Ohio—Disposition of Medical Records in State Mental Hospitals

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ON JANUARY 3, 1961, Dr. Robert A. Haines, Director of the Ohio Department of Mental Hygiene and Correction, announced the establishment of a department-wide records management program. In the directive establishing the program, he said that it was the policy of the department "to provide for the effective management of its records and paperwork in order to improve the manner in which records are created, to improve their maintenance and availability, and to provide for their retirement or disposal when they have served the purpose for which they were created." The scope of the program included records disposition, files maintenance, microfilming, forms analysis, and paperwork creation studies.

Although the Department of Mental Hygiene and Correction is relatively new as a separate entity, having been created July 1, 1954, some of the institutions under its jurisdiction date back to the nineteenth century. Ohio Penitentiary, for example, has been in its present location in Columbus since 1835. Columbus State Hospital (originally the Ohio Insane Asylum) was established in 1838 although it did not move to its present location until 1878. The main buildings of both Cleveland and Dayton State Hospitals have been in continuous use since 1855. Until 1911 the juvenile, correctional, and mental institutions of Ohio were administered as separate agencies, each with its own board of trustees. In that year, however, the separate boards were abolished and the 18 institutions then existing were placed under the jurisdiction of a Board of Administration, which was renamed the Department of Public Welfare in 1921. The three divisions of mental hygiene, corrections, and juvenile research, classification, and training were

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separated from the Department of Public Welfare in 1954 to form the Department of Mental Hygiene and Correction.

Because of the great age of many of the institutions, accumulations of inactive and obsolete records had become an increasingly burdensome and costly problem. Furthermore, some of the more recently constructed institutions had a minimum of storage space for records and files. Several of the institution superintendents, therefore, had asked that steps be taken to permit the destruction of obsolete materials. Authority for disposal, however, had never been obtained, and for this reason the initial concentration of the records management program was on disposition.

Accordingly, on February 10, 1961, instructions were issued to the superintendents for an inventory of all institution records as the first step in obtaining authorization for their disposition. This directive was followed by five regional orientation and training sessions in various places in the State at which the institutional records management representatives received specific information concerning the inventory. The deadline for the records inventory worksheets to be submitted to Columbus was June 30, 1961. The institutions, therefore, had approximately four months in which to complete their inventories.

About a year before the department's records management program was announced, Dr. Haines had established a Medical Records Committee for the purpose of standardizing medical records, forms, and procedures throughout the department. Under the chairmanship initially of Dr. H. J. Leuchter and then of Dr. Donald W. Martin, the committee consists of medical directors of the juvenile and corrections divisions and of superintendents of the different types of mental institutions in the State. The committee found that there were neither standard procedures nor standard forms used throughout the department for medical records. It also found (particularly in the older records and in the records of patients who had been hospitalized for a long period of time) that the medical documentation was frequently incomplete. By April 1961 the committee had designed a series of standard medical forms, the use of which was made mandatory throughout the department; and it had drafted a medical records manual to standardize procedures for the creation and maintenance of such records. The new system represented by the forms and the manual went into effect on July 1, 1961.

Because of the change from the old to the new medical records system, the records management program intended, originally, to

bypass temporarily the disposition of "medical records." It was soon discovered, however, that the term "medical records" required careful definition and that it actually referred to two main groups of records. The first of these was the individual case history file normally maintained in the hospital records department (also known as the patient record, medical record, treatment record, patient history, and other titles), which contains all of the legal, administrative, and other information concerning the admission, diagnosis, treatment, and discharge of a patient. The other main group of documents, frequently consisting of copies of forms and papers in the case file, and scattered among all operating units of the facility, contained medical information. Because the medical- and psychiatric-treatment information was voluminous, it was decided to include the latter main group of records in the institutional schedules but to leave the matter of the disposition of the composite record (the medical case history) for further study.

The institutions submitted their records inventories, generally, by July 1, 1961. They reported approximately 37,000 cubic feet of records, of which a third consisted of medical case history files in the mental hygiene institutions and inmate files in the correctional institutions. These 12,000 cubic feet of records were not included in the initial institutional schedules.

Following receipt of the records inventories in Columbus, the worksheets were classified by records series title. Differences in terminology generally did not prove to be a serious problem. Preliminary analysis of the worksheets showed that the records fell into several well-defined functional categories. These were: agricultural and farming, educational, nursing education, correctional, juvenile, maintenance and engineering, activities therapies, food service and subsistence, personnel and payroll, accounting and supply, and medical and custodial records. The last category referred primarily to records of the mental hygiene institutions, although some correctional and juvenile institution records were included.

After review of the worksheets, schedules were drafted and were reviewed by division and staff representatives within the department and by personnel of other affected or interested agencies (for example, Auditor of State, Personnel Department, and Education Department). The institution schedules, consisting of 530 separate records series, were then submitted to and approved by the State Records Commission on October 2, 1961.

The approved schedules did not include provision for the medical case history files, except in the juvenile institutions. They did,

however, authorize the destruction of copies of various medical forms when the originals were in the case history, as well as the disposal of several other significant records series.

The schedules provided that certain records at the institutional level were to be retained permanently. These were:

Admission register.
Diagnosis and disease index.
Outpatient index.
Death record and death certificates.
Patient index.
Patient register.
X-ray index.

In addition, the department's central office permanently retains a patient statistical card, which summarizes the admission and social history, diagnosis, discharge or death, and movement of the individual patient.

The institutions were authorized to destroy duplicate patient charts (medical case history files) after three years except for (a) duplicate charts used for research purposes and (b) duplicate copies of certain specified forms the use of which is prescribed in the new medical records system. In many instances, the medical case history is maintained both in the medical record room and on the ward or in the cottage where the patient lives. The ward or cottage record may consist of duplicate copies of various documents or of originals periodically sent to the medical record room for filing. This schedule item permits the maintenance of a single principal medical case history file and minimizes the dispersion of essential medical information in two or more places.

The schedules as originally approved also authorized the destruction of treatment records. This is usually a visible card record maintained for the convenience of the doctors and nursing staff at the ward or cottage and also in the correctional and juvenile institution hospital or infirmary. It is carried on "rounds" and is the source document from which the case history is subsequently posted. Authorization was given to destroy treatment records 16 years after death or discharge, providing that in the case of a minor discharged prior to age 21 the 16-year period is construed as beginning at the time the patient reaches 21. This period was established because it applied to records not only in the mental hygiene institutions but also in the correctional and juvenile institutions. Careful analysis of the time interval after discharge or

final release during which an adult offender reenters the Ohio correctional system for another offense indicated that virtually all such reentries take place within about 15 years.

The only part of the medical case history file for which disposal authorization was obtained in the original schedules was the nursing notes. These forms, upon which the nursing staff enters observations daily or at regular intervals concerning the patient, accumulate rapidly. Some of the case histories consist of nursing notes and little else. The problem of volume has become so serious in some institutions that medical record librarians as a matter of routine strip the forms from the file and keep them separate from the other, more essential documents. Nursing notes were scheduled for destruction after five years, except for nursing notes relating to patients who have met accidental death, have committed suicide, or have attempted suicide. For these three exceptions the nursing notes are to remain with the case history. Subsequent study indicated that the voluminous medication and temperature-pulse-respiration reports could also be discarded from the case file.

X-ray film has also presented a serious problem because of its volume and bulk. The original schedules authorized the disposal of x-rays on the following basis:

Admission or entrance x-rays—destroy 5 years after death, discharge, or release, provided that x-rays of discharged minors are kept for 5 years after the minor reaches the age of 21.

X-rays with normal findings—destroy after 5 years.

X-rays with abnormal findings—destroy 16 years after release, death, or discharge from the institution.

As far as the schedules that were approved October 2, 1961, were concerned, no decision was made concerning the medical case history files of the mental hygiene institutions, except for nursing notes. Medical case records in the juvenile institutions were authorized for disposal as the result of their consolidation with the principal boy and girl case history; but these medical records represent either hospitalization or outpatient treatment while in the juvenile institution and not prolonged or intensive psychiatric treatment. Boys are received in the juvenile institutions as early as age 10 and girls at age 12. No boy or girl 18 years of age or older is committed to a juvenile institution, although jurisdiction may be retained until the boy or girl reaches the age of 21. The maximum period of jurisdiction over a boy, therefore, is 11 years and over a girl 9 years. In the juvenile institutions the medical record is

consolidated with the principal case history when the boy or girl leaves the institution; the juvenile then generally goes on placement and is discharged after a period of time in this status. The case histories are scheduled for disposal 15 years after discharge. The juvenile division maintains jurisdiction over the boy or girl usually until the age of 18; the principal case histories, with the medical record as a part, are therefore retained until the juvenile offender has reached a maximum age of 33.

Following approval of the initial schedules on October 2, 1961, an extensive study concerning the possibility of disposing of the medical case history files in the mental hygiene institutions was initiated. This study covered a period of six months and culminated in State Records Commission approval of their destruction ten years after death or discharge of the patient.

The initial inclination was to accept the standard suggested by the American Hospital Association of retaining medical case history files for a period of 25 years after death or discharge. This standard is based in part on the common-law principle that a statute of limitations on an action in which a minor is involved is tolled until the minor reaches the age of 21. Careful consideration indicated, however, that this blanket period of time could be materially reduced for the records of the State mental hygiene institutions. The Ohio statute of limitations, for example, is only 2 years on negligence liability, so the suggested period could immediately be reduced to 23 years. In addition, a child is not accepted in the Ohio mental hygiene system until reaching the age of 6; so the suggested period could be further reduced to 17 years. As various elements were considered, the decision was reached that it would be best to consider the whole matter on its own merits, without reference to any suggested periods of time or to retention periods accepted by any other State.

In making its recommendation to the State Records Commission, the Department of Mental Hygiene and Correction considered three aspects of the value of the medical case history files. The first of these was their administrative usefulness after the death or discharge of the patient concerned. Their administrative need after discharge or death arises from the possibility of readmission, their use in development of workload data for budgeting purposes, or their usefulness in furnishing information to other agencies concerned with the discharged patient. Careful analysis of the approximately one-third of the discharged patients that are readmitted indicated that virtually all readmissions take place within five years

of the previous discharge. If the readmission takes place after a period of more than five years, the information in the case history is of marginal value in relation to the rehospitalization. The usefulness of the records for preparing workload data in developing biennial budgetary forecasts is completed, at most, within five years after death or discharge; moreover, the Department issues monthly and annual statistical reports from which such forecasts may be prepared more readily. An incidental value of the case histories is as a source of information for welfare and other agencies that have been dealing with the patient. All of the information in this category is available in abstract form in the central office statistical summary card, which is filed by patient name and retained permanently.

The second aspect of their value concerned the legal implications and the needs of the institution for information showing treatment, custody, incompetency, and other data affecting the patient's legal rights and status. Review of the statutes and cases relating both to malpractice and negligence liability and the legal disabilities of the patient while under treatment showed clearly that legal requirements would be met if a record is kept for two years after death or discharge in relation to tort liability and for ten years in relation to the removal of legal disability. Although *Avellone* v. *St. John's Hospital* (165 O.S. 467) establishes the liability of a private hospital for the negligence of its professional and nonprofessional servants, the constitution of Ohio provides that the State may not be sued, and this prohibition extends, of course, to the State mental hospitals as a part of the State government. Action cannot be brought against the State, therefore, for the alleged negligence of its servants or agents, but it can be brought against the person concerned. Furthermore, significant information relative to the legal status of a former patient is contained in the central office statistical summary card.

The third aspect considered was the research value of the records. It was the consensus that because of the lack of uniformity of past records in terminology, reporting, and other features, the existing medical case history files could not be economically exploited for research purposes. It further appears that any research could be accomplished by using the central office statistical summary cards. Moreover, the new medical records system that became effective July 1, 1961, has reporting devices built into it that will, in the future, provide readily available research data in abstract form.

On the basis of this analysis, the department requested and, on March 14, 1962, the State Records Commission approved the destruction of all medical case history files in all mental hygiene institutions after the following periods:

Destroy 10 years after discharge provided that the patient is at least 21 years old upon discharge.

If patient dies, destroy 10 years after death.

If patient is discharged before reaching the age of 21, retain until the patient would have become 31 years old.

In addition, the commission approved the destruction of correspondence from patients' relatives, friends, legal representatives, and others one year after the end of the fiscal year in which the correspondence originated and was answered.

With this action, the Ohio Department of Mental Hygiene and Correction has rounded out its program for the disposition of medical records of State mental institutions. The various retention periods have been tailored to Ohio's particular requirements; but they do suggest that the wholesale appraisal of State medical records as "permanent" must be reevaluated.

Of course . . .

A final measure connected with *continuity of management* is the preservation of essential records. Aside from the practical matters involved in preserving vital records, there are some legal problems. The laws generally require that certain corporate records be kept and in some instances also require that they be kept at a specified place, such as the principal place of business. Examples are the stock and transfer books.

At a minimum, it would seem important to preserve the certificate of incorporation, the bylaws, the stock record books, the minute book and sufficient materials relating to the corporate finances to be able to reconstitute the balance sheet. Of course, engineering and design records must be preserved also. However, the legally important fact in connection with this planning is that there would seem to be no difference in law from the normal rules relating to the preservation of records and the use of duplicates.

—OFFICE OF CIVIL DEFENSE, *Continuity of Corporate Management in Event of Nuclear Attack; a Special Report to Corporate Secretaries*, p. 9 (Washington, 1963).