HB 172 – medical records
Testimony by Megan Frantz Oldham
For the Ohio Association for Justice
Before the House Health Committee
October 25, 2017

Good morning Chairman Huffman, Ranking Member Antonio, and Members of the Committee.

My name is Megan Frantz Oldham. I am a partner at Tzangas Plakas Mannos law firm in Canton and Akron. I am testifying today on behalf of the Ohio Association for Justice, the state bar association for attorneys who help people get back on their feet financially after they have been injured in a car collision or in the workplace, by a defective product, or as a result of a medical error. We oppose the legislation as drafted and urge the committee to find a better way to address the issue raised by the proponents.

I have had the opportunity to review the proponents' testimony and appreciate their concern of patients and subsequent medical providers receiving Electronic Medical Records (EMRs) which are redundant, voluminous, unnecessary, and incomprehensible. However, there are ways to address their concerns without giving medical providers the complete discretion to decide what is or is not a medical record.

There are already things that medical providers do to prevent the production of unwieldy medical records by giving patients the option to specify specifically what medical information they want. For example, Ohio Health's medical release has patients specify exactly what medical records they are requesting, whether it be a discharge summary, test results, etc. or their complete record. See Ohio Health's medical release attached hereto as Attachment 1 (specific documents that the patient consents to being released highlighted); see Cleveland Clinic's similar release attached hereto as Attachment 2.

Further, with respect to the medical provider's burden of producing voluminous records, most providers produce medical records on disc or flash drive so that there is no difference whether it produces 50 or 500 or 5,000 pages. If paper copies are still produced, R.C. 3701.741 establishes that medical providers are permitted to charge per page for medical records.

If the proposed legislation passes, medical providers will be given complete discretion to determine what is a medical record and there will be no uniformity across the state. This will result in many issues including:

1) **Lack of retention:** If a record is determined not to be a medical record, there is no obligation to retain the record for six years, the required retention for medical records.
2) **Inconsistency with federal law:** HIPPA states what records a medical provider is required to maintain, which it terms "Designated Record Set." 45 CFR 164.501. Medical providers are not given discretion by HIPPA to determine what is or is not a Designated Record Set.
3) **Negatively affect subsequent care:** If a record indicates a medical error, the medical provider has the green light to label the record as a nonmedical record and destroy it or not produce it to the patient or subsequent medical provider. This will not only affect the

patient's right to know, but could affect subsequent care. For example, a patient is misdiagnosed and the test results to support the misdiagnosis are deemed not to be a medical record and, as such, they are never provided to the patient or subsequent care provider. The subsequent care provider is never made aware of the support for the misdiagnosis and continues to treat the patient for the incorrect diagnosis.

4) **Frustration to pursue legal rights:** Even if a law firm agrees to pursue a case, pursuant to Civil Rule 10(D), in order to file a medical malpractice case, a patient must obtain an affidavit of merit from a medical doctor who has reviewed the medical record and opines that there was a breach of the standard of care that caused injury to the plaintiff. If the medical provider determines that records that indicate medical error are not "medical records," the patient will have no right to those records and will not be able to get a medical doctor to sign an affidavit of merit prior to filing suit.

Giving medical providers the complete discretion to decide what is a medical record is in contravention to a patient's fundamental and inherent right to know what has been done and being done to their bodies. It is in contravention of the goal of transparency. It is in contravention of ensuring that subsequent medical providers are accurately and fully informed.

Proponents of the bill point to the exception that the legislation does not limit the information that must be provided by a medical provider if the information "relates to litigation." However, in order for a patient to determine whether there is an actionable medical malpractice claim, they must be able to access the entirety of their medical record before litigation is initiated, this includes knowing whether there was a breach of the standard of care that caused injury, whether an expert medical doctor will support the case, and if so, knowing who to file suit against. The exception "relates to litigation" only encourages additional lawsuits against more doctors -- lawsuits just to attempt to get the patient's entire medical record and a shotgun approach to ensure that all possible doctors are named as defendants.

As part of my practice, I evaluate potential medical malpractice claims and litigate them if, and only if, a medical doctor finds that there was a breach of the standard of care that proximately caused injury to the patient. Families come to us for answers when they have not received answers elsewhere. Our firm and others that investigate medical malpractice claims turn down more than 95% of medical malpractice inquires; just because a patient has a bad, unexpected outcome does not mean that that a medical provider was negligent.

One medical malpractice case that our Firm accepted was that involving the death of Howard Griffith. His case, and specifically his medical records, were at issue in the Supreme Court case captioned *Griffith v. Aultman Hospital,* 146 Ohio St.3d 196, 2016-Ohio-1138. Representative Schuring testified that the bill at issue was introduced to negate this Supreme Court decision.

Mr. Griffith was at Aultman Hospital to have a portion of his lung removed. The surgery went well but he soon after developed intermittent atrial fibrillation and was ordered to be on continuous cardiac monitoring. The early morning of May 6, 2012, an x-ray technician discovered Mr. Griffith with his cardiac monitors no longer attached to his body, his gown ripped off, and his central line lying on floor. He was nonresponsive and without a heartbeat. After a code blue was initiated, Mr. Griffith was resuscitated but had suffered severe anoxic

brain damage and was transferred back to the ICU. On the advice of his doctors, life support was discontinued, and he passed away on May 8, 2012.

When leads become detached from a patient's chest at Aultman Hospital, multiple alarms are supposed to sound throughout the hospital and nurses are supposed to check on the patient immediately. It was discovered that no one had checked on Mr. Griffith after his cardiac monitor leads became detached for 40 minutes, when the x-ray tech went to his room to take an x-ray.

The family and our law firm made a total of four requests for Mr. Griffith's complete medical record. The response to each request provided a set of records that was patently incomplete. A lawsuit was filed pursuant to R.C. 3701.74(C) which allows for patients or their representatives to file a lawsuit to get medical records. Through that lawsuit, it was discovered that Aultman had EKG monitoring information which revealed what was going on with Mr. Griffith's heart before his leads became detached and exactly when the leads became detached. Every single page of the EKG monitoring information states "Medical Record" at the top of the page. A sample page of such EKG monitoring information is attached hereto as Attachment 3.

Aultman took the position that, although a medical provider had elected to save the EKG monitoring information, because the EKG monitoring information was stored by its Risk Management Department, and not in its Medical Records Department, it did not have to produce the records as part of Mr. Griffith's "medical record."

After the trial court and Fifth District Court of Appeals agreed with Aultman, the Supreme Court held as part of its syllabus that: "[T]he physical location of the data is not relevant to the determination whether that data qualifies as a medical record. Instead, the focus is whether a healthcare provider made a decision to keep data that was generated in the process of the patient's healthcare treatment and pertains to the patient's medical history, diagnosis, prognosis, or medical condition. We hold that for purposes of R.C. 3701.74(A)(8), 'maintain' means that the healthcare provider has made a decision to keep or preserve the data."

The proposed legislation would give Aultman the license to do exactly what it attempted to do in Mr. Griffith's case; the absolute discretion to decide what it considers a medical record and, therefore, what it has to give or not to give to a patient.

During oral arguments of the case, Chief Justice Maureen O'Conner aptly questioned whether a patient should be entitled to not only a mammogram report, but also the underlying mammogram imaging, and that she was at a loss for why the patient should not be entitled to both. See archive of video oral arguments, 41:38 to 45:37. If the proposed legislation becomes law, a medical provider is permitted to categorize a mammogram image as anything other than a medical record and, as such, would not have to provide it to a patient or any subsequent care provider.

AARP filed a brief in support of our position in the *Griffith* case, in which it stated: "It is axiomatic that an individual has a right to choose his/her medical treatment. As written, Ohio's statutory provision at issue in this case – R.C. 3701.74 – fully recognizes this right to autonomy. The statute's purpose is to provide the mechanisms through which people can exercise the right to self-determination in medical treatment by gaining access to information about their own

health status and medical treatment – information that will necessarily be in the possession and/or control of entrusted medical professionals. . . . Ohio's policy underlying the individual rights recognized in the statute and the practical mechanisms to enforce that right are equally self-evident – people need unfettered access to their medical information to make informed decisions about their health and well-being.

If the proposed legislation passes, everything that AARP said is no longer true as R.C. 3701.74 will effectively be nullified. Patients will no longer have unfettered access to their medical information in order for them to make informed decisions about their health and well-being. Instead, medical providers will have the unfettered right to determine what medical information patients and their subsequent medical providers are entitled to.

Concluding, we urge you that there are better ways to address the issues raised by the proponents of HB 172, and that HB 172 as written has significant unintended consequences which will detrimentally affect patients of the State of Ohio. We are willing to work with the committee to find an acceptable resolution that will not give rise to these unintended consequences.

Mr. Chairman, thank you for this opportunity to testify. If you or members have questions, I'll do my best to answer them.