THE LIMITS ACCESS OF MEDICAL RECORDS IN INDONESIA AND A BROADER PROPOSE TO SUPPORT PATIENTS IN MALPRACTICE CLAIMS

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ABSTRACT

Objective: This study aims to describe the deficiency of the regulations governing medical records access in Indonesia as well as its impacts on proofing malpractice claims and propose a broader scope of the access from the personal data privacy rights perspective.

Methods: It uses a normative legal approach to analyse qualitatively the Indonesian Health Laws regarding access of medical records, related case law on malpractice, and existing literature on personal data privacy rights.

Result: The result shows that the Indonesian Health Law limits access to data in medical records, namely only the right to request a medical data resume. The research also found that in five malpractice cases, the lack of access to medical records hindered patients’ ability to present evidence.

Conclusion: It concludes that limited access to medical records leaves patients vulnerable to abuse, including the alteration of their data and difficulties in proving malpractice. The research contribute a proposal to granting patients greater access to their medical records to view and control their data at any time to ensure its authenticity, and to present it as a strong evident in malpractice’ claims.

Keywords: access, malpractices, management, medical records, normative.

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RESUMO

**Objetivo:** Este estudo tem como objetivo descrever a deficiência das normas que regem o acesso aos registros médicos na Indonésia, bem como os seus impactos na análise de alegações de má prática e propor um escopo mais amplo do acesso sob a perspectiva do direito à privacidade de dados pessoais.

**Métodos:** Utiliza uma abordagem jurídica normativa para analisar qualitativamente as Leis de Saúde da Indonésia em relação ao acesso a registros médicos, jurisprudência relacionada sobre práticas incorretas e literatura existente sobre direitos de privacidade de dados pessoais.

**Resultado:** O resultado mostra que a Lei de Saúde da Indonésia limita o acesso a dados em prontuários médicos, ou seja, apenas o direito de solicitar um currículo de dados médicos. A pesquisa também constatou que, em cinco casos de negligência médica, a falta de acesso aos registros médicos prejudicou a capacidade dos pacientes de apresentar provas.

**Conclusão:** Conclui que o acesso limitado aos prontuários médicos deixa os pacientes vulneráveis a abusos, incluindo a alteração de seus dados e dificuldades em comprovar práticas incorretas. A pesquisa contribui com uma proposta para conceder aos pacientes maior acesso a seus registros médicos a fim de visualizar e controlar seus dados a qualquer momento a fim de garantir sua autenticidade e apresentá-los como um forte evidente em alegações de má prática.

**Palavras-chave:** acesso, práticas abusivas, gestão, prontuários médicos, normativo.

1 INTRODUCTION

Malpractice is misconduct that can cause harm to patients and put their lives at risk. The healthcare system involves three parties, namely doctors, patients, and hospitals. These parties are in a legal relationship, which includes rights, obligations, and responsibilities between doctors, hospitals, and patients in providing healthcare services. The relationship in an agreement is called an informed consent or therapeutic agreement (Supriyatin, 2016). According to studies by Ming et al (2021) and Retnowati & Sundari (2020), malpractice occurs when there are wrong actions, negligence, lack of skills, lack of care, or unethical practices in the planning and execution of professional duties by doctors or hospitals.

Indonesian Health Law does not provide a specific definition of malpractice. However, it regulates various forms of malpractice in several articles of various laws, including Articles 58, 77, and 190-200 of Law 36 of 2009 about Health (hereinafter referred to as the Health Law), Articles 77 and 83-86 of Law 36 of 2014 about health workers (further referred to as Health Professions Law), and Articles 66 and 75-80 of
Law 29 of 2004 about medical practices (hereinafter referred to as Medical Practices Law).

Based on the provisions in Article 58, Articles 190-200 of the Health Act and Article 77, Articles 83-86 of the Health Professions Law, as well as Article 66, Articles 75-80 of the Medical Practice Law, malpractice can be prosecuted civilly by patients or their families, and criminally by public prosecutors (Retnowati & Sundari, 2020). In prosecuting civilly, Retnowati & Sundari suggest two things that plaintiffs, or malpractice claimants, should consider the legal basis for prosecuting and evidence of alleged malpractice. The civil claims commonly base on tort as stipulated in Articles 1365 to 1967 of Staatblad 23 of 1847 (hereinafter referred to as Burgerlijke Wetboek, BW) and Article 58 of the Health Law. Furthermore, the obligation to prove the truth of the alleged malpractice as the provisions of Article 163 of Staatblad 44 of 1941 (further referred to as Het Herziene Indonesisch Reglement, HIR) regulate the Plaintiff.

In the context of a malpractice lawsuit in Indonesia, the submission of valid evidence is imperative to establish the facts of the case. According to Article 164 of HIR, such evidence may include written evidents, witness testimony, presumptions, confessions, and oaths. Medical records, which contain information about patient identity, examination, treatment, actions, and other services provided, are considered to be written evidence as per Article 1 Point 1 of the Regulation of the Minister of Health of the Republic of Indonesia No.269/Menkes/PER/III/2008.

However, the judicial outcome of malpractice lawsuits in Indonesia has shown a disparity between the number of dismissed cases and those granted. Per the Directory of Supreme Court Decisions, out of 70 malpractice lawsuits, 56 cases were dismissed, while only 14 cases were granted (The Supreme Court of Republic of Indonesia, 2022). One of the primary reasons for this disparity is the difficulty in proving malpractice, particularly regarding the availability of evidence.

Under civil procedural law, the court will reject the claim when the Plaintiff cannot prove the allegations (Mertokusumo, 2013), even in malpractice claims. Anny has research that focuses on the role of medical records in the legal protection of hospitals’ using doctors and patients as evidence (Retnowati, 2013). It found that medical record has the important role in proving malpractices. Fatimah(2017), Abduh (Rokhim, 2020), Abduh (2021), and Wahyuni & Sari (2017), supports Retnowati’ s research by examined the strength of medical records as letter evidence. Their research found that medical
records are included in the scope of authentic deeds so that they have decisive evidentiary power. It will affect the success of the malpractice lawsuit by the patient. Nevertheless, their research has not examined how difficult it is to submit medical records as important evidence in a malpractice lawsuit.

Manurung et al. (2019) focused on how anyone falsifies medical records, harming patients. The research has not yet linked how harm can extend to the difficulty of proving the truth of facts about malpractice in court. The difficulty to submit medical records as important evidence can be associated to the results of Reginal & Richards's studied, which examines that there are problems regarding confidentiality due to unclear laws governing ownership and patient access to data in medical records (Jones & Richards, 1978). Unclear legal rules regarding ownership can affect access to data in medical records.

Retnowati & Sundari (2021) examined malpractice from a criminal law policy. However, Retnowati & Sundari (2020) also suggested that patients can prosecute malpractice civilly. In civil lawsuits, Sundari & Widiastani (2019) and Sundari & Candera (2019) concluded that proof is a crucial stage in a civil lawsuit because it can determine the outcome of the claim. Since the Plaintiff cannot prove the claim, it will be rejected (Mertokusumo, 2013).

Research should be developed to show the weaknesses in the principles of ownership and access to medical records in Indonesia which affecting the difficulty of submitting medical records as evidence of malpractice in court as well as to develop the patient’s right to medical data into a broader right.

This research examines the principle of ownership and access to medical records for evidence in malpractice suits to show its weaknesses. Therefore, the focus is on access to medical records by patients. The aim is to develop strong arguments showing the weakness of the principle of ownership and access to medical records in Indonesian Health Law. Furthermore, this will continue by providing an idea to broaden the patient’s right as the owner of data in the medical record.

2 THEORETICAL FRAME WORK

Royal found (2017), that dualism of ownership of medical record causing uncertainty about confidentiality. As a medical record, the hospital, as the owner, has full rights with the patient in maintaining the confidentiality of their data. Furthermore, Royal continued that the distinction between ownership of medical records and health data is
historically understandable. One of the factors is that medical professionals, especially doctors, also had a massive stake in documenting their treatments, tests, and reviews. Over time, it is realistic view that medical professionals - doctors, in particular, own the records and patients on the information. The medical record is also the examination results or activities conducted by the hospital and doctor.

However, several studies consider advances in patients’ rights as the owners of medical data in the records. Ayu et al. studied (2019), that the owner of personal data is an individual to whom particular information is attached. It is related with the fact that health information in the medical records is about a person. Royal’s point of view (2017) support Ayu et al by concluding that the medical record belongs to that person, and when associated with the theory of data ownership, patients should have the full right to control the original data about their Health. This includes the control of personal data from falsification efforts, or other misuses of personal data, as the research of Manurung et al (2019), or other misuses of personal data. In the other aspect, Huang et al. (2022) and Hsieh et al (2021) continue to propose the blockchain and asymmetric encryption methods to overcome the weakness of privacy protection scheme of medical electronic health records. Ayu et al, Huang et al, and Hsieh et al discovery can be utilized to safeguard the privacy of individuals whose information is contained in medical records. The theory of medical records’ confidentiality can provide a broader right for patients to obtain and control health data. Fernández-Castelló et al. (2020) promotes with the reference that patient safety is continually moving target, including the context of healthcare risk management.

Personal data in the medical record may be compared to a birth’s certificate that also containing the person’s data. The civil registry officer is only in charge of recording and storing the data and quickly gives the applicant a copy of the birth certificate. When given immediately, the registrant can determine the availability of the birth certificate when received immediately. In the event of an error, the applicant can immediately submit a request for amendment. There is greater control and access from the data owner, and the right to control a medical record should be similar to the birth certificate. Comparing to birth certificates, the patient then, may have the right to know the correctness of the medical record. The hospital is responsible for protecting the accuracy, validity, integrity, and privacy of patient information when it has custody of such data, under the premise
that the owner should manage the property rights. It should provide a security system to prevent data from changing without the owner’s consent or knowledge.

Since the patient’s data is controlled and stored by the doctor or hospital, legal protection is necessary due to privacy. Privacy is a universal concept that describes the spiritual needs of humans for their thoughts respective, feelings, and the right to enjoy their personal lives (Warren & Brandeis, 1890). However, according to Bennett (2019), there is no clear and sharp definition of privacy. Furthermore, Charman & Britten (1995) conclude that “…assumptions of shared doctor-patient’s definitions of confidentiality would be misplaced…” It is especially true for medical records which containing the data of the patient and the treatment given by the doctor.

Relating the right to privacy, Article 12 of the Universal Declaration of Human Rights provides that “…No one shall be subjected to arbitrary interference with privacy... Everyone has the right to the protection of the law against such interference or attacks…” (United Nations, 2022). The right to privacy is universally protected and is even part of human rights.

In practice, as Schermer has studied (2007), the right to personal data privacy together with personal data access, highly depends on a particular country’s cultural and social context. Therefore, one country may differ from another in regulating access to personal data, including personal data in medical records. Pyper et al. (2004) and Paszkowska’s research (2018) for instance, found that many countries have developed national patient access to online primary care electronic records, while the other countries have not. Israel is another one that giving patients the right to obtain only the copy of medical records, but giving them the right to inspect their medical records (Beth Israel Deaconess Medical Center, Beth Israel Deaconess Medical Center 2022). The right to inspect will prevent from abuse and falsification of the patient’s medical data. The United States has similar policy for the patient’s right, based on the court’s order in Ciox Health, LLC v. Azar, No. 18-cv-0040 (Office for Civil Rights of The U.S. Department of Health and Human Services, 2015), and 45 CFR § 164.524 of HIPPA, by providing the right of patients to:

- Obtain a copy of data in medical records.
- Have alterations added to the data in medical records.
- Receive a notice that tells the patients how their data in medical records may be used and shared.
- Decide when patients want permission before their data can be used or shared for specific purposes.
- Request that a Health Provider restrict how it uses or discloses the data in the medical record.
- Get a report on when and why the hospital shared its data in medical records for specific purposes.

The debate about the ownership of data on medical records can have an impact on the difficulty of patients to present medical records as evidence of alleged malpractice. From a review of Indonesian court judgement records (The Supreme Court of Republic of Indonesia, 2022), Sundari & Candera (2019) and Mertokusumo (2013) stated that the judge dismissed an unproven lawsuit, likewise in malpractice suits.

3 RESEARCH METHODS


Furthermore, the norms will be analysed qualitatively to showcase their weakness and implications in malpractice claims. The pre-existing contemporary research can be analysed qualitatively to propose a broader scope of patients’ right to their data in medical records and better health care management, and the conclusions use a deductive way of thinking (Elo et al, 2014). The goals of the research include: (i) learning from the impact of Indonesia’s weak Health Law on patient rights, and (ii) expanding patients’ rights to their medical data in medical records.
4 RESULT AND DISCUSSION

4.1 THE WEAKNESS OF REGULATION OF OWNERSHIP AND ACCESS TO MEDICAL RECORDS

Indonesian Health Law has norms regarding ownership and access to medical records, and the access is a part of health information management. Article 70(4) of the Health Professions Law and Article 47(2) of the Medical Practice Law stipulate that medical records should be kept confidential by professionals and the management of healthcare facilities. The two Articles do not explain against whom the confidentiality of medical records should be maintained.

Article 71 of the Health Professions Law also states that medical records belong to health service providers. Therefore, according to the Health Professions Law, medical records do not belong to the patient, and based on Article 71, Paragraph 2 of the Health Professions Law, the patient may only request the resume of medical records from health service provider. In the other hand, Article 47(1) of the Medical Practice Law specifies that the data in the medical record belongs to the patient. According to Minister of Health Regulation No. 36 of 2012, patient health privacy in medical records includes identity, history of illness, examination results, and treatment. The dualism pertains to the ownership and accessibility of medical records as regulated in the Indonesian Health and supports what Royal found (2017), about uncertainty of medical record’s ownership. The dualism of ownership in Indonesian Health Law limits the patient’s right to access, control, and participate in recording medical data. Patients only have the right to request a resume of their health data in medical records. It is the first weakness of the Indonesian Health Law in protecting the right to health data in the medical record. Israel and the United States have broader patient's right to his or her health data in medical records than Indonesia. They give the right to receive a copy, review, inspect the medical records and keep the information private.

Indeed, Article 47(1) of the Medical Practice Law has provided that the data in the medical record belongs to the patient. It supported by Ayu et al. studied (2019, Royal’s point of view (2017), and Manurung et al (2019) research, who conclude that the health information in the medical records should belong to the person of which the information be made of. The person should have the full right to access her/his personal data to prevent from misuses of personal data. By giving patients the right to obtain only medical records resumes, as provided in Article 71(2) of the Health Professions Law they cannot control
and see the originality of data from falsification efforts. The resume is not following the original data because the patient needs to have the right to see the information. It is the second weakness of Indonesian Health Law in giving suitable access to their data in medical records.

Comparing to the Israel and the United States health law policy relating to the rights of patients as the owner of their data in medical records for instance, the hospital is responsible for protecting the accuracy, validity, integrity, and privacy of patient information, under the premise that the owner should manage the property rights. It should provide a security system to prevent data from changing without the owner’s consent or knowledge. Indonesian Health Law, has no provisions governing these rights. Patients do not have direct or online access to their medical records, and there is no provision to request information about securing their medical data. The hospital is under no obligation to disclose its methods for collecting, storing, or protecting health information. Patients have an unfettered right to know which hospital staff members have access to their medical records.

Article 28G(1) of the 1945 Constitution stipulates that:

“All individuals shall possess the right to safeguard their physical and emotional well-being, familial relationships, reputation, self-worth, and possessions under their authority. They shall possess the right to safety and defense against intimidation that coerces or prohibits the exercise of any inalienable human rights.”

From the provisions of Article 28G Paragraph (1) of the 1945 Constitution, as supported by Niffari pint of view (2020), protecting patient data in medical records may be interpreted as a part of human rights, since it protects the patients’ possession, i.e. medical data. As a part of human right, it is common sense, as provided in Article 12 of the Universal Declaration of Human Right and Budhijanto conclusion (2020), that the patient’s protection may expand or enhance to the right to know and control the existence and correctness of patient information in his/her medical records.

Providing patient the right to inspect or check medical records immediately can prevent earlier the efforts of misusing and forgerying patient’s health data. Moreover, with the electronic storage of medical record data which is easier to change, transmit or transfer to other parties, the security and protection of information have become increasingly urgent. Creating a robust security system to maintain the medical records using blockchain and asymmetric encryption methods for instance (Huang et al, 2022),
may support furthermore the prevention. However, even supposing patient protection is a part of human rights, there are no provisions at the health law policy that regulate the patient’s right to inspect or check their medical records, except the right to request the resume of medical records, as provided at Article 71, Paragraph 2 of the Health Professions Law. The patient’s rights limitation has caused problems in practice regarding the right to full access to their medical data to prove malpractice claims as described below.

4.2 THE IMPLICATION OF LIMITED PATIENT’S ACCESS TO MEDICAL RECORDS TO PROVE MALPRACTICE CASES

Data on filing malpractice lawsuits taken from the Supreme Court Decision Directory showed 70 malpractice lawsuits, and the court dismissed 56 lawsuits and granted 14 (The Supreme Court of Republic of Indonesia, 2022). Table 1 shows some implications of the ownership and confidential nature of medical records as evidence in lawsuits.

<table>
<thead>
<tr>
<th>No.</th>
<th>Case registration</th>
<th>The parties</th>
<th>Submission of medical records as evidence by patients as plaintiffs</th>
<th>Implication</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>34/Pdt.G/2014/PN Atb.</td>
<td>Farouq Salim &amp; Salim Atubel vs The Director of “D” Hospital in Atambua &amp; dr.Srso, Sp.B</td>
<td>The patient could not submit the medical record resume, but the defendant did, namely MR.05.50.54.</td>
<td>The judges dismissed the case because the patient could not prove the fact.</td>
</tr>
<tr>
<td>2</td>
<td>21P/HUM/2011</td>
<td>Yohan Candera vs. The Ministry of Health of the Republic of Indonesia.</td>
<td>Requested medical records but was refused by “W.B.” Surabaya Hospital because only Medical Resumes could be provided based on the Minister of Health Regulation No.269/Menkes/Per/III/2008. Plaintiff’s objection: The content of the Medical Resume is fundamental and has nuances of cooperation between the Director of the Hospital, who is also a doctor.</td>
<td>The case was dismissed on the basis that the patient was deemed unable to prove their case.</td>
</tr>
<tr>
<td>3</td>
<td>No.751/Pdt.G/2015/PN Tangerang</td>
<td>Bastinus jansen vs. “P” Hospital in Bintaro</td>
<td>Plaintiff cannot submit a medical record resume. Defendant’s argument: following the provisions of the laws and regulations and supported by the Peace</td>
<td>The case was rejected in the source because the patient was deemed unable.</td>
</tr>
</tbody>
</table>
As shown in Table 1, it was difficult for the patients to present their original data in the medical records, since Article 71(2) of the Health Professions Law, only gives them the right to copy the medical records resume, not the original. The concept of privacy, especially regarding data in medical records shared between the patient and the doctor, in practices affect the data access norms as well as pose a barrier to accessing such records to prove malpractice in court.

The difficulty for patients to present their original medical records is a form of uncertainty due to the dualism in ownership, as studied by Royal (2017). The condition even shows that positioning patient’s protection as a part of human rights does not necessarily give full rights to patients to present their original data of medical records before the court.

Ayu et al.(2019), Royal’s (2017), and Manurung et al (2019) conclusion, which are based on the theory of personal data ownership belongs to that person, becomes invalid when faced with another theory, namely dualism of medical records’ ownership. It also becomes misplaced about the confidentiality, as Charman & Britten (1995) conclude, if medical records assumpts a shared doctor-patient’s ownership.

In Indonesian Health Law, patients do not have direct or online access to their medical records, and there is no provision to request information about securing their data.
medical data. The hospital is under no obligation to disclose its methods for collecting, storing, or protecting health information. Patients have an unfettered right to know which hospital staff members have access to their medical records.

Limiting patients’ access to their original medical data implies proving malpractice cases. In case No. 34 / Pdt.G / 2014 / P.N.Atb, Plaintiff could not submit a medical record resume, but the defendant submitted it to the hospital, and a similar problem occurred in case No. 21P/HUM/2011. The Plaintiff had requested medical records but was rejected by “W.B.” Surabaya Hospital. This is because only Medical Resumes could be provided based on the Minister of Health Regulation No.269/Menkes/Per/III/2008. The legal policy implies that patients under the Indonesian Health Law have no right to obtain medical records because the data are the property of health providers. The Plaintiff’s objection in Case No. 21P/HUM/2011 states that “the Medical Resume has tones of cooperation between the Director of the hospital who is also a doctor.” It occurs in practices because the data that may indicate malpractice is under the control of the party suspected of committing malpractice. Since the data is in the control of the party charged with misconduct, the tendency to “avoid” punishment by “altering” or “falsifying” patient information in medical records is high.

Another similar problem arose in case No. 751/Pdt.G/2015/PN Tangerang, where the Plaintiff needed help submitting a medical record resume. Under the reason there was an out-of-court settlement, the defendant refused to provide a resume of the medical records, which was the right of Plaintiff as the patient. The hospital should still provide the medical records requested with or without an amicable settlement in a malpractice claim dispute.

The incident of the hospital’s refusal to provide medical records, which resulted in the Plaintiff’s lawsuit not being granted, also occurred in 71/Pdt.G/2012/PN.JBI. The judge rejected the Plaintiff’s provisional order that the defendant hand over the medical records belonging to the hospital. Meanwhile, the defendant who presented an expert witness did not commit malpractice in this case. The right to prove that the hospital committed malpractice based on the evidence in the medical records was lost. The defendant is in a position to benefit from the cooperative ownership of medical records. The hospital in the above cases has a sense of ‘fear’ that when medical records are submitted, allegations of malpractice will be proven.
Article 71 of the Health Professions Law states that medical records belong to health service providers. According to the Health Professions Law, medical records do not belong to the patient. This provision is one of the factors that make it difficult to submit medical records as one of the main types of evidence, as shown in the cases in Table 1 above. The regulation is a weapon to limit the patient’s right to access medical records, including the evidence in court.

The subject of the patient’s ability to exercise agency over the supplied resume has been challenged. Even with witnesses, it may be difficult for the patient to prove anything when the resume submitted does not match the realities. According to the law, witnesses are those who have seen, heard, or experienced the facts themselves. These criteria in the practice of health services should be nurses, doctors, or paramedics of the hospital, who tend to favor the hospital.

The patient should have the right to thoroughly inspect the medical record, including controlling the personal health data in the medical record that matches the facts. The doctor, paramedic, or hospital staff enter the patient’s data into the medical record. The hospital does not inform the patient about recording the health data, including obtaining the recording directly. Without the ability to record the facts during the procedure, the patient in the operating room is aware that surgery will be performed based on informed permission.

Another problem that arises due to the dualism management of ownership of medical records is who has the right to keep or divulge the secrets of data in medical records. In case No.130/Pdt.G/2016/PN Tng, Achmad Haris, as the Plaintiff, has sued “S.I.” Hospital, dr.”P.Sgo,” dr. “Bad” as the defendant, and dr.”Mar” as the co-defendant. The basis of the lawsuit was that the co-defendants disclosed the medical records of the illness and actions taken against the Plaintiff’s child in public. The defendants argued that previously Plaintiff had shown medical records on the same television program. Article 71 of the Health Professions Law states that medical records are the property of health service providers.

Health data belongs to the patient and is confidential. In Indonesian Health Law, the patient’s right to health data is limited in scope, as the patient is entitled to access only the resume. This limitation has caused problems in practice regarding the right to full access to their medical data to prove malpractice claims. As feared by the Plaintiff in Case No. 21P/HUM/2011, the medical resume tends to protect the doctor.
4.3 DEVELOP THE PATIENT’S RIGHT TO MEDICAL DATA INTO A BROADER RIGHT

Supporting the opinion of Budhijanto (2010), it may develop the patient’s right to medical data into a broader right. Furthermore, the basis is the principle of individual property rights that are absolute and privacy. The multiple nature of property rights gives the owner autonomy or authority to conduct anything with the rights, including protecting them from attempts by other parties. Since the hospital controls medical data that belongs to the patient, it is very vulnerable to being deleted or changed without the knowledge or permission of the patient. Providing patients with unrestricted access to their medical records, including the capacity to examine, control, and request customized care, is essential for reducing this vulnerability. The use of the keywords “right to view” in both Israeli Health Law Policy (Beth Israel Deaconess Medical Center, 2022) and American law and policy (Office for Civil Rights of The U.S. Department of Health and Human Services, 2020) illustrate this trend. These keywords do not exist in Indonesian Health Law, referring to the development of patients’ rights to their medical data.

Since giving patients the “right to view” and control their medical data is to prevent misuse and falsification, access should be made with an online system. Technology that prevents data from being altered, added to, or deleted without the knowledge of the owner or depositor is necessary for the reliable storage of sensitive medical information. Article 2(2) of the Regulation of the Indonesian’s Minister of Communication and Information Number 20 of 2016 on the Protection of Personal Data in Electronic Systems has regulated the principles of personal data protection, such as ‘ease of access and correction of Personal Data by the Personal Data Owner’. This provision can be a norm for developing patients’ rights to their health data in medical records stored electronically.

Article 47(1) of the Medical Practice Law stipulates that the data in medical records belong to the patient. Therefore, the patient can keep or disclose medical record data. Article 44, paragraphs (2) and (3) of Law No. 44 of 2009 concerning Hospitals resolves the conflict of the right to disclose the secret. It rules that the hospital can legally reveal the patient’s identity in court or to the public as part of the “right to reply” where confidential information has been shown from the medical records. From the provisions of Article 44 of Law No.44 of 2009, the legislator places the patient as the primary holder of the right to disclose the confidentiality of the medical data. Health service providers
should not precede disclosing secrets even though medical records belong to health service providers according to Article 71 of the Health Workers Act.

The right to inspect medical records can prevent efforts to misuse the patient’s health data earlier, including from forgery, with the support of a robust security system to maintain the medical records. This right will further support efforts to prevent misuse of health data when the patient can immediately check the medical record data. Moreover, with the electronic storage of medical record data which is easier to change, transmit or transfer to other parties, the security and protection of information have become increasingly urgent.

In health information management, the hospital may carry out medical record data security systems through the support of modern technology. It may be used with blockchain and asymmetric encryption methods (Huang et al, 2022) or other more secure technologies.

The idea of equating medical records with birth certificate can open a new discourse, in order to strengthen the argument for expanding patient to check their personal data in medical records. Equal to birth certificate registry officer, the hospital is only in charge of recording and storing the data of patient’s medical records. As a registry officer, the hospital has to give the patient a copy of the medical records directly after giving medical services. If there is a mistake in apart, patients may quickly ask for it to be corrected and get another correct copy. The hospital is responsible for protecting the accuracy, validity, integrity, and privacy of patient information when it has custody of such data, under the premise that the owner should manage the property rights. It should provide a security system to prevent data from changing without the owner’s consent or knowledge. Since the patient’s data is controlled and stored by the doctor or hospital, legal protection is necessary due to privacy. However, rendering to Ayumeida & Wijaya (2021), Indonesia needs to have specific laws and regulations governing the legal protection of personal data as a solution in various cases.

5 CONCLUSION

There is a limitation in Indonesian health regulations for patients to access their medical data, namely only the right to request a medical data resume. Theoretically, it implies vulnerability to abuse, including falsification of the patient’s medical data. The research also found that in five malpractice cases, the lack of access to medical records
hindered patients’ ability to present evidence. This statement suggests that when a patient has limited access to their medical records, it may hinder their ability to pursue a malpractice claim successfully.

The research contributes a proposal to advance patients’ right to their medical data by giving them the rights to view and control their data in medical records at any time to ensure its authenticity, and to present it as a strong evident in malpractice’ claims.
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