, and other library materials that discuss legal substances on legal aspects of health information and confidentiality of patient identity.

RESULTS AND DISCUSSION

Health facilities are responsible for protecting health information contained in medical records against possible loss, damage, falsification and unauthorized access. Maintaining information security, information accuracy and easy access to information is the guideline for health service organizations and health practitioners as well as authorized third parties. Meanwhile, parties who need information must always respect patient privacy. Overall, security, privacy, confidentiality and safety are devices that fortify information in medical records (Erlindai, 2018).

Indonesia has laws and regulations governing the administration of medical records contained in Law Number 23 of 1992 on Health, Law Number 29 of 2014 concerning Medical Practice, and Minister of Health Regulations (2008). In addition, there are also statutory provisions concerning the obligation to keep medical secrets related to the implementation of Health Information Management, such as the article of the Criminal Code on the secrets of position/occupation, Government Regulation Number 10 of 1966 concerning Obligation to keep medical secrets, and the two laws above (Firdaus S, 2008).

Medical information in the Medical Record

Medical record is a file that contains records and documents regarding patient identity, examination, treatment, actions and other services that have been provided to patients. Medical records must be made in writing, complete and clear or electronic (Permenkes RI No. 269/Menkes/Per/III/2008 Article 1 paragraph (1) and Article 2 paragraph (1) on medical records). According to Law no. 29 of 2004 article 46 paragraph (1) concerning medical practice, "Medical records are files containing notes and documentation about patient identities, examinations, treatments, actions, and other services that have been provided to patients." Based on the duties and functions of the medical record, the completeness of medical record data is highly dependent on the performance of the medical record officer.

Medical record is information both written and recorded regarding identity, history taking, physical examination, laboratory, diagnosis and all medical services and actions provided to patients, and treatments either inpatient, outpatient or emergency services (Depkes RI, 2006). In a simpler sense, a medical record is a record containing the patient condition, treatment, and any actions or health services provided to patients, either outpatient, inpatient, or emergency care.

Purpose of medical information in Medical Records

The purpose of medical records is to support the achievement of administrative order in attempt to improve health services of hospitals. Medical records are made for orderly administration at hospital which is one of the determining factors in advancing health services. According to the regulation of Minister of Health of the Republic of Indonesia number 269/Menkes/Per/III/2008 Article 13 Paragraph (1), medical records can be utilized/used for health maintenance and patient treatment, evidence in the law enforcement process, medical discipline, ethical enforcement of medicine, and dentistry for the medical profession, educational and research purposes, basis for the cost of health services, and health statistical data.

Use of medical information in medical records

According to the Ministry of Health of the Republic of Indonesia (2006), the usefulness of medical records can be seen in several aspects as follows:

- a. Administrative aspect; medical records have an important role in hospital management. The health worker administrators can actually carry out health service activities properly if they are equipped with medical records.
- b. Legal aspect; which medical records are useful as evidence for patients and for health workers in front of a court session, because it contains who, when, and how medical action took place.
- c. The financial aspect; the records in the medical record have financial value because the content of the medical record can be used as material to determine the cost of services obtained without which actions or services, payment cannot be accounted for.
- d. Research aspect; all diseases and their process as well as the effect of treatment and others come from data taken from medical records that can be used for research purposes.
- e. Educational aspect; medical records can also be used as a tool in education as they contain complete and ordered information by time (chronological order) so that the records can be used as study material.

- f. Documentation aspect; with good and complete records, medical record will become a good documentation tool or source of memory and can be useful in the future as material for hospital responsibility. Medical records have very broad uses because they do not merely concern patients and health care providers.

Review of Legal Aspect of Medical Information Confidentiality in Medical Records

Security, privacy, confidentiality and safety are aspects that fortify data/information in health records (printed or electronic format). All parties involved in health services, either doctors, dentists, nurses, midwives and other health practitioners, including medical record officers and parties requesting data or information, must maintain the security of patient data or information (Harie Sakti Yusuf and Imas Masturoh, 2015).

The main source of information from administrative activities in health care facilities starts from medical records. Therefore, these records can be used as a basic tool of evidence and a valid defense tool if a lawsuit persists any time against the service provider or the health service facility itself. Medical records have legal value for their contents involve the issue of guaranteeing legal certainty on the basis of justice in the context of efforts to enforce the law and provide evidence to uphold justice. The legal aspects of medical records are also contained in the Law of the Republic of Indonesia Number 29 of 2004 concerning medical practice as stated in Article 51: "Doctors or dentists in performing medical practice have the obligation to provide medical services in accordance with professional standards and standard operating procedures as well as the patient's medical needs, keep everything they knows about the patient secret, even after the patient having received medical treatment died."

Availability, accessibility, privacy, and security are the main factors in implementing safe health medical records. Several mechanisms are used to protect health care records to avoid tampering and reduce the risk of information loss (Nisreen Innab, 2018).

General Review of Release of Medical Record Information

Based on the definition of medical record, it can be seen that the information contained in the medical record belongs to the patient obtained from medical contact between the patient and the doctor during the patient's treatment period. This is also explained in the Regulation of Minister of Health Number 269/Menkes/Per/III/2008 CHAPTER V Article 12 as follows:

- 1) Paragraph (1)
"Medical record files are the property of health service facilities"
- 2) Paragraph (2) "The content of the medical record is the property of patient in the form of medical summary".
- 3) Paragraph (3)
"A summary of medical record can be given, recorded, or copied by the patient or the authorized persons by written consent of the patient or the entitled patient's family."

Procedure for Release of Information to Other Parties

The procedure for releasing information to third parties within the scope of the court consists of releasing information for Jasa Raharja (Insurance Company) claim and requesting a Visum Et Repertum. The procedure for releasing information for Jasa Raharja claims and requests for Visum Et Repertum is almost the same as the process for releasing information for insurance claims and requests for medical resumes. Specially for requests for Visum Et Repertum, an official letter is required from the requesting party, namely the investigator or police who are given direct responsibility from the applicant.

According to Regulation of Minister of Health of the Republic of Indonesia Number 269/Menkes/Per/III/2008 CHAPTER V Article 13 Paragraph (1), medical records can be used as:

- a. Health maintenance and patient treatment;
- b. Evidence in the process of law enforcement, medical discipline, and dentistry and the enforcement of medical ethics and dental ethics;
- c. Educational and research purposes;
- d. Basis for payment for health services; and
- e. Health statistics data

Furthermore, paragraph (2) states: "The use of medical records as referred to in paragraph (1) letter c must obtain written approval from the patient or his heirs and must be kept confidential". Meanwhile, according to paragraph (3), the utilization of medical records for educational and research purposes does not require the patient consent if it is done for the state interests."

In terms of disclosing medical secrets, it is reaffirmed in the Decree of Minister of Health of the Republic of Indonesia Number 269/Menkes/Per/III/2008 CHAPTER 1V Article 10 Paragraph (2): "Information regarding identity, diagnosis, disease history, examination history, and medical history may be disclosed in the following conditions:

- a. For the benefit of the patient's health
- b. Fulfilling requests from law enforcement officials in the context of law enforcement on the basis of court orders
- c. By government or patient's own agreement
- d. Requests from institutions based on available provisions
- e. For research purposes and medical audits as long as patient's identity is not mentioned. Based on paragraph (3), "Requests for medical records for the purpose as referred to in paragraph (2) must be made in writing to the head of health service facilities".

The parties involved in the release of information in ensuring the confidentiality of the medical record are: officers at the registration section, the medical record unit, the treating doctor and officers in the treatment room or the nurse concerned.

CONCLUSION

Information contained in medical records is confidential and must be kept confidential by doctors and other health professionals. In the release of medical record information or data, it is necessary to have a valid Standard Operating Procedure to requests for medical record data or information at every health service facility. In providing and explaining the content of the patient's medical record to other people or certain parties, medical record officers must know the flow and procedures in providing and explaining the content of the patient's medical record document. If an error occurs any time in the procedure for releasing the content of the patient's medical record, medical record officers may be sued at the court by the patient as the patient feels that the secret about his illness is being spread or known by other parties/others.

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