**Chapter 8**

**Health Law**

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**Real-World Case 8.1**

Although medical malpractice is usually associated with physician liability, it actually applies to the professional liability of healthcare providers generally, including not only physicians but also nurses, therapists, and others involved in the delivery of patient care. For example, a patient filed a lawsuit against a physical therapist, alleging that he refused to stop treatment when she requested it. The patient alleged that the treatment caused physical injuries that were serious and permanent, and she also suffered mental injuries. The therapist had a very positive reputation, but co-workers testified as to his aggressiveness. The parties settled out of court for $400,000 with an additional $38,000 in legal expenses. It was estimated that a jury would have likely awarded the patient $800,000 had the case gone to trial (Healthcare Providers Service Organization 2006).

Healthcare Providers Service Organization. 2006. CNA HealthPro Physical Therapy Claims Study. http://www.hpso.com/ptclaimstudy.

# Real-World Case Discussion Questions

1. This case highlights the fact that healthcare professionals in addition to physicians are subject to professional malpractice liability. Why do you think physicians are most frequently linked with the term “medical malpractice?”

Physicians are most frequently linked with the term ‘medical malpractice” because the Physician-Patient relationship is a contract. The Physicians are the primary care providers of the patients. They diagnose and treat patients and give orders to the rest of the health workers like the nurses, and other allied health workers. It is the Doctors who take the main decisions and inform the patients therefore, if there is a problem, they are the ones who will be held responsible.

2. Of the three types of negligence, which type do you think most closely describes a physical therapist who acted too aggressively?

Misfeasance

3. Why it is likely that a much larger award would have been rendered at trial than through settlement?

# This is because at trial many other factors are taken into consideration and levels of injures are calculated before an award is made.

**Real-World Case 8.2**

Healthcare organizations develop record retention guidelines in accordance with applicable laws (for example, a state’s statute of limitations for medical malpractice and Medicare Conditions of Participation retention requirements) and operational needs (for example, research, education, and strategic planning). As long as an organization follows its guidelines, and those guidelines conform to applicable laws, the organization is legally compliant. Further, there is no requirement that patients be notified of an organization’s record retention periods. This, however, is not the case in California. California Senate Bill 1415 (2008) requires:

…physicians, podiatrists, dentists, optometrists, and chiropractors…who create patient records, at the time the initial patient record is created, to provide a statement to be signed by the patient, or the patient’s representative, that sets forth…the intented retention period for the records, as specified in applicable law, or by the health care provider’s retention policy.” Further, the bill “requires a health care provider, if he or she plans to destroy patient records earlier than the period specified in the signed statement, to notify the patient.

In comments accompanying the bill, it was stressed that it is important for patients to be able to access their health records so that they can follow the patient’s lifespan.

# Real-World Case Discussion Questions

1. What is your opinion of California Senate Bill 1415? Do you think patients should be made aware of an organization’s record retention period, although this has not been industry practice? Why or why not?

In my opinion, I think the California Senate Bill 1415 is very appropriate, because though the records belong to the healthcare organization, it belongs to the patient as well (mutually owned), both parties have mutual interest therefore if the record is to be destroyed, I think the patient must be informed, because they also use their health record to follow their lifespan.

2. A patient requested a copy of their health record and learned that it had been destroyed. The patient complains to the state health department because they were not notified that their record would be destroyed. What response would you expect from the state health department?

I expect the state department to issue a sanction or a punishment to the health organization, and compensation should be arranged and given to the patient to prevent a suit.

3. Do you believe healthcare facilities should destroy health records? Justify your choice.

# I believe that healthcare facilities should destroy health records after

# Statute of limitation, after which they are sure nobody would file for a law suit because the statute of limitation has passed.

# I believe also that the patient must be informed before the health records are destroyed. This is because if the patient knows that the records are being destroyed, he/ she could ask for a copy to keep for his/her private purpose.

# Application Exercises

*Instructions:* Answer the following questions.

1. The National Practitioner Data Bank (NPDB) was established to limit the movement of physicians through the US who have negative histories of medical malpractice lawsuits, loss or suspension of licensure, and loss of privileges at previous employers. Although, theoretically, this provides a safety net, such safeguards are not always realized. Why?

2. Review the AHIMA record retention standards which can be found in table 8.1. What are the recommended retention periods for the master patient index, adult health records, minor health records, and register of deaths? Why do you think AHIMA established these recommended retention periods?

3. You have been invited to make a presentation on advanced directives to a senior citizen group. Create a slide deck presentation and write your script using the notes function.

**Review Quiz**

*Instructions:* For each item, complete the statement correctly or choose the most appropriate answer.

1. The content of the health record \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_.

a. May include documentation by only the physician

b. Is not subject to accreditation standards

c. Should facilitate retrieval of data

d. Should include many abbreviations to save space

2. The length of time health information is retained \_\_\_\_\_\_\_\_\_\_\_\_\_\_.

a. Must account for state retention laws, if they exist

b. Must be approved by patients whose health information is being maintained

c. Should not take into account the organization’s operational needs

d. Is ultimately the physician’s decision

3. Which type of law defines the rights and duties among people and private businesses?

a. Public law

b. Private law

c. Corporate law

d. Administrative law

4. Which stage of the litigation process focuses on how strong a case the opposing party has?

a. Deposition

b. Discovery

c. Trial

d. Verdict

5. Which document directs an individual to bring originals or copies of records to court?

a. Summons

b. Subpoena ad testificandum

c. Subpoena duces tecum

d. Deposition

6. Errors in the health record should be which of the following?

a. Corrected by drawing a single line in ink through the incorrect entry

b. Obliterated so the incorrect information will not be used

c. Ignored because information in the health record cannot be removed

d. Corrected by administration only

7. Congress passes laws, which are then developed by federal agencies to provide a blueprint for carrying out these laws. What do the federal agencies develop?

a. Statutes

b. Regulations

c. Judicial decisions

d. Ordinances

8. In order for Susan to be able to prove negligence, she must be able to prove injury, standard of care, breach of standard of care and which of the following?

a. Misfeasance

b. Causation

c. Malfeasance

d. Joinder

9. Jeremiah files a medical malpractice lawsuit against Dr. Watson, who performed his surgery. He names no other defendants in the lawsuit. Dr. Watson files a complaint against his assistant surgeon, Dr. Crick. By doing this, Dr. Watson has completed which legal action?

a. Counterclaim

b. Crossclaim

c. Default judgment

d. Joinder

10. In Lindsay’s lawsuit against her physical therapist, her attorney a) obtained copies of most documents that he requested such as medical records, contracts, e-mail communications, bills, and receipts. However, at trial, Lindsay was surprised to learn that b) several of these documents were not permitted to be considered by the jury as evidence. The concepts associated with a) and b) are which of the following?

a. Subpoena; default

b. Counterclaim; discovery

c. Deposition; voir dire

d. Discovery; admissibility

11. Elizabeth arrived at the nearest urgent care facility after being bitten by her cat, Felix. The physician examined her and gave her a tetanus shot. Based on these facts, a physician-patient relationship has \_\_\_\_\_\_\_\_\_.

a. Been created by express contract

b. Been created by implied contract

c. Not been created

d. Been breached

12. Alex fell from a tree and was taken to the emergency room. The physician did a physical exam and diagnosed Alex with contusions. In fact, Alex suffered a punctured lung that would have been detected by a radiologic image. In this case, the physician committed which of the following?

a. Nonfeasance

b. Misfeasance

c. Malfeasasance

d. No wrongdoing

13. If a patient is not asked to sign a general consent form when entering the hospital, and later sues the hospital for contact that was offensive, harmful, or not otherwise agreed to, what cause of action has the plaintiff most likely included in his lawsuit?

a. Battery

b. Lack of informed consent

c. Negligence

d. Breach of contract

14. A durable power of attorney for healthcare decisions \_\_\_\_\_\_\_\_\_\_\_\_\_\_.

a. Should not be included in an individual’s health record

b. Applies only when the individual is competent

c. Applies when the individual is no longer competent

d. Prohibits the use of cardiopulmonary resuscitation in the event of a cardiac arrest

15. The maintenance of health records \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_.

a. Is governed by state laws only

b. Is governed by Medicare Conditions of Participation for organizations that treat Medicare and Medicaid patients

c. Is always left solely to the discretion of the healthcare organization that maintains the records

d. Are not addressed by accrediting bodies and governmental agencies

16. Disclosure of health information without the patient’s authorization \_\_\_\_\_\_\_\_\_\_\_\_\_.

a. Is prohibited by federal law

b. Is prohibited by most state laws

c. May be required by specific state statutes

d. Is only required for cases of suspected child abuse

17. Metadata are which of the following?

a. Found in personal health records only

b. Data about data

c. Found in paper records only

d. A patient’s billing records

18. Stacie is writing a health record retention policy. She is taking into account the statute of limitations for malpractice and contract actions in her state. A statute of limitations refers to which of the following?

a. A limited number of state laws

b. The period of time that a case must be brought to trial

c. The timeliness of the health records in her facility

d. The period of time in which a lawsuit must be filed

19. The Registered Health Information Technician (RHIT) credential is an example of which of the following?

a. Licensure

b. Certification

c. Accreditation

d. Validation

20. Dr. Smith is being sued by a former patient. At issue is whether the care he provided the patient was consistent with that which would be provided by an ordinary and reasonable physician treating a patient in the plaintiff’s condition. The concept in question is whether \_\_\_\_\_\_\_\_\_\_\_\_\_.

a. Dr. Smith owed a duty to the patient

b. Dr. Smith was practicing medicine with a valid license

c. There was a causal relationship between Dr. Smith’s actions and the harm to the patient

d. Dr. Smith met the standard of care

21. Which of the following tyeps of destruction is appropriate for paper health records?

a. Degaussing

b. Demagnetizing

c. Overwriting

d. Pulping

22. A child’s health record should be retained for how long?

a. The statute of limitations plus five years

b. The age of majority plus the statute of limitation

c. The age of majority

d. The age of majority plus three years

23. Which of the following is a true statement about the legal health record?

a. It includes PHI stored on any medium

b. It includes PHI on paper only

c. It includes PHI on paper and electronic formats only

d. It includes electronic PHI only

24. Policies that address how PHI is used inside the organization deal with which of the following?

a. Legal health record

b. Priviledged communications

c. Disclosures

d. Use

25. What type of negligence would apply when a physician does not order the necessary test?

a. Nonfeasance

b. Malfeasance

c. Misfeasance

d. Intentional tort