Dr. Henry writes about Medical Records

There has been much discussion regarding the saving and destroying of medical records. I believe the regulations vary from state to state. In Virginia, when a doctor retires or dies, he or she is required to maintain the records of patients for at least five years. Most doctors and hospitals keep them much longer for their own protection. There are some exceptions. With the assessibility of records to so many outsiders (insurance companies, gatekeepers, lawyers, etc, I would suspect that many doctors do thin their records after five or seven years for old patients that have not been seen in that time. Those doctors may feel that destroying records somehow protects them. In VA, the statute of limitations is two years for malpractice suits. A claim for malpractice needs to filed within two years of the event, but there are always legal loopholes to some of this.

Another issue is storage space for records. Medical records now are volumnous because of the extensive copying and sharing of records with so many health care workers. Doctors now organize in large groups to survive and prosper financially and the records multiply in large groups as you can imagine. I had lithotrypsy for a kidney stone five years ago. My urologist (whom I like and he helped me immensely) is in a group of 20+ doctors. This group has four office locations in Richmond. I have seen him in two of these locations, one time in one location for my convenience and another time in a different location for his convenience, but it allowed me to get an earlier appointment. This group has several employees to just deal with the management and transport of medical records. My file consists of multiple x-ray films, lab reports, office notes and insurance data. It is a fairly thick chart and I only saw him a total of six times in five years. In contrast, I was able to see my polio records on microfilm at the medical records library at the Medical College of VA. Hospital where I was hospitalized for three months with polio in 1950. The ENTIRE record consisted of about 20-25 pages and included my hospital bill which was $1058.00

Overall, I think most doctors and hospitals perfer to retain records for their own protection and also in case the patient returns for care after many years. In my practice, I had many patients who would return after absences of ten or more years because their problems were episodic or they had moved away years ago and returned to the community later. I was delighted to have their old record available.

In general, teaching or university hospitals are much more likely to microfilm old records because of the value of clinical research that may be relevant at a later date. This is particularly true for our polio population.

Actually now that I am retired from private practice, I have my patient records stored at home and I would not part from them. These records are a testament to my years of patient care. I can pull any old chart out at any time, and recall the story of a life that I hopefully affected in some positive way. In a way, these records are a part of my life. I would not destroy them for that reason. I believe most solo practitioners (a dying breed) feel that way about their records. This is less likely the case in large corporate group practice because the records belong to the group or corporation.

Persistance does help in dealing with hospitals. I was successful in seeing my polio record of 1950 only after speaking to the Director of medical records at MCV.

Enough said by me on this topic.

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