

**Ohio Supreme Court Expands Definition Of “Medical Records”
For Purposes Of Discovery
Griffith v. Aultman Hospital
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In *Griffith v. Aultman Hospital*, the Ohio Supreme Court recently reversed the Fifth District Court of Appeals (located in Canton) on the question of what constitutes “medical records” in Ohio, that must be produced to a patient upon request.

The Court of Appeals had held that the medical records that must be produced upon request are those that are maintained by the hospital’s medical records department and for which medical providers made a decision to keep or preserve to further the treatment process.

The Supreme Court’s ruling preserved part of this standard, but did so in a way that expanded the concept of what is a medical record to include all “records” regardless of where in the hospital they are kept, or which department of the hospital keeps the records. This new standard will almost certainly prove cumbersome and may ultimately be unworkable. For example, records kept by risk management departments, multi-disciplinary committees, and by IT departments (including extremely large volumes of electronic records that are never reduced to print) may now be discoverable. The burdens that will be imposed in gathering and producing these types of records will likely be considerable. Many sophisticated testing procedures “create” thousands of images. This can result in the technical production of theoretical “records”, a small fraction of which are relied upon or preserved by medical records departments.

The Supreme Court remanded the *Aultman* decision to the trial court to reconsider what must be produced under the facts of that case. Justices Terrence

O'Donnell and Judith Lanzinger dissented and would have defined medical records consistent with the Court of Appeals. Justice Lanzinger succinctly recognized the practical implications raised by AMCNO in its *Amicus Curiae* Brief to the Supreme Court as follows:

The judgment of treating healthcare providers must be relied upon to determine what is (or is not) part of a patient's medical record, those providers being best able to determine what information is relevant to a patient's treatment. Hospitals and other providers have teams of employees dedicated to collecting and maintaining this information, and, as the *amici curiae* have noted, many hospitals have multidisciplinary committees that determine what information should be included in a medical record. The information in the medical record presents the relevant and necessary information that is always subject to being supplemented in the clinical judgment of the treating providers.

In our view, this dissenting opinion did a much better job at capturing the essence of the issue. That is, what is the relevant and necessary information for making a determination on standard of care? Unfortunately, the majority seems to have bought into the suggestion that "records" kept outside the medical records department of a hospital are being kept away from patients, so that they cannot learn about all of their treatment and care.

The majority decision did recognize "that the term "medical record" in R.C. 3701.74(B) does not include all patient data but **includes only that data that a healthcare provider has decided to keep or preserve** in the process of treatment." But the opinion is less clear where it states that "[t]he statute defines 'medical record' to mean any patient data 'generated and maintained by a health care provider,' **without any limitation as to the physical location or department where it is kept.**"

An initiative with the Ohio Legislature to clarify the meaning of R.C. 3701.74 could prove helpful on this issue. Nobody is looking to prevent patients from having full access to their medical records. But at the same time, hospitals and other medical providers should not be burdened with large scale additional documental retrieval responsibilities that will be extremely time consuming but add little of substance to questions of whether medical negligence occurred.