THE INTERNATIONAL JOURNAL OF HUMANITIES & SOCIAL STUDIES

Medical Record as a Tool to Control Doctor for Not Malpractice

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Abstract:
Process Medical Record (Medical Record) is procedures for admission of patients who will be treated to a clinic or to be treated as part of the system procedures hospital services. Patients in hospitals can be categorized as a patient polyclinics (outpatient treatment) there are outpatient and inpatient. The arrival of the patient to the hospital are either: delivered by physicians practice outside the hospital, sent by other hospitals, health center, or other type of health care, come on their own. Patient medical records made to the Emergency Department, Outpatient inpatient. The doctor's responsibility in manufacturing Medical Record (Medical Record) As the Certificate is that the rules governing ethical responsibility and a doctor is the Code of Medical Ethics and pronunciation Oath Indonesia Physician. Codes of ethics are the guidelines behaviour. Medical Record is written evidence of the services provided by doctors and other health professionals to patients, it is a reflection of the cooperation than one the health teanga for healing the patient. Written proof of service performed after inspection action, so that treatment can be justified.

Keywords: *Medical records, control, malpractice*

1. Introduction

The growing world of health in Indonesia, the medical record has a role no less important in supporting the implementation of the National Health System (NHS). Medical record is very important in addition to medical diagnosis as well as to the evaluation of health services, improving work efficiency through reduced mortality and motility as well as the treatment of patients who have been more perfect.

Terminology medical records according to Indonesian law could be classed as objects or goods (tangible objects). File medical records are the property of health care facilities, while it belongs to the patient. M Article 47 paragraph (1) of Law 29 of 2004 on Medical Practice (Then PK referred to as the Act) provides that documents medical records referred to in Article 46 paragraph (1) of the PK is owned by a doctor, dentist or care facility health, while the content of the patient's medical record. In the implementation of the medical record, good activities, recording and storage provided for in the Act PK, Minister of Health Regulation 269 of 2008, and the standard procedures that are health-care facilities, also in accordance with medical ethics Indonesia. Thus, it is clear that the medical records are not allowed to come out and health care facilities.

Medical Records before known, as now, the medical use of the term "patient status". Because foreign languages (Dutch), then the person is trying to replace this term with Indonesian more appropriate so that the term medical records, medical documents and others. In simple terms it can be said that the medical record is a collection of information about identity. Results anamnesis, inspection and record all activities of the health care on the patient and over time. This entry in the form of text or image and the latter could also be the medical records such as computers, microfilm and sound recordings.

In the sense discussed meds first record will stated meaning of medical ream itself. Medical records, they mean "statements whether written or recorded on the identity, anamnesis, determination of physical laboratory, diagnostics of all services and medical treatment given to the patient, and treatment of both treated inpatient, outpatient or getting emergency services". If interpreted superficially, medical records as if only the records and documents on the state of the patient, but when examined more in medical records has a wider meaning than just annals usual, because in such records is already reflected all information concerning a patient that will be basis in determining further action in service efforts and other medical action given to a patient who came to the hospital.

Medical records have an understanding, a very knowledgeable not only a bunch of registration activities, but have a sense as a system implementation medical records. While the activities of the recording itself must be one activity than organizing medical record, organizing Medical records a process of activities held at the time of receipt of the patient in the hospital, passed activity of recording patients' medical records for patients to obtain medical services at the hospital and continued with file handling medical record storage and expenditure see organizing files from storage to serve requests if the patient or for other uses.

In PERMENKES 269 / Menkes / Per / III / 2008 concerning medical records on Article 1 paragraph 1 stated that the definition of medical records is the file containing the records and documents on his identity, examination, treatment, action and other services to patients in care facilities health. The elucidation of Article 46 paragraph (1) of the Medical Practice Act took definitions referred to in the Minister of Health, is a medical record is a file that contains records and documents on his identity, examination, treatment, action

and other services that have been given to patients. As stated in Permenkes 269 / Menkes / Per / III / 2OO8, of the Medical Records explained that the medical record is the file containing the records and documents on his identity, examination, treatment, action and other services to patients in health care facilities. Both understanding medical records above shows the difference that Permenkes only emphasize on health care facilities, whereas in the Medical Practice Act no. It shows the setting of medical records at the Medical Practice Act more broadly, applies to both health facilities and outside health facilities. Likewise Gemala R. Hatta formulate medical records as a collection of all the activities of the health service which written, pictured, on their activities to the patient.

Medical record is written and recording information about the identity, history, physical determination, laboratory examination / radiology, diagnosis, all the services and medical treatment given to patients either outpatient services, inpatient, and emergency care provided to patients. Significantly more extensive medical records in addition to registration activities but also organizing medical records system. Implementation of medical records is a process that begins when the patient began to enter the health care service facilities. Medical data for medical services continued with file handling medical record that includes the delivery and storage. In the Indonesian legal system, known as 'material' which involves understanding:

1. Goods (object-bodied, tangible objects) are visual objects, whether movable or immovable, such as land buildings, animals, cars etc.
2. Rights (disembodied objects, intangibles) is a non-visual objects such as accounts receivable, the computer program.

Medical records should contain full information about the process of medical services in the past, the present and forecast occur in the future. Ownership of medical records is often a debate among health workers, because doctors assume full authority to the doctor but the patient medical records clerk insisted on maintaining a file of medical records in their work environment. On the other hand, patients are often forced to carry or read a file that contains a history of the disease. This shows that the medical record is very important. Medical record is complete and accurate is an absolute requirement for evidence in cases of medicolegal cases.

Advances in science and technology in the health sector in recent years have led to frequent lawsuits arising dani patients who feel harmed by errors and negligence by doctors in carrying out medical action. It is often associated with a form of error doctor physician malpractice in the use of skills and knowledge that is commonly used to treat patients not to harm or injure even make the patient suffer.

2. Procedure for Medical Record

The procedure for admission of patients who will be treated to a clinic or to be treated are some of the procedural system for hospital services. It can be said that this is where the first service that is received by a patient's arrival at the hospital, it is no exaggeration to say that in the procedure of admission of a patient is getting better or not better impression of the service of a hospital. The procedure for serving the patients can be assessed properly when operated by someone degan where a friendly attitude, polite, orderly and responsibly.

1. Patients in hospitals can be categorized as a patient polyclinics (outpatient treatment) there are outpatient inpatient.
2. Acceptance of outpatient inpatient

a. In terms of hospital care of patients come to the hospital

b. Meanwhile, according to the type of his visit patients can differentiate into:

1) new patient: is the patients who first came to the hospital for treatment purposes

2) Patient long time: Is a patient who had come earlier for treatment purposes.

c. The arrival of the patient to the hospital may be due to:

1) Posted by physicians practice outside the hospital

2) Posted by lai hospital, health center, or other type of health care

3) Come on their own volition.

The admission procedure can be adapted to the system adopted by each rumag sick.

1. Acceptance of outpatients:

a. new patients

Every new patient is received in place Patient Admissions (TTP) and will be interviewed by the officers in order to obtain identity data will fill in the form and summary of clinical history.

Each new patient will get the number of patients that will be used as identification cards, which must be taken at each subsequent visit to the hospital nginap.

Summary data on the clinical history of which contains:

3. The doctor in charge of the clinic
4. Number of patients
5. Full address
6. Place / date of birth
7. Age
8. Gender
9. Family status
10. Religion
11. Work

Summary of clinical history was also used as the basis for the patient's main index cards (KIUP). New patients with a medical record file will be sent to the clinic in accordance degan within your patient. After obtaining enough service from the clinic, there are several possibilities of each patient:

1. Patients can go home
2. The patient is given a slip of a treaty by clinic personnel to come back in the day and the stairs; who had remained in charge. To a patient who asked to come back. Must report back to the TPP.
3. The patient was referred / sent another to the hospital.

b. Older patients

Old patient came to the reception of patients that has been set. These patients can be distinguished:

1. Patients who come to agreement
2. Patients who come not with an agreement (on their own)

Neither patients nor the agreement of patients who come on their own. After buying the ticket, will get a new service in the TPP. Patients agreement will go directly to the clinic on purpose because of their medical records had been prepared by the clerk. Medium for patients who come on their own. Had to wait while their medical records requested by the officer TPP to the medical record. After recording medisya sent to the clinic, patients will get services at the clinic in question.

a. Patient Emergency Procedures

Patients come to the place emergency patient admission. TPP is open for 24 hours. Different premises pelayaa new patients da procedures plain old patient, patient here helped the new first settlement administration. After obtaining enough service, there are several possibilities of each patient.

1. Patients can go home
2. The patient was referred / sent to another hospital
3. The patient should be hospitalized

a. patients that have been selected and brought a letter of introduction to in-patient can be immediately brought into the room or space perawata temporary shelters waiting sambing empty beds of shelter space

b. If the patient has been and can be interviewed. Hospitalization central officers visited / family to obtain more identity

d. Outpatient Medical Record:

Patients buy ticket in writing the ticket booth

Patients with a ticket, sign up for a reception outpatients. Officers place of acceptance outpatients recorded in the register book: patient name, number RM, Identity and social data and record patient complaints at the clinic card. Where admissions officers, made medical card for patient by given replications, in addition to showing the ticket, the officer will take the patient's medical record file of the replay.

Polyclinic clinic card sent to the destination in accordance with the patient's complaints, while the patients present themselves to poloklinik. Officers noted a history hospital sheet, examination results, diagnosis therapy in telepasi with the disease, the Card / medical records of patients. In hospital officer (nurse / midwife) to make a report / daily recapitulation outpatient. After service in the clinic was completed held, clinic officials send the entire file medical records of patients hospitalized following net daily recapitulation outpatient medical record unit to at least 1 hour before ending work hours.

Officers checked fillingmedical records completeness of medical records, and to incomplete completeness be promoted. The patient's medical record file is saved by medical record number (if it adheres to the decentralized system) records of outpatient stored in a reception outpatients.

e. Description Flow Medical Record Rawat inpatient

1. Each patient was carrying a letter from a doctor requests inpatient care clinics, emergency unit Emergency, contact the admissions inpatient place, being patient referrals from other health services first examined by a hospital doctor in question

2. If the beds in inpatient is still willing to accept the officer noted in his patient register receipt nginap patient: Name, Number RM, Identity and other social data. And to prepare / fill data on a sheet entry Patient Identity (RM).

3. Where applicable system of advances, non patient-specific access and are considered able, the family of the patient is asked to contact the finance department to make an advance payment of care in accordance with applicable regulations.

4. The reception clerk inpatient transmit patient medical record file together with the patient to the ward inpatient question.

5. Patients Received by officers in ward inpatient and recorded in the register book.

6. The doctor on duty noted the challenge the medical history, physical examination, therapy and all action is given to the patient on the sheet of medical records and sign signature. Nurse noted their observations to patients and care aid they provide to patients in the note nurse and signed his name, and fill out the graph of temperature, pulse, and respiration of a patient

7. While in space inpatient, nurse adding sheets of medical records in accordance with the service needs of the service provided to patients.

8. Nurse obligation to make daily census of patients mutation that provides an overview start at 00.00 until 24.00 hours. Daily censusmade three signed copies inpatient Head Space (Central Hospitalization) and one sheet archive inpatient ward. Daily census delivery no later than 08.00 hours the following morning.

9. The room attendant check the complete patient record file, before it is submitted to the Medical Record Unit.

10. After the patient out of the hospital medical record file immediately returned to the unit medical record no later than 24 hours after the patient out, complete and true.

11. Officers Medical Record Unit Medical records the process is complete, the card is inserted into the Disease Index, Index Operations, Death Index, etc, to create statistical reports and hospital.
12. Officers Medical Record Unit recapitulation daily census of each end of the month and sent to PART / PPL for material Affairs hospital report.
13. Medical Record Unit to save files medical records of patients according to his RM number (if embracing centralized system, medical record file outpatient and inpatient inpatient for each patient together).
14. Officers Medical Record Unit issued a Medical Record Unit, if there is a demand both for the patient's treatment or other purposes.
15. Any request for medical records must use a letter, called a request card.
16. Card request made double 3 (three), one copy affixed to the medical records, a copy is placed in a storage rack as exit signs, and one archive copy as requested.
17. If the medical records are borrowed have been returned, a second copy of the request cards discarded
18. Medical Record patient never do again to the hospital during the past five years, expressed as inactive record.
19. Files medical colleagues who have been declared as inactive records are removed from storage shelves and in warehouses hospital / destroyed.

1. Working Procedure

The Committee shall meet once a month. They should pursue stress attention to qreuality improvement. Ideally Services committee should study the medical records of medical records. All patients who had recently come out of hospital a month ago to primarily assess the cases without diagnosis, differences opinion about causes of death diagnostics Usually assess patient medical records randomly only.

To this should be made a regular assessment schedule that must be followed to ensure that must be arbitrarily kinds of cases hospitalized maybe can be included in the assessment. The clerk handed medical records fill medical records that are not standard to the committee. Medical Records earlier may specifically from one of patient, eg Medical Records of patients gineologi. The Committee should also examine medical records patients were still being treated in-patient. Special assessments on a regular basis should be done by the committee in the medical records to assess the quality of medical services. Medical Records of patients who died within 24 hours after admission in the emergency department should receive special attention. The responsibility of the Committee to assess the quality of medical services medical records and inpatient only for patients, but also for outpatients. All sheets should medical records be examined by medical record it to prevent duplication, the content uniformity medical records uniform shapes and sizes and reducing the number of medical records. In order for the task and function medical records committee can be efficient and effective so medical records committee authorized :

- Provide final assessment of the quality of clinical data entry
- Refusal medical records that do no meet the standards.
- Implement measures actions toward improving medical records that do not satisfy any medical personnel, paramedics and other health workers are obliged complete charging medical records must approve the terms of existing and, if refused will charged sanctions (e.g. Decline DP3 for Government hospitals).

2. The working relationship:

1. Medical Record Unit Outpatient Unit, inpatient Care Unit, Emergency Unit and other relevant , responsible for the implementation of activities of medical records, as with the limits of authority and responsibility.
2. In performing their duties, the medical records are required to apply Coordination, Integration and Sinkronsasi good environmental daam Internal Unit with other units concerned, in accordance with their respective duties.
3. Chief Medical Record Unit and Units related to the implementation of medical records, responsibility and coordinating their respective subordinates each as well as provide guidance for the implementation of the subordinate officers.
4. Chief Medical Record Unit and Units related non implementation of the medical records, must follow and comply with the instructions and responsibilities to their respective superiors and to submit periodic reports on time.
5. In performing the duties head of Medical Record Unit and other unit associated with the implementation of medical records, in order to develop and provision of guidance required mengadaan regular meetings, both among medical personnel and between Medical records unit leader with the other units related with the implementation of the medical record in the hospital.
6. Medical records l Unit has coordination relationship with ain units in the Secretariat. Outpatient Unit. inpatient Care Unit. Emergency room. Supporting units and institutions related to the implementation activity medical records at the hospital.

2. Conditions Completion of Medical Records

Medical Record shall be made promptly and fully equipped after the patient received the service with the following provisions:

a. Every action on a patient consultation at the latest within 1 x 24 hours must be recorded in the medical record sheet.
b. All registration must be signed by a doctor / other health personnel in accordance with the written name kewenangnya and brightness as well as by date.
c. Recording made by medical students and other students signed and are the responsibility of the treating physician or by a physician preceptor.
d. Notes made by Residens should be known by doctors guardian.
e. The treating physician can correct errors of writing and do it at that time and given the initials
f. Elimination of paper in any way is not allowed.

Many forms of medical records used by various hospitals. But all of them must meet the basic necessities, as has been described in the medical record usefulness. Forms medical records alone do not guarantee proper medical data recording and good. If the physician and the staff carefully medical records not complement the information on each sheet in need medical records properly.
Form medical records include medical records for outpatient and medical record form for outpatient inpatient. Relative health manteri No. 749a / Menkes / Press / XII / 1989 on the medical records:
1. Complete medical records in outpatient settings can be made the fullest and least make: identity, anamnesis, diagnosis and action / treatment
2. Fill in the patient medical record for at least the following inpatient

- → The identity of the patient
- → anamnese
- → Disease History
- → Results of laboratory tests
- → Diagnosis
- → Approval of medical action
- → Measures of treatment
- → Business nursing
- → Notes clinical observation and treatment outcome
- → Resume end and evaluation of treatment

Formulis used is usually in the form of checks patient's card. Where information on the identity of the patient, the diagnosis and the actions taken against sepewrti patient anamnesis, therapy kartyu was recorded in the outpatient clinic needs to be made a summary sheet, commonly called identiats and a summary of the clinic. These sheets as a basis in preparing the patient's main index cards (KIUP) that contains the identity of the patient as well as a summary of the polyclinic.
Information requested from the identity, include:

- → The name of the patient - religion Status
- → Number of medical records - Religion
- → Place / Date of Birth - Name of the Father
- → Gender - Mother's Name
- → Jobs - Address

Address changes to note, if the patient bewrpindah termpat address of residence, besides it must be noted how patient visits are sent by anyone.
While history shows infoermasi clinic:

- → Visit Date
- → Polyclinic who serve
- → Diagnosis
- → Measures granted
- → Doctors who deal

3. Functions of Medical Record
The usefulness of medical records can be viewed and several aspects, among others:
1. Aspects of administration
Medical record administration has meaning because it involves action by the authority and responsibility for health workers.
2. Medical Aspects
Medical records have medical value for the note used as the basis for planning treatment and care will be provided.
3. The legal aspects
Medical record has legal value because it comes to guarantee legal certainty on the basis of justice in an effort to enforce the law and evidence to uphold justice.
4. Financial aspects
Medical records may be material to the payment of health care costs.
5. Aspects of research
Medical records have research value because it contains data or information as aspects of research and development of science in the field of health.
6. Aspects of education
Medical records have educational value because the data concerning information about the chronological development of medical services to patients that can be learned.
7. Aspects of documentation
Medical records have value as a source preferred used as an ingredient of accountability and reporting.
2. The purpose of the Medical Record
The purpose of the medical record itself, whereas here is usability of medical records. The purpose is to support the medical record the attainment orderly administration in an effort to improve health services in the hospital. Without the support of a manager of

medical records system is good and right, impossible orderly administration of the hospital will be managed as expected. While orderly administration is a sive in efforts to improve health services in the hospital. Interest Medical Records in detail will be seen and is analogous to the use of medical ream itself.

Medical Records Committee is responsible to the medical committee refers to the Decree of the Minister of Health RI. No. 983 / SK / Menkes / XI / 92 of Article 42 of the Medical Committee.

Paragraph (1): Understanding Medical Committee is a medical groups whose members are elected from the members of the medical staff of Functional.

Paragraph (2): Medical Committee has the task:

- → Assist the Director to set standards, service and monitor its implementation.
- → Implement coaching professional ethics
- → Professional medical staff members fungsionl
- → As well as developing service programs, education and training and research & development.

Paragraph (3): Implementation assignment, the medical committee may be assisted by a committee whose members consist functional medical staff and professionals.

Paragraph (4): the Committee is a special working group within the medical committee needed to address the issue specifically.

Paragraph (5): formation committee assigned by the Director.

Medical records is a working group composed of health workers involved in health care, in order to assist the medical committee that quality medical ream Organizing Committee Medical Record responsibility.

Usefulness Medical Record can be viewed from several aspects among others:

a. Administrative aspects

A medical records files has a value of administration, because contents involves action based onauthority and responsibility as medical and paramedical personnel in achieving health care objectives.

b. aspect Medical

A medical record file has medical value, because such records used as a basis for planning the treatment / care should be given to a patient.

c. Legal aspects

A file of medical brekam have legal value, because content comes to their legal kepasian guarantee on the basis of justice, in order to attempt to enforce the law as well as the provision of proof to uphold justice.

d. Financial aspect

A medical record file has a value of money, kerna contents certainty by containing data / information that can be used as the financial aspect.

e. aspects of Research

A medical files have research value. Because it involves data / information that can used as aspects of research and development in the field of health sciences.

f. aspect Education

A file of medical records has educational value, concerning the contents because data / information about the chronological development and activity medical services provided to patients, the information can be used as material / reference teaching profession in the field wearer.

g. Documentation aspects

A medical record file has a value of documentation, because content regarding memory resources that should be documented and used as a take-charge and hospital reports.

With the view of keeping the aspects mentioned above, medical records have utility very broad, as it not only involves the patient with service providers only. The usefulness of medical records in general are:

1. As communication tool between physicians among other experts who took part in providing care, treatment, care to patients.
2. Part of the basis for planning the treatment should be given to a patient.
3. As the book is written for all activities services, distribution and treatment development for patients visits hospitalized.
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 and physicians and other health professionals.
6. Provide specific data is very useful for research and educational purposes.
7. Some basic calculation costing a patient's medical care.
8. Be a source of memories that should be documented, as well as accountability and reporting materials.

4. Medical Record Function as a Tool to Control the Doctor

Medical personnel, paramedics and other health personnel provide good service direct nor indirect to a patient not responsible for the quality of their gift from. Fulfilling these responsibilities of medical personnel, paramedics and other health professionals should take part in the body that has to do with patient care. They carry out tanggunag Javanese through a body called "Committee for Medical Record" good medical records will reflect the quality of medical services provided to a patient. The committee will help the implementation manager medical records that meets the standards that have been set.

1. Provide suggestions and considerations in record-keeping, and ensure that all information in the record as well as possible and ensure the availability of data need to assess the service provided to patients.
2. Ensure the exercise has been well filling record, manufacture Indes, Medical Record storage and availability of medical records of all patients.
3. Asking proposal to the Hospital Director about changes in the contents of the medical record size.
4. Fostering cooperation with the Legal Adviser in terms of relationships out and expenditure data / information to bodies outside the hospital.

In Law No. 32 of 1996 on Health Workers (hereinafter called the Health Workers Act), Chapter I Article I point 1 determined that:
What is meant by health personnel are all people who dedicated themselves in the field of health care workers and have the knowledge or skills through education, in the health sector for certain types of health need to make health efforts.

In the Indonesian regulations can not find a rule expressly to formulate tasks doctor, only in the form of requirements to do the job as a doctor, provided for in Article 3 of the Law of Health Workers, which is that health professionals are required to have knowledge and skills in the field of health expressed with diplomas and educational institutions requirements are requirements in the form of knowledge and skills in the field of health for health workers should be appropriate to the type and level of education of health personnel.

If the patient has died, and requesting a copy of the medical record is the legal representative and the patient's family, then this should not be granted. It is given that patients who have died are not able to pass on the contents of the medical records to his family because of the contents of the medical records are not items that can be traded and passed, in addition to the oath that must keep the patient even though the patient had died.

5. Conclusion

Medical records as a form of accountability doctor, medical record document should be part and evidence in the trial. Based on its position as evidence medical records can contain things that can be justified by law. Proof become very important in the effort to explain the doctor's responsibility in respect of any medical record that has been issued in the case of alleged malpractice. Code of Criminal Procedure seeking truth materially. Even the procedures in the search for the material truth, obliging be used evidence.

Everything the doctor's responsibility is intended that physicians account for his actions relating to losses suffered by patients due to improper medical procedures performed by him by giving compensation to the patient or the patient's family. In the doctor's liability for errors then the aggrieved party must be able to prove the guilt of doctors to provide medical services. But it is certainly very difficult to prove. Moreover, the aggrieved party is a layman's knowledge of medicine and do not know if this includes fault or negligence of a doctor.

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