Protection Of Medical Records In Corona Virus Disease-19 Patients Based On The Law

Lusia Indrastuti

Department of Law, Faculty of Law, Slamet Riyadi University of Surakarta, Indonesia
* Corresponding Author:
Email: lusia24.indrastuti@gmail.com

Abstract
This study aims to describe the protection of medical records for patients with Covid 19, as it is known that legal protection of patient medical records in general can be seen through various regulatory provisions including Law Number 29 of 2004 concerning Medical Practice, Regulation of the Minister of Health Number 269 of 2008 concerning Medical Records, Law Number 36 of 2009 concerning National Health, this of course provides a variety of perspectives on the protection of medical records which of course has an impact on the existence of the medical record itself, especially if it is associated with the existing conditions of the Covid 19 pandemic. Based on research results It is known that regarding legal protection of patient medical records associated with the Covid 19 Pandemic, the national positive law tends to lack existence and still has various weaknesses, including: a. regulation regarding the permission to open medical records in the case of "public interest" which is still classified as ambiguous or absurd, then b. there are no legal implications of opening or leaking medical records for both doctors and hospitals, in the context of the Covid-19 pandemic, because there is no regulation regarding criminal sanctions in the event that medical records are opened by doctors or hospitals.

Keywords: *Legal protection, medical records, covid 19, public health*

I. INTRODUCTION.

Health services are one of the efforts that can be made to improve the welfare of the community as a whole. Health services are: Every effort, either individually or jointly in an organization, to improve and maintain health, prevent disease, treat disease and restore health aimed at individuals, groups or communities. In providing health services, hospitals are expected to provide quality services. Benjamin said that good health services in general means having a good medical record (Sitanggang, 2017). Medical record is a file containing records and documents regarding patient identity, examination, treatment, action, and services that have been provided by health workers to patients. Medical records are very necessary in every health service facility, as well as health services for legal aspects. From the legal aspect, medical records are used as evidence in legal cases. According to Law Number 44 of 2009 concerning Hospitals, Article 46, hospitals are legally responsible for all losses caused by negligence committed by health workers in hospitals. Hospital legal responsibilities in implementing health services to patients can be seen from aspects of professional ethics, administrative law, civil law and criminal law.In health services, medical records are very much embedded in health service activities, so there is an expression that medical colleagues are third parties when doctors receive patients. This is understandable because medical records are records of examinations and actions related to the handling of patients by doctors.

Medical record is a file that contains notes and documents about the patient's identity, examination, treatment, action, and other services that have been provided to the patient. Medical record is a collection of information about the identity, the results of anamnesis, examination and records of all activities of health care workers on patients and from time to time.Borrowing the views of Gemala R. Hatta (in Sitanggang, 2017) in his paper entitled "The Role of Health/Patient Medical Records (medical records) in Medical Law", states that:“Medical records are formulated as a collection of all activities carried out by health care workers which are written, described, on activities for patients. Medical records must be made in writing, complete and clear or electronically.Medical records are written and recorded information about identity, history taking, physical determination, laboratory/radiological examination, diagnosis, all medical services and actions provided to patients, both outpatient, inpatient, and emergency services provided to patients.

According to the Ministry of Health, medical records are very important in measuring the quality of medical services provided by hospitals and their medical staff. One of the parameters to determine the quality of health services in hospitals is data or information from good and complete medical records. Indicators of good medical record quality are completeness of content, accuracy, timeliness and fulfillment of legal requirements. In the event of an error in recording the medical record, files and records may not be deleted or deleted in any way. Changes in notes or errors in the medical record can only be made by deleting and affixing the initials of the officer concerned. General uses of medical records include:

1. As a means of communication between doctors and other experts who take part in providing services, treatment and care to patients.
2. As a basis for planning treatment / care to be given to a patient.
3. As written evidence for all service actions, disease progression and treatment during the patient's visit/care in the hospital.
4. As a useful material for analysis, research and evaluation of the quality of services provided to patients.
5. Protecting the legal interests of patients, hospitals as well as doctors and other health workers.
6. Provide special data for research and education purposes.
7. As a basis in calculating the cost of paying for patient medical services.
8. Become a memory that must be documented as well as material for accountability and reports.

In addition to the 8 (eight) points that the author describes above, the use of medical records can be used as (Sitanggang, 2017):

1. Health maintenance and patient treatment.
2. Evidence in the process of law enforcement, medical and dental disciplines and the enforcement of medical ethics and dental ethics.
3. Education and research needs.
4. Basic payment for health services.
5. Health statistics data.

The actions of the institution/health service facility that must be recorded in the patient's Medical Records are regarding the patient's identity, examination, treatment, actions and other services to patients. So in the Medical Records it will also include the type of patient and even the patient's family history of illness which is the reference for healing the patient's disease that has something to do with hereditary diseases, for example. So it means that the patient's and patient's family secrets are in it. The secret belongs to the patient, which is the contents of the Medical Records file made by the health workers who treat him both outpatient and inpatient. Therefore, to protect the confidentiality of the patient's disease, it was originally regulated in the Minister of Health Regulation No. 749a/ 1989, which was later also regulated in Article 47 Paragraph (1) of Law No. 29 of 2004 concerning Medical Practice and Minister of Health Regulation No. 269 of 2008 concerning Medical Records. in which it is stated that the medical record file physically belongs to the Health Service Facility (Saryankes) and the contents of the medical record file are the property of the patient (Ramadianto, 2018). Furthermore, related to the confidential nature of the contents of Medical Records, there are several rights which are juridical manifestations of the confidential nature, including (Sujadi, 1994):

1. Privacy Rights
2. Patient Access Rights
3. Right to Medical Secrets
4. Right to refuse to disclose medical secrets.

In the following, the authors describe the 4 (four) aspects of the rights that overshadow medical records in juridical manifestations related to their confidentiality. First, the right to privacy According to Fred Ameln, the Right to Privacy is a personal right, a right to personal freedom or privacy that comes from "The Right to Self Determination (TROS)" (Ameln, 1991). The essence of this right is the right to self-determination over oneself (the body) which should not be disturbed or, more specifically, "A right to be free from unwanted publicity". The Privacy Rights, among others, are sourced from:

1. International Conventions a. Article 12 Universal Declaration of Human Rights b. Article 17 international Covenant on civil and Political Rights 1946 c. Item 6 Hospital Patients Charter, 1979.

2. The 1945 Constitution
3. Law Number 29 of 2004 concerning Medical Practice (hereinafter referred to as the Law on Medical Practice).

In a doctor-patient relationship that contains an element of trust that the doctor is able to provide medical services and can be trusted to keep medical secrets regarding the patient's illness and other matters of a privacy nature. In this case, the doctor assumes a professional ethical obligation (Physician Profession Oath) as well as a legal obligation from the above statutory provisions to maintain the confidentiality of the contents of the Medical Records of his patients, as regulated in Article 51 of the Medical Practice Law which contains the obligations of doctors or dentists in carrying out their practice. medicine, namely (See Article 51 of Law Number 29 of 2004 concerning Medical Practice):

1. Provide medical services in accordance with professional standards and standard operating procedures as well as the patient's medical needs;
2. Refer the patient to another doctor or dentist who has better skills or abilities, if unable to carry out an examination or treatment;
3. Keep everything he knows about the patient, even after the patient dies;
4. Carry out emergency assistance on a humanitarian basis, unless he believes that someone else is on duty and capable of doing it; and
5. Increase knowledge and follow the development of medical science or dentistry.

In point 3 (three) of Article 51 of the Medical Practice Law it is clearly and clearly stated that doctors are obliged to keep everything they know about patients even after the patient dies, this is in line with Article 47 of the Medical Practice Law which regulates medical records which states that:

1. The medical record document as referred to in Article 46 belongs to the doctor, dentist, or health service facility, while the contents of the medical record belong to the patient.
2. The medical record as referred to in paragraph (1) must be kept and kept confidential by the doctor or dentist and the head of the health service facility.
3. Provisions regarding medical records as referred to in paragraph (1) and paragraph (2) shall be regulated by a Ministerial Regulation.

So it can be said that in this section the correlation of medical records is the privacy right of the patient which must be kept confidential by the doctor or dentist, with the consequence that if this is violated, the doctor must be prepared to receive ethical sanctions based on his professional code of ethics as well as sanctions in the form of civil lawsuits. and/or punishment for the mistake. Failure to keep medical secrets may be subject to prosecution in Article 322 of the Criminal Code regarding the act of revealing position secrets, while violations of Privacy Rights cannot be criminally prosecuted but are more likely to be an Onrechmatigedaad, which can be sued through Article 1365 of the Civil Code. Right of Access to Medical Secrets as the owner of the contents of Medical Records, logically-juridically, patients based on the provisions of the Minister of Health Number 269 of 2008 concerning Medical Records have access to the contents of Medical Records for the following reasons:

1. Because the medical data recorded in the medical record is the patient's personal data, it is a continuation of the disclosure of the patient's illness to the doctor, so it is logical if the patient wants to know the doctor's actions against him.
2. The doctor's good faith in legal relations is in the form of "Inspanningsverbintenis", in an effort to cure the patient's illness.
3. The right of access to medical secrets contained in the medical records is a continuation of patient rights and is based on general legal principles and principles that doctors must obey. If the patient can know about the disease, then he should be able to know about the treatment.

The right to medical secrets The term "medical secrets" consists of the word 'secret' and the word 'medical'. According to Indonesian rules, the word pattern (term) is "Explained-Explained", so Medical Secrets means secrets in the field of medicine, not secrets belonging to doctors as common people think so far. Doctors are only obliged to keep secrets entrusted to them as their professional obligations as one of the trusted professions such as those of priests, bankers, notaries, and so on. The provisions in the Minister of

Health Number 434/Men/Menkes/XI/1983 concerning the enactment of the Indonesian Medical Code of Ethics for Doctors in Indonesia are guidelines for carrying out the doctor's obligation to keep the patient's disease secret until he dies.Right to Refuse to Disclosure *(Verschoningsrecht)* Medical Secrets The right to refuse to disclose can be interpreted as a doctor's right to refuse/object to the disclosure of secrets known as professional people who have the essence of "trust beneficiary" which contains the obligation to maintain the trust given to the patient. Ethically this is regulated in the code of ethics which became known as Permenkes Number 434/Menkes/XX/1983 article 11, while other legal provisions are in the form of Article 332 of the Criminal Code which requires doctors to keep secrets entrusted to them with a maximum prison sentence of 9 (nine) month or a maximum fine of Rp. 600 (old).

The provisions of Article 332 of the Criminal Code are a weapon for doctors not to violate their professional obligations. What is interesting from other provisions in the Criminal Code is Article 224 which contains provisions requiring doctors to disclose medical secrets in terms of the obligation to give testimony in court hearings related to the evidence provided for in KUHAP articles l87b and l87c jo. Articles 8b and 184c jo. Article 14b of Permenkes no. 749a/1989. So it is legal to disclose the contents of Medical Records in line with the doctrine of "subpoena duces tecum", which Eric W. Springer said: "Subpoena which requires not only that the witness attends but also that he brings to the court certain books, documents, papers or records described in the subpoena " (Springier, 1971).On the other hand, in the midst of the rampant Corona Virus Disease-19 (hereinafter referred to as Covid 19) pandemic in Indonesia, as of the time of this writing, the number of Covid 19 patients exposed in Indonesia reached 977,474 with 27,664 deaths (covid19.go.id, 2021).).

Indirectly showing the problems in society, often the identity of the patient or person who has been exposed to Covid 19 is known by the community in their environment, which has implications for the isolation of the patient from the surrounding community (www.cnbcindonesia.com, 2021). There are also frequent leaks of the identity of Covid-19 patients in the surrounding community due to information coming out of the hospital with the aim of preventing the spread of the virus, usually the leak starts from a conversation between hospital employees and family members, which then spreads the information to the community and is added. accompanied by the development of information that causes the information to spread more quickly.If it is studied using the definition of the Medical Record which contains the identity and illness of the patient, in fact the information related to the patient with Covid 19 is prohibited from spreading in the community as regulated in Article 47 of the Medical Practice Law, namely:

1. The medical record document as referred to in Article 46 belongs to the doctor, dentist, or health service facility, while the contents of the medical record belong to the patient.
2. The medical record as referred to in paragraph (1) must be kept and kept confidential by the doctor or dentist and the head of the health service facility.
3. Provisions regarding medical records as referred to in paragraph (1) and paragraph (2) shall be regulated by a Ministerial Regulation.

In addition, it is added with the obligation of doctors and hospitals to maintain the confidentiality of medical records as contained in Article 51 Letter c of the Medical Practice Law which requires doctors to "confidentially everything they know about patients, even after the patient dies". However, as the author conveyed in the previous section, in the community, especially after the status determination that Covid-19 is a non-natural national disaster, the identity of the Covid-19 sufferers is mostly leaked in the surrounding community so that it has implications for the negative stigma obtained by sufferers in their community environment (www. cnbcindonesia.com, 2021). Meanwhile, in the Law of the Republic of Indonesia Number 4 of 1984 concerning Outbreaks of Infectious Diseases (hereinafter referred to as Law 4/1984) it is known that there is no clear nomenclature under what conditions the Medical Record contains the identity and history of a patient suffering from an infectious disease (Covid). 19) can be published to the public, for example in Article 5 Paragraph (1) of Law 4/1984 it is stated that in an effort to control an epidemic, it is carried out by covering:

1. Epidemiological investigations;
2. Examination, treatment, care, and isolation of patients, including quarantine measures;

3. Prevention and immunity;
4. Extermination of the cause of the disease;
5. Handling of corpses due to epidemics;
6. Outreach to the public;
7. Other countermeasures.

If it is understood grammatically, then Article 57 Paragraph (2) letter d of the Health Law can be used as a basis for argumentation in the leakage of patient data with Covid-19 which has been happening so far, but the question is how technically and what kind of protection is obtained by patients with Covid-19 19 who actually experienced a bad stigma in the community after the opening and publication of data regarding the medical records they suffered. Therefore, through writing in the form of this paper, the author feels interested in analyzing and explaining the legal views regarding the condition of the leaking of identity information and history of Covid-19 sufferers in the community recently, the power of confidentiality of medical records and under what conditions the medical records can be obtained. disseminated to the public in this study, the author will compare the Medical Record settings in the Medical Practice Law, Health Law and Infectious Disease Outbreak Act.

II. METHODS

The method used in this research is normative legal research. normative legal research is research conducted by reviewing the applicable laws and regulations on a particular legal issue. According to Johnny Ibrahim (in Prahassacitta, 2019), normative legal research is a scientific research procedure to establish truth based on scientific logic from the normative side. The normative side here is not limited to laws and regulations. In this study, researchers examined the protection of medical records in patients with corona virus disease-19 based on the law. Paying attention to the phenomenon of COVID-19 sufferers who are often ostracized by the community and even in various places they get discriminatory behavior for being a Covid-19 sufferer. On the other hand, this disease is highly contagious and very difficult to detect if only relying on human observation alone. So that someone who is exposed to the Covid-19 virus must be immediately isolated and not allowed to roam in the community. People who are infected with Covid-19 are temporarily not allowed to socialize and interact with family, friends, and the community. It's just that, is it necessary for a Covid-19 sufferer to announce that he has been exposed to Covid-19, or with self-awareness to carry out medical tests to confirm this. Then, medical records obtained through tests need to be managed according to the current law. In collecting data, researchers also used online news sources that were verified for validity as well as literature studies (Hasudungan et al., 2020).

III. RESULT AND DISCUSSION

Legal Perspective on the Right to Public Information on Medical Record Data of Patients with Covid-19

Before describing the position of patient's medical record data in various legal instruments that apply nationally, it will first be described about the Conception of Rights and information. Context Rights according to Sudikno Mertokusumo are defined as protected interests, while interests are defined as individuals or groups that are expected to be fulfilled. Interests essentially contain powers that are guaranteed and protected by law in carrying them out. Observing this definition, rights can be qualified as something that is inherently inherent in human beings and their implementation is applied to the sphere of freedom and equality when carrying out interactions with fellow individuals and institutions. Mertokusumo, 2021). Meanwhile, the meaning of information, the word information comes from the word informare which means to give shape and to inform which means to inform. From the two definitions concerned, so inform can be interpreted as notification of a certain matter in order to form his views on something conveyed based on his knowledge.

Act. 14 of 2008 concerning Public Information Disclosure (hereinafter referred to as the Law on Public Information Openness) defines information as information, statements, ideas, and signs that contain values, meanings, and messages, both data, facts and explanations that can be seen, heard , and read which is

presented in various packages and formats in accordance with the development of information and communication technology electronically or non-electronically. This regulation describes the context of public information as information that is generated, stored, managed, sent, and/or received by a public agency related to state administrators and administration and/or organizers and administration of other public bodies in accordance with this Law as well as information other matters relating to the public interest.

Fig 1. Explaining about covid-19 medical record protection

In the national legal system, a number of regulations classify Information on Health into two domains, namely the public law aspect and the private legal aspect. Health information in the scope of public law consists of two kinds, namely general and specific health information. Public information related to general health consists of hospital service information systems in the form of costs, types and mechanisms of services, operational standards, service facilities and financing systems. Meanwhile, public information on health of a specific nature includes information on the results of research reports on a disease, prevention and control programs for disease outbreaks, data on the development of types of infectious diseases, patterns of spread or transmission of a disease, areas of spread of disease outbreaks and statistics of an event or which describes the pattern of spread. disease . A number of scopes of types of public health information above must be opened to the public as mandated by law. A number of important reasons underlying the urgency of information disclosure to the public must be considered, among others: First, the era of globalization when access to government records information occurs almost all over the world, so that the government is required to start opening up to any access to information that is needed by the public (Yustina, 2007). 2014). Second, the implication of human rights enforcement that requires information disclosure through active community involvement in order to control government policies. Third, advances in information technology that make it easier for people to get news quickly and efficiently. Fourth, the information transparency policy is the legal basis for creating good governance. In terms of public law, the regulation of public information is formulated in a number of laws including the Law on Public Information Disclosure and Law Number 36 of 2009 concerning Health (hereinafter referred to as the Health Law). Transparency Public access to health information is regulated in Article 169 of the Health Law which states that: "The government makes it easy for the public to gain access to health information in an effort to improve the health status of the community."

During the Covid-19 pandemic, it created a dilemma for the governments of countries in the world, especially in terms of stopping the transmission of this disease outbreak. Uncertainty regarding the discovery of a vaccine as a cure for the Covid-19 virus disease adds to the burden of threats to the stability of a country not only in terms of health, but also disturbances in the socio-economic field. In order to anticipate the systemic effects of this outbreak, every country is trying to issue a non-medical policy in the form of a "Social Vaccine". The Social Vaccine is a step and strategy of the Government by providing important information and data to increase public awareness to lead a healthy life in the midst of the outbreak of the Covid-19 disease. Provision of transparent and actual information and literacy to the public must be applied by the Government in controlling the spread of the Covid-19 pandemic. Anticipatory measures such as the development of case management using blood plasma therapy from patients who have recovered from

Covid-19, the rate of positive and negative cases with Covid-19, the number of deaths, the population of recovered patients, methods of reducing the spread ratio, handling procedures and bodies of patients with Covid-19 until the length of the quarantine period. Information points that are accurate, open and accountable are expected to be used by the Government in reducing risk through appropriate policies to reduce the increase in the number of people suffering from the Covid-19 Virus.In the perspective of fulfilling the patient's rights as consumers in the provision of health services, the right to access health information is also part of the focus of the problem which is considered a top priority. This is as regulated in Law. No. 8 of 1999 concerning Consumer Protection and Laws. No. 44 of 2009 concerning Hospitals. According to the provisions of Article 4 paragraph (3) of the Law. Consumer Protection which clearly accommodates the Consumer in the right to obtain correct, clear, and honest information regarding the conditions and guarantees of goods and or services. If it is associated with the above provisions with the fulfillment of the right to public health information, it can indirectly be said that the public as consumers/patients who use health services are entitled to clear and honest information in receiving health services by the organizers.

The obligation of transparency on the provision of Health information is also imposed on the Hospital as a health service provider entity. In the provisions of article 29 paragraph (1) of Law Number 44 of 2009 concerning Hospitals it is stated that hospitals are required to provide correct information on services provided to the community. The scope of information that must be provided accurately and transparently includes the types of services; budget transparency; ease of access; and other public obligations regarding its status as a public service body. The disclosure of information data to the public during the Covid-19 Pandemic as regulated in several laws and regulations above is a follow-up to the regulation of human rights contained in the 1945 Constitution of the Republic of Indonesia. Based on the provisions of Article 28 E and 28 F of the 1945 Constitution of the Republic of Indonesia, it provides guarantees for all citizens. the state of Indonesia to possess, obtain and disseminate informational news to the public. When it comes to handling the Covid-19 outbreak, the Government's fulfillment of information needs for the community for valid, accurate and continuously updated data according to current conditions and risk mitigation must be carried out without exception. Openness and coordination of the Government of the Republic of Indonesia in the delivery of information in an integrated manner with the Regional Government is the key in controlling the spread of Covid-19 so that it does not become more massive. In addition, the accuracy and delivery of accountable information about the Covid-19 outbreak can be used as signs to prevent the receipt of asymmetric information that endangers the public, including procedures for using disinfectants, using supplementary medicines that are not recommended and the act of hoarding medical devices.

Fig 2. Health worker vaccinate the community

While the type of health information that is private. The scope of the medical record consists of data and the health condition of the patient, both formulated in the medical record data and known by the health service providers, both hospitals, clinics and doctors. Patient medical record data is qualified as sensitive personal data. This is inseparable from the potential legal risks that are feared to occur such as compilation, access and dissemination of medical record data to other parties who do not have competence without the knowledge and consent of the patient himself. For example, it can be used economically by other service-

providing industries such as the drug industry, the insurance industry so that what is called direct selling will occur (Rosadi, 2016).The provisions of Article 1 paragraph 1 Regulation of the Minister of Health of the Republic of Indonesia No. 269 of 2008 concerning Medical Records states that medical records are records and documents containing patient identities, examinations, treatment, actions and other services provided to patients. The information contained in the medical record is confidential. This is because the content of medical records explains the unique relationship between patients and doctors so that they must be protected from leakage in accordance with the medical code of ethics and applicable laws and regulations (Retnowati, 2016). The element of confidentiality in medical record data consists of reports which are the results of patient examinations which are not allowed to be disseminated to unauthorized parties, because they involve the patient's personality. In principle, patients have the right to obtain confidentiality and privacy for their illness. This is as regulated in Article 32 letter i of Law Number 44 of 2009 concerning Health.

Medical record data principally consists of two aspects, namely information that is confidential and information that does not contain confidentiality (Retnowati, 2013). Confidential information consists of reports or examination results of the patient's health condition, so the content of this document is not allowed to be opened or disseminated to parties who do not have the authority. Notification regarding the patient's illness to the patient/family is the responsibility of the patient's doctor, the other party has no rights at all. Meanwhile, information that does not contain confidentiality includes identity and non-medical information. Medical record information belonging to patients with Covid-19 is a type of private information. Patient personal data is information that is excluded from being disclosed to the public. These provisions are regulated in Article 17 h of the Law on Public Information Disclosure and Article 57 paragraph (1) of Law Number 36 of 2009 concerning Health which states that: "Everyone has the right to the confidentiality of his personal health condition that has been disclosed to the health service provider".Information content that contains medical records and non-medical personal data of Covid-19 patients is exempted information which is strict and limited to be published to the public. This data can only be opened with the permission of the owner or based on the orders of the laws and regulations, if anyone violates this provision, they can be subject to legal sanctions according to the applicable laws and regulations. However, in the context of the leaking of medical records of patients with Covid-19, this is again clashed with the public interest even though there are no regulations that provide legal certainty regarding this matter, as it is known that the opening of medical records may only be carried out under several conditions stipulated in the Health Law which is in Article 57 states that, the provisions regarding the right to confidentiality of personal health conditions as referred to in paragraph (1) do not apply in the event that:

1. Statutory orders;
2. Court order;
3. The relevant permit;
4. Public interest; or
5. The person's interests.

The question then is in the 5 (five) conditions that allow the opening of the medical records of patients with Covid-19 above, in the current context, in what cases such leakage can occur. As the author described at the beginning of the discussion, the conclusions regarding the leakage of data or patient medical records are always linked to point d related to the interests of the community. However, what kind of public interest is this, it deserves to be questioned considering that so far the arrangement in this matter seems abstract. In terms of limiting the confidentiality of medical records with the interests of the community, the above is actually a derivative of Aquinas' view, based on Aquinas's thinking, the inclusive nature should be attached to the patient's property rights to the contents of the medical record. The inclusive nature will give birth to a use value for the contents of the medical record which is not only for the benefit of the patient but also allows the use value to be aimed at other interests outside the interests of the patient. Thus, the contents of the patient's medical record also have a social function that will provide benefits to the interests of the wider community which, as Rawls thinks, is beneficial for the general welfare (Ramadianto, 2019).

The social function of property rights according to an ethical perspective should not be viewed through a utilitarian mindset, which only focuses on benefits because it is prone to neglecting ethical aspects.

This is because the patient information documented in the medical record is ethically attached to the patient's good name and honor. That is why the social function of property rights should be viewed through the perspective of virtue ethics (Dewantara, 2017). According to ethics, the primacy of implementing the social function of property rights should be in the 'middle way' between two extreme conditions, namely between placing property rights exclusively and placing property rights in an inclusive-utilitarian manner. The ethics of virtue views that the social function of property rights has a great value for benefits other than for the holder of the property rights so that these property rights can be used for the benefit of the wider community in order to realize the general welfare. However, it does not mean that the great benefit is a justification for overriding the rights of the property rights holder which should still be respected. Through this priority perspective, it is hoped that justice can be achieved both for property rights holders and for people who need the social function of these property rights.

Based on this thought, it can be stated that the contents of the patient's medical record should have a social function so that it can provide great value for the wider community. However, this great benefit does not mean that the patient's rights as the owner of the contents of the medical record are ignored, so they must be respected. Concretely, this thought can manifest in the form of pre-approval from the patient or the existence of certain compensation for the patient when the contents of his medical record are used for the public interest. So that order in society in terms of empowering the social function of the contents of the patient's medical records for general welfare can be guaranteed, of course the role of the state is needed through regulation in positive law.

Protection of Medical Records of Patients with Covid-19 and its Implications

The disclosure of personal identity information and medical record data belonging to Covid-19 positive patients has caused debate in the community. Requests to disclose data on positive Covid-19 patients in total for some groups are considered very necessary, in order to contain the rate of transmission to the community. With the disclosure of medical information belonging to Covid-19 patients, it is hoped that the public can find out about the subject, domicile location and history of social interaction of patients or suspected positive Covid-19. Proponents of disclosing medical record data have the view that transparency is needed as a means of early protection against the risk of transmission by limiting distance. This argument is based on the increase in the number of subjects indicated to be infected with the Covid-19 virus each month published by the competent agency.But on the one hand, the disclosure of data on positive Covid-19 patients also has legal consequences, in the form of violations of sensitive parts of human rights. Information on medical data of positive Covid-19 patients must be protected and set aside to be opened to the public. A number of risks have the potential to occur due to the disclosure of personal medical data to Persons Under Monitoring (ODP), Patients Under Supervision (ODP), Positive Patients and Recovered Patients by parties who do not have the competence to cause violations of individual human rights. The negative stigma attached to the four types of subjects above is a carrier of the virus. So that many of them were expelled from their homes and even those who had died received rejections when they were going to be buried.

During the Covid-19 response period, in practice in the field, several cases that occurred, often health service providers had to deal with two choices, namely: First, doctors or medical officers continued to provide information about the health condition of a patient as a warning and prevention so that the community avoided the transmission of the epidemic. disease. Second, the doctor or medical officer remains guided by the regulations while maintaining the patient's medical confidentiality. If it refers to the rules for disclosing medical record data of positive Covid-19 patients normatively in the Act. Disclosure of Public Information, the patient's medical information is confidential and limited, meaning that his legal position is the type of information that gets exceptions so that it is not disseminated to the public. This provision is also emphasized in the Regulation of the Minister of Health of the Republic of Indonesia Number 269 of 2008 which stipulates that health service facilities are responsible for medical records. The health service provider is required to make or record all events related to the services provided to the patient; manage well; and keep it confidential.Taking into account this, it can be concluded that patient health data does not include information that must be maintained and protected, it can only be opened with the permission of the patient with Covid-19 in question or based on the provisions of the legislation it can be submitted to the public.

Medical secrets/medical secrets are patient rights that must be respected. The right of medical confidentiality related to the condition of the patient's medical record is a limitation that should not be violated in obtaining the right of access to health information. The right to privacy in patient medical record data is part of the individual's basic rights (the rights to self-determination) in health services. Medical record data is a legal object in Health law which is part of the Medical Secret Trilogy Concept. In the Trilogy Secrets of medicine includes a series of correlated relationships between one medical action and another. The medical/therapeutic service relationship consists of three elements, namely informed consent, medical record and medical confidentiality.

Therapeutic relationship between doctor and patient begins with giving the right to initial information regarding the patient's medical condition. Then the doctor as part of the Health service device is obliged to ask for and get the consent of the patient concerned (informed consent). In essence, informed consent is a medical action that begins with the provision of information from a doctor who provides medical services and ends with the patient's consent to take medical action. This information is a right which the patient must know. So it must be carried out even if the patient does not ask. In the Regulation of the Minister of Health No. 290 of 2008 concerning Medical Records, the act of informed consent must be carried out by doctors in good faith, honest and not intimidating to patients and must be fully described regarding the positive and negative impacts of medical actions that will be taken by doctors.Doctors and medical officers who treat positive Covid-19 patients have an obligation to make medical records for all actions taken for the patients they treat. The content of the medical record contains a summary of the patient's contact with health service facilities which consists of a number of components, namely patient personal data, examination, type of treatment, actions taken by doctors and correspondence for the continuity of control and consultation services. The summary of patient medical records contained in the medical record can be compiled manually with complete and clear handwriting and/or electronic data based on the provisions of laws and regulations.

The role of the medical record also functions as a compilation of facts on the health condition and illness suffered by the patient. so that the patient's medical record data will contain two things, among others: Documentation of the comparison of the progress of the disease suffered by the patient in the past with the current condition and written documentation of document actions that have not been, are being and will be carried out by the doctor. Taking into account the two components above, at least the substance summarized in the patient's medical record must contain three things, including: a. Who (Who) concerns the patient's identity information and Who (Who) is the doctor who treats/provides medical action. b. What (what) the patient's complaint, when did it start to be felt, why (why) or the cause of the occurrence and how (how) the medical treatment received by the patient. c. The results or impact (Outcome) of medical actions and treatments that have been received by the patient. Data containing the three elements above must not be wrong, accurate and should not be left behind, because the data has a fatal impact on the safety of the patient's life if an error occurs (Sudjana, 2016). The responsibilities and obligations of health service providers to carry out medical records are regulated in Article 29 Paragraph (1) letter h of Law No. 44 of 2009 concerning Hospitals which states that: "Every hospital has the obligation to: organize medical records".

The context of organizing medical records as described in the article above, is carried out in accordance with international standards which will be adjusted gradually. If this provision is violated by the health service provider, administrative sanctions will be imposed in the form of a warning, written warning, fine and revocation of hospital license. This rule is also emphasized in the provisions of Article 70 and Article 71 of Law no. 36 of 2014 concerning Health Workers emphasizes that: "Every health worker who carries out individual health services is obliged to make a medical record of the recipient of the health service which must be completed immediately after the recipient of the health service has finished receiving the health service". Each Patient's Medical Record must attach the name, time, and signature or initials of the Health Workers who provide services or actions. Furthermore, the document will be stored by the health service provider. The patient, the patient's family and the authorized person may request a copy of the medical record data. Legal status of ownership of medical records is divided into two, namely file and content. Patients have ownership rights to the content of medical records, while documents are under the

authority and are owned by health service providers. Although in fact the two things are one unit. In addition to the obligation to produce medical record evidence, the organizers are also required to store for the security of the document in a document. The storage method in the form of scrip is divided into two types, namely the storage of scripts that are still in process or not yet completed (pending files) and storage of scripts that have been processed (permanent files). The procedure for storing medical record files is regulated based on systematic steps consisting of; Inspection, indexing, marking, data selection and storage. The duration of inpatient data storage in the hospital is 5 years from the last date the patient was hospitalized or discharged.

Observing the content contained in the medical record data contains urgency and a very large risk to the patient's personal and medical code of ethics. So that management and its use is limited only for the benefit of patient treatment. However, it is very unfortunate that in a number of cases it shows that there is a leak of medical data, especially the two initial patients and medical officers in charge of treating patients who are positive for the Covid-19 virus. Leaks of medical records that are revealed to the public actually show a weakness in the supervision of the management of health service institutions. The security of medical record data is not only concerned with the dignity of the human rights of Covid-19 patients, but also regarding the secrets of the professional position of a health service provider. The legal instrument that regulates the guarantee of the protection of the patient's medical record data security is in the provisions of Article 79 letter b of the Medical Practice Law which formulates the application of criminal sanctions which state that: “Shall be punished with a maximum imprisonment of 1 (one) year or a maximum fine of Rp. 50,000,000.00 (fifty million rupiah), any doctor or dentist who: intentionally does not make a medical record as referred to in Article 46 paragraph (1) ".

However, the criminal provisions imposed on doctors who commit violations are revoked through the Decision of the Constitutional Court of the Republic of Indonesia No. 4 /PUU-V/2007 which states that Article 75 Paragraph (1) and Article 76 as long as it concerns a maximum imprisonment of 3 (three) years or and Article 79 as long as it concerns a maximum imprisonment of 1 (one) year or and Article 79 letter c as long as the word or letter e in the Medical Practice Law is declared by the Constitutional Court to be contrary to the 1945 Constitution and declared to have no binding legal force (The Constitutional Court of the Republic of Indonesia, 2007). In its ruling, the Constitutional Court of the Republic of Indonesia is of the opinion that the logic of criminalizing confinement and imprisonment in the Medical Practice Law, when examined with legal philosophy theory, is very disproportionate and has the potential to cause intimidation for doctors in carrying out their profession. This can have implications for the reduction of health services to the community, so that the criminalization policy in the medical practice law has the potential to conflict with human rights in Article 28H paragraph (1) of the 1945 Constitution which states that everyone has the right to obtain health services. It's just that the provisions that were annulled by the Constitutional Court were related to the medical profession which in the actions taken in providing medical services to patients intentionally did not make medical records, the question that then arises is what about the medical profession or hospitals that carelessly only leak the patient's medical records. especially patients with Covid-19. Especially if it is associated with the Covid-19 Pandemic condition, in the event of a medical record leak by a hospital or doctor, the patient with COVID-19 is unable to take criminal legal remedies, and tends to use civil legal remedies or the closer is the application of sanctions. against violators of the limits of public information disclosure, the legal basis used to impose sanctions is the origin of the 54 Law on Public Information Openness which states that: Anyone who knowingly and without rights accesses and/or obtains, provides information that is excepted shall be punished with imprisonment of at most 2 years and a maximum fine of Rp. 10 million. With the existence of these norms, any violation of personal information can be subject to legal sanctions in accordance with these laws and regulations, but of course not all people understand this.

IV. CONCLUSION

Based on the descriptions that the author has mentioned above, it is known that the existence of regulations regarding legal protection of patient medical records associated with the Covid 19 Pandemic in national positive law tends to lack existence and still has various weaknesses, including: a. regulation

regarding the permission to open medical records in the case of "public interest" which is still classified as ambiguous or absurd, then b. there are no legal implications of opening or leaking medical records for both doctors and hospitals, in the context of the Covid-19 pandemic, because there is no regulation regarding criminal sanctions in the event that medical records are opened by doctors or hospitals.

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