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# To Retain or Destroy--That is the Health Care Records Question

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# TO RETAIN OR DESTROY? THAT IS THE HEALTH CARE RECORDS QUESTION

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## I. INTRODUCTION

The following scenarios occur daily in many hospitals: the patient seeks medical records to substantiate a claim of personal injury; the state issues a subpoena to discover medical records containing the results of blood-alcohol tests; and a lawyer seeks discovery of nonparty patients' medical records who have undergone similar treatment by the defendant physician.<sup>1</sup> The maintenance and

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<sup>1</sup> The following courts have held that the medical records of other patients of the defendant are discoverable in medical malpractice actions where such identifying information as names and addresses are deleted: *Ziegler v. Superior Court In and For Pima County*, 656 P.2d 1251 (Ariz. Ct App. Div. 2 1982) (court sanctioned the disclosure of medical records of other patients who had undergone pacemaker implantations); *Cochran v. St. Paul Fire and Marine Ins. Co.*, 909 F. Supp. 641 (W.D. Ark. 1995) (holding that medication incident reports, kept by the defendant hospital when the medication differed from the physician's orders, were discoverable); *Community Hospital Ass'n v. District Court In and For Boulder County*, 570 P.2d 243 (Colo. 1977) (discovery of medical records concerning patients on whom surgeon had performed operation did not violate the physician-patient privilege); *Amente v. Newman*, 653 So. 2d 1030 (Fla. 1995) (holding that medical records of obese nonparty patients did not violate patients' rights of privacy and confidentiality due to protection by the requirement that all identifying information be redacted); *Terre Haute Regional Hosp., Inc. v. Trueblood*, 600 N.E.2d 1358 (Ind. 1992); and *Tanzi v. St. Joseph Hosp.*, 651 A.2d 1244 (R.I.

management of medical records perplexes both the health care industry and the legal system. All health care organizations must keep complete medical records to ensure quality care is given to patients, to comply with federal and state laws, and to minimize exposure to medical malpractice liability.<sup>2</sup>

This comment undertakes a study of West Virginia and federal law and hospital practices in this state as they relate to the hospitals' handling of such documents. The West Virginia Supreme Court of Appeals has declined to determine if hospitals have a duty to preserve medical records,<sup>3</sup> and the West Virginia Legislature has not passed a bill that would permit the destruction of medical records. Two concerns that arise when considering the destruction of medical records are the legal ramifications of destroying them and the possible effect that it may have on the quality of patient care. This comment further addresses whether the West Virginia Legislature should pass a bill regarding retention and destruction of medical records, summarizes the retention statutes of other states, reports inquiries regarding the record retention practices of several West Virginia hospitals, and discusses the potential impact of computer-based records on the hospitals' retention practices.

## II. QUALITY OF PATIENT CARE

The retention of patient health information<sup>4</sup> is integral to providing continued patient care, and supports research, education, and other concerns. For example, in *Harrison v. Davis*,<sup>5</sup> Ms. Harrison's infant daughter, Meagan, died the day after birth in February 1989.<sup>6</sup> In 1993, Ms. Harrison became pregnant with another child.<sup>7</sup> As a result of Ms. Harrison's history of an infant death, her obstetrician requested Meagan's medical records and autopsy report from Raleigh

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1994). On the other hand, the courts held that redacted medical records were not discoverable in the following medical malpractice actions: *Parkson v. Central DuPage Hosp.*, 435 N.E.2d 140 (Ill. 1st Dist. 1982) (holding that redacted nonparty patients' records are not available because even if the names are deleted, the possibility of recognition exists); and *Glassman v. St. Joseph Hosp.*, 631 N.E.2d 1186 (Ill. 1st Dist. 1994) (stating that records were protected by patient-physician privilege and that patients' confidentiality might be compromised, even with deletion of identifying information). See also Annotation, *Discovery, in Medical Malpractice Action, of Names and Medical Records of Other Patients to Whom Defendant Has Given Treatment Similar to That Allegedly Injuring Plaintiff*, 66 A.L.R.5th 591 (2000).

<sup>2</sup> See *infra* note 78 and accompanying text.

<sup>3</sup> *Harrison v. Davis*, 478 S.E.2d 104 (W. Va. 1996).

<sup>4</sup> "Health information" is "information, whether oral or recorded in any form or medium, that (A) is created or received by a health care provider, health plan, public health authority, employer, life insurer, school or university, or health care clearinghouse; and (B) relates to the past, present, or future physical or mental health or condition of an individual, the provision of health care to an individual, or the past, present, or future payment for the provision of health care to an individual." 42 U.S.C. § 1320d(4) (2001); 45 C.F.R. § 160.103 (2000).

<sup>5</sup> 478 S.E.2d 104 (W. Va. 1996).

<sup>6</sup> See *id.* at 107.

<sup>7</sup> See *id.*

General Hospital to potentially prevent the death of her next child.<sup>8</sup> Raleigh General, however, no longer had the fetal monitor strips from Ms. Harrison's labor and delivery.<sup>9</sup> Although the trial court in *Harrison* issued, and our Supreme Court of Appeals affirmed, a decision that the statute of limitations prevented plaintiffs' claims due to the plaintiffs' failure to exercise reasonable diligence in discovering Meagan's injuries,<sup>10</sup> the factual scenario in *Harrison* is an example of an instance where patient needs were compromised by the destruction or loss of records despite the fact that the record destruction was not actionable.

### III. STATE RETENTION STATUTES

The variability in federal and state law requirements for the retention and destruction of medical records, as well as the fact that some states have record retention statutes and regulations and some do not, make it difficult for West Virginia to specify a single retention period. State laws concerning the retention of medical records vary considerably. Some states that allow destruction of records require notification of patients, prior approval of a state agency, specific methods of destruction, and/or an abstract prior to destruction, or prohibit destruction altogether.<sup>11</sup> Due to storage and fiscal restraints, several states have found it necessary to pass retention statutes. State retention statutes differ with regard to the following: identification of hospitals or health care providers, specification of retention periods, treatment of radiological images, cessation of practice, and prohibition of destruction.

#### A. *Hospitals or Health Care Providers*

One way that state retention statutes differ is with regard to which entities the statute applies. Most laws mention "hospitals" specifically, while others refer generally to "health care providers."<sup>12</sup> For example, the retention statutes of Illinois,<sup>13</sup> Louisiana,<sup>14</sup> Minnesota,<sup>15</sup> Mississippi,<sup>16</sup> New Mexico,<sup>17</sup> Tennessee,<sup>18</sup> and

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<sup>8</sup> See *id.*

<sup>9</sup> See *id.*

<sup>10</sup> See *Harrison*, 478 S.E.2d at 106-07.

<sup>11</sup> See *infra* notes 51-54 and accompanying text.

<sup>12</sup> 42 U.S.C. § 1320d (3) (2000) defines a "health care provider" as "a provider of services . . . , medical or other health services . . . , and any other person furnishing health care services or supplies." Regulations provide: "Health care provider means a provider of services (as defined in section 1861(u) of the Act, 42 U.S.C. 1395x(u) (2000), a provider of medical or health services (as defined in section 1861(s) of the Act, 42 U.S.C. 1395x (s) (2000)), and any other person or organization who furnishes, bills, or is paid for health care in the normal course of business." 45 C.F.R. § 160.103 (2001).

<sup>13</sup> 210 ILL. COMP. STAT. 85/6.17 (West 2000).

<sup>14</sup> LA. REV.STAT. ANN. § 40:2144 (F)(1) (2000).

Washington<sup>19</sup> mention “hospitals,” while the statutes of Arizona<sup>20</sup> and Hawaii<sup>21</sup> refer to “health care providers.” On the other hand, the Virginia statute does not mention “hospitals” or “health care providers,” but rather this statute applies to “public agencies acting as custodians of medical records.”<sup>22</sup> The Arizona statute refers generally to “health care providers,” but the retention period is shorter for nursing care institutions than for other health care providers.<sup>23</sup> The Hawaii statute also refers to “health care providers;” however, this statute lists the records exempt from the retention requirement.<sup>24</sup> In reading the state retention statutes, unless otherwise specified by the statute, the rules are the same for both hospitals and office settings. In sum, the state retention statutes vary considerably with regard to whether it applies to hospitals or health care providers.

### B. Retention Periods

Another variation among state retention statutes is the stipulated retention

<sup>15</sup> MINN. STAT. § 145.32 (2000). The Minnesota statute permits “hospitals” to divest and destroy portions of the medical record that do not comprise an individual permanent record after seven (7) years without transfer to photographic film. *Id.* After three years (3) if the records have been transferred and recorded, hospitals may destroy the records with consent of the superintendent or other chief administrative officer of any public or private hospital and with the consent and approval of the board of directors or other governing body of the hospital. *Id.* “Individual permanent medical record” includes outpatient diagnostic and laboratory results. *Id.*

<sup>16</sup> MISS. CODE ANN. § 41-9-69 (1) (2000).

<sup>17</sup> N.M. STAT. ANN. § 14-6-2 (A) (2000). Retention in microfilm or other photographically reproduced form shall be deemed to be in compliance. *Id.*

<sup>18</sup> TENN. CODE ANN. § 68-11-305 (a)(1) (2000).

<sup>19</sup> WASH. REV. CODE (ARCW) § 70.41.190 (West 2000).

<sup>20</sup> ARIZ. REV. STAT. § 12-2297 (A)(1) (2000).

<sup>21</sup> HAW. REV. STAT. § 622-58 (a) (2000). The Hawaiian statute mandates that “health care providers” computerize or minify medical records by the use of microfilm or any other similar photographic process and that the original or reproduced form be retained for a minimum of seven (7) years after the last data entry except in the case of minors whose records shall be retained for seven (7) years after the minor reaches majority. *Id.* After the seven-year retention period or minification, the medical records may be destroyed. *Id.* at (d).

<sup>22</sup> VA. CODE ANN. § 42.1-79.1 (2000).

<sup>23</sup> Arizona requires that a “health care provider” retain adult medical records for at least (7) seven years after the last date the adult patient received services from that provider. ARIZ. REV. STAT. § 12-2297 (A)(1) (2000). A nursing care institution shall retain patient records for five (5) years after the date of discharge. *Id.* § (C).

<sup>24</sup> “Records exempt from the retention requirement are: public health mass screening records; pupils’ health records and related school health room records; preschool screening program records; communicable disease reports; and mass testing epidemiological projects and studies records; including consents; topical fluoride application consents; psychological test booklets; laboratory copies of reports, pharmacy copies of prescriptions, patient medication profiles, hospital nutritionists’ special diet orders, and similar records retained separately from the medical record but duplicated within it; public health nurses’ case records that do not contain any physician’s direct notations; social workers’ case records; diagnostic or evaluative studies for the department of education or other state agencies.” HAW. REV. STAT. § 622-58 (b) (2000).

period. Some state laws stipulate a retention period for all medical records, while others specify different retention periods for adults, minors, disabled persons, survivors of a potential wrongful death action,<sup>25</sup> persons involved in pending litigation,<sup>26</sup> etc. Some states require that adult medical records be retained for at least seven (7) years,<sup>27</sup> while other states mandate a retention period of ten (10) years.<sup>28</sup> The states that stipulate a discrete retention period for minors usually require the records be retained for a specified number of years upon reaching the age of majority.<sup>29</sup> Similar to the retention period for minors, the retention period for disabled persons is generally a stated number of years after the removal of the disability or a stipulated number of years after the last treatment, whichever is longer.<sup>30</sup>

<sup>25</sup> The Mississippi statute states that complete "hospital records shall be retained . . . for the period of minority or other known disability of any survivors in all cases where the patient was discharged at death, or is known by the hospital to have died within thirty (30) days after discharge, and the hospital has reason to believe that such patient or former patient left one or more survivors under disability of minority or otherwise who may be entitled to damages for wrongful death of the patient." MISS. CODE ANN. § 41-9-69 (1) (2000).

<sup>26</sup> The Illinois and Louisiana statutes, unlike other statutes, address the problem of pending litigation. The 1999 amendment, effective January 1, 2000, added subsection (c) to the Illinois statute:

(c) Every hospital shall preserve its medical records in a format and for a duration established by hospital policy and for not less than 10 years, provided that the hospital has not been notified in writing by an attorney before the expiration of the 10 year retention period that there is litigation pending . . . then the hospital shall retain the record of that patient until notified in writing by the plaintiff's attorney, with approval of the defendant's attorney of record, that the case in court involving such record has been concluded or for a period of 12 years from the date that the record was produced, whichever occurs first in time. 210 ILL. COMP. STAT. 85/6.17 (West 2000).

The Louisiana statute requires that hospital records be retained for longer periods of time when requested in writing by "legal counsel for a party having an interest affected by the patient's medical records." LA. R.S. 40:2144 (F)(2)(c) (2000).

<sup>27</sup> See, e.g., ARIZ. REV. STAT. § 12-2297 (A)(1) (2000), HAW. REV. STAT. § 622-58 (a) (2000), 210 ILL. COMP. STAT. 85/6.17 (West 2000), LA. REV. STAT. ANN. 40:2144 (F)(1) (2000), MINN. STAT. § 145.32 (2000).

<sup>28</sup> See e.g., 210 ILL. COMP. STAT. 85/6.17 (2000); LA. REV. STAT. 40:2144 (F)(1) (2000); MISS. CODE ANN. § 41-9-69 (1) (2000); N.M. STAT. ANN. § 14-6-2 (A) (2000); TENN. CODE ANN. § 68-11-305 (a)(1) (2000); VA. CODE ANN. § 42.1-79.1 (2000); WASH. REV. CODE § 70.41.190 (West 2000).

<sup>29</sup> See ARIZ. REV. STAT. § 12-2297 (A)(2) (2000) (requiring health care providers to retain the minor's medical records for whichever date occurs last of the following situations: at least three years after the child's eighteenth birthday or at least seven years after the last date the child received services from that provider); HAW. REV. STAT. § 622-58 (a) (2000) (mandating that, in the case of minors, records shall be retained for seven years after the minor reaches majority); MINN. STAT. § 145.32 (2000) (requiring the records of minors to be maintained for seven years following the age of majority); MISS. CODE ANN. § 41-9-69 (1) (2000) (stating that the records of minors be retained for the period of minority plus seven additional years, but not to exceed twenty-eight years); TENN. CODE ANN. § 68-11-305 (a)(2) (2000) (stipulating that the records of minors be retained for the period of minority, plus one year, or ten years following the discharge of the child, whichever is longer); VA. CODE ANN. § 42.1-79.1 (2000) (indicating that the medical records of minors be retained for a minimum of five years following the last date of contact, whichever comes later); WASH. REV. CODE § 70.41.190 (West 2000) (requiring the records of minors to be preserved for a period of no less than three years following attainment of the age of eighteen years, or ten years following such discharge, whichever is longer).

<sup>30</sup> See MISS. CODE ANN. § 41-9-69 (1) (2000) (stating that the records of patients under known disability be retained for the period of disability plus seven additional years, but not to exceed twenty-eight

State laws concerning the retention of medical records vary considerably. For instance, in Massachusetts, hospital records must be retained for thirty (30) years after the patient's discharge or final treatment.<sup>31</sup> The scope of discovery rules in other states means that records should conceivably be held indefinitely. Furthermore, evidence of fraud could extend the statute of limitations indefinitely. The American Medical Association (AMA) recommends that physicians keep patients' charts for five to seven years from the last office visit,<sup>32</sup> whereas the American Health Information Management Association (AHIMA) recommends that patient health/medical records be retained for ten (10) years after the most recent encounter.<sup>33</sup> Most state statutes abide by AHIMA's recommended retention period of ten (10) years.<sup>34</sup>

### C. *Radiological Images*

Unless otherwise specified by statute the term "medical records" includes radiographs and other images produced in the course of radiological examinations. State laws concerning the retention of radiological images also differ notably. According to most state laws and regulations, medical records and x-rays are the property of the hospital subject to the patient's interest in the information contained in the record.<sup>35</sup> In a few states, (for example, Arkansas, Louisiana, Mississippi), an x-ray or radiological image is distinguished from its interpretation, and only the latter is regarded as part of the medical record.<sup>36</sup>

In Louisiana, hospitals shall retain "[g]raphic matter, images, x-ray films and like matter" for a minimum period of three (3) years.<sup>37</sup> The Louisiana statute also stipulates that such graphic matter, images, x-ray films and like matter shall be retained for longer periods when requested in writing by an "attending or consultant physician of the patient," "the patient or someone acting legally in his behalf," or "legal counsel for a party having an interest affected by the patient's

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years), TENN. CODE ANN. § 68-11-305 (a)(2) (2000) (stipulating that the records of patients under known mental disability be retained for the period of disability, plus one year, or ten years following the discharge of the patient, whichever is longer), and VA. CODE ANN. § 42.1-79.1 (2000) (indicating that the medical records of persons under a disability be retained for a minimum of five years following the last date of contact, whichever comes later).

<sup>31</sup> See MASS. ANN. LAWS ch. 111, § 70 (2001).

<sup>32</sup> See *infra* note 87 and accompanying chart.

<sup>33</sup> See Donna M. Fletcher, *Retention of Health Information (Updated)*, J. AHIMA 1, (June 10, 1999) <<http://www.ahima.org/journal/pb/99.06.html>>.

<sup>34</sup> See *e.g.*, 210 ILL. COMP. STAT. 85/6.17 (2000); LA. REV. STAT. 40:2144 (F)(1) (2000); MISS. CODE ANN. § 41-9-69 (1) (2000); N.M. STAT. ANN. § 14-6-2 (A) (2000); TENN. CODE ANN. § 68-11-305 (a)(1) (2000); VA. CODE ANN. § 42.1-79.1 (2000); WASH. REV. CODE § 70.41.190 (2000).

<sup>35</sup> See CHERILYN MURER ET AL., *THE COMPLETE LEGAL GUIDE TO HEALTHCARE RECORDS MANAGEMENT* (1999).

<sup>36</sup> See ARK. CODE ANN. § 16-46-301 (2001); LA. REV. STAT. § 40:2144 (F)(2) (2000); MISS. CODE ANN. § 41-9-69 (2) (2000).

<sup>37</sup> LA. REV. STAT. § 40:2144 (F)(2) (2000).

medical records.<sup>38</sup> In Mississippi, like Louisiana, an x-ray or radiological image is distinguished from its interpretation, and only the latter is regarded as part of the medical record.<sup>39</sup> Further, in Mississippi, the written and signed findings of a radiologist, that is, the interpretation of x-ray film and graphic data, shall be retained for the same periods as hospital records; however, the x-ray film and graphic data may be retired four years after the date of exposure.<sup>40</sup> In New Mexico, the retention periods for laboratory tests and x-ray films are one year and four years respectively, provided that written findings are placed in the hospital record.<sup>41</sup> In Tennessee, x-rays may be retired within four (4) years after the date of exposure, as long as the findings or interpretations of the radiologist are retained for the requisite retention period.<sup>42</sup>

As illustrated by the statutes above, one of the obstacles in specifying a single retention period is the regulations that prescribe different retention periods for x-rays as opposed to "medical records" per se. AHIMA's recommended retention period for diagnostic images (such as x-ray film) is five years.<sup>43</sup>

#### D. *Cessation of Practice*

When health care providers terminate their practice, the health care records should be retained according to federal and state laws and regulations.<sup>44</sup> Some state laws require that hospitals or physicians try to contact the patient before the records are destroyed.<sup>45</sup> For instance, in Maryland, after the death of a physician, the estate must forward a notice to the patient before records are destroyed or transferred; if the patient cannot be located, a notice must be published in a local newspaper about the date and location of disposal.<sup>46</sup> In Florida, the physician's estate must keep the patient's records for two years from the date of death.<sup>47</sup>

The Hawaii statute also addresses the procedure for when a health care provider stops operations.<sup>48</sup> In Hawaii, if a health care provider stops operations, the health care provider has to make arrangements for the retention and

<sup>38</sup> *Id.*

<sup>39</sup> See MISS. CODE ANN. § 41-9-69 (2) (2000).

<sup>40</sup> See *id.*

<sup>41</sup> See N.M. STAT. ANN. § 14-6-2 (B)-(C) (2000).

<sup>42</sup> See TENN. CODE ANN. § 68-11-305 (b) (2000).

<sup>43</sup> See Donna M. Fletcher, *Retention of Health Information (Updated)*, J. AHIMA 1 (June 10, 2000) <<http://www.ahima.org/journal/pb/99.06.html>>.

<sup>44</sup> See *id.*

<sup>45</sup> See e.g., MD. CODE ANN. HEALTH-GENERAL I. § 4-403 (e) (2000).

<sup>46</sup> See *id.*

<sup>47</sup> See FLA. STAT. ch. 456.058 (2000).

<sup>48</sup> See HAW. REV. STAT. § 622-58 (e) (2000).



preservation of the records for the prescribed period, subject to health department approval.<sup>49</sup> In Tennessee, records must be sent to the local department of health when a practice or hospital is closed.<sup>50</sup>

#### E. Destruction

Most states view the microfilmed record and the original as equivalents, either immediately or after a certain specified period. For instance, in Virginia, if the nursing care facility, hospital, or other licensed health care provider creates an unalterable record by computerization, microfilm, or other electronic process, the health care provider is not required to maintain paper copies of medical records.<sup>51</sup> Prior to destruction, some states require notification of patients, prior approval from a state agency, or the creation of an abstract. For example, Tennessee requires the creation of an abstract prior to destruction.<sup>52</sup> Furthermore, the Tennessee statute provides that hospital records shall be destroyed by "burning, shredding, or other effective method in keeping with the confidential nature of its contents."<sup>53</sup> In New Mexico, the hospitals may destroy such records after the retention periods specified in the statute without incurring liability.<sup>54</sup>

The health care facilities that have adopted a destruction policy claim to have found it necessary due to storage and fiscal restraints.<sup>55</sup> In contrast, some computer system designers do not see any reason to purge and destroy computerized data as the process may be more expensive than retention.<sup>56</sup> In sum, a state must consider a plethora of variables in the drafting of a retention law.

### IV. THE 1996 PROPOSED RETENTION STATUTE FOR WEST VIRGINIA

West Virginia presently does not have a state statute governing records retention. Obstacles in specifying a retention period include regulations that prescribe different retention periods for x-rays as opposed to "medical records" per se and the problem of deciding which health care providers must retain their

<sup>49</sup> See *id.*

<sup>50</sup> See TENN. CODE ANN. § 68-11-308 (2000).

<sup>51</sup> See 12 VA. CODE ANN. 5-410-950 (2000).

<sup>52</sup> See TENN. CODE ANN. § 68-11-306 (a) (2000).

<sup>53</sup> *Id.* § 68-11-305 (c)(1) (2000).

<sup>54</sup> See N.M. STAT. ANN. § 14-6-2 (D) (2000).

<sup>55</sup> See Gwen Hughes, Practice Briefs, *Destruction of Medical Records*, J. AHIMA (June 10, 2000) <<http://www.ahima.org/journal/pb/00.04.html>>.

<sup>56</sup> See *id.*

patients' records.<sup>57</sup> Other obstacles specific to West Virginia include the scope of discovery, the eligibility for governmental assistance programs, and exposure of workers to hazardous materials—coal.<sup>58</sup> However, the West Virginia Legislature has attempted to specify a retention period.<sup>59</sup>

On January 24, 1996, Senator Wooten introduced a bill to amend article twenty-nine, chapter sixteen of the code of West Virginia.<sup>60</sup> Delegates Amores, Leach, Jenkins, Hunt, Manual and Douglas introduced this same bill in the House on January 30, 1996.<sup>61</sup> This bill would have added a new section entitled "retention and destruction of health care records."<sup>62</sup> The purpose of the bill was to provide timeframes (10 years following the last date of treatment or contact for adults) for retention of medical and other health care records, including diagnostic media, and methods for destruction of the records.<sup>63</sup> The bill that the West Virginia Legislature declined to pass in 1996 read as follows:

§16-29-3. Retention and destruction of health care records.

(a) The health care records of all persons who are not minors or under a disability, or both, shall be retained by the custodian of such records for ten years following the last date of treatment or contact. The health care records of minors shall be retained for a minimum of two years following the age of majority or ten years following the last date of treatment or contact, whichever comes later. The health care records of all persons who are under a disability shall be retained for a minimum of two years following the removal of the disability or ten years following the last date of treatment or contact, whichever comes later. The health care records of deceased persons shall be retained for a minimum of seven years following the date of death.

(b) Health care records may be computerized or minified by the use of microfilm or any other similar electronic or photographic process: *Provided*, That the method used shall create an unalterable record, after which the original records may be destroyed.

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57 See discussion *supra* Part II.A, C.

58 See Long Interview, *infra* note 78.

59 See *infra* note 64 and accompanying text.

60 See S. 117, Reg. Sess. (W. Va. 1996).

61 See H. 4312, Reg. Sess. (W. Va. 1996).

62 *Id.*

63 See *id.*

(c) Diagnostic media filed with the medical record is subject to the provisions of subsection (a) of this section. Diagnostic media retained separately from the medical record shall be retained for at least five years, after which they may be presented to the patient or destroyed: *Provided*, That interpretations or separate reports of diagnostic media are subject to subsection (a) of this section.

(d) If the custodian of any health care records subject to retention ceases operation, it shall notify the department of health and human resources in writing of the arrangements it has made for retention of the health care records. If the department does not approve of the arrangements, it shall notify the custodian of its disapproval within thirty days of receipt of the notice and shall assist the custodian in making alternate arrangements of which the department approves. If the custodian is succeeded by another person, the burden of compliance with this section shall rest with the successor.

(e) Health care records may be destroyed after the retention period set forth in subsection (a) of this section or after minification, in a manner that will preserve the confidentiality of the information in the records: *Provided*, That the custodian shall retain master patient indices permanently. The health care records may be destroyed by incineration, shredding or pulping but may not be buried as a means of destruction and shall be destroyed only in compliance with state and federal environmental laws.

(f) Nothing in this section shall be construed to prohibit the retention of health care records beyond the periods described in this section or to prohibit patient access to health care records as provided in section one of this article.

(g) Health care records exempt from the retention requirements of this section are public health mass screening records; pupils' health records and related school health records; preschool screening program records; communicable disease reports; mass testing epidemiological projects and studies records, including consents; topical fluoride application consents; psychological test booklets; laboratory profiles, hospital nutritionists' special diet orders and similar records retained separately from the medical record but duplicated within it; public health nurses' case records that do not contain any physician's direct notations; social workers' case records; and diagnostic or evaluative studies for the department of education of other state agencies.

(h) The following terms have the following definitions as used in

this section:

(1) "Custodian" means any health care provider that maintains health care records in connection with its operations.

(2) "Diagnostic media" includes laboratory slides, paraffin blocks, X ray films, electroencephalogram tracings, video tapes, fetal strips, photographs and photographic images, the results of which are entered into the medical record by means of written interpretation.

(3) "Health care records," when used with respect to inpatient hospitalization, means the recorded documentation regarding the hospitalization, including, but not limited to, those medical histories, reports, summaries, diagnoses, prognoses, records of treatments and medication ordered and given, notes, entries, radiology reports and other written or graphic data prepared, kept, made or maintained by hospitals that pertain to hospital confinements or hospital services for which a physician order is written.

(4) "Master patient indices" means, with respect to a physician or other noninstitutional health care provider, basic information including the patient's name and birthdate, a list of dated diagnoses and intrusive treatments and a record of all drugs prescribed or given, and, with respect to a hospital or other institutional health care provider, basic information including the patient's name and birthdate, dates of admission and discharge, names of attending physicians, final diagnosis, major procedures performed, operative reports, pathology reports and discharge summaries.

(5) "Minor" means a person under the age of eighteen.<sup>64</sup>

The West Virginia Legislature considered a plethora of variables in the drafting of its proposed retention statute, such as the following: identification of hospitals or health care providers, specification of retention periods, treatment of radiological images, cessation of practice, and prohibition of destruction. The proposed West Virginia statute, like the Virginia statute, applies to "custodians" of health care records.<sup>65</sup> The term "custodian" is defined in the proposed West

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<sup>64</sup> *Id.*

<sup>65</sup> *See* VA. CODE ANN. § 42.1-79.1 (2000).

Virginia statute as “any health care provider.”<sup>66</sup> Also the West Virginia proposed statute, similar to the Hawaii statute, lists records exempt from the retention requirement.<sup>67</sup> The West Virginia proposed statute, like most state statutes, abided by AHIMA’s recommended retention period of ten years.<sup>68</sup> This proposed statute also stipulated a discrete retention period for minors and persons under a disability. The proposed statute prescribed different retention periods for x-rays as opposed to “medical records” (interpretation of radiological image is regarded as part of the medical record), and abided by AHIMA’s recommended retention period for diagnostic images (such as x-ray film) of five years.<sup>69</sup> The proposed statute also implements a procedure for the cessation of operations.<sup>70</sup> Finally, the proposed statute permitted the destruction of records after the retention period or after minification.<sup>71</sup> In conclusion, the West Virginia proposed statute seems to thoroughly address many of the same issues of the other state retention statutes. In fact, the proposed West Virginia statute is much more complete than other state statutes.

The West Virginia Hospital Association proposed legislation that would permit hospitals to destroy records after five years.<sup>72</sup> The association chose five years because that seems to be the standard time period nationwide.<sup>73</sup> In the proposed West Virginia statute, the retention period was lengthened from five to ten years; however, that statute still did not pass.<sup>74</sup> A similar measure was introduced during previous legislative sessions, but killed by the plaintiff attorneys’ lobbying effects.<sup>75</sup> The association had a new approach for the year 2001 and had hoped that the law would be in effect by the year 2002, but this did not happen.<sup>76</sup> Steven Summer of the Hospital Association also confirmed that it was more hopeful for passage in the future.<sup>77</sup>

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<sup>66</sup> See Proposed W. VA. CODE § 16-29-3(h)(1) *supra* in text accompanying note 64.

<sup>67</sup> See HAW. REV. STAT. § 622-58(b) (2000).

<sup>68</sup> See Donna M. Fletcher, *Retention of Health Information (Updated)*, J. AHIMA 1 (June 10, 2000) <<http://www.ahima.org/journal/pb/99.06.html>>.

<sup>69</sup> See H. 4312, Reg. Sess. (W. Va. 1996).

<sup>70</sup> See *id.*

<sup>71</sup> See *id.*

<sup>72</sup> Telephone Interview with Jim Kranz, Vice President of Professional Activities, West Virginia Hospitals Association (June 7, 2000).

<sup>73</sup> *Id.*

<sup>74</sup> See H. 4312, Reg. Sess. (W. Va. 1996); see also S. 117, Reg. Sess. (W. Va. 1996).

<sup>75</sup> *Id.*

<sup>76</sup> *Id.*

<sup>77</sup> Telephone Interview with Steven Summer, President, West Virginia Hospitals Association (June 7, 2000).

## V. RETENTION PRACTICES OF WEST VIRGINIA HOSPITALS

The following chart depicts the retention practices of several West Virginia hospitals. To compile this information, I interviewed the directors, supervisors, and personnel who work directly with medical records on a daily basis, and thus have first-hand knowledge of the retention practices of their facilities.<sup>78</sup>

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<sup>78</sup> See Telephone Interviews with Sue Terry, Health Information Administrator, Beckley Appalachian Regional Hospital (Dec. 22, 2000 and Aug. 3, 2001); Telephone Interview with Barbara Rose, Medical Records Supervisor, Beckley VA Medical Hospital, W. Va. (Dec. 22, 2000); Telephone Interview with Deborah Boland, Director of Medical Records, Charleston Area Medical Center (June 12, 2000); Telephone Interviews with Cathy Allen, Manager, Health Information, Fairmont General Hospital (Jan. 25, 2001 and Aug. 3, 2001); Telephone Interviews with Caroline Long, Director of Medical Records, Highland Hospital (June 8, 2000 and July 27, 2001); Telephone Interview with Deb Williams, Director of Medical Records, Mountain View Regional Rehab. Hospital (Jan. 25, 2001); Telephone Interview with Nancy Hoffman, Director of Medical Records, Preston Memorial Hospital (Jan. 25, 2001 and Aug. 3, 2001); Telephone Interview with Coweta Faulkner, Medical Records Clerk, Putnam General Hospital (June 8, 2000); Telephone Interview with Teresa White, Director of Medical Records, Putnam General Hospital (July 27, 2001); Telephone Interview with Dana Hitchcock, Director of Medical Records, Raleigh General Hospital (Dec. 21, 2000); Telephone Interviews with Melissa Martin, Ruby Memorial and Chestnut Ridge Hospitals (March 1, 2001); Telephone Interviews with Sherri Peyton, Director of Medical Records, Saint Francis Hospital (June 7, 2000) and (July 27, 2001); Telephone Interviews with Shannon Brillhart, Director of Medical Records, Thomas Memorial Hospital (June 8, 2000 and July 27, 2001).

	BECKLEY APPALACHIAN REGIONAL HOSPITAL	BECKLEY VA MEDICAL HOSPITAL	CHARLESTON AREA MEDICAL CENTER
1. Are the medical records paper-based or electronic-based?	Paper-based (business office functions are electronic-based)	90% electronic-based	Paper-based (all its indices are computerized, and have been for the last 10 years)
2. How long are the original records kept?	5 years, then stored on microfiche	75 years	Permanently; CAMC has a no destruction policy.
3. Are the records kept on or off the premises?	On the premises	3 years on the premises, then the records are sent to the Federal Records Center	
4. In your opinion, does West Virginia need to pass a bill that addresses the retention and destruction of health care records?	Yes. It should be state mandated.	Yes.	
5. If a law were passed that specified a period of retention, what do you believe the hospital's practice would be?	It would follow the statutory requirement.	It would not be applicable, but in the private sector the retention period should be 10 years.	CAMC would not purge medical records because it is a teaching facility.
6. In your opinion, what would be the most efficient manner to retain medical records?	Electronic (if you can afford it), optical disk, . . . Mircofilm tends not to be clear.	Computer storage	

	FAIRMONT GENERAL HOSPITAL	HIGHLAND HOSPITAL	MOUNTAIN VIEW REGIONAL REHAB. HOSPITAL
1. Are the medical records paper-based or electronic-based?	Both—moving toward optical disk, e.g., discharge summaries on optical disk.	Paper-based	Paper-based
2. How long are the original records kept?	Permanently; FGH has been open since 1939. Older records are kept on microfilm and microfiche.	5 years, then transfers them to microfilm HH adheres to the best practice of the National Medical Records Association that advocates, in the absence of state law, retention of hard copies for 5 years.	7 years, abides by the Federal Joint Commission Requirement (facility has been open for 10 years and currently has all 10 years of records)
3. Are the records kept on or off the premises?	On the premises	On the premises	2 years on-site, then sent to storage facility
4. In your opinion, does West Virginia need to pass a bill that addresses the retention and destruction of health care records?	Yes. It costs money to transfer records to film. Older film turns brittle. Paper starts to deteriorate. Problems: physical space, cost of retention, and expense of retrieval.	Yes. However, the needs of the patient should come first. Medical records are necessary to substantiate how long someone has had a disability for social security and to track medical history.	Yes. Maintaining medical records is expensive and there is not enough space.
5. If a law were passed that specified a period of retention, what do you believe the hospital's practice would be?	It would follow the statutory requirement.	It would follow the more stringent requirements.	It would follow both the federal and state statutory requirements.
6. In your opinion, what would be the most efficient manner to retain medical records?	Electronic, if we could guarantee that the medium would be stable. CDs have not been around long enough to know how durable they are	Computer storage	Computer storage



	PRESTON MEMORIAL HOSPITAL	PUTNAM GENERAL HOSPITAL	RALEIGH GENERAL HOSPITAL
1. Are the medical records paper-based or electronic-based?	Paper-based	Paper-based	Paper-based (dictation on computer only)
2. How long are the original records kept?	Until transferred to microfilm Volunteers have done the majority of microfilming	Clinical records for 1 year and in-patient records for 2 years, then shipped to archive service for microfiche copying	Permanently
3. Are the records kept on or off the premises?	On the premises	3 years on the premises. We have access to all the records since the hospital opened.	2 years on the premises, then shipped off-site
4. In your opinion, does West Virginia need to pass a bill that addresses the retention and destruction of health care records?	Yes.	Yes.	Yes, from a space perspective.
5. If a law were passed that specified a period of retention, what do you believe the hospital's practice would be?	Discharge summaries would be maintained.	PGH would not destroy medical records.	RGH would never destroy medical records.
6. In your opinion, what would be the most efficient manner to retain medical records?	Microfilm. Microfilm has reduced storage space immensely.	Electronic	Computer storage

	RUBY MEMORIAL AND CHESTNUT RIDGE HOSPITALS	SAINT FRANCIS HOSPITAL	THOMAS MEMORIAL HOSPITAL
1. Are the medical records paper-based or electronic-based?	Paper-based (store electronically doctor's orders and operating, radiology, laboratory, and pathology reports)	Paper-based	Paper-based, but has moved forward with electronic records.
2. How long are the original records kept?	Permanently	Permanently or until microfilm copies are made. SFH has a no destruction policy.	Permanently or until microfilm copies are made. TMH abides by federal regulation. TMH opened in 1946 and has all in-patient, out-patient surgery and emergency department records in paper or on microfilm since it opened.
3. Are the records kept on or off the premises?	3 years on the premises, then shipped to off-site warehouse across town	2 years on the premises, then shipped off-site	On the premises
4. In your opinion, does West Virginia need to pass a bill that addresses the retention and destruction of health care records?	Yes.	Yes.	Yes. State specific guidelines would be helpful for the retention and destruction of electronic media.
5. If a law were passed that specified a period of retention, what do you believe the hospital's practice would be?	We would probably keep records a little beyond the requisite. 7 years seems appropriate	SFH would follow state guidelines.	TMH would follow state guidelines.
6. In your opinion, what would be the most efficient manner to retain medical records?	Electronic	Electronic	Microfilm. Microfilm has reduced storage space immensely.

Currently, the general practice of the West Virginia hospitals is to keep all medical records, and most hospitals abide by the federal regulation. Under the Code of Federal Regulations, medical records, in absence of a state statute, are

retained for five years from the date of discharge; or in the case of a minor, three years after the patient becomes of age under state law, whichever is longest.<sup>79</sup> Medicare and Medicaid law also mandates that records be retained for five years.<sup>80</sup> In further support of the West Virginia hospitals' retention practices, Steven Summer of the Hospital Association noted that he knows of no hospitals in West Virginia that destroy records without making microfilm or microfiche copies, regardless of the date of treatment.<sup>81</sup>

## VI. LEGAL RAMIFICATIONS

The only West Virginia regulation regarding record retention provides that "[m]edical records, including records of patients treated in the emergency room or outpatient department, shall be preserved in the original form, by microfilm or by electronic data process."<sup>82</sup> This provision seems to leave little room for equivocation on the issue of whether records should be kept or may be destroyed.

At the very least, information should be retained for the period during which medical negligence claims may be brought within the statute of limitations.<sup>83</sup> If the patient is a minor, the hospital should retain information until the patient has reached the age of majority plus the period of the statute of limitations, or, at the outside, 20 years after the injury occurred.<sup>84</sup> A longer retention period may be prudent concerning adults because the statute may not begin to run until discovery of the injury if knowledge of the potential action was kept from the plaintiff by the actions of the alleged tortfeasor, and because the 10 year limit does not appear to apply to adults.<sup>85</sup> Claims may be brought up to 10 years after an alleged tort under the False Claims Act.<sup>86</sup>

The American Health Information Management Association recommends that specific patient health information be retained for the following minimum time periods:

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<sup>79</sup> 42 C.F.R. § 405.2139 (e) (1999).

<sup>80</sup> *Id.*

<sup>81</sup> Telephone Interview with Steven Summer, President of West Virginia Hospitals Association (June 7, 2000).

<sup>82</sup> W. VA. CODE ST. R. tit. 64 § 12 (10.3.5) (1987).

<sup>83</sup> *See* W. VA. CODE § 55-7B-4 (1986).

<sup>84</sup> *Albright v. White*, 503 S.E.2d 860, 867 (W. Va. 1998).

<sup>85</sup> *Harrison*, 478 S.E.2d at 114-15.

<sup>86</sup> *See* 31 U.S.C. § 3729 (2000).

**AHIMA's Recommended Retention Standards<sup>87</sup>**

Health information	Recommended Retention Period
Diagnostic images (such as x-ray film)	5 years
Disease index	10 years
Fetal heart monitor records	10 years after the infant reaches the age of majority
Master patient/person index	Permanently
Operative index	10 years
Patient health/medical records (adults)	10 years after most recent encounter
Patient health/medical records (minors)	Age of majority plus statute of limitations
Physician index	10 years
Register of births	Permanently
Register of deaths	Permanently
Register of surgical procedures	Permanently

Where hospitals have failed to apply retention policies uniformly, courts have held that an inference of guilt or negligence may arise from the failure to produce records in a medical malpractice suit.<sup>88</sup> In other words, the spoliation or destruction of evidence relevant to a case might raise a presumption or an inference that the evidence would have been unfavorable to the spoliator or might create another cause of action—spoliation of evidence.<sup>89</sup>

To avoid a presumption or inference of medical malpractice, a hospital

<sup>87</sup> Donna M. Fletcher, *Retention of Health Information* (Updated), J. AHIMA 1 (June 10, 2000), <<http://www.ahima.org/publications/2a/pract.brief.699.html>>.

<sup>88</sup> See *Harrison*, 478 S.E.2d at 117 (The Supreme Court of Appeals of West Virginia stated that the viability of a spoliation of evidence claim has not been decided in West Virginia, and the court similarly declined to determine whether defendant Raleigh General Hospital had a duty to preserve the medical records).

<sup>89</sup> In the following cases, a hospital's failure to produce medical records resulted in an inference of negligence: *Rice v. United States*, 917 F. Supp. 17 (D. D.C. 1996) (finding that hospital failed to preserve tainted blood sample in action by patient infected with HIV during surgery); *May v. Moore* 424 So. 2d 596 (Ala. 1982) (failure of the physician to treat an infant properly was almost concealed by the loss of the infant's original chart); *Public Health Trust of Dade County v. Valcin*, 507 So. 2d 596 (Fla. 1987) (a year and one-half after undergoing tubal ligation to be sterilized, plaintiff suffered a ruptured ectopic pregnancy which nearly killed her); *DeLaughter v. Lawrence County Hosp.*, 601 So. 2d 818 (Miss. 1992) (holding that where evidence is positive that hospital deliberately destroyed original medical record, inference arises that record contained information unfavorable to hospital). See also Thomas G. Fischer, Annotation, *Medical Malpractice: Presumption or Inference From Failure of Hospital or Doctor to Produce Relevant Medical Records*, 69 A.L.R. 4th 906 (2000).

should develop a retention schedule and destruction policy approved by the health information manager, chief executive officer, medical staff, and legal counsel. A hospital should not destroy any records involved in an open investigation, audit, or litigation. Some states require notification of patients, prior approval from a state agency, specification of the method of destruction, or require creation of an abstract prior to destruction. Prior to developing a policy to dispose of records, it would be helpful to review AHIMA's practice brief, *Destruction of Patient Health Information*.<sup>90</sup>

The most prudent course that hospitals should follow with regard to medical record retention is to keep all records in one form or another. This result appears to be dictated by the West Virginia Code of State Regulations,<sup>91</sup> by patient care concerns, and by the potential negative inferences that could result in medical negligence actions, and is followed by all hospitals from which information was obtained regarding record retention.<sup>92</sup> The discovery rule and its tolling of the statute of limitations further clouds the question of when it is "safe" from a liability standpoint to destroy records.<sup>93</sup> Hence, a hospital should retain its records permanently, at least until state law provides an approved retention schedule and destruction policy.

## VII. THE IMPACT OF COMPUTER-BASED PATIENT RECORDS

The Computer-based Patient Record Institute (CPRI) defines a computer-based patient record (CPR) as follows:

A CPR is electronically maintained information about an individual's lifetime health status and health care. The computer-based patient record replaces the paper medical record as the primary source of information for health care meeting all clinical, legal and administrative requirements. It is seen as a virtual compilation of non-redundant health data about a person across a lifetime, including facts, observations, interpretations, plans, actions and outcomes. The CPR is supported by a system that captures, stores, processes, communicates, secures and presents

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<sup>90</sup> Gwen Hughes, Practice Briefs, *Destruction of Medical Records*, J. AHIMA, (June 10, 2000) <<http://www.ahima.org/journal/pb/00.04.html>>.

<sup>91</sup> See W. VA. CODE ST. R. tit. 64 § 12 (10.3.5) (1987).

<sup>92</sup> See *supra* note 78 and accompanying text.

<sup>93</sup> See W. VA. CODE § 55-7B-4 (1986). The Legislature enacted this section in recognition that, in the area of medical malpractice actions, often the plaintiff is not aware of the fact that an injury has been inflicted because the physician's negligence may consist of some improper diagnosis or improper surgery when the plaintiff is unconscious. See *id.*; see also *Gaither v. City Hosp.*, 487 S.E.2d 901 (W. Va. 1997).

information from multiple disparate locations as required.<sup>94</sup>

Currently, some hospital records are kept manually in voluminous paper files.<sup>95</sup> "Information about a single episode of care could reside in the records of several different providers—history and symptoms in a physician record, laboratory results and surgical procedures in a hospital record, and rehabilitation in a home care agency record."<sup>96</sup> In the not too distant future, all of our medical records will be electronically based. To date, over twenty-five percent of hospitals have computerized their patient records.<sup>97</sup> However, one of the biggest barriers in health care information technology is the lack of standards.<sup>98</sup> Having one standard would simplify the business of health care, reduce the cost of complying with several standards, improve the accessibility and accuracy of patient information, and accelerate the automation of health records.<sup>99</sup> Moreover, a patient-based longitudinal health record and uniform national standards for the retention and destruction of health information will ameliorate the hospitals' handling of such information.<sup>100</sup> At the same time, computer-based patient records will have an impact on whether a law is necessary for the retention and destruction of health care records. It would make retention statutes moot.

Several governmental and private committees have proposed automation of health data.<sup>101</sup> The federal government specifically cites the need for access to

<sup>94</sup> American Medical Association, *Definition* (2000) <<http://www.ama-assn.org/med-sci/cpt/emrdef.htm>>.

<sup>95</sup> The General Accounting Office estimates that the 34 million annual hospital admissions and 1.2 billion physician visits could generate the equivalent of 10 billion pages of medical records. See Information Management and Technology Division, General Accounting Office, *Automated Medical Records: Leadership Needed to Expedite Standards Development*, GAO/IMTEC-93-17, 2 n.2 (1993). For earlier accounts of the sheer volume of paper records in the health care system, see Institute of Medicine, *The Computer-Based Patient Record: An Essential Technology for Health Care* 12-14 (Richard S. Dick & Elaine B. Steen eds., 1991).

<sup>96</sup> Amy Marie Haddad, *Case Study: Keep Confidences*, 12 AM. PHARMACY 50, 50 (1993).

<sup>97</sup> American Medical Association, *Practice Size/Setting and Current Status of EMR Systems* (2000) <<http://www.ama-assn.org/med-sci/cpt/emrpract.htm>>.

<sup>98</sup> Now, there is one standard. In spring 2001, the Department of Health and Human Services released its HIPAA regulations, about 1,700 pages long, that mandates *all* electronic transactions containing health information follow one of nine electronic data exchange standards. Everyone must comply. See generally, Mary Beth Johnston and Leighton Roper, *HIPAA Becomes Reality: Compliance With New Privacy, Security, and Electronic Transmission Standards*, 103 W. VA. L. REV. 541 (2001).

<sup>99</sup> See INSTITUTE OF MEDICINE, *THE COMPUTER-BASED PATIENT RECORD: AN ESSENTIAL TECHNOLOGY FOR HEALTH CARE* 12-14 (Richard S. Dick & Elaine B. Steen eds., 1991); see also, Paul T. Cuzmanes and Christopher P. Orlando, *Automation of Medical Records: The Electronic Superhighway and its Ramifications for Health Care Providers*, 6 J. PHARMACY & L. 19 (1997).

<sup>100</sup> See INSTITUTE OF MEDICINE, *supra* note 99, at 12-14.

<sup>101</sup> See *id.* at 32-35; Information Management and Technology Division, General Accounting Office, *Medical ADP Systems: Automated Medical Records Hold Promise to Improve Patient Care*, GAO/IMTEC-91-5 at 5 (1991); WORK GROUP ON COMPUTERIZATION OF PATIENT RECORDS, U.S. DEP'T OF HEALTH AND HUMAN SERVS., *TOWARD A NATIONAL HEALTH INFORMATION INFRASTRUCTURE* at v-x (1993);

health data as one of the driving forces behind its initiative for a national information infrastructure that would link institutions and resources throughout the country.<sup>102</sup> Two technological innovations that are likely to accelerate the pace of automation of health records are health identification cards and patient-based longitudinal health records. Patient-based longitudinal health records are automated versions of health records containing all data relevant to the health of an individual collected over a lifetime.<sup>103</sup> One view of the ideal is a single record expanded from pre-birth to death and health identification cards storing substantial data on the cardholder's health and finances for every person in the United States.

#### A. Health Identification Cards

Health identification cards that have the capacity to store information and to manipulate that information are often called smart cards. Smart cards are defined as "a credit card-sized device containing one or more integrated circuit chips, which perform functions of a microprocessor, memory, and an input/output interface."<sup>104</sup> Approximately 100 pilot projects using electronic card technologies have been initiated in health care systems internationally, including projects in Australia, Canada, France, Germany, Japan, Italy, Great Britain and Sweden.<sup>105</sup>

However, privacy advocates in the United States have expressed concern about incorporating the use of electronic card technologies.<sup>106</sup> Concerns exist as to whether smart cards would solve or exacerbate privacy problems in automated information systems. At the current level of technology, smart cards would also have value to third parties for marketing, insurance or media coverage of public figures, so they would be vulnerable to theft or fraudulent use.

However, several technologies are available to restrict access to sensitive data, including personal identification, user verification, and cryptography.<sup>107</sup>

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WORKGROUP FOR ELECTRONIC DATA INTERCHANGE, DEP'T OF HEALTH AND HUMAN SERVS., OBSTACLES TO EDI IN THE CURRENT HEALTH CARE INFRASTRUCTURE at iii-v (1992).

<sup>102</sup> WORK GROUP ON COMPUTERIZATION OF PATIENT RECORDS, *supra* note 101, at 8; *see also* Computer Systems Policy Project, Perspectives on the National Information Infrastructure: CSPP's Vision and Recommendations for Action 1 (1993).

<sup>103</sup> *See* Sheri Alpert, *Smart Cards, Smarter Policy: Medical Records, Privacy, and Health Care Reform*, 23 HASTINGS CTR. REP. at 13-14, Nov.-Dec., 1993.

<sup>104</sup> CONGRESSIONAL OFFICE OF TECHNOLOGY ASSESSMENT, PROTECTING PRIVACY IN COMPUTERIZED MEDICAL INFORMATION, OTA-TCT-576, 55 (1993).

<sup>105</sup> *See* Tom Wright, *Health Card Technology: A Privacy Perspective* at 7-10 (1992); INSTITUTE OF MEDICINE, *supra* note 99, at 78-79; CONGRESSIONAL OFFICE OF TECHNOLOGY ASSESSMENT, *supra* note 104, at 59-62; Simon Davies, *Identity Cards: National Proposals Increase*, INT'L PRIVACY BULL., Apr.-June 1994, at 1. *See also*, Ronald L. Scott, *Cybermedicine and Virtual Pharmacies*, 103 W. VA. L. REV. 407 (2001).

<sup>106</sup> *See, e.g.*, Mark A. Rothstein, *Taking the Patient's View of Health Care Reform*, J. AM. HEALTH POL'Y, Sept.-Oct. 1993, at 27.

<sup>107</sup> Cryptography is used to encode data, authenticate messages, and create digital signatures that protect against fraud. *See* CONGRESSIONAL OFFICE OF TECHNOLOGY ASSESSMENT, *supra* note 104, at 91; *See* CONGRESSIONAL OFFICE OF TECHNOLOGY ASSESSMENT, DEFENDING SECRETS, SHARING DATA: NEW LOCKS AND KEYS FOR ELECTRONIC INFORMATION, OTA-CIT-310, 174-80 n.27 (1987).

Health care law will require stronger security standards, particularly with the enactment of HIPAA.<sup>108</sup> As a result, smart cards could provide patients with tighter security, greater control over access, and greater knowledge of information contained in their files. Smart cards provide a medium for the storage of the equivalent of 800 printed pages.<sup>109</sup> In sum, smart cards will improve the quality of patient services by making data available to help participants in the health care system.<sup>110</sup>

#### B. *Patient-Based Longitudinal Health Records*

Patient-based longitudinal health records, like smart cards, will improve the quality of patient services.<sup>111</sup> Patient-based longitudinal health records would contain information from pre-birth to death on a single smart card, rather than approximately 800 printed pages.<sup>112</sup> Computerized patient records may make retention laws a moot point because consumers would be empowered to retain their own health records, and archives would no longer be needed to store voluminous paper files. Hence, the need for retention laws from a storage perspective will be outdated with the automation of health records.

The automation of health records will provide health care professionals access to full information about their patients, including their behavioral and clinical history, immunizations, screenings, allergies to medications, diagnostic tests, treatments, and insurance information.<sup>113</sup> Access to a full patient record is valuable in emergency situations and in the management of complex cases. The automation of health records makes it easier to gain access to a full patient history. Patient records can be easily stored on CD-ROM or other media, so that access is virtually instantaneous. Genetic databases with complete personal and family histories may become vital for testing, counseling, and treatment of persons with genetic traits, predispositions, or disease.<sup>114</sup> Databases that include prescriptions and sales of pharmaceuticals could help pharmacists and primary care providers to track their proper use among elderly patients or to report adverse drug reactions.<sup>115</sup>

At the same time, for a physician to fail to make such a search and miss a possible problem or drug interaction may lead to liability. The automation of health records creates other liability risks for physicians and privacy concerns for patients.

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<sup>108</sup> See generally, Johnston & Roper, *supra* note 98.

<sup>109</sup> See Lawrence O. Gostin, *Health Information Privacy*, 80 CORNELL L. REV. 451, 462 (1995).

<sup>110</sup> See *id.*

<sup>111</sup> See *id.* at 458.

<sup>112</sup> See *id.* at 462.

<sup>113</sup> See Ronald L. Scott, *Cybermedicine and Virtual Pharmacies*, 103 W. VA. L. REV. 407 (2001).

<sup>114</sup> See generally George Annas, *Privacy Rules for DNA Databanks: Protecting Coded Future Diaries*, 270 JAMA 2346 (1993).

<sup>115</sup> See Gostin, *supra* note 109, at 477.



These privacy concerns are evidenced by the privacy related bills introduced in the House of Representatives and the Senate.<sup>116</sup> One liability risk created by reliance on computer record keeping is the failure to protect such computerized patient records. Computer storage also raises issues of security and integrity of computer records. Breaches of security and unauthorized access to patient information can lead to a range of tort suits, from invasion of privacy to negligence in record maintenance. A physician or institution also has a duty to detect and cripple viruses. Physicians who fail to properly protect patient and other files from corruption may be as negligent as physicians who fail to keep proper paper records.

Thus, the automation of health care records may improve quality of care while creating privacy concerns for patients and other liability risks for physicians. The lack of accurate, comprehensive, and accessible information makes it more difficult, time consuming, and costly to provide a full range of health services to patients. A computerized patient record would enable health care providers to furnish quality services far more efficiently,<sup>117</sup> especially when the health care providers are abiding by the HIPAA electronic security standards.

### VIII. HIPAA

The Health Insurance Portability and Accountability Act of 1996 (HIPAA)<sup>118</sup> restricted access to health information. HIPAA and the regulations promulgated thereunder dictate certain standards with respect to privacy, security, and the electronic transmission of individually identifiable health information. However, the HIPAA standards do not apply to all instances of use and disclosure of patients' "protected health information."<sup>119</sup> In fact, HIPAA explicitly provides that standards promulgated under the Act shall not supersede contrary provisions of state law if the state law imposes more stringent requirements.<sup>120</sup> Some of the directors, supervisors, and personnel interviewed expressed concern about the HIPAA regulations and anticipate changes with compliance.<sup>121</sup>

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<sup>116</sup> See EPIC.org, Bill Track, *Tracking Privacy, Speech, and Cyber-Liberties in the 106th Congress*, <<http://www.epic.org/privacy/bill-track.html>>. Bills targeted to protect health care information included H.R. 448, entitled "Patient Protection Act of 1999" (setting rules on confidentiality of health care information); H.R. 1057, entitled "Medical Information Privacy and Security Act" (establishing general rules on use and disclosure of medical records); and S. 573, entitled "Medical Information Privacy and Security Act" (comprehensive medical privacy bill).

<sup>117</sup> See Gostin, *supra* note 109, at 476.

<sup>118</sup> 42 U.S.C. § 1320d (2000). Passed on August 21, 1996, the Act amends the United States Code, and its stated purposes include the portability and continuity of health insurance, combating waste, fraud, and abuse in health care and health insurance, and reducing administrative costs of health insurance. See *id.*

<sup>119</sup> Janlori Goldman and Zoe Hudson, *Virtually Exposed: Privacy and E-Health*, HEALTH AFFAIRS, November/December 2000.

<sup>120</sup> See 42 U.S.C. § 1320d-7 (a) (2000).

<sup>121</sup> See *supra* note 78 and accompanying text.

## IX. CONCLUSION

The reasons for retaining health care records substantially outweigh those for destruction. The West Virginia regulation regarding record retention provides that medical records be preserved in the original form, by microfilm or by electronic process.<sup>122</sup> If West Virginia adopts a retention law, it should be one that, like the regulation, requires preservation. A law that requires preservation not only leads to the retention of medical records, but also saves human lives. Accurate, comprehensive, and accessible health information facilitates a full range of health services to patients. In emergency situations, every second counts. Something as simple as being able to access a blood type or an adverse drug reaction could save a life. Furthermore, genetic databases with complete personal and family histories could save lives of relatives by preventive care with regard to genetic traits, predispositions or diseases. More importantly, an expectant mother, like Ms. Harrison, should be permitted to prevent the death of another child by having access to her own medical records. The preservation of life and the quality of patient care significantly outweigh the need to destroy health care records due to fiscal and storage restraints. The West Virginia Legislature should help fund the public hospitals to move toward electronic maintenance for which destruction is irrelevant. In conclusion, West Virginia hospitals should continue to preserve health care records in order to better preserve lives.

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*See* W. VA. CODE ST. R. tit. 64 § 12 (10.3.5) (1987).

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