What is the legal exposure when a patient’s chart is missing, incomplete or destroyed?

**Answer:** Missing patient records plague your private practice, you waste time looking everywhere for a chart that isn’t in your file room or you attempt to review a patient’s history and lab report, but the documents are not in the chart. While these seem to be common scenarios in many medical practices, the consequences may be more serious than you realize.

The medical record serves many purposes, with the primary one being to plan for patient care and provide continuity in information about the patient’s medical treatment. As a permanent record, it informs other healthcare providers about the patient’s health history, including illnesses and impairments.

The medical record is used to perform quality and peer review evaluations by internal and external entities such as state licensing and regulatory agencies. For hospitals, the medical record is an important element of the accreditation process (e.g., Joint Commission). In fact, the safety of patients, promptness of reimbursement and the outcome of litigation all depend on the adequacy, completeness, timeliness, legibility and accuracy of medical records.

New Jersey law requires physicians (“licensees”) to prepare a contemporaneous, permanent professional treatment record for each patient. All treatment records, bills and claim forms must accurately reflect the treatment or services rendered. Treatment records must be maintained for seven years from the date of the most recent entry.

The regulations outline the categories of data that should be documented in the record (NJAC, Board of Medical Examiners’ General Rules of Practice, § 13:35-6.5, b).

This section of the rules also includes criteria for maintaining computerized records and requirements for access to or release of information, confidentiality and transfer of records (the latter when licensee is planning to cease practice for more than three months).

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By Lilly Cowan, JD, ARM, CPCU
Princeton Insurance Healthcare Risk Consultant

**Criminal sanctions for destruction**

Criminal penalties are authorized if a medical record is intentionally destroyed to commit a fraudulent act. It is against the law in New Jersey (fourth degree crime) to destroy, alter or falsify medical records with the intent to deceive or mislead anyone. This includes but is not limited to a diagnosis, test, medication, treatment or psychological test concerning a patient (NJSA § 2C:21-4.1; NJ Code of Criminal Justice). This offense was added as part of the Professional Medical Conduct Reform Act of 1989.

The state must prove four material elements: (1) that the record relates to the care of a medical, surgical or podiatric patient; (2) that the defendant destroyed, falsified or altered the record; (3) that the defendant did this purposefully; (4) that the defendant had a purpose to deceive or mislead a person as to the information.

Attempts to change the record will harm the defense, especially if the patient obtained a copy of it before it was altered. If the plaintiff can show that the record was changed without justification, the credibility of the whole record may be destroyed.

**“Missing” Record**

Ultimately, the medical record serves as the basis for your defense in a malpractice suit. When a record (or part thereof) is missing, it will be difficult, if not impossible, to prove that the physician provided a certain type of treatment or otherwise acted appropriately. Court decisions have shown that if you can’t produce the documentation, and can’t reasonably explain why the record can’t be found, then your version of events will be suspect. Thus, even if you provided appropriate medical care, if you can’t produce the documentation, then it didn’t happen.

Operative or procedure reports or discharge summaries dictated too long after an event may handicap other physicians who care for the patient or who are on-call for another physician. Serious diagnostic and treatment errors have resulted in injury and litigation because these reports were not available. And, as with altered records, reports dictated too long after a complication is identified lack credibility, whether or not the complication resulted from negligence.

**Spoliation of Evidence**

The law implies a duty to preserve evidence in your possession that is likely to be...
used in litigation. Spoliation of evidence is a legal term for the “intentional destruction, mutilation, alteration or concealment of evidence” (Black’s Law Dictionary, 1409 [7th ed. 1999]). The party responsible for the loss of evidence can suffer severe consequences. The trial judge has wide discretion in evaluating the impact of the missing evidence in each case, and determining an appropriate penalty.

In a well-known New Jersey malpractice case in which the patient/plaintiff lost (due to materiality of the missing evidence), the judge ruled that the plaintiff could bring a second claim against the physician/defendant for fraudulent concealment. Further, the judge held that the plaintiff was entitled to damages amounting to what could have been recovered in the underlying case, had the evidence been available for the trial, plus punitive damages for defendant’s intentional wrongdoing (Rosenblit v. Zimmerman, 166 N.J. 391; 2001).

Other penalties that courts may impose include monetary sanctions, directed verdict against the party responsible for the spoliation and various jury instructions (e.g., jury can infer that the spoliation was fraudulently destroyed because it would have been damaging to your position.)

Recently, the term “spoliation” has been broadened to include inadvertent or negligent loss of evidence. Negligent spoliation can occur several ways. For example, medical records or imaging films might be inadvertently filed under an incorrect patient name. In this situation, the consequences for the responsible party are less severe.

**Destruction due to catastrophe**

Paper records can be destroyed (or severely damaged) as a result of a catastrophic event such as fire or flood; electronic records can be destroyed or their security and integrity can be compromised as a result of a computer malfunction or major power failure.

Certainly, the loss of patients’ medical records would disrupt your practice operations and create significant problems for some patients. However, beyond the business (recovery operations, billing issues) and follow-up issues related to trying to take care of patients without their medical records, it is unlikely that you would be held liable for the loss of these files, under the spoliation theory. In order to bring a valid claim, a patient would have to prove that the physician or someone on the practice staff negligently caused the event that led to the records’ destruction (e.g., employee smoked in the records area and accidentally started a fire).

**Handling & maintaining records**

As a physician in an office practice, you have a responsibility to maintain and preserve medical records. Consider the following strategies for developing policies, procedures and systems for handling your medical records.

**Retention of records:** Follow state and federal requirements for retention of records (In New Jersey, seven years minimum). Keep at least as long as the statute of limitations for malpractice claims. Follow the same standard for records of minor patients, but begin counting after patient has reached legal age of majority.

**Records destruction:** Establish a policy with guidelines for destroying records “in the ordinary course of business.” Routine destruction is done when the retention period has expired or the record has been transferred to a different medium (microfilm, computer file). The method needs to be thorough (e.g., shredding, incineration) in order to avoid any breach of confidentiality. Exception: Do not destroy documents if you have reason to believe they will be required for present or future litigation.

**Records release:** Do not release original records, specimens or radiology film unless required by law. When records are requested for legal proceedings, make every effort to submit a copy. Have a policy addressing removal of medical records; prohibit all physicians, employees, contractors or agents from removing records from the premises.

**Tracking/sign-out procedure:** Develop policies and procedures to prevent loss of records; confirm in writing the return of original films, records, slides, or specimens. Establish secure record storage areas, and limit access only to authorized users. Develop and implement procedures to identify charts that are misfiled, incomplete, improperly altered, removed or viewed by unauthorized individuals or lost.Depending on status of an identified event (patient who complains about care, incident, notice of suit), it may be prudent to sequester the original record, and make it available only under direct supervision. It might also be prudent to make copies and store those copies at a location other than the office, so that they will be available if the original records are accidentally lost or destroyed, and update versions as needed. This will also avoid the possibility of records that are important to the defense of a malpractice claim being inappropriately altered.

**Timeliness of transcription:** Require physicians to enter notes the day of the patient visit. Monitor the time it takes to transcribe and file information in the patient charts once dictated. Ensure that dictated notes are authenticated (e.g. reviewed and signed) by the responsible provider. Uncorrected errors in transcription can lead to errors in patient care and erode a provider’s credibility in a malpractice case.

**Correction policies:** Ensure that physicians and office staff understand that they should never attempt to change or falsify data in a patient chart, especially not after an adverse event or notice of lawsuit. Instruct physicians on proper error correction and amendment protocols. See resource: American Health Information Management Association provides guidelines for error correction and amendments, including computerized records.*

**Transfer to other medium:** When medical records are being transferred to another medium (e.g. stored on a disc, scanned into a computer), develop a system to verify that the transfer was done without alteration and that the documents are readily retrievable. Verification should be recorded in a log.

**Disaster preparedness and recovery:** Practice should protect records in a way that minimizes risk of damage from fire and water-related disasters, and power failures. Facilities must have back-up systems in place to access records during an emergency and methods to recover medical records damaged by disaster (e.g., restoration companies for fire/water/storm damage). Be mindful of privacy and confidentiality of patient information.

**Sale or transfer:** To comply with New Jersey law, send out adequate advance notice to all patients regarding the sale or transfer of a practice; provide advice on how they may continue care and obtain copies of their records or have them transferred to another provider.

**Conclusion**

As a physician, you have a duty to your patients to maintain adequate and accurate patient medical records, whether the care is provided in the office or within a hospital or a nursing home.

The recommendations offered here can help you reduce your potential liability for loss or destruction of medical documentation and other evidence. 

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