

Hospital Responsibilities in Storing Electronic Medical Record Documents

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Abstract

Medical records in hospitals are data for compiling health information and every health service, whether providing outpatient or inpatient services, is required to make a medical record and sanctions are imposed for those who violate it in accordance with applicable laws and regulations. The aim of this research is to analyze the norms for storing and destroying manual medical record documents and to analyze the legal responsibility of hospitals for storing electronic medical records in hospitals. The type of research used in this research is legal research. This type of research is carried out by examining legal norms in applicable laws and regulations related to guidelines and codes of ethics for a profession, especially in this case, medical laboratory technology experts in providing health services. Specifically, the type of research is normative juridical or doctrinal research. The findings of this research are that the legal responsibility of hospitals for storing electronic medical records in hospitals has been regulated by the Minister of Health Regulation No. 24 of 2022, while the responsibility of hospitals in implementing electronic medical records is also outlined in the Ministry of Health in the form of ministerial supervision through the director general. If deviations occur, administrative sanctions will be given in the form of a warning or revocation of accreditation status.

Keywords: medical records, hospital responsibilities, document storage

INTRODUCTION

In Law Number 44 of 2009 concerning Hospitals, medical records are mentioned. In this law, hospitals are required to maintain medical records, as a form of reflection of responsible health services. Medical records as a document file have two forms/types, namely conventional medical records and electronic medical records. Conventional medical records are writing/notes/documentation that chronologically and systematically describe and explain a person's medical history of illness. In Law No. 44 of 2009 article 53, it is stated that hospitals are obliged to maintain records and reports carried out for a certain period of time in accordance with the provisions of statutory regulations.

Electronic medical records (RME) can be defined as an electronic document file that contains a person's medical history. In its implementation, like any other electronic information system, it will require a data input process and to access it again it will require a form of access code which must be individual to ensure confidentiality. RME is the application of information and communication technology (ICT) in the health sector. With RME, patient health data is integrated in a system, so that health workers can obtain previous patient health history data more easily, regardless of distance and time. This will certainly make it easier to exchange information, especially in areas where the distance between health facilities is very wide.

Medical records in hospitals are data for compiling health information and every health service and every health service, whether providing outpatient or inpatient services, is required to make a medical record and sanctions are imposed for those who violate it in accordance with applicable laws and regulations. Medical records have a very broad meaning, not just recording activities, but are understood as a system for administering medical records, while recording activities are only one of the activities of maintaining medical records.

The application of RME has been adopted in hospitals in many countries starting in 1999. Developing countries have also begun to adopt RME to gain effectiveness and efficiency in health services. In Indonesia there are no specific regulations regarding RME, but its validity as legal evidence is regulated by the Law on Electronic Information and Transactions (ITE) No. 19 of 2016 and Minister of Health Regulation (Permenkes) no. 24 in 2022.¹

Depreciation of inactive medical records is an activity of reducing inactive medical record files from the active medical record file storage shelf. The aim is to reduce the increasing number of medical record files, prepare sufficient facilities to provide storage space for new medical record files, maintain the quality of service by speeding up the preparation of medical records if needed at any time, save medical records that have high use value and reduce waste. no use value/low use value or use value has decreased.

In general, medical records are declared inactive if they have not been used in the last 5 years. If there is no place to store active medical record files, activities must be carried out to set aside inactive medical record files in accordance with the addition of new medical records and when inactive medical records are retrieved, an exit sign must be placed in the original place, to prevent searches that are too separate from the record section. medical records or made into microfilm, active and inactive medical records can be stored at the same time, because microfilm storage does not take up much space.² Regulation of the Minister of Health of the Republic of Indonesia No. 24 of 2022 concerning medical records, eighth part concerning Storage Period, Article 39:

- 1) Electronic Medical Record data storage in Health Service Facilities is carried out for a minimum of 25 (twenty five) years from the date of the patient's last visit.
- 2) After the time limit as intended in paragraph (1) has expired, Electronic Medical Record

¹Putri Dianita Ika Meilia, Buah Simalakama Electronic Medical Records: Benefits Versus Ethical Dilemmas, Indonesian Journal of Medical Ethics, No.2 Volume 3, Dec 2019, p. 61-66.

²Wasiyah, Tri Purnama Sari, Overview of the Implementation of Shrinking and Destruction of Inactive Medical Record Files at the Rokan Hulu Regional General Hospital, No.2 Volume 01, 2021, p. 183-198.

data can be excluded from being destroyed if the data is still to be used or exploited.

- 3) Destruction of Electronic Medical Records is carried out in accordance with statutory provisions.³

In its implementation, the use of RME technology requires the readiness of health workers including doctors, medical records officers and patients when dealing with this information system technology. In Indonesia, the change from paper medical records to electronic medical records has not been widely implemented, far behind America which started in 1999, England since 2000 and New Zealand since 2002.

It is hoped that RME management will facilitate access to patient information. This is certainly very profitable for the entitled parties. However, RME provides new opportunities for other parties who want to abuse it, such as several cases in America where hospital systems were hacked and resulted in disruption of hospital operations. For this reason, privacy is needed to maintain RME security. The basic principle that medical records are confidential must remain valid, both in paper form and in electronic form. Just like conventional medical records, only certain parties are allowed to enter and find out information from RME.⁴

In the Criminal Code article 322(1) states that anyone who deliberately discloses a secret which he is obliged to keep because of his position or pursuit, whether current or former, is threatened with imprisonment for a maximum of nine months or a fine of a maximum of nine thousand rupiah. Meanwhile, in Law no.1 of 2023 concerning the Criminal Code article 443(1) Any person who discloses a secret that he or she is obliged to keep because of his or her position, profession, or duties assigned by a government agency, either current or former secrets, shall be punished by imprisonment for a maximum of 1 (one) year or a fine of a maximum of category III. Regarding the diseasekeep medical secrets, all health workers are required to keep medical secrets, including medical record files. Regarding hospital planning and maintenance, there is clarity for hospitals regarding the obligation to maintain medical records. In order to support the implementation of a good master plan, each hospital must: Have and manage statistical data, so that it can produce up to date information data; Having procedures for maintaining medical records that are based on predetermined provisions, the aim of these regulations is so that every health service institution, including hospitals, can organize and run medical records properly.⁵ According to statutory regulations, medical records must be kept and kept confidential because the data contained in the medical record belongs to the patient. This obligation is the responsibility of doctors or dentists and heads of health service facilities.

Manual medical records have become a guide for health care providers in Indonesia, since the Dutch era medical records have been applied in recording actions given to a patient. The problem that often arises if the medical record information system is still not integrated is that there is no link between each health service provider regarding the information in the medical record. In fact, patients can have health checks at different health service providers at any given time. If there is no linkage between individual health care providers, the same examination will occur over and over again. Even though previous medical record data is very useful in subsequent health examinations. This greatly helps reduce the possibility of misdiagnosis. A

³Eka Wilda Faida, Amir Ali, Readiness Analysis for Implementing Electronic Medical Records using the DOQ-IT (Doctor's Office Quality-Information Technology) Approach, *Indonesian Journal of Health Information Management*, No.1 Volume 9, March 2021, p. 59-66

⁴Cinthia Mutiara Hapsari, Ary Subiyantoro, Juridical Study of the Use of Electronic Medical Records in Hospitals, *Scientific Journal of Nursing and Public Health Sciences*, No.1 Volume 14, January 2019, p. 7-17.

⁵Putri Dianita Ika Meilia, Gilbert Mayer Christianto, Buah Simalakama Electronic Medical Records: Benefits versus ethical dilemmas, *Indonesian Journal of Medical Ethics*, No.2 Volume 3, Dec 2019, p. 61-66.

problem that also often arises is the patient's complaint that every time they enter a health service provider they say they answer the same questions at every visit or diagnosis.

Patients complain that the questions asked by doctors at the time of diagnosis are almost the same. What this means is, for example, a patient who gets a referral from a hospital to a hospital that has more adequate facilities, previously at the patient's home hospital the complaints and illness they were suffering from were diagnosed, but at the referral hospital the patient was re-diagnosed all over again. This causes the accumulation of the same data about diagnoses and medical records over and over again. Based on the problems mentioned above, it is necessary to design a centralized electronic medical record system that accommodates a patient's medical records in a centralized database. Centralized storage (centralization) referred to here is a situation where outpatient and inpatient medical records are stored in one file and in one storage database. However, with the development of advanced technology, the guidelines are now starting to shift towards electronic medical records. The aim of this research is to analyze the norms for storing and destroying manual medical record documents and to analyze the legal responsibility of hospitals for storing electronic medical records in hospitals.

RESEARCH METHODS

The type of research used in this research is legal research.⁶This type of research is carried out by examining legal norms in applicable laws and regulations related to guidelines and codes of ethics for a profession, especially in this case, medical laboratory technology experts in providing health services. Specifically, the type of research is normative juridical or doctrinal research. The approach taken is a statutory approach (Statute Approach) and a conceptual approach (Conceptual Approach). First, a legislative approach will be carried out by examining all laws and regulations related to the legal issue being handled so as to open up the opportunity to study whether there is consistency and conformity between one law and other laws. For this research, a legislative approach was used between the Health Law, Hospital Law, Government Regulations, Decree of the Indonesian Minister of Health in determining legal responsibilities in electronic medical records. Second, the conceptual approach originates from the views and doctrines that develop in legal science so that it will find ideas that give rise to legal understanding, legal concepts and legal principles that are relevant to the issue at hand.⁷Apart from that, it also uses a comparative approach, which is an approach used to compare the laws of one country with the laws of other countries.

DISCUSSION

The development of the world of technology has had a broad influence in the world of health, so it also has an impact on recording patient progress, in this case medical records, in the field of health services that is currently developing towards digital, namely electronic medical records. Apart from digital developments in the form of electronic medical records, it is also necessary to think about storing these electronic medical records in health service facilities, they can be stored on servers and with the development of technology, these electronic medical records can use a cloud basis to support the storage of electronic medical records. Cloud services are actually a facility that has long been used in developed countries. Technology Cloud Computing, this technology which is still relatively new, has also contributed to the development of the world of health, especially for storing electronic medical records.

Participation from the government with regulations and laws is also needed, as regulated in Law no. 29 of 2004 concerning Medical Practice which explains that every doctor and

⁶Peter Mahmud Marzuki, *Legal Research*, Revised Edition, Kencana, Jakarta, 2016, p.56.

⁷*Ibid*, p.32

dentist, when carrying out medical practice, must make medical records and their confidentiality must be maintained by the doctor or dentist and the head of the health service facility. The roles and responsibilities of Medical Recorders in Hospitals are as follows:⁸

1. Create a medical record database, including patient examination history cards
2. Manage databases so they can be provided quickly when needed
3. Processes database information, summarizes patient medical and disease statistics
4. Provides summary data to medical experts for research
5. Responsible for maintaining and organizing the confidentiality of medical records

Legal responsibility is a state of being obliged to bear everything that has been regulated in statutory regulations or in agreements that have been made by the parties. Hospitals have the main function of providing perfect care and treatment to patients, both inpatients, outpatients and emergency patients. Medical records are hospital property that must be maintained because they are useful for patients, doctors and the hospital.

The hospital is responsible for protecting the information in the medical record against the possibility of loss of information or falsifying the data in the medical record or being used by other people who have not been given permission. Responsibility for Medical Records, including:

1. Hospital Responsibility for Medical Records

Hospitals have the main function of providing perfect care and treatment to patients, both inpatients, outpatients and emergency patients. Hospital leaders are responsible for the quality of medical services provided to patients in the hospital. Medical records are very important in ensuring the quality of medical services provided by hospitals and their medical staff. Medical records are hospital property that must be maintained because they are very useful for patients, doctors and the hospital. The obligation to maintain medical records for hospitals is regulated in Law no. 44 of 2009 concerning Hospitals Article 29 letter g regarding the home's obligations, namely maintaining medical records. The hospital is responsible for protecting the information in the medical record against the possibility of loss of information or including data contained in the medical file or being used by people who are not authorized to use it. Medical records must be provided with sufficiently detailed data, so that other doctors can know how the treatment and care as well as the actions given to the patient and the consultant can provide the right income after he examines it or the doctor concerned can estimate the future condition of the patient from the procedure that has been carried out. held.

Aspects of criminal law, medical records can be used as a means of evidence as regulated in Article 1866 of the Civil Code and Article 184 of the Criminal Procedure Code. The provisions of Article 1866 of the Civil Code state that evidence includes: written evidence; witness evidence; estimate; confession; and swear. Meanwhile, Article 184 Paragraph (1) of the Criminal Procedure Code, valid evidence in criminal law: Witness testimony; Expert testimony; Letter; Instruction; Defendant's statement. Therefore, if the storage of medical records is not good, it will cause problems in the future, if there is a claim from the patient to the health worker or health service facility.

Aspects of civil law, if there is a problem or unlawful act related to the implementation of medical records in a hospital, the basis for the lawsuit if there is a case arising from the implementation of medical records can refer to Article 1365 of the Civil Code, which regulates unlawful acts which results in the perpetrator of the unlawful act compensating the victim for the losses caused by the act. In principle, unlawful acts arising from the implementation of medical records will cause harm to patients, so Article 1365 of the Civil Code is appropriate to serve as the legal basis for a lawsuit. Given the above, it is necessary to record and document

⁸Husada Borneo College of Health Sciences, Responsibilities of Medical Recorders, in <https://stikeshb.ac.id/ini-borne-respons-perekam-medis-di-rumah-sakit/>, accessed March 26 2023, 07.08 WITA

these medical records, as well as good storage, so that when problems occur, these medical records can be used as evidence.

From the aspect of administrative law, the 2023 health law which was just passed at the plenary session of the DPR RI during the fifth session of the 2022-2023 session on Tuesday 11 July 2023, in Article 283, states that medical personnel and health workers in carrying out mandatory practice: create and maintain records and/or documents regarding examinations, care and actions taken; and article 292 states that every medical worker, health worker and head of a health service facility who does not implement the provisions may be subject to administrative sanctions. The administrative sanctions referred to are in the form of: verbal warning; written warning; administrative fines; and/or revocation of permits. Therefore, it is very important to pay attention to the storage of medical records, not only for the benefit of patients but also for the needs of medical personnel and health service facilities.

2. Responsibilities of Caring Doctors, Dentists and Health Personnel

Based on the Medical Practice Law no. 29 of 2009 Article 46 paragraph (1) states that every doctor or dentist who practices medicine is obliged to keep a medical record. The main responsibility for the completeness of filling out medical records lies with the treating doctor and dentist. The treating doctor or dentist is responsible for the completeness and correctness of the contents of the medical record. In recording several medical information such as disease history, physical examination and discharge summary (the resume may be delegated to expert assistants and other doctors. The accuracy and completeness of the patient's medical record data must be studied, corrected and signed by the treating doctor. Currently, many hospitals provide doctor's staff to complete the medical record. However, the main responsibility for the contents of the medical record remains with the treating doctor. The scientific value in the medical record file is in accordance with the standards of treatment and care given to the patient by the treating doctor. Therefore, it is reviewed from Several aspects of sanctions medical records are important because:⁹

- a. Medical records are useful for patients, for the purposes of a history of the development of their disease now and in the future.
- b. Medical records can protect hospitals and doctors from a legal perspective (medico legal). If there are incomplete and incorrect medical records, it is likely to be detrimental to the patient, doctor or hospital itself.
- c. Medical records can be used to examine activity records and medical records as well as activity records and administrative records for patients. Medical record officers can only use the data contained in the medical record file.
- d. If there is an incorrect or incomplete diagnosis then automatically the disease code will not be correct, this can affect the filling in of the disease index and home report. Statistical data and reports reported to relevant agencies must contain accurate and complete data.

The obligation of every doctor and dentist to keep a medical record every time they carry out medical practice is clearly regulated in Article 46 of Law no. 29 of 2009 concerning Medical Practice, then if a doctor or dentist is negligent in not making medical records and therefore causes a problem then the doctor or dentist can be subject to sanctions. As stated in Article 79 paragraph (2) Law no. 29 of 2009 concerning Medical Practice states "Sentenced with a maximum imprisonment of 1 (one) or a maximum fine of 50,000,000 (fifty million), every doctor or dentist who deliberately does not make a medical record as intended in article 46 paragraph (1).

3. Responsibilities of Medical Records Officers

Recording activities and filling in medical record files are carried out in accordance with

⁹Sari Ulina, Legal Accountability of Medical Records for Medics and Paramedics in Efforts to Improve Health Services at the Tembilahan Regional General Hospital, Thesis, Legal Studies Program Master of Laws, Islamic University of Indonesia, Yogyakarta, 2008, p.102

the policies and regulations set by hospital leadership, medical staff and various organizations, for example official professional associations. The medical records officer assists the treating doctor in reviewing the contents of the medical record. Quantitative analysis was carried out to determine deficiencies in the completeness of the content contained in the medical record file. This analysis must be carried out the next day after the patient is discharged or dies, so that missing or doubtful data can be corrected again before the patient's data is forgotten. Medical record officers must carry out qualitative analysis and quantitative analysis activities to assist doctors in recording and filling in complete and accurate medical record files.

The medical record officer is responsible for evaluating the quality of the medical record itself to ensure the accuracy and completeness of the contents of the medical record. In connection with the above, the medical record officer must adhere to the following guidelines:¹⁰

- a. All diagnoses are written correctly on the entry and exit sheets, according to the terminology used, all diagnoses and surgical procedures performed must be recorded in the final resume.
- b. The use of symbols and abbreviations is not permitted.
- c. Notes made by the treating doctor must be dated and signed by the doctor concerned. If a patient is treated by more than one doctor who is also a consultant, they must make a note and give a date and signature in the patient's medical record file.
- d. Medical history, physical examination, final resume and admission and discharge summary sheets must be filled in completely and it is not enough if they are only signed by a doctor.
- e. The medical history report and physical examination must be recorded completely and contain all notes regarding the patient, both positive and negative.
- f. Progress notes provide a chronological overview and clinical analysis of the patient's condition. The frequency of recording is determined by the state of the patient's own health development
- g. The results of laboratory examinations and x-ray examinations must be recorded accompanied by the date and signature of the examiner.
- h. All medical treatment or surgical procedures must contain the date and signature of the doctor.
- i. All consultations must be completely recorded and signed and must be carried out in accordance with applicable medical regulations.
- j. The results of the consultation include the consultant's findings during the physical examination of the patient, including his opinions and recommendations.
- k. In prenatal and delivery cases, records during observation are recorded completely, including test results and all examinations from prenatal to hospital admission. Complete recording starting from labor to birth from the time the patient enters the hospital until the patient leaves the hospital.
- l. If the patient is a patient referred from outside, then records of observations and treatment as well as actions given that have been signed by the staff must be included when the patient is admitted to the hospital.
- m. The final resume is written when the patient goes home or dies. The resume should contain a summary of findings, important events during the patient's treatment, discharge conditions, suggestions and subsequent treatment plans.
- n. If an autopsy is performed, a provisional diagnosis or anatomical diagnosis is recorded immediately (in less than 72 hours), a complete statement must be made and combined with the patient's medical record file.

¹⁰*Ibid.*,p.103

- o. Qualitative analysis is carried out by medical record officers evaluating the quality of recording carried out by doctors. This activity was carried out to evaluate the quality of medical services provided by the treating doctor. The quality of medical record recording can reflect the quality of service of a health service agency

4. Responsibilities of Hospital Leadership

Hospital leaders are responsible for providing facilities and activities for the activities of the medical records unit or section which include activity rooms, shelves, files, computers, activity support equipment and medical records officers. In this way, medical records officers can work effectively and efficiently. All activities related to medical record job descriptions can be carried out as well as possible by medical record officers in each health service agency.

The responsibility of hospital leaders for medical records is regulated in Minister of Health Regulation No. 24 of 2022 concerning Medical Records in Article 32 which states "(1) The contents of medical records must be kept confidential by all parties involved in health services at health service facilities even if the patient has died. (2) The parties as referred to in paragraph (1) include: Health Workers providing health services, doctors and dentists, and/or other Health Workers who have access to patient health data and information and leaders of Health Service Facilities."

Thus, if a case arises that is in conflict with the article above, the hospital management is responsible in accordance with the violation.

5. Medical Staff Responsibilities

Medical staff also have an important role in hospitals and the organization of medical staff directly determines the quality of service to patients so that they can carry out their duties appropriately and well. The Deputy Medical Director, who is the superior of all hospital medical staff, is responsible for the effectiveness of medical service activities in the hospital. This responsibility of the Deputy Medical Director is adjusted to the provisions stipulated in the decision of the Minister of Health of the Republic of Indonesia regarding the organization and work procedures of General Hospitals. Class A, B, and C.

Doctors and dentists who do not create medical records, in addition to receiving legal sanctions, can also be subject to disciplinary and ethical sanctions in accordance with the Medical Practice Law, KKI Regulations, the Indonesian Medical Code of Ethics and the Indonesian Dental Code of Ethics. In the Indonesian Medical Council (KKI) Regulation no. 16/KKI/PER/VIII/2006 Concerning Procedures for Handling Cases of Alleged Violations of MDKI and MDKIP Discipline, there are three disciplinary alternatives, namely:

1. Providing written warnings
2. Recommendations for revocation of registration certificates or permits
3. Obligation to attend education or training at a medical or dental educational institution.¹¹

In addition to disciplinary sanctions, doctors and dentists who do not create medical records can be subject to ethical sanctions by professional organizations, namely the Honorary Council for Medical Ethics (MKEK) and the Honorary Council for Dental Ethics (MKEKG).

There are three reasons why medical doctors and doctors are required to sign medical records, namely:

1. Patients must be protected
2. The treating physician's signature is relevant if the case reaches court;
3. To prevent failure for hospitals in obtaining accreditation¹²

For these three reasons, medical records can function as legal documents, namely as valuable documentary evidence as information/expert witness as stated in Article 1866 of the Civil Code for civil cases, and Article 184 of the Criminal Code for criminal cases.

¹¹H. Mukshen Sarake, Textbook of Medical Records, Hasanudin University, Makassar, p.33

¹²*Ibid.*, p.34

Thus, the affixing of a signature is proof that the decision taken by the patient is his responsibility, while what is done by doctors and paramedics who provide complete and accurate information are responsible for the completeness and correctness of the information.

Medical records containing informed consent can function as evidence in the judicial process, so the contents of a modern medical record (Contents of a Modern Medical Record) must include the following:

1. *Identification Data*(Data identification);
2. *Provisional Diagnosis*(Initial diagnosis);
3. *Chief Complaint*(Main complaint);
4. *Present Illness*(Current illness/at the time of admission);
5. *History and Physical examination*(History of physical examination);
6. *Consultations*(Consultant/consultants if more than one);
7. *Clinical Laboratory Reports*(Clinical laboratory report);
8. *X-ray Reports*(Clinical laboratory report);
9. *Tissue Report*;
10. *Medical and Surgical Treatment*;
11. *Progress Notes*(Progress Notes)
12. *Final Diagnosis*(Final diagnosis);
13. *Autopsy Findings*(autopsy findings)¹³

Thus, according to modern medical record criteria, for medical records to function as evidence according to the law in the judicial process is not easy without fulfilling the main requirements mentioned above, even though they contain or contain agreement between the patient or his family and the doctor or hospital.

As for Legislative regulations regarding medical record law relating to forms of legal accountability for medical records, namely:

1. UU no. 29 of 2004 concerning Medical Practice
In article 66 paragraph 1, patients can make complaints to the MKDKI (Indonesian Medical Discipline Honorary Council), and can file criminal and civil lawsuits as regulated in Article 66 paragraph 3, and then in paragraph 79 paragraph c it is mentioned regarding the penalty of 1 year in prison/ a fine of 50 million for doctors who do not carry out their obligations.
2. The new 2023 health law was passed at the DPR RI plenary session on 11 July 2023, article 185 states that hospitals have an obligation: to maintain medical records. If implementation is not carried out, there will be administrative sanctions.
3. Aspects of criminal law, medical records can be used as a means of evidence as regulated in Article 1866 of the Civil Code and Article 184 of the Criminal Procedure Code. The provisions of Article 1866 of the Civil Code state that evidence includes: written evidence; witness evidence; estimate; confession; and swear. Meanwhile, Article 184 Paragraph (1) of the Criminal Procedure Code, valid evidence in criminal law: Witness statements; Expert testimony; Letter; Instruction; Defendant's statement. Therefore, if medical records are not stored well, it will cause problems in the future.
4. Aspects of civil law, if there is a legal problem related to the implementation of medical records in a hospital, the basis for the lawsuit is that cases arising from the implementation of medical records can refer to Article 1365 of the Civil Code, which regulates unlawful acts that result in the perpetrator unlawful acts compensate the victim for losses caused by the act. In principle, unlawful acts arising from the implementation of medical records will cause harm to patients, so Article 1365 of the

¹³*Ibid.*,p.35

Civil Code is appropriate to serve as the legal basis for a lawsuit. With the above, it is necessary to record and document these medical records, as well as good storage, so that when problems occur, these medical records can be used as evidence.

5. Aspects of administrative law, in the 2023 health law which was just passed at the plenary session of the DPR RI during the V session of the 2022-2023 session on Tuesday 11 July 2023, in Article 283, states that Medical Personnel and Health Workers in carrying out practices obliged to: make and keep records and/or documents regarding examinations, care and actions taken; and article 292 states that every medical worker, health worker and head of a health service facility who does not implement the provisions may be subject to administrative sanctions. The administrative sanctions referred to are in the form of: verbal warning; written warning; administrative fines; and/or revocation of permits. Therefore, it is very important to pay attention to the storage of medical records, not only for the benefit of patients but also for the needs of medical personnel and health service facilities

CONCLUSION

Based on the research conducted, researchers can conclude that the norms for storing and destroying manual medical record documents are regulated in Minister of Health Regulation Number 24/MENKES/PER/III/2022. In medical records in Indonesia, this storage and destruction activity is an obligation that must be carried out in health service facilities because it has been legally regulated since the Minister of Health Regulation Number 24/MENKES/PER/III/2022.

Article 20 reads: Electronic Medical Record Storage is the activity of storing Medical Record data on digital-based storage media at Health Service Facilities. Digital-based storage media as intended are: servers; cloud computing system that is certified in accordance with statutory provisions; and/or other digital-based storage media based on certified technological and information developments. In this Minister of Health there is no mention of storage arrangements for manual medical records.

Destruction of medical records, in Minister of Health Regulation no. 24 of 2022, Article 39 (1) Storage of Electronic Medical Record data in Health Service Facilities is carried out for a minimum of 25 (twenty five) years from the date of the patient's last visit. (2) After the time limit as intended in paragraph (1) has expired, Electronic Medical Record data can be excluded from being destroyed if the data will still be used or exploited. (3) Destruction of Electronic Medical Records is carried out in accordance with statutory provisions. This only regulates the destruction of electronic medical records, whereas there are no written regulations for manual medical records.

In addition, the legal responsibility of hospitals for storing electronic medical records in hospitals is regulated by Minister of Health Regulation No. 24 of 2022, while the responsibility of hospitals in implementing electronic medical records is also outlined in the Ministry of Health in the form of ministerial supervision through the director general. If deviations occur, administrative sanctions will be given in the form of a warning or revocation of accreditation status.

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