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(RESEARCH ARTICLE)

Study on hospital responsibilities regarding the completeness of medical resumes

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Abstract

Objective: Hospitals are legally responsible for the excellent service quality provided to patients based on statutory provisions. Hospital responsibilities in health services include criminal, civil and administrative liability. This study aims to determine the responsibility of the hospital in documenting medical resumes.

Methods: The research method used is literature review, through review of research journals related to the completeness of medical resumes that have been published on accredited journal platforms in 2010-2020. This research was conducted in August-October 2020.

Results: Analysis of 20 research journals relating to the completeness of medical resumes in the reviewed hospitals, it is known that the completeness of medical resume documents in the hospital is on average 75.80% Only 2 hospitals out of 20 hospitals documented medical resumes in accordance with the minimum hospital service standards. Based on the prevailing laws and regulations, the hospital is not criminally responsible for the incomplete documentation of medical resume, but the hospital is responsible civilian based on the principle of representative responsibility and administratively.

Conclusion: The hospital has not optimally documented medical resumes in accordance with the minimum hospital service standards. As a result, the hospital is both civilly and administratively liable. Supervision of the doctor's performance in documenting medical resumes and the role of the medical record committee in ensuring medical staff complete all medical records of patients served is required.

Keywords: Hospital Responsibility; Medical Record Document; Completeness; Medical Resume

1. Introduction

Hospital is a health service institution providing complete individual health services for inpatient, outpatient and emergency services. In carrying out its functions, the hospital has an obligation to document the medical records [1]. The definition of medical records in the Regulation of the Minister of Health Number 269 of 2008 concerning Medical Records is "Files containing notes and documents regarding patient identity, examination, treatment, actions and other services having been provided to patients"[2].

Hospitals are legally responsible for the quality of care provided to patients. The hospital responsibility in the patient care and the documentation of patient medical records is delegated to doctors, nurses and health care professionals[3]. The doctor's responsibility is stated in Article 46 paragraph 1 and paragraph 2 of Law Number 29 of 2004 concerning Medical Practice. What stated in the paragraph (1) is that every doctor or dentist in carrying out medical practice is

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obliged to document medical records, and in the paragraph (2), it stated that medical records as referred to the paragraph (1) must be completed immediately after the patient has received health services [4].

Medical records are documents as evidence of all service actions, disease progression and treatment during a patient's visit or hospitalization [5]. Data and information in medical records can be used for health care and treatment of patients, evidence in the process of law enforcement, medical and dental disciplines and enforcement of medical and dental ethics, educational research purposes, basic health service fee payers and health statistical data"[2].

Proper documented medical records will be able to support hospitals, doctors, health workers as legal protection in case of medical disputes, however, improper documented medical records can affect the quality of services at the hospital and also cause harm to hospitals, doctors and health personnel involved because it cannot provide convincing evidence for the services having been provided to patients.

The contents of the medical record are the property of the patient. Therefore, the patient possesses the right to obtain the contents of the medical record. This right is as stated in Article 8 of Law Number 36 of 2009 concerning Health, stating that "Every person has the right to obtain information about his/her health data, including actions and treatments that have been or will be received from health practitioners"[6]. The same regulation is also regulated in Article 17 paragraph (3) of the Regulation of the Minister of Health Number 4 of 2018 concerning Hospital and Patient Obligations. It states that patient rights include access to the contents of medical records. The contents of the medical record that the patient is entitled to are in the form of a summary of the medical record. The summary of medical records can be given, recorded, copied by the patient or those who are authorized or with the written consent of the patient or the patient's family entitled to do so[2].

As a consequence of fulfilling the patient's rights in Article 29 paragraph (1) letter (m) of Law Number 44 of 2009 concerning Hospitals, hospitals have an obligation to respect and protect patient rights. To fulfill the patient's right to a summary of the medical record, in carrying out medical practice, the doctor must document the comprehensive results of the services provided in the medical record. However, in health services practice, there are still problems and obstacles, in which medical records are documented incompletely and unclearly; and medical records aren't documented on time [7].

Based on the aforementioned background, this study aims at examining the responsibility of the hospital for documenting medical resumes. These issues are reviewed based on the applicable legal regulations/laws in Indonesia. This research is expected being able to be an input for the hospital in understanding its responsibility for medical records.

2. Methods

This research is literature review research, in which this research reviews research journals examining the completeness of medical resume documentation. The journals reviewed are journals published in accredited journals platform in the 2010-2020. This research was conducted in August-October 2020. Data is collected and reduced according to the information required.

The research data were then analyzed descriptively and qualitatively with a normative juridical approach, "which is an analysis that explains or describes the applicable regulations, then linked to the reality that occurs in society, and finally conclusions are drawn"[8]. The regulations used are the regulations in Indonesia governing the hospital's responsibility for completing medical resumes.

3. Results

3.1. Screening process for the selection of research results

The screening process and the selection of research results are analyzed and summarized in Figure 1. In this screening process, the results of the research selected are research examining the completeness of medical resume documentation or other terms, namely discharge summary.

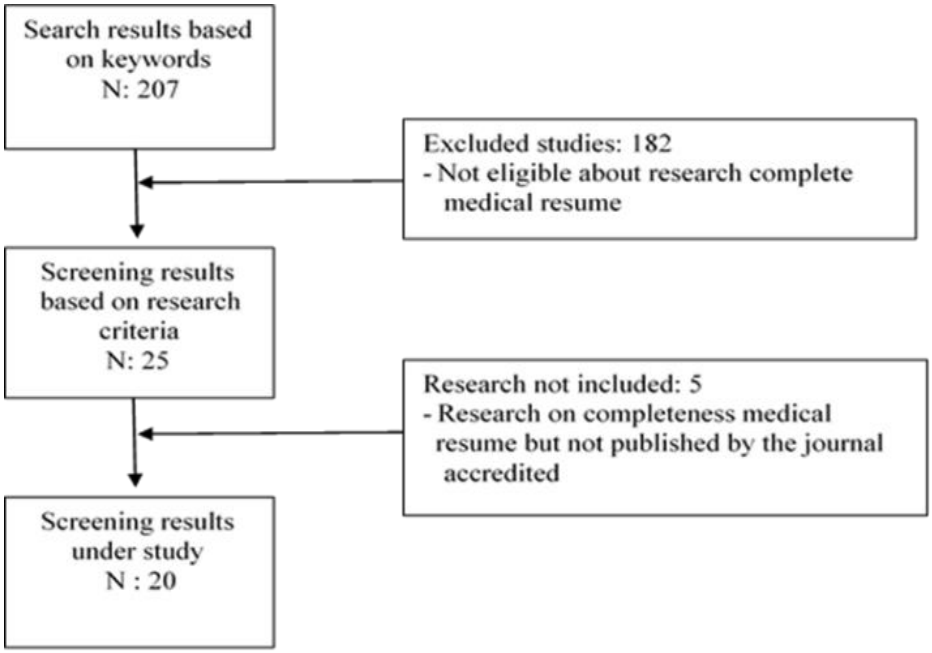

Figure 1 Screening process for the selection of research results.

3.2. Summary of screening results

From the screening process of research results in Figure 1 regarding the completeness of medical resumes, it was found that the research results meeting the criteria to be seen were 20 research results. Summary of research results can be seen as follows.

Table 1 Summary of screening results

Reference	Sample	Research Year	Results
Purwanti et al., 2019 [9]	103	2017	The completeness of the 100 samples is 100% complete
Sugiyanto et al., 2018 [10]	100	2015	Completeness of the 100 samples was from the review of identification: 82.3%, the review of important reports : 25.5%, the review of authentication : 54.7% and the review of recording : 35%
Devhy and Widana, 2019 [11]	95	2019	Completeness of the 95 samples was 100% complete
Pratiwi, 2020 [12]	95	2019	From 95 samples of medical records, it is known that the completeness is as follows: - Sign in Patient Indication: 62% complete, 38% incomplete Important Physical Findings and Other Findings: 79% complete, 21% incomplete - Diagnostic Actions and Therapeutic Procedures Having Been Carried Out: 54% complete, 46% incomplete - Drugs Given during Hospitalization 64% complete, 36% incomplete - Patient's Condition (Present Status): 74% complete, 26% incomplete - Summary of Containing Follow-up Instructions: 37% complete, 63% incomplete - Summary of Discharge Patient Explained and Signed by Patient/Family: 76% complete, 24% incomplete

			- Completeness of Medical Resume Form: 60% complete, 40% incomplete
Dzakiy et al., 2020	83	2018	The completeness of 83 medical resume samples were complete as many as 72 (86.7%) and incomplete as many as 11 (13.3%)
Kartini and Liddini [14]	50	2019	Completeness of medical resumes from 50 samples were from the item of patient identity: complete as many as 43 (86%) and incomplete as many as 7 (14%); the item of anamnese: complete as many as 44 (88%) and incomplete as many as 6 (12%); the item of diagnosis: complete as many as 45 (90%) and incomplete as many as 5 (10%); the item of physical examination results: complete as many as 41 (82%) and incomplete as many as 9 (18%); the item of supporting examination results: complete as many as 47 (94%) and incomplete as many as 3 (6%); the item of treatment: complete as many as 47 (94 %) and incomplete as many as 3 (6%); the item of action: complete as many as 46 (92%) and incomplete as many as 4 (8%); the item of doctor's name and signature: complete as many as 43 (86%) and incomplete as many as 7 (14%).
Lubis, 2017 [15]	50	2016	Of the 50 medical resume samples, it was found that the completeness of the item of patient's identity: complete as many as 44 (88%) and incomplete as many as 6 (12%); the item of medical record number: complete as many as 43 (86%) and incomplete as many as 7 (14%); the item of history: complete as many as 33 (66%) and incomplete as many as 17 (34%); the item of diagnosis: complete as many as 26 (52%) and incomplete as many as 24 (48%); the item of doctor's name and signature: complete as many as 35 (70%) and incomplete as many as 15 (30%).
Tri et al., 2019 [16]	73	2019	Of the 73 samples of medical resumes, it was found that 70 (96%) were complete, and 3 (4%) were incomplete.
Irmawan et al., 2013 [17]	123	2012	The completeness of the 123 medical resume samples is known from the review of identification: complete as many as 95 (77.24%) and incomplete as many as 28 (22.76%); the review of important reports: complete as many as 17 (13.83%) and incomplete as many as 106 (86.17%); the review of authentication: complete as many as 80 (65.05%) and incomplete as many as 43 (34.95%); the review of proper recording: complete as many as 123 (100%)
Pratiwi and Mudayana, 2019 [18]	263	2018	The completeness of the 263 medical resume samples is known from the review of identification: complete as many as 263 (100%); the review of important reports: complete as many as 150 (57%) and incomplete as many as 113 (43%); the review of authentication: complete as many as 260 (98.86%) and incomplete as many as 3 (1.14%); the review of proper recording: complete as many as 260 (98.86%) and incomplete as many as 3 (1.14%)
Erlindai and Nasution, 2017 [19]	48	2017	The completeness of the 48 medical resume samples was found to be 43 (89.5%) complete and 5 (10.5%) incomplete
Irmawati et al., 2018 [20]	97	2017	The completeness of the 97 medical resume is known that the review of identification: complete as many as 60 (61.86%) and incomplete as many as 37 (38.14%); the review of important reports: complete as many as 82 (84.54%) and incomplete as many as 15 (15.46%); the review of authentication: complete as many as 71 (73%) and incomplete as many as 26 (27%); the review of proper recording: complete as many as 123 (67%)

Chastuti et al., 2014 [21]	106	2014	The completeness of the 106 medical resume is known that the review of identification: complete as many as 98 (92.05%) and incomplete as many as 8 (7.95%); the review of important reports: complete as many as 96 (90.43%) and incomplete as many as 10 (9.57%); the review of authentication: complete as many as 83 (77.99%) and incomplete as many as 23 (22.01%); the review of proper recording: complete as many as 89 (84.23%) and incomplete as many as 17 (15.77%).
Utomo, 2016 [22]	49	2016	The completeness of the 49 medical resume samples was found to be 30 (61.2%) complete and 19 (38.8%) incomplete
Ani and Viatiningsih, 2017 [23]	102	2017	The completeness of the 102 medical resume is known that the review of identification: complete as many as 101 (99%) and incomplete as many as 1 (1%); the review of important reports: complete as many as 78 (77%) and incomplete as many as 24 (23%); the review of authentication: complete as many as 78 (76%) and incomplete as many as 24 (24%); the review of proper recording: complete as many as 71 (69%) and incomplete as many as 31 (31%).
Weningsih and Kristina, 2013 [24]	95	2009	The completeness of the 95 medical resume samples was found to be 70 (74%) complete and 25 (26%) incomplete
Setiawan et al., 2020 [25]	200	2019	The completeness of the 200 medical resume samples was found to be 175 (87.5%) complete and 25 (12.5%) incomplete
Kumalasari et al., 2018 [26]	39	2018	The completeness of the 39 medical resume samples was found to be 33 (84.6%) complete and 6 (15.4%) incomplete
Sukiatun, 2018 [27]	140	2017	The completeness of the 140 medical resume samples was found to be 67 (47.9%) complete and 73 (52.1%) incomplete
Fajariani et al., 2020 [28]	87	2020	The completeness of the 87 medical resume samples was found to be 48 (55.2%) complete and 39 (44.8%) incomplete

The results of research on the completeness of medical resumes from the results of a review of journals published in 2010-2020, it is recognized that according to the criteria of this study, there are 20 research results conducted in government hospitals and private hospitals. The results showed that the completeness of the medical resume was 75.80%, while the incompleteness was 18.86%. Of the 20 hospitals, there are two hospitals that have 100% documentation of medical resume, namely RSUD Sanjiwani Gianyar and RS Ganesa in Gianyar City, while 18 other hospitals have documentation of medical resume below 100%.

Based on the classification of the quantitative review component, it includes the review of identification, important reporting, authentication and recording. Completeness results was obtained the review of identification of 85.49%, the review of important reports of 63.80%, the review of authentication of 74.38%, the review of records of 74.26%. The highest completeness of documentation is found in the review of identification component, while the lowest documentation is in the review of important reports. From each item review component, the incompleteness in the review of identification is in the writing of the number of medical records, name, age, gender. The incompleteness in the review of important reporting is found in Indication at admission, physical findings, diagnosis, diagnostic measures and therapeutic procedures that have been done, drugs administered during hospitalization, patient condition (present status), and follow-up instructions. The incompleteness in the review of authentication is in the incomplete writing of the name, date and signature of the doctor and the signature of the patient or family as summary evidence has been explained. The incompleteness in the review of recording is in the existence of an empty part of filling out the medical record.

Table 2 Summary of percentage of completeness of documenting medical resumes from 20 hospitals

No	Hospital Name	Research Year	Research Sample	Completeness		Incompleteness	
				C	%	IC	%
1	Sanjiwani Hospital, Gianyar	2017	103	103	100	0	0
2	R.A Kartini Hospital, Jepara	2015	100	49	49.4	51	50.6
3	Ganesha Hospital, Gianyar	2019	95	95	100	0	0
4	dr. Soedono Hospital Madiun	2019	95	57	60	38	40
5	Sumberrejo Hospital, Bojonegoro	2018	83	72	86.7	11	13.3
6	Mitra Meditama Hospital	2019	50	44.5	89	5.5	11
7	Imelda Pekerja Indonesia Hospital Medan	2016	50	36	72	14	28
8	Delta Surya Hospital Sidoarjo	2019	73	70	96	3	4
9	Ratuzalecha Hospital. Martapura	2012	123	79	64	44	36
10	PKU Muhammadiyah Hospital Bantul	2018	263	190	72	73	28
11	Dr. Pirngadi Hospital Medan	2017	48	43	89.5	5	10.5
12	Ungaran Hospital	2017	97	61	63	36	37
13	Tangerang Regency General Hospital	2014	106	89	84.23	17	15.77
14	DR. Soegiri Hospital Lamongan	2016	49	30	61.2	19	38.8
15	Hajj Hospital Pondok Gede Jakarta	2017	102	82	80.39	20	19.61
16	Santo Yusup Hospital Bandung	2009	95	70	74	25	26
17	Dharmais Cancer Hospital Jakarta	2019	200	175	87.5	25	12.5
18	Aisyiyah Hospital Bojonegoro	2018	39	33	84	6	15
19	dr. Iskak Hospital Tulungagung	2017	140	67	47.92	73	52.1
20	City General Hospital. Makassar	2020	87	48	55.2	39	44.8
Avearge					75.80		24.20

C: Complete, IC: Incomplete

4. Discussion

Hospital as a legal subject in providing health services is bound and must be responsible for all things arising as a result of the implementation of its legal position as the bearer of rights and obligations [29]. Hospital responsibility in documenting medical resumes is delegated to the doctor in charge providing direct services to patients.

Based on Article 4 of the Regulation of the Minister of Health Number 269 of 2008 concerning Medical Records, it is stated that the discharge summary must be made by the doctor or the dentist handling the patient. The contents of the discharge summary should at least include the patient's identity, admission diagnosis and indication of the patient being treated, summary of physical examination results and support, final diagnosis, treatment, follow-up, name and signature of the doctor or the dentist providing health services.

Every medical service activity must have a complete and accurate medical record for each patient; and every doctor and dentist must fill out medical records correctly, completely and on time [30]. The results showed the average completeness of documenting medical resumes was 75.80%, while the incompleteness of documenting medical resumes was 24.20%. According to the Decree of the Minister of Health of the Republic of Indonesia Number 129/Menkes/SK/II/2008 concerning Minimum Hospital Service Standards, it states that the standard of completing filling in medical records 24 hours after completion of service is 100%. Completeness of filling out the medical record includes patient identity, history, care plan, implementation of care, follow-up and resume.

The completeness of filling out medical resumes on average 75.80% indicates that the documentation is not yet in accordance with the minimum hospital service standards set by the government. Whereas, the purpose of making a medical resume is to ensure continuity of high-quality service if the patient is hospitalized again. It can be also to be an assessment material for medical staff to fulfill requests from official agencies or individuals like insurance companies. Moreover, it is to be given a copy to expert systems that require records of patients they have treated [31].

The incompleteness of documenting medical resumes is in accordance with what was conveyed by the Indonesian medical council that the primary problems and obstacles in the implementation of medical records are that medical records are recorded incompletely, unclearly and not on time [7]. However, the importance of medical records is to support the quality of better service provided given in health facilities, documenting incomplete medical records is exceedingly common throughout the world [32].

The results of research on documenting medical records in Iraq Basrah general hospital, During June 2016, from 268 samples of inpatients, it was found that the level of incomplete documentation reached up to 78% [32]. The study results of the at the Referral Hospital of Menelik I, Addis Ababa, Ethiopia also demonstrated the identical thing, which is the completeness of the discharge summary of 64%, but after intervention with inpatient health personnel training (doctors and nurses), the completeness increased to 83.8% [33]. A study on 16 hospitals at the Hospitals of Mazandaran University of Medical Sciences in 2014 showed that the average admission of discharge summary sheets for teaching hospitals (academic medical center) was 74% and 73% for non-nursing hospitals [34].

Incomplete medical records, especially medical resumes, are a fundamental problem and occur in many countries. Hospitals as health service providers based on Law Number 44 of 2009 concerning Hospitals are obliged to provide the safe, quality, anti-discrimination, and effective health services by prioritizing the interests of patients in accordance with Hospital service standards [1]. For this reason, hospitals need to take seriously about documenting medical records.

Several ways can be performed by the hospital including optimizing the role of the medical record committee. Among the functions and responsibilities of the Medical Records Committee are review medical records to ensure that medical records are accurate, clinically relevant, complete and available for continuing patient care, medico-legal requirements, medical research and ensure that medical staff complete all patient medical records under care by recording discharge diagnoses and writing discharge summaries for each patient who is discharged within a certain period of time [3]. Conduct training of doctors, nurses and health workers on the importance of documenting a complete medical resume. The results of previous research at the Referral Hospital of Menelik II, Addis Ababa, Ethiopia was proven with the intervention in the form of training that can improve documentation of medical records. In addition, rewards are needed for doctors or health workers who are orderly in documenting medical resumes and vice versa, and punishment is required for doctors or health workers who are not orderly in documenting medical resumes.

The impact of inaccurate data can result in errors and adverse incidents [35]. Losses for patients or families can be in the form of physical or financial losses. For instance, a patient's illness becomes worse due to inappropriate therapy due to incomplete information, or a patient's refusal to submit an insurance claim to an insurance company.

The responsibility of the hospital for the incompleteness of documenting medical resumes in terms of criminal liability, civil liability and administrative liability are as follows

4.1. Criminal Liability

Criminal liability in health services by the hospital must first be proven of professional wrongdoing by health personnel in the hospital. In health service, it is called criminal malpractice. The responsibility of criminal malpractice is always individual (not corporate) and personal (only those who do it), therefore it cannot be transferred to other people or to the hospital [36].

A person that can be convicted according to the opinion of legal experts must be, at least, possess three elements, namely the act violate the written law; the act is against the law; and the act has an element of error (dolus) [29]. In documenting a medical resume, the hospital delegates to the primary doctor who handles the patient for the documentation of filling out a medical resume. Whereas, based on Article 14 of the Regulation of Minister of Health Number 268 of 2008 concerning Medical Records, hospitals, as the head of health service facilities, is responsible for securing the information contained in medical records against the possibility of loss of information or falsifying data in medical records or being used by parties who do not have the authorization.

The results showed the level of completeness of documenting medical resumes on average was 75.80%. In accordance with the principle of criminal liability, those who commit mistakes must be responsible. In Article 46 paragraph (1) and paragraph (2) of Law Number 29 of 2004 concerning Medical Practice, it states that every doctor or dentist in carrying out medical practice is obliged to make medical records (Paragraph [1]), and medical records as intended in paragraph (1) must be completed immediately after the patient has received health services (Paragraph [2]). Of these two paragraphs, it can be concluded that who are responsible for the documentation is a doctor or dentist.

If the provisions of Article 46 are unimplemented, based on the similar law, the Article 79 may be subject to criminal sanctions, namely "shall be punished with imprisonment for a maximum of 1 (one) year or a maximum fine of IDR 50,000,000.00 (fifty million rupiah), every time, a doctor or dentist who: b. isn't intentionally making medical records as referred to in Article 46 paragraph (1)."

From the formulation of the law, it is comprehensible that those responsible for filling in medical records including medical resumes are doctors, and it is not hospitals' responsibility. However, these criminal sanctions only apply if doctors in practicing medicine do not make medical records. In the case of a doctor making a medical record but incomplete, he/she will not be subject to criminal sanctions as formulated in Article 79 of Law Number 29 of 2004 concerning the medical practice.

4.2. Civil Liability

The legal relationship that occurs between hospitals and patients in the perspective of civil law is a contractual relationship creating rights and obligations on each party. From various cases, civil problems occur, generally in the form of acts against the law and default. The form of default is wrong or fallacious to take health efforts, while the act of violating the law includes doing or not doing that which violates the rights of other people and is against legal obligations both to oneself or other people's objects [29].

Based on the research results, the hospital has not carried out its obligations in organizing medical records optimally. It is where the average of the completeness of medical resumes is 75.80%. Based on the Decree of the Minister of Health of the Republic of Indonesia Number 129/Menkes/SK/II/2008 concerning Hospital Minimum Service Standards, the completeness of medical resumes requires completeness of completing medical records in 24 hours after completion of service is 100%.

The impact of the incomplete medical resume causes harm to the patient. The law provides patients the opportunity to sue the hospital. According to Article 55 of Law Number 36 of 2009 concerning Health, it is stated that every person possesses the right to claim compensation for a person, health worker, and/or health provider who causes losses due to errors or negligence in the health services they receive. If traced further, the losses that may occur due to incomplete medical resume documentation are the responsibility of the doctor who handles the patient. It is since the responsibility for completing medical resume documentation belongs to the doctor handling the patient.

Hospitals can also be held liable under the civil code article 1367 of the Civil Code, which reads “a person is not only responsible, for losses caused by his own actions, but also for losses caused by the actions of the people who are dependent on him or due to goods under his control” [37]. The responsibility of this hospital is based on the principle of vicarious liability.

The liability of this hospital arises based on the result of mistakes made by the subordinate (employee) who works in his position as a sub-ordinate (employee) who is in charge of carrying out the hospital's obligations [36].

4.3. Administrative Liability

The liability of administrative law in the legal relationship between the hospital and the patient is related to policies or provisions which are the requirements for the administration of health services that must be fulfilled in the context of providing quality health services [38].

The provisions governing medical resumes are contained in Article 4 and Article 5 of the Regulation of the Minister of Health Number 269 of 2008 concerning Medical Records, stating that a discharge summary must be made by the doctor handling the patient. The contents of the discharge summary should at least include the patient's identity, admission diagnosis and indication of the patient being treated, summary of physical examination results and support, final diagnosis, treatment, follow-up, name and signature of the doctor or the dentist providing health services. Article 5 paragraph (2) states that medical records must be made promptly and completed after the patient receives service.

The results of the study of the 20 hospitals studied were only two hospitals that had 100% documentation. Meanwhile, 18 hospitals were not in accordance with the minimum hospital service standards. The lowest completeness is in the review of the important report (63.80%) where the incompleteness is in the indication at admission, physical findings, diagnosis, diagnostic actions and therapeutic procedures that have been performed, drugs given during hospitalization, patient condition (present status) and follow-up instructions.

Looking at the results of the research and compared with the provisions contained in the Regulation of the Minister of Health No. 268 of 2008 concerning Medical Records, it is clear that there has been a deviation or mismatch in its implementation practices. Therefore, the Minister, the head of the provincial health service, the head of the regency/city service office, can issue administrative sanctions to the hospital in the form of verbal warning, written warning, up to the revocation of the license according to their respective authority.

In addition, in Law Number 44 of 2009 concerning Hospitals, Article 29 paragraph (1) letter (o) states: "Every hospital has an obligation to respect and secure the rights of patients." Patients' rights to medical records are regulated in Article 17 paragraph (3) of the Regulation of the Minister of Health Number 4 of 2018 concerning Hospital and Patient Obligations. It states the intended right is the right to access the contents of medical records. In Article 12 paragraph (3) of the Regulation of the Minister of Health Number 268 of 2008 concerning Medical Records, the contents are in the form of a medical record summary.

Due to the violation of the hospital's obligations to Article 29 paragraph (1), the hospital may be subject to administrative sanctions in the form of: warning; written warning; or fines and revocation of hospital license."

5. Conclusion

Based on the research results, it can be concluded as follows:.

The hospital's responsibility for documenting medical resumes has been unimplemented according to the regulations regarding the minimum standard of hospital services. Hence, it can have an impact on the fulfillment of patient rights which are not optimal.

For criminal legal liability, the hospital is unresponsible for the incompleteness of documenting medical resumes carried out by doctors. In the scope of civil law, hospitals are responsible for actions undertaken by doctors in documenting incomplete medical resumes based on the principle of vicarious liability. In the scope of administrative law, a hospital may be subject to administrative sanctions in the form of warning, written warning; or fines and revocation of hospital licenses for not carrying out their obligations in accordance with the provisions of the Regulation of Minister of Health Number 269 of 2008 concerning Medical Records and Law Number 44 of 2009 concerning Hospitals in carrying out the obligation to fulfill patient rights.

Hospitals need paying attention to their responsibilities in carrying out their obligations in documenting medical resumes through monitoring the performance of doctors and the fellow health workers. Moreover the hospital can involve a medical record committee to help monitor compliance with medical resume documentation.

Compliance with ethical standards

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Disclosure of conflict of interest

All authors have stated that this activity does not contain a conflict of interest

Statement of ethical approval

According to the standard guidelines for participant approval and ethical approval has been collected and preserved by the author

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