MEDICAL RECORDS AND THE LAW

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AN ASPEN PUBLICATION

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AN ASPEN PUBLICATION®

1985

Gaithersburg, Maryland

Library of Congress Cataloging-in-Publication Data

Roach, William H.
Medical records and the law
"An Aspen publication."
Includes bibliographies and index.
1. Medical records – Law and legislation – United States.
I. Chernoff, Susan N. II. Esley, Carole Lange. III. Title,
[DNLM: 1. Medical Records – United States – legislation,
WX 33 AA1 R6M]
KF3827.R4R63 1985 344.73'041 85-3975
ISBN: 0-87189-098-4 347.30441

Editorial Services: Jane Coyle Garwood

Library of Congress Catalog Card Number: 85-3975
ISBN: 0-87189-098-4

Printed in the United States of America

9 10

MEDICAL RECORDS AND THE LAW

Acknowledgments

Producing this work while pursuing our professions proved for us to be a sizable enterprise, one we could hardly have managed without the help of others. We are most appreciative of research assistance furnished by the following law students who worked as summer associates at Gardner, Carton & Douglas: Mary Layne Ahern (DePaul University), S. Naseem Anjam (DePaul University); Stephanie E. Balcerzak (Yale University), Darien Creamer (DePaul University), Wendy Freyer (Northwestern University), Deborah L. Gersh (George Washington University), Edwin A. Getz (Washington University), Stephen G. Gilles (University of Chicago), Frederic R. Gumbinner (University of Michigan), Treazure Johnson (University of Virginia), Jonathan Levin (Northwestern University), Joyce McArdle (University of Chicago), Pamela Nehring (University of Pittsburgh), Paul J. Novack (University of Michigan), David D. Peterson, Jr. (Northwestern University), Michael Regier (University of Virginia), Jill Sugar (Northwestern University), Klaus U. Thiedmann (Cornell University), Ann L. Vix (University of Michigan), Adrian Von Hassell (Vanderbilt University), G. Andrew Watson (Northwestern University), Bettina Weis (Vanderbilt University), Steven Wright (University of San Diego), and Cora Yang (New York University). In addition, Robin C. Friedman, James D. McDonough, Helen J. McSweeney, and Thaddeus J. Nodzenski, associate attorneys, and Patrice Maloney, a legal assistant, all of Gardner, Carton & Douglas, were extremely helpful in providing legal research for the project.

Frank Pace, Director of Medical Records at Michael Reese Hospital and Medical Center in Chicago and an experienced records practitioner and teacher, gave us his considered and careful evaluation of the manuscript. Cheryl K. Smith, RRA, Director of Medical Information Service at Penobscot Bay Medical Center, reviewed an early manuscript and gave us useful direction for the final work. Our inestimable secretaries, Mary L. Born, Rose Davis-Duffy, Danielle LaVine, Marcia Neilis, Deborah Raymond, and Genevieve Perpall, were throughout

understanding, tireless, and patient. The director of the Word Processing Center at Gardner, Carton & Douglas, Pat Agema, and her staff provided valuable assistance in producing the manuscript. Our editor, Michael Brown, gave us unending encouragement with unfailing patience. To all these individuals we are deeply indebted.

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May 1985

Note on Legal Citations

This book includes references to numerous court decisions. The numbers and letters following each case name indicate where to find the court's decision in the volumes of cases contained in law libraries. The name, numbers, and letters together are called the *citation* for the decision. For example, in *Natanson v. Kline,* 186 Kan. 393, 350 P.2d 1093 (1960), "P.2d" is the abbreviation for the reporter system: it means the *Pacific Reporter, Second Series*. The first number, 350, refers to volume 350 of the *Pacific Reporter, Second Series*. The next number, 1093, is the page number in volume 350. The date of the decision is given in parentheses. Sometimes the case is reported in more than one reporter system, so there will be another set of numbers and letters before the parentheses. Here, the decision is reported also in volume 186 of the *Kansas Reports* at page 393.

Where there is another set of numbers and letters after the parentheses, they refer to another court's decision concerning the same case. If the second court is a higher court, it will be preceded by letters such as *aff'd, rev'd*, or *cert. denied*, which indicate that the court affirmed, reversed, or declined to review the lower court's decision. *Mikel v. Abrams*, 541 F. Supp. 591 (W.D. Mo. 1982), *aff'd* 716 F. 2d 907 (8th Cir. 1983), shows that this case was decided in 1982 by the Federal District Court for the Western District of Missouri, whose decision may be found in volume 541 of the *Federal Supplement* reporter at page 591, and that the Federal Court of Appeals for the Eighth Circuit affirmed the lower court's decision in 1983. The appellate court's decision can be found in volume 716 of the *Federal Reporter, Second Series*, at page 907. In some situations the order of the references is reversed, so that the higher court is listed first. In those situations the abbreviations will be *aff'ing* or *rev'ing*, indicating whether the higher court is affirming or reversing the lower court.

Decisions are found in numerous reporter services, and citations vary widely. If you are looking for a particular decision, ask your law librarian or your legal counsel to assist you.

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Chapter 1

Patient Record Requirements

RECORDS THAT MUST BE KEPT

The medical record consists of four types of data concerning an individual patient: (1) personal, (2) financial, (3) social, and (4) medical. Personal information is usually obtained upon admission and will include name, birth date, sex, marital status, next of kin, occupation, identification of physicians, and other items needed for specific patient identification. Financial data include the name of the patient's employer, the patient's health insurance company, types of insurance and policy numbers, Medicare and Medicaid numbers, if any, and other information that will enable the hospital to bill for its services. Social data include the patient's race and ethnic background, family relationships, life style, any court orders or other directions concerning the patient, community activities, and other information related to the patient's position in society. Medical data form the patient's clinical record, a continuously maintained history of the treatment provided to the patient in the hospital. These data include the results of physical examinations, medical history, the treatment administered, progress reports, physician's orders, clinical laboratory reports, x-ray reports, consultation reports, anesthesia record, operation record, signed consent forms, nurses' notes, and other reports that may be generated during the patient's treatment.[1]

The medical record may be written, typed, or computer generated. The computerized record can aid the information network on a patient, enhancing completeness and accuracy as well as immediate availability of the record to authorized personnel.[2] Whether written, typed, or in computer form, the medical

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[1]*See* K. WATERS & G. MURPHY, MEDICAL RECORDS IN HEALTH INFORMATION, 39–95 (1979).

[2]*See generally* Wynstra, *Computerized Medical Records: Legal Problems and Implications*, 2:2 TOPICS IN HEALTH RECORD MANAGEMENT, 75–84, (Dec. 1981).

record should be a complete, accurate current record of the history, condition, and treatment of the patient and the results of the patient's hospitalization.

The medical record is used not only to document chronologically the care rendered to the patient, but also to plan and evaluate the patient's treatment and to enhance communication among the patient's physician and other health care professionals treating the patient. The record also provides clinical data for medical, nursing, and scientific research. In addition, individuals who conduct medical and nursing audits and peer review evaluations rely heavily on documentation in medical records.

Hospital medical records are also important legal documents to the hospital and the patient. For example, where hospital bylaws designate standards of care to be established by individual departments, examination of patient records can provide verification that the standards are being maintained. Also, administrative and clinical assessment programs may be targets of legal scrutiny, and patient records can again aid evaluation and justification of the programs.[3]

The key to the importance of medical records as legal documents is that they are essential to the defense of professional negligence actions. Since such actions are often litigated two to five years after the plaintiff received the treatment in question, the hospital record is frequently the only detailed record of what actually occurred during the hospitalization. Persons who participated in the plaintiff's treatment may not be available to testify on behalf of the defendants or may not remember important details of the case. A good record enables the hospital to reconstruct the patient's course of treatment and to show whether the care provided was acceptable under the circumstances.[4] The contents of the hospital record are usually admissible in evidence for or against the hospital and physicians. It is essential that everyone involved in medical record documentation and management understand the legal implications of the record so that they will create and maintain a record that will be useful to them in any future litigation. (For a discussion of admissibility of medical records, see Chapter 5.)

LEGAL REQUIREMENTS FOR CONTENT OF A MEDICAL RECORD

The requirement that hospitals maintain medical records is found in state and federal statutes and regulations, municipal codes, and hospital accreditation

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[3]*See* K. WATERS & G. MURPHY, *supra* note 1, at 247.

[4]*See, e.g.*, Foley v. Flushing Hosp. and Medical Center, 34 N.Y. 2d 863, 359 N.Y.S. 2d 113 (1974) (infant plaintiff's medical records provided evidence sufficient to prevent dismissal of malpractice suit).

standards. In a few states, hospital-licensing statutes set forth the minimum record requirements.[5] The Utah statute is illustrative:

§26–15–58 Licenses—Minimum Requirements

> . . . In order to qualify as a licensed hospital, the following minimum requirements must be met:
> . . . (4) All tissues removed at surgery must be submitted for examination to a pathologist approved by the department [of health] and the pathologist's written report shall be made part of the permanent record of each patient operated upon.
> (5) Each patient shall have a clinical record which shall include: detailed clinical history, description of physical examination, reports of laboratory tests and of pathology and X-ray examinations, admission (provisional) and prerogative diagnosis, clear description of treatments given, including all operative procedures, postoperative diagnosis, progress notes by the physician, final complete diagnosis, and results of treatment at the time of discharge from the hospital and other reports as specified by the department in regulations. These records shall be properly indexed and filed in the hospital.[6]

In most states, the regulatory agency for hospitals has the power to promulgate rules and regulations governing the content of hospital medical records.[7] These rules and regulations set forth the specific information that must be kept in medical records of a licensed hospital.[8] The pertinent Illinois regulation, for example, reads:

> For each patient there shall be an adequate, accurate, timely, and complete medical record. Minimum requirements for medical record content are as follows: patient identification and admission information; history of patient as to chief complaints, present illness and pertinent past history, family history, and social history; physical examination report; provisional diagnosis; diagnostic and therapeutic reports on laboratory tests results, x-ray findings, any surgical procedure per-

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[5]*See, e.g.*, N.Y. Pub. Health Law §4165 (McKinney 1977); Tenn. Code Ann. §68–11–302 (1983).

[6]Utah Code Ann. §26–15–58 (1953).

[7]*See, e.g.*, Mass. Gen. Laws Ann. ch. 111, §70 (West Supp. 1983); Miss. Code Ann. §41–9–63 (1972).

[8]*See, e.g.*, Tenn. Minimum Standards and Regulations for Hospitals ch.1200.8.3.05; Rules and Regulations for the Licensure of General and Special Hospitals in Virginia §208.6 (1982); Wash. Hosp. Rules and Regulations §248–18–440 (1979).

> formed, any pathological examination, any consultation, and any other diagnostic or therapeutic procedure performed; orders and progress notes made by the attending physician and when applicable by other members of the medical staff and allied health personnel; observation notes and vital sign charting made by nursing personnel; and conclusions as to the primary and any associated diagnosis, brief clinical resume, disposition at discharge to include instructions and/or medications and any autopsy findings on a hospital death.[9]

State licensing regulations are divided into three groups: those detailing specific information required; those specifying the broad areas of information required; and those stating simply that the medical record shall be adequate, accurate, or complete.[10] (The state licensing regulations are summarized in Appendix B.)

The law and regulations setting forth conditions of participation in federal reimbursement programs also require hospitals to maintain medical records and specify minimum content requirements for such records. The conditions of participation in Medicare programs state that:

> The medical records contain sufficient information to justify the diagnosis and warrant the treatment and end results. The medical records contain the following information: Identification data; chief complaint; present illness; past history; family history; physical examination; provisional diagnosis; clinical laboratory reports; X-ray reports; consultations; treatment, medical and surgical; tissue report; progress notes; final diagnosis; discharge summary; autopsy findings.[11]

In some cities, municipal codes require certain information not otherwise required by state law or regulation.[12] In addition, some state statutes have special provisions concerning certain specific types of information to be maintained. In Illinois, for example, there is a special section of the Public Health Statutes that

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[9]Ill. Hosp. Licensing Requirements §12–1.2(b) (1979).

[10]Arkansas, California, Colorado, Georgia, Idaho, Maryland, Massachusetts, Michigan, Nevada, New Mexico, New York, North Carolina, Tennessee, Utah, Washington, West Virginia, Wisconsin, Wyoming, and Puerto Rico have detailed provisions. Alabama, Alaska, Florida, Illinois, Kansas, Louisiana, Minnesota, Mississippi, Missouri, Montana, Nebraska, New Hampshire, New Jersey, Oregon, Rhode Island, South Dakota, and Vermont specify broad areas. Arizona, Connecticut, Hawaii, Indiana, Iowa, Kentucky, Maine, Ohio and Virginia contain only a general statement.

[11]42 U.S.C. §1395x(e)(2) (1974); 42 C.F.R. §405.1026(g) (1982).

[12]*See, e.g.*, Chicago, Ill., Code §137–14 (1978).

requires retention of x-rays "as part of the regularly maintained records" for a period of five years.[13]

The Joint Commission on Accreditation of Hospitals (JCAH) requires hospitals to maintain patient care records as a standard of accreditation.

> An adequate medical record shall be maintained for every individual who is evaluated or treated as an inpatient, ambulatory care patient, or emergency patient, or who receives patient services in a hospital-administered home care program.[14]

The JCAH also specifies in considerable detail the information that should appear in the medical record.[15] In the absence of specific statutory or regulatory direction, hospitals should adopt institutional policies concerning the content of medical records. The policy may be a detailed list of data required, or may reference some other policy, such as the JCAH standards and interpretations. Generally, detailed policies require closer periodic review to keep them current, while broad policies remain applicable as circumstance and practice change. Hospitals should balance the need for providing enough specificity to guide medical records practitioners and hospital staff against the desire to avoid continual policy revisions. Most accredited hospitals in states that provide no statutory or regulatory direction concerning patient record content rely on the JCAH accreditation standards as a guide to record content policy.

In all states, however, hospitals should keep abreast of state, federal, and JCAH medical records requirements. State and local associations of medical record practitioners often publish changes in the applicable law and accreditation standards. Hospitals also receive notice of these changes from state and national hospital associations and from hospital legal counsel. All health care institutions should develop reliable ways of communicating new laws and regulations to the individuals responsible for making policy recommendations concerning medical record content, particularly to medical record practitioners and the medical staff.

In addition, these individuals should understand the various functions of the medical record and their interrelationships as well as how those functions are affected by the nature of the specific institution and current legislative, regulatory, and licensing requirements. Creating effective record content policy requires the involvement of a variety of disciplines within the institution. Policy makers must be willing to find ways to make practical adjustments to medical record content. In

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[13]Ill. Ann. Stat. ch. 111–1/2, §157–11 (Smith-Hurd 1977).

[14]Joint Commission on Accreditation of Hospitals, Accreditation Manual for Hospitals 79 (1984).

[15]*Id.* at 84–88.

doing so, they should strike a balance between the administrative, financial, and other demands placed upon the medical record and the record's basic patient care function.

RECORD RETENTION REQUIREMENTS

The length of time a medical record is retained will be determined by federal or state law and regulations, or by sound hospital administrative policy and medical practice. It will also be greatly influenced by the nature of the institution and resources available to maintain a long retention period. Achieving a practical and workable solution to medical record retention policy becomes more difficult in an era of reduced financial resources. In the past, state-of-the-art microfilming and computer systems were considered a means for improving the medical information collection and retention capabilities of the organization. The extent to which that solution can be applied becomes a question of trading the cost of that solution off against the cost of basic patient care needs for a growing number of organizations today. Certainly expenditures for medical record retention are being more closely scrutinized to determine the clear justification and cost/benefit ratios. The cost of originating and maintaining records in any form will be looked at more closely as the institution's financial performance becomes more critical. With that scrutiny will come the review of basic assumptions concerning medical record content and maintenance with a more clear differentiation between the "need to have" and the "nice to have." These kinds of questions cannot be answered without a good understanding of the statutory and regulatory requirements governing medical record maintenance and the record's various functions in the health care environment.

The hospital-licensing acts and regulations of a few states establish specific medical record retention requirements that govern medical records generally[16] or certain parts of the medical record, such as x-rays.[17] (See Appendixes A and B.) Some states have established different retention requirements for different classifications of patients, such as minors, the mentally ill, and the deceased.[18] Several state regulations require hospitals to keep records in accordance with hospital policy for a period equal to the statute of limitations for contract or personal injury actions.[19] In four states that have adopted the Uniform Preservation of Private

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[16]*See, e.g.*, N.M. Stat. Ann. §14–6–2 (1978), 7 Pa. Admin. Bull. 3657 (1977).

[17]Ill. Ann. Stat. ch. 111–1/2, §157–11 (Smith-Hurd 1977); Tenn. Minimum Standards and Regulations for Hospitals ch. 1200.8.3.05(3)(b).

[18]Miss. Code Ann. §41–9–69 (1972): Rules and Regulations for the Licensure of General and Special Hospitals in Virginia §208.9 (1977).

[19]Ill. Hosp. Licensing Requirements §12–1.4 (1979); N.M. Licensing Regulations, pt. 2, at H24 (1965); N.C. Hosp. Licensing Regulations, pt. XIII, §.1400 *et seq.* (1964).

Business Records Act,[20] the three-year records preservation requirement of the act may apply to the medical records of private hospitals, even though there are no specific statutory medical records retention provisions. As a condition of participation in federal reimbursement programs, hospitals must retain their medical records for a period "not less than that determined by the statute of limitations in the respective State,"[21] presumably the statute of limitations for tort actions. However, discharge summaries and clinical and other medical records relating to Medicare health insurance claims must be retained for "a period of five years after the month the cost report to which the materials apply is filed with the intermediary."[22]

In the absence of regulatory requirements, each hospital should establish its own policy governing medical records retention. It is clear that hospitals should retain medical records for as long as there is a medical or administrative need for them, e.g., for subsequent patient care, medical research, review and evaluation of professional and hospital services, and defense of professional or other liability actions.

There are several factors that the hospital should consider in establishing a retention policy: statutory and regulatory requirements, statutes of limitations and future litigation, extent of medical research, storage capabilities, microfilming and other processes, and recommendations of hospital associations.

Clearly, the hospital must first comply with all applicable statutory and regulatory retention requirements. Where the hospital considers it prudent to have a retention period longer than statutory or regulatory requirements, however, it may establish one.

It has often been suggested that a key factor to be considered when establishing a record retention policy is the statute of limitations on contract and tort actions. Except in the case of minors' records, retaining the record for the longer limitations period would not likely impose a burden on the hospital medical records department, since limitations periods are generally shorter than the period the record would be retained for medical reasons. If the statute of limitations were used as a guide, the medical record of a minor would have to be kept until the patient reached the age of majority plus the period of the statute. In states in which the age of majority is 18 years and the statute of limitations for torts is 2 years, the retention period for a newborn's record would be 20 years. While the possibility

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[20]Ill. Ann. Stat. ch. 116, §59–64 (Smith-Hurd Supp. 1980); Md. Ann. Code art. 15B, §1–6 (1976); N.H. Rev. Stat. Ann. §§337–A:1–337–A:6 (1966); Okla. Stat. Ann. tit. 67. §§251–256 (West Supp. 1983–84).

[21]42 C.F.R. §405.1026(b) (1982).

[22]1 MEDICARE AND MEDICAID GUIDE (CCH) 6420.85 (1983).