IVMA Self-Study Continuing Education Project

A Self-Study in Legal Requirements for Animal Health Records
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This course provides an overview of the legal requirements for the creation of animal health records under Indiana law as well as the best practices for record keeping. This course includes generalized information concerning animal health records. Nothing contained herein should be construed, and is not intended, as legal advice to anyone, under any circumstances. Legal consultation is recommended before acting on any information contained in this course. Additionally, the information below represents the opinions of the author alone.

Record-Keeping Obligations

Accurate record-keeping is a must. Furthermore, it is required by law. Not having an adequate medical record negatively impacts your defense to any malpractice/negligence lawsuit or a licensing complaint. Memories fade over time and the record is the proof of the actions taken in the case. The adage that "if it isn't documented, it didn't happen" is alive and well in the practice of veterinary medicine. Deficient animal health records can lose a case, while detailed and accurate records can win a case.

Indiana law requires a veterinarian to maintain written animal health records. 888 Indiana Administrative Code 1.1-5-1. For companion animals, a veterinarian is required to keep a record for each animal. Each animal health record must include at least the following information:

- Name, address and telephone number of the owner
- Name, number, or other identification of the animal or group
- Species, breed, age, sex and color of the animal
- Immunization record
- Beginning and ending dates of custody of the animal
- A short history of the animal's condition as it pertains to its medical status
- Physical examination findings and laboratory data
- Provisional or final diagnosis
- Treatment and medication administered, prescribed, or dispensed
- Surgery and anesthesia
- Progress of the case

888 IAC 1.1-5-2(a). See also, Indiana Code § 25-38.1-4-5.5(a) (each person who provides veterinary medical services shall maintain medical records as defined by rules adopted by the Board); Ind. Code § 25-38.1-4-5.5(b) (veterinary records include all written records and notes, imaging studies, recordings, photographs, lab reports, other information received as part of a consultation, authorizations, waivers, releases, identification of the owner). In practice, more information rather than less information is preferred to be included in the record.

The above list of requirements is not as clear as may appear on first blush. For example, the Administrative Code requires animal health records to include "surgery and anesthesia." Is it sufficient to only document that an animal underwent a foreign body removal surgery on a particular date? Based upon the language of the law, a colorable argument might be advanced that such a limited description of services satisfies the legal requirement. However, in practice, this type of limited description would likely not suffice and could subject the practitioner to discipline. Best practices would include a description of the surgery performed, the method and manner of induction and method for maintaining the anesthetic plane, documentation of the start and stop times of anesthesia, the patient's vital signs throughout the procedure, the surgical technique, closure technique including type and size of suture, and more. The level of detail recommended to be included in an animal health record for surgery and anesthesia is fact sensitive. If complications occur during the surgery, more detail might be necessary. It bears repeating that more information is almost always preferred. The only record you will likely regret is the record you do not have.

You will observe that the requirements set forth in the Administrative Code do not include the documentation of a patient's weight on the exam or treatment date. However, in practice, the animal's weight is necessary information and should be included. There have been cases where the veterinarian was subjected to discipline for failing to include the patient's weight during a return visit or on the date a new prescription was dispensed.

How much information is necessary to satisfy the legal requirement to document "physical examination findings and laboratory data?" Again, this is a fact sensitive question. In a particular case, the documentation that "exam looks normal" may be considered insufficient to satisfy the legal requirements. Using a labeling system to document each body part considered (eyes, ears, skin, heart, lungs, etc.) with the notation "wnl" may be the better tactic. And, if any examined system is abnormal, a narrative description of the abnormality likely should be included.

Records must be retained and be readily retrievable for three years following the last treatment or examination. 888 IAC 1.1-5-2(d); see also Ind. Code § 25-38.1-4-5.5(g). Animal health records for companion animals shall be maintained for each animal. 888 IAC 1.1-5-2(b). Animal health records for economic animals may be maintained on a group or client basis. 888 IAC 1.1-5-2(c). If the veterinary practice includes a mobile practice, all records must be maintained at the permanent facility and the information contained in the records shall be readily accessible. 888 IAC 1.1-4-2.

Potential Discipline Arising from Deficient or Non-Existent Animal Health Records

The failure to comply with the above legal requirements can subject a veterinarian to disciplinary action. A veterinarian may be found guilty of incompetent practice of veterinary medicine and may be disciplined if the veterinarian fails to maintain written animal health records as defined by 888 IAC 1.1-5-2. 888 IAC 1.1-5-1(1). Pursuant to Indiana Code § 25-1-9-4(a)(3), a veterinarian is subject to disciplinary sanctions if the Board of Veterinary Medical Examiners finds after a hearing that the veterinarian has "knowingly violated any state statute or rule, or federal statute or regulation, regulating the profession in question." The Indiana Administrative Code, including 888 IAC 1.1-5-1 (cited in the above section) is one such state rule regulating the veterinary profession. The State may also charge the veterinarian with professional incompetence for failing to keep adequate records. Ind. Code § 25-1-9-4(a)(4)(A). Sometimes, the State will charge the professional with becoming unfit to practice due to failing to keep abreast of current professional theory or practice. Ind. Code § 25-1-9-4(a)(4)(B).

A practitioner is subject to discipline for inadequate or non-existent animal health records even if the care provided was consistent with current standards of practice. Regardless of the theory advanced by the State against the professional relating to deficient animal health records, discipline ranges from a letter of reprimand or censure to a probation or revocation/suspension of the practitioner's license to practice. Ind. Code § 25-1-9-9. With probation, the licensing board is authorized to place the veterinarian's license on probation and place conditions on the license. Ind. Code § 25-1-9-9(5)(C) (the licensing board may "continue or renew professional education under a preceptor, or as otherwise directed or approved by the board, until a satisfactory degree of skill has been attained in those areas that are the basis of the probation"). Often, continuing education on proper record keeping is required and ordered as part of the stipulated discipline. There are certain continuing education courses on record keeping which are available only if specifically ordered by a licensing board.

Legible handwriting is necessary for the record to serve its intended purpose. If the practitioner's handwriting is not legible, a staff member can write the information into the record. In such instances, best practices would include the veterinarian's review of the documented information along with initialing the record to document approval of the stated information.

Record keeping software is a helpful tool to meet the legal standards. However, to be effective, the data entered must be accurate and complete. Some computer software systems include prompts to include necessary information. Be sure if a computer program is used that a narrative explanation of information (such as observed abnormalities and the plan of care) is included in the record.

Record labels are an acceptable means of documenting required information, so long as the use of the label coincides with documented abnormalities. If the staff member completes the labeling information, be sure that the veterinarian reviews and confirms the accuracy of the information stated. If a check mark is included in the label to document an abnormality, ensure that the narrative includes a description of the abnormality.

Important Records

In addition to the legal requirements, there are certain instances where a form or separate document besides the animal health record is the best practice. Below are examples of such instances.

a. Informed Consent

Best practices include maintaining a signed, written informed consent from the owner. You may develop a standard protocol for distributing informed consent forms. If an assistant is responsible for advising an owner of the risks of a surgical procedure, be sure to properly train and retrain these employees about what information needs to be communicated to the owner. As the veterinarian, you should also reinforce the critical information which is shared with your patients. Ultimately, it is the veterinarian's responsibility to advise the owner about the risks of a procedure. The veterinarian may delegate that responsibility to an assistant, but the assistant's failures will be deemed the veterinarian's failures. What to include in the informed consent is based upon what a reasonably prudent veterinarian would tell an owner under the same or similar circumstances. The information to be relayed by the veterinarian so that the consent provided by the owner is informed, varies on the specifics of the procedure and may likely change over time. Known risks of a procedure may change. It is incumbent on the veterinarian to stay updated and communicate the information to owners.

When informed consent is not written, disputes will inevitably develop about which risks were and were not communicated to the owner. If the patient suffers an injury following a surgery, the owner may challenge whether the risk of that injury was ever disclosed. If pre-anesthetic blood work is not performed and the patient dies while undergoing anesthesia, the owner may challenge whether she was ever informed of the risk of anesthetic death. When the key evidence of informed consent is demonstrated through an untrained or inexperienced staff member, the finder-of-fact may not view the defense evidence favorably. Verbal informed consent can be enhanced by a consistent and long-standing procedure. Being able to testify that the procedure used with a patient is the same procedure which has been used by the employee during each surgical case for the last 10 years in which the assistant has been employed may overcome the lack of a writing. That said, a writing is always the preferred method of obtaining informed consent. A frequent allegation made against the veterinarian is that the owner was not informed of the risks of the procedure. This allegation often arises in a lawsuit for monetary damages or a licensing complaint pending before the licensing board.

b. Declining Services

Written documentation should exist when a client declines authorization to perform a recommended treatment, test or procedure. The most common example of circumstances requiring a declination of service is when the owner refuses the recommendation for pre-anesthetic blood work. In that situation, the recommendation/denial of authorization should be documented and signed by the owner. Some practices have fulfilled this requirement by having the charge for the blood panel preprinted on an invoice with a spot for the owner to authorize or decline and sign. Other practices use a label or form where the owner is informed of the importance of the blood work and is required to sign the declination. In addition to denying pre-surgical blood work, other instances where a signed denial are helpful include, but are not limited to, not performing a recommended surgery, undergoing a diagnostic test, submitting a mass for biopsy, etc.

c. Euthanasia Records

In all cases where an animal is euthanized, best practices is to obtain a signed authorization which expressly authorizes the veterinarian to euthanize the animal. The date of service and the patient's name should appear in the authorization. You may wish to include an affirmative statement that the owner signing the authorization is the legal owner of the patient and is authorized to make the decision to euthanize the patient. It may worth including whether the owner requests cremation, return of the body, etc. A special form can be created for this purpose, or the owner can sign the animal health record which clearly expresses the authorization provided. Ensure the record otherwise includes the information required above.

d. Late/Corrected Entries

Practitioners often misunderstand the opportunity to correct or supplement the animal health record. Animal health records should never been changed or destroyed to avoid the production of detrimental or harmful information. This is especially true during the course of a litigation or licensing matter. However, there are appropriate circumstances where corrections and additions can be made to the record. If a later review of the animal health record reveals erroneous information, a correction can be made via an entry, denoted as a "late entry" which includes the corrected information and any information to explain how the documenting error occurred (for example, the wrong pet record was selected among several pets owned by one person, the wrong lab work was referenced, etc.) Alternatively, the erroneous information can be struck though with the words "error" denoted next to the erroneous information and then a subsequent entry completed to include a narrative explanation of the error.

Omitted information which later has significant importance can be added to the animal health record, *so long as the addition is clearly and plainly denoted as a "late entry" in the record with the date that the late entry was added and the reason the additional information is being included.* The practitioner should use late entries sparingly and with good reason. Best practices are for the relevant, necessary information to be documented during the time of service. However, in limited circumstances, a late entry can prove beneficial. For example, information learned during a conversation with the owner that was not detailed in the record at the time of service but which is relevant to the care at issue should be included in the animal health record.

Prescriptions

A licensed veterinarian may write prescriptions which are given the same recognition by a pharmacist as a prescription from a practitioner holding an unlimited license to practice medicine or osteopathic medicine. However, a valid veterinarian-client-patient relationship must exist before a licensed veterinarian dispenses or writes a prescription. Ind. Code § 25-38.1-1-14.5. The veterinarian-client-patient relationship is described as follows:

> Veterinarian-client-patient relationship means a relationship between a veterinarian and client that meets the following conditions:
>
> (1) The veterinarian has assumed the responsibility for making clinical judgments regarding the health of the animal and the need for medical treatment, and the client has agreed to follow the veterinarian's instructions.
>
> (2) The veterinarian has sufficient knowledge of the animal to initiate a diagnosis of the medical condition of the animal. The veterinarian has recently seen and is personally acquainted with the keeping and care of the animal by either of the following:
>
> > (A) An examination of the animal.
> >
> > (B) By recently seeing and being personally acquainted with the keeping and care of representative animals and associated husbandry practices by making medically appropriate and timely visits to the premises where the animal is kept.
>
> (3) The veterinarian is readily available or has arranged for emergency coverage for follow-up evaluation if there is an adverse reaction or failure of the treatment regimen.
>
> (4) When appropriate, the veterinarian has arranged for continuing care with another licensed veterinarian who has access to the animal's medical record.

Indiana law restricts the use of prescriptions without this current veterinarian-client-patient relationship. Ind. Code § 25-38.1-4-5(c). "Veterinary prescription products, including drugs and immunizing products restricted by state and federal law for use by licensed veterinarians, may not be diverted or transferred to an individual for use on an animal if there is not a current veterinarian-client-patient relationship with the original prescribing veterinarian." Id.

If a veterinarian prescribes a drug for the client's animal, upon request, the veterinarian must provide the prescription to the client, unless prohibited by state or federal law or to prevent inappropriate use. Ind. Code § 25-38.1-4-5(d).

Production of Animal Health Records

The owner is entitled to a copy of the animal health records. Ind. Code § 25-38.1-4-5.5(c). A written authorization form is recommended but not required. The veterinarian may charge a reasonable copying fee. Indiana law defines the scope of the record as including all written records and notes, imaging studies, recordings, photographs, lab reports, other information obtained during a consultation, authorizations, waivers, releases, identification of the agent of owner for purposes of authorizing veterinary care. Ind. Code § 25-38.1-4-5.5(b). Other documentation may also constitute the animal health record, such as correspondence to or from the client.

Except in limited circumstances or upon a written authorization of the client, an animal's veterinary medical record and medical condition is confidential and may not be furnished to or discussed with any person other than the client or other veterinarian included in the care or treatment of the animal. Ind. Code § 25-38.1-4-5.5(d). Such exceptions include when access to the record is specifically required by state or federal statute, by an order of a court upon the issuance of a subpoena, as part of an inspection or investigation conducted by the Board, as part of a request from a regulatory or health authority, as part of an animal cruelty report or to a law enforcement agency. Ind. Code § 25-38.1-4-5.5(e). In these circumstances, the animal health record must be produced within five business days without written client authorization. Other exceptions for the production of records without written client authorization include to the School of Veterinary Medicine at Purdue University, the animal disease diagnostic laboratory, or a state agency or commission, but the records remain confidential unless the information is disclosed in a manner allowed by the statute. Ind. Code § 25-38.1-4-5.5(f).

IVMA Questions:

1. Indiana's Administrative Code includes the explicit requirement of documenting anesthetic monitoring.
    a. True
    b. False

2. Best practices for animal health records includes documenting the patient's weight at each visit.
    a. True
    b. False

3. Which of the following is not required by the Indiana Administrative Code for animal health records?
    a. Provisional or final diagnosis
    b. The patient's owner's contact information
    c. The patient's weight
    d. The immunization records

4. Indiana law requires signed consent for euthanasia of a patient.
    a. True
    b. False

5. Which of the following is not permissible?
    a. Striking through erroneous information in an animal health record and denoting the misinformation as "error"
    b. Deleting information from an animal health record after a bad result
    c. Entering an addendum to the medical record identifying the error and correcting the information as necessary
    d. Creating a late entry, properly denoted as such

6. Lab results are part of the animal health record and must be maintained and readily retrievable.
    a. True
    b. False

7. A veterinarian must provide a copy of the animal health record to the owner upon request, verbal or written.
    a. True
    b. False

8. A veterinarian can be disciplined by the Board of Veterinary Medical Examiners solely on the basis of deficient records and even if the veterinary medicine meets accepted standards of practice.
    a. True
    b. False

9. The failure to document the surgical technique used in a routine surgical procedure may subject the veterinarian to discipline.
    a. True
    b. False

10. Animal Health Records must be maintained for how long?
    a. Indefinitely
    b. 7 years from the last treatment date
    c. 5 years from the first treatment date
    d. 3 years from the last treatment or examination