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Medical Records are Valid Evidence Based on the Criminal Procedure Code

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ABSTRACT

Medical records play an important role in the legal world, especially in criminal proceedings as a form of evidence. This study aims to examine the position and validity of medical records as valid evidence according to criminal procedure law in Indonesia. The method used is a normative legal analysis approach with an analysis of relevant laws and regulations, court decisions, and legal doctrines. The results of the study indicate that medical records, although not included in the main evidence as regulated in Article 184 of the Criminal Procedure Code, can be qualified as documentary evidence and/or instructions that support evidence in criminal cases. The validity of medical records as evidence is highly dependent on the authenticity, completeness, and relevance of their contents to the criminal event that occurred. Thus, medical records have significant evidentiary power and can be used as a basis for judges' considerations in deciding criminal cases. This study recommends the need to strengthen regulations related to medical record standards and protection of the confidentiality of medical information in the context of criminal law evidence.

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1. INTRODUCTION

Pointing to Pancasila and the 1945 Constitution, health is a human right and one of the elements of welfare that must be realized in accordance with the ideals and goals of Indonesia's national and the awakening of awareness of human rights, especially in the health sector, moreover, the higher the patient's knowledge, the doctor cannot be too free to treat the patient, but must pay attention to the patient's condition seriously[1]. Therefore, health is a human right, so the consequence of every activity and effort for the highest degree of public health is the principle of prudence and the principle of

[1] Nomensen Sinamo. Hukum Kesehatan dan Sengketa Medis, Jala Permata Aksara, Bekasi, p. 1.

non-discrimination, participation, protection and sustainability.[2] Health is once again very important and valuable. If a person is sick, the cost is very high, the meaning or essence inherent in human beings is an internal part of human existence and his life ideals[3].

Health and healthy living are the rights of everyone as part of a series (Articles 4, 5, 6, 7 and 8 of Law No. 36 of 2009) rights guaranteed by the state to its people. This includes access to health is also a right of everyone. In addition to access to medical treatment when sick, there is also access to get health information about oneself. In other words, people have the right to get information whether they are healthy or not and this is a right guaranteed by the government. In Article 12 of the Law, it is stated that "everyone is obliged to maintain and improve the health status of others for whom he is responsible." So it is better for individual people who want to live a healthy life to control themselves without being influenced by the behavior of the surrounding community[4].

Law and health are two different aspects. The law talks about the rules, the basis of the rules, then health talks about a person's condition whether he is healthy or not. A little similarity between law and health is that law and health both have references and indicators that can judge whether a person is right or wrong in the eyes of the law, and healthy or not in the eyes of health.

If these two aspects are combined, health law can be said to be a law related to health science which discusses the relationship between health workers and the community as patients. Patients and health workers have their own rights and obligations which are in accordance with what has been written and outlined in the existing Health Law. [5]

Health laws are relatively young when compared to other laws. in the form of rules and norms (rules) that aim to protect medical personnel such as doctors, dentists, nurses and patients as well as members of the public based on the 1945 Constitution, Law Number 29 of 2005, Law Number 36 of 2019 and others".[6] In this case, the element

[2] *Ibid*., p, 2
[3] *Ibid*., p, 3
[4] *Ibid*. p.9
[5] https:tahuntahunwww.bphn.go.idtahundatatahundocumentstahunkpd-2011-6.pdf
[6] Nomensen Sinamo. *Op.cit* hal 1.

of legal action is a statement of intent where a patient consents to medical action on his or her order by a doctor through informend consent.[7]

In health law, there is a rule that regulates the actions and obligations of one health worker, namely a doctor. The rules are made and outlined in a Medical Practice Law. In health law, there is also known as medical records. A medical record is a record made by a health worker, either a doctor or a nurse, which contains the condition of the patient who is undergoing treatment from the beginning of arrival to the current state of the patient. Medical records are records that contain very detailed information about health history (disease), patient personal data, type of treatment and so on which are complemented by signatures from related parties involved in it.[8]

Based on the existing legal rules in Indonesia, precisely the Regulation of the Minister of Health Number 269 of 2008 and Law No. 29 of 2004 states that all health facilities and health workers are required to make a medical record. A medical record is a record (*file*) that contains data related to a patient being treated as well as records that contain records (*history*) about medical traces given by doctors or health workers to the patient. Do not forget that in this medical record a valid sign is given which states that it is true that the doctor is treating the patient. Usually this valid mark is given in the form of the signature of a doctor or health worker associated with it.

Even legal experts have different and diverse perspectives on medical malpractice. The views of legal experts are also influenced by the legal knowledge they have. In other words, medical malpractice is often viewed only from one discipline, besides that knowledge and control of the law that are not the same cause differences in views on medical practice. Regarding the term related to this, literally, malpractice or practical malpractice means bad *practice* or bad practice. "The term malpractice is interpreted (translated) wrong in giving medicine, or wrong in terms of taking action on the handling of a patient's health.

The law in Indonesia is regulated in writing and the process is carried out with the existing system and contained in positive law. For criminal law, there is the Criminal Code which is a holy book to see whether an act is right or wrong. The Criminal Code is a formal law or a written law. As for implementing it, there is a material law, namely how the law is carried out which has been outlined in the Criminal Procedure Code.

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[7] *Ibid*. p.18

[8] https:years – years_of_mini.blogspot.com_tahun2015tahun08tahunrekam-medis-pengertian-tujuan-fungsi.html science

In the legal process in Indonesia, if there is a legal problem, it must be resolved by legal process. There are a series of flows that must be considered before being able to determine whether a person is guilty or otherwise. Starting from the investigation to the stages of imposing the verdict. However, before getting there, there is a evidentiary process that is used as a venue for competition for evidence to be able to convince the judge before making a verdict.

There are several types of evidence, namely expert testimony, evidence of defendant testimony, witness testimony, letter evidence and instructional evidence. The regulations regarding evidence have been explained in the Criminal Procedure Code as written in Article 184 Paragraph 1 where the content has been described.[9]

A medical record is a record (*file*) that contains everything related to medical procedures between a patient and related health workers. For example, the patient's disease history from the beginning to the present, the patient's personal data and the medical actions carried out by the doctor on the patient. Medical records in the world of medicine also apply to dentists. Because medical records are in the form of important health records, they must be done and recorded sequentially and chronologically so as not to cause confusion and are easy to understand by ordinary people who are not part of health workers. Medical records are very mandatory for a doctor and dentist in terms of carrying out their practice. That is the mandate that has been contained in Law Number 29 of 2004 concerning Medical Practice in Article 46.

In the Regulation of the Minister of Health Number 269 of 2008 concerning Medical Records, it is also stated that in terms of the duties and responsibilities of a doctor or dentist in carrying out his obligations is to make medical records that are only intended and given to patients about all personal data and medical actions that have been carried out and can be used as evidence if a problem occurs at some point.

Where the contents of the letter from the Medical Record can be used as valid evidence according to the law because it meets the criteria for a letter made on the oath of office of a doctor or dentist. In Article 184 paragraph 1 letter d, it is also stated that one of the evidence is instructions. It is further explained in Article 188 paragraphs 2 and 3 that clues can be obtained from witness statements, letters and statements of the defendant which are examined by the judge wisely and wisely with full care and fairness based on his conscience so that. give confidence to the judge on the evidentiary

[9] KUHP dan KUHP, p. 268

strength of the instructions. The grading of the instructions is left to the discretion of the judge. From the content of the above Article, it can be interpreted that if a doctor is accused of committing a criminal act and is submitted to the court as a defendant, the doctor's statement, letter and witness statement can provide instructions to the judge to prove.[10] the doctor is guilty or not. The letters used as evidence that may be able to alleviate the doctor include medical records. Based on the above background, the author is interested in researching and studying whether Medical Records are Valid Evidence based on the Criminal Code**.**

2. METHOD

Normative research is carried out by examining existing secondary data, namely primary, secondary and tertiary legal materials that are studied with literature research. Then to complete it, an approach will be carried out by analyzing the laws and regulations related to the problem. The type of data used by the researcher is *library research* which consists of various kinds of books or references, and document studies that can support the research. The data collection technique in this study is through literature studies by examining and analyzing secondary data related to the research being conducted. The data that has been collected, both secondary and primary data, is then analyzed qualitatively.

3. RESULTS AND DISCUSSION

Medical Records are Valid Evidence under the Criminal Code

Law and health are two different aspects. The law talks about the rules, the basis of the rules, then health talks about a person's condition whether he is healthy or not. A little similarity between law and health is that law and health both have references and indicators that can judge whether a person is right or wrong in the eyes of the law, and healthy or not in the eyes of health. If these two aspects are combined, health law can be said to be a law related to health science which discusses the relationship between health workers and the community as patients. Patients and health workers have their own rights and obligations which are in accordance with what has been written and outlined in the existing Health Law.[11] Health laws are relatively young

[10] Munir Fuady, 2006, Teori Hukum Pembuktian (Pidana dan Perdata), Publisher PT Citra Aditya Bakti, Bandung, p. 4

[11] https:tahuntahunwww.bphn.go.idtahundatatahundocumentstahunkpd-2011-6.pdf

when compared to other laws. in the form of rules and norms (rules) that aim to protect medical personnel such as doctors, dentists, nurses and patients as well as members of the public based on the 1945 Constitution, Law Number 29 of 2005, Law Number 36 of 2019 and others".[12] The subjects and objects in health law exist are about individual human beings and legal entities (*Recht Person*). Humans here are doctors or dentists and legal entities here are hospitals, both government hospitals and private hospitals. In fact, a legal subject can be defined as a legal entity or institution that can be burdened with legal acts, legal subjects can also acquire, have or bear rights and obligations.

While the object of law here is everything that is a legal relationship or everything that is the focus or purpose of the existence of a legal relationship, while legal acts can be defined as the actions of the subject of the law that are shown to cause legal consequences that are deliberately desired by the subject of law.[13] In this case, the element of legal action is a statement of intent where a patient consents to medical action on his or her order by a doctor through *informend consent* . In addition to legal objects, legal objects of legal acts are also highlighted in terms of legal relations and legal protection. We know that a legal relationship occurs because of a legal event, something that regulates and determines the rights and obligations of each party who has a legal relationship so that its interests are protected. Regarding this matter, it can be read in the section of Law Number 36 of 2009, both for the benefit of doctors and patients to receive appropriate and equal legal protection.[14]

Health and healthy living are the rights of everyone as part of a series (Articles 4, 5, 6, 7 and 8 of Law No. 36 of 2009) rights guaranteed by the state to its people. This includes access to health is also a right of everyone. In addition to access to medical treatment when sick, there is also access to get health information about oneself. In other words, people have the right to get information whether they are healthy or not and this is a right guaranteed by the government. In Article 12 of the Law, it is stated that "everyone is obliged to maintain and improve the health status of others for whom he is responsible." So it is better for individual people who want to live a healthy life to control themselves without being influenced by the behavior of the surrounding community.

[12] Nomensen Sinamo Hukum Kesehatan dan Sengketa Medis Jala Permata Aksara,Bekasi,p. 1.
[13] *Ibid*. p.17
[14] *Ibid*. p.18

Still in the same legal rule, precisely Article 9 says that all parties have the same obligation to create, improve and maintain the health status of the entire community to the highest level. This includes individuals and developments that prioritize health insights. Article 10 of Law Number 39 of 2009 states that all parties have an obligation to respect the property rights of others with the aim that everyone has a healthy environment, be it social, physical and biological.

Article 13 of Law Number 39 of 2009 states that everyone is obliged to participate in the social health insurance program which is regulated in accordance with laws and regulations. We know that in Law No. 40 of 2014 concerning BPJS Kesehatan is made as the implementer of the National Health Insurance (JKN).

It should be added that there are 4 factors that affect the status of health degrees, namely:

1. Lifestyle-related;
2. Relating to environmental factors, both social, economic, political and cultural;
3. Related to genetic factors (heredity);
4. Related to health service quality factors;

Therefore, it is better for people individually or independently who want to live a healthy life to control themselves without being influenced by the behavior of the surrounding community[15].

Literally, a medical record is a file in which there is a track record/history/*history* related to the medical information of a patient. It is called a medical record because the record is made or compiled based on an organized timeline or arranged based on the chronology of the patient's examination. In the medical world, medical records are classified into two types as regulated in the Minister of Health Regulation Number 269 of 2008 concerning Medical Records. If juxtaposed with the Criminal Procedure Code, there are two types of medical records that can be said to be medical records that can be used as evidence in trials, namely:

1. Conventional Medical Records

   Conventional medical records are records that contain traces of health records of a patient that are recorded and written in such a way that they are in accordance with the patient's medical history. As the name implies,

[15] *Ibid*. p6

there is a conventional word, meaning that this medical record is still recorded using a conventional system.

2. Electrical Medical Record.

   Regarding electrical medical records, there is actually no legal rule that contains details about electrical medical records. However, in fulfilling its obligations, an electric medical record is also required for hand bunches and must be well maintained for authenticity and confidentiality. This must also be in accordance with what has been mentioned in the Joint Commission International (JCI) as one of the international hospital accreditation bodies and the Electronic Code of Federal Regulations (e-CFR) beta test SITE. Regarding electronic signatures, the regulation, in accordance with Article 11 paragraph (2) of Law Number 11 of 2008 concerning Information and Electronic Transactions, will be regulated later. This does not exist yet. The use of information technology developments in general plays an important role in trade and economic growth.

Health laws are relatively young when compared to other laws. in the form of rules and norms (rules) that aim to protect medical personnel such as doctors, dentists, nurses and patients as well as members of the public based on the 1945 Constitution, Law Number 29 of 2005, Law Number 36 of 2019 and others". In this case, the element of legal action is a statement of intent where a patient consents to medical action on his or her order by a doctor through informend consent.

In health law, there is a rule that regulates the actions and obligations of one health worker, namely a doctor. The rules are made and outlined in a Medical Practice Law. In health law, there is also known as medical records. A medical record is a record made by a health worker, either a doctor or a nurse, which contains the condition of the patient who is undergoing treatment from the beginning of arrival to the current state of the patient. Medical records are records that contain very detailed information about health history (disease), patient personal data, type of treatment and so on which are complemented by signatures from related parties involved in it.

According to Permenkes Number 269 of 2008 & Law Number. 29 of 2004 Every health facility is required to make a medical record, made by a doctor and/or other related health personnel, must be made immediately and completed after the patient receives the service, and must be affixed with a signature providing the service.

In this case, if Medical Records as evidence are seen from a legal perspective in the Regulation of the Minister of Health Number 269/Menkes/Per/III/Year 2008 concerning Medical Records, Law Number 36 of 2009 concerning Health, Law Number 29 of 2004 concerning Medical Practice, Law Number 44 of 2009. Proof is a central point in the court where it proves a truth that actually happened. Proving is something that what we do can make people believe what we say. The process of proof in law is a series of processes that can make a person believe in the words, arguments and legal opinions expressed. Especially in a trial, because talking about the evidentiary process, we talk about the trial process where the parties are given the opportunity to prove to the judge.

In the Criminal Procedure Law, there are 4 theories about proof, namely

1. Positive legal proof (*Positiff Wettelijk Stelsel*).

   Basically, this theory states that good evidence is only based on the law, meaning that the judge is only given the authority to assess a proof only based on legal considerations, thus eliminating all subjective considerations of the judge himself.
2. Proof is based on the judge's conviction alone.

   According to this theory, a proof for one of the defendants or not is solely based on the judge's own beliefs.
3. Proof based on the judge's logical conviction *(conviction raisonnee*).

   This theory emphasizes a judge's conviction based on clear reasons.
4. Proof based on the law in the negative (*negatief wettelijk bewijs theotrie*)[16]

   It is a mixture of conviction raisonnee proof with a positive legal proof system. The formulation of this system is, whether or not a defendant is wrong is determined by the judge's conviction based on legal methods and evidence.

If referring to the Criminal Procedure Code 183, it is said that in Indonesia, the proof system used is a negative proof system according to the law. The panel of judges is only allowed to make a decision on the defendant in the trial if there are two valid pieces of evidence and there is a conviction of the judge stating that the defendant is guilty according to the existing legal rules. As has been described, the evidence in question is the testimony of witnesses, defendants, letters of instruction and expert statements.

[16] Tolib Effendi, The Basic Basis of Criminal Procedure Law (Development and Reform in Indonesia) (Malang equivalent to press 2014)

Proof is a crucial point in the trial because the evidence will show the panel of judges which party has made a mistake in the legal process. The burden of proof is given to the Prosecutor as the state's lawyer and to the defendant to prove that what was postulated to him was indeed wrong. For this reason, evidence is the main weapon that will be used by the parties to convince the judge who is proven and who is not.[17]

Proof will always exist in every type of law in Indonesia. Be it criminal law, civil law, constitutional law and health law and other laws. In health law, one of the evidence tools that has been often used is medical records. If going back to the explanation of medical records has a function as a patient's medical record, *a patient's medical track record* in a certain period of time, then medical records are very crucial evidence because they record all important things and aspects related to a patient's medical history. Interestingly, because this medical record is a scientific record from an expert (doctor), the medical record is evidence of expert testimony and letter evidence at the same time.[18]

During the examination by the investigator, the investigator is allowed to request medical records from the patient with a power of attorney signed Dasar Dasar Hukum Acara Pidana (Pembangunan dan Reformasi di Indonesia) (Malang setara pers 2014) by the patient as evidence from expert testimony. Health workers who are fully responsible for a patient are allowed to submit a medical record letter in the form of a copy to the investigator. It is also possible for health workers to provide a record that contains data that is in accordance with what is contained in the medical record.

Looking at the evidentiary system in our country which adheres to a negative legal proof system, medical record evidence, whether it is in its position as evidence of letters and expert testimony evidence, this medical record does not have binding evidentiary power. If interpreted, this medical record evidence is free or non-binding. The judge could have looked at the medical record but did not use it as a reference in making decisions at the trial.

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[17] Gerry Muhamad Rizki Criminal Code and Criminal Code (Constitutional Court Decision Letter No. 6/PUU-V/2007 concerning Amendments to Articles 154 and 156 in the Criminal Code) (Permata Press 2007) p. 268

[18] Regulation of the Minister of Health of the Republic of Indonesia, PERMENKES R.I. Number 585/MENKES/PER/IX/1989 concerning the Approval of Medical Measures Article 5.

The types of medical procedures that require written consent are as follows:[19]

1. Procedures that are invasive and operative or require anesthesia, either to establish a diagnosis or therapeutic measures;
2. Special treatment measures, such as cytostatic therapy or radiotherapy for cancer;
3. Specific actions related to medical research or clinical trials (related to bioethics) are not discussed in this medical skills activity.

Evidence in the context of formal criminal law is a tool (means) that can help find a true truth (material truth) The true truth that is sought or proven is about the circumstances of certain circumstances that have passed at the time of the event. In relation to the issue of proof, Article 14 of the Regulation of the Minister of Health of the Republic of Indonesia Number 749a/Menkes/Per/XII/1989 concerning Medical Records, emphasizes that Medical Records can be used as evidence in trials. Meanwhile, various types of evidence (legal) according to Article 184 of Law Number 8 of 1981 concerning the Criminal Procedure Law.

The conditions that must be met for the delegation of medical measures are as follows:[20]

1. The enforcement of the diagnosis, the administration or determination of therapy and the determination of indications must be decided by the doctor himself. Decision-making cannot be delegated. Only in the context of the implementation of the decision can authority be delegated, but the doctor is still responsible for delegating the authority.
2. Delegation of medical measures is only allowed if the doctor is absolutely sure that the delegate is capable of carrying it out properly.
3. Delegation must be done in writing, including clear implementation instructions, how to act if complications arise, and so on.
4. There must be medical guidance or supervision in its implementation. This supervision depends on the actions taken. Whether the doctor is in the place or can be called and come in a short time.
5. The person who wants to be handed over the delegation of authority has the right to refuse if they feel incapable of carrying out the medical procedure.

[19] Dental Universe Indonesia, "Informed Consent", http://www.dentaluniverseindonesia.com/home/62-persetujuan-tindakan-medik.html.
[20] Noor M Aziz. (2010). Laporan Penelitian Hukum tentang Hubungan Tenaga Medis, Rumah Sakit, dan Pasien. BPHN: Jakarta.

Indonesia adheres to the principle of negative proof where, it is not enough for a person to be declared proven to have committed a criminal act based on evidence that according to the law (in this case Article 184 of the Criminal Code) is cumulative, but also must still be accompanied by the judge's conviction. For the sake of proof in court, the doctor concerned can provide a photocopy of the Medical Record in addition to the conclusion.[21] In such a case, the investigator, may request a photocopy and conclusion of the Medical Record. In the event that the patient is admitted to the hospital, the request for a photocopy of the Medical Record is shown to the head of the hospital where the patient is treated.

Because evidence is a tool that is used to prove in the evidentiary hearing at the trial, it must be really used as well and as much as possible. Regarding medical records that are used as evidence, medical records can be evidence which can prove that there has been negligence from a doctor towards his patients. The opposite also applies. Medical records can be valid evidence if the doctor has carried out his obligations as a doctor to a patient who comes to him for treatment.

For example, if there is a suspicion of malpractice to a doctor, then the medical record can be used as evidence where when the judge looks at the medical record in order to see whether the allegation of malpractice to a doctor is true or otherwise. In other words, medical records can be used as evidence from a patient who makes accusations to a doctor that he has been negligent in carrying out his profession in accordance with the Occupational Operational Standards (SOP).

As for the doctor, if he is accused of malpractice on the patient's father, the medical record must be used as evidence which is used as much as possible to show the accusations that have been wrongly given to him. Medical records can be said to be evidence which can be the basis for legal protection and the basis for the doctor's defense. [22]

As mentioned above, in Article 184 of the Criminal Code, there are 5 types of evidence. Judging from the five pieces of evidence above, Medical Records fall into the category of witness testimony, expert testimony or letters. ? witness testimony according to Article 184 of the Criminal Code paragraph (1) explains that what is meant by witness testimony is what a witness states in the trial. Meanwhile, in criminal

[21] Ebta Setiawan, "Arti atau Arti Pembuktian" in http:// KBBI.web.id/arti atau arti pembuktian

[22] Bambang Poernomo, Hukum Kesehatan, Penerbit Program Pendidikan Pascasarjana, Fakultas Kedokteran, Magister Manajemen Rumah Sakit, Gadjah Mada University, Yogyakarta,

law there is a principle that reads *unus testis ullus testis* (one witness is not a witness), meaning that the information given by one witness is not enough to be used as a basis for stating the existence or absence of a person's negligence. Without any other evidence, the testimony is only considered sufficient if there is other supporting evidence such as expert testimony and others.[23]

In this case, proving the case in a case of malpractice in the medical field, the Medical Record can be categorized as a "letter evidence" in accordance with Article 184 of the Criminal Code, as well as as an "expert testimony". Medical Records used as evidence can be categorized as ''letter evidence'' because Medical Records are made in accordance with the provisions of Article 184 letter a of the Criminal Code[24].

The expert testimony referred to in Article 184 of the Criminal Code paragraph (2) is what an expert states in a court session. In the relationship between doctor and patient, the expert testimony referred to in Article 184 of the Criminal Code is biased, written or unwritten (oral), written expert testimony can be in the form of a medical *record* which is in a formal sense where it is a collection or record containing a course of disease and treatment or treatment of the patient. Meanwhile, in terms of material, the Medical Record is content in the form of personal data (identity), diagnosis, examination history and medical history. This has clearly been stated in Article 3 and Article 10 of the Indonesian Ministry of Health Regulation Number 269/Menkes/Per/III/2008 concerning Medical Records.

There is a need for an expert witness to deliver his testimony, must first take an oath or promise that will provide the best and most honest information without any coercion from any party and nothing is hidden. An expert witness must also be within the scope of medical science based on his knowledge and expertise. This is mandatory for the sake of justice as regulated in Article 179 paragraphs (1) and (2) of the Criminal Code. Even if the judge is convinced of the opinion, it can be used as a value of the strength of independent evidence and there is no requirement for the judge to accept the truth of the expert's testimony. Therefore, if the judge is not sure, the judge can ask for the testimony of other experts and can even be allowed to conduct a re-examination, with a personal composition that can be from another agency that has

[23] See Article 184. Paragraph (1) of the Criminal Code
[24] Bahder Johan Nasution, Hukum Kesehatan, Tanggung Jawab Dokter, Rineka Cipta, Jakarta 2005

expertise or authority in that field which has been regulated in Article 180 paragraphs (1) and (4) of the Criminal Code.

Regarding letter evidence, according to Article 187 of the Criminal Code, the evidence in question is a letter issued by official officials in the form of minutes, deeds, certificates or other letters that are related to a case that is being heard. The absolute requirement can be used as a letter as evidence in the trial, namely, the letter must be made by an official official on the oath of office or also strengthened by an oath. This is mandatory because the official who has the authority to make the letter does not need to appear in court in person, but the letter has been made based on the oath of office both orally and in writing to be conveyed in the trial of a case.

There is a need for an expert witness to deliver his testimony, must first take an oath or promise that will provide the best and most honest information without any coercion from any party and nothing is hidden. An expert witness must also be within the scope of medical science based on his knowledge and expertise. This is mandatory for the sake of justice as regulated in Article 179 paragraphs (1) and (2) of the Criminal Code. Even if the judge is convinced of the opinion, it can be used as a value of the strength of independent evidence and there is no requirement for the judge to accept the truth of the expert's testimony. Therefore, if the judge is not sure, the judge can ask for the testimony of other experts and can even be allowed to conduct a re-examination, with a personal composition that can be from another agency that has expertise or authority in that field which has been regulated in Article 180 paragraphs (1) and (4) of the Criminal Code.

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If health workers are harmed by the actions of another party, either intentionally or intelligently, then health workers can hold the party legally accountable, both

civilly, criminally, or administratively.[25] Regarding the issue of whether a doctor is suspected of committing medical malpractice, the Criminal Code regulates that fault is the most absolute element of criminal responsibility so that a person can be punished. Therefore, the relationship between guilt and crime becomes brightly illuminated, because guilt is the basis for a person's crime, which is usually called in Latin, *namely geen straaf zonder schuld* (no punishment without guilt). Medical records are an important element in the event of a malpractice case that a patient reports to his doctor. Medical records can be seen as important evidence that can explain an event.

From the information obtained related to medical records, the panel of judges in the trial can get a bright spot on the case of alleged malpractice by looking at and examining medical records that are used as evidence at the trial. The goal is clear in order to be able to see and determine whether the doctor who did commit malpractice or the patient was wrong and made accusations against the doctor. However, it must be remembered and clear that medical records can be seen and examined by a panel of judges, public prosecutors and others if medical records are used and presented in court as evidence by doctors or dentists which can prove that negligence has occurred or has not occurred by doctors or dentists.

4. CONCLUSION

Medical records both as evidence of expert testimony and as evidence of letters are free evidence. However, formally, evidence in the form of a Medical Record has a perfect value to be used as letter evidence. This means that on the one hand the Medical Record as evidence of a letter that has the evidentiary force that has the evidentiary force that has been listed in the Government Regulation of the Republic of Indonesia Number 26 of 1960 concerning the Recitation of the Doctor's Oath, on the other hand the Medical Record as evidence meets the elements required by Article 187 of the Criminal Code, namely based on what the doctor writes as the content of the Medical Record based on what he has experienced, and what he saw for himself.

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