

ORIGINAL

IN THE SUPREME COURT OF OHIO

GENE'A GRIFFITH, EXECUTRIX
FOR THE ESTATE OF HOWARD
E. GRIFFITH, DECEASED

CASE NO. 14-1055

Plaintiff-Appellant,

On Appeal from Stark County
Court of Appeals, Fifth Appellate District
Case No. 2013 CA 00142

v.

AULTMAN HOSPITAL

Defendant-Appellee.

MEMORANDUM OF APPELLEE, AULTMAN HOSPITAL, OPPOSING JURISDICTION

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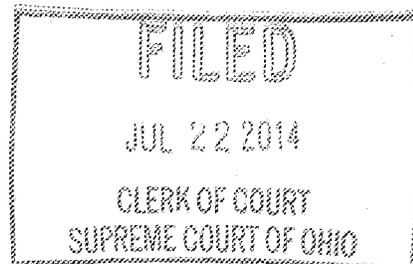
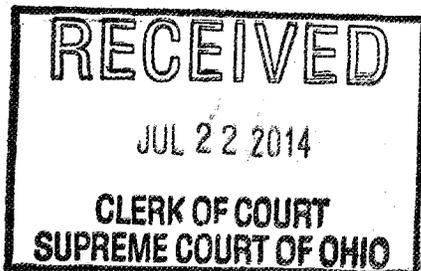


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**STATEMENT OF WHY THIS CASE IS NOT OF PUBLIC
OR GREAT GENERAL INTEREST**

There are three reasons this case is not of public or great general interest.

First, it fails for lack of a controversy. Appellant's jurisdictional memorandum never describes any relief she hopes to gain by disturbing the judgment below. This appeal has no practical effect on the parties.

Appellant has used this action in tandem with a separate suit for medical negligence and wrongful death she filed against Aultman Hospital in the Stark County Court of Common Pleas; that case has been running simultaneously with this medical records case, and appellant has, through discovery, obtained voluminous records in the negligence case. Appellant makes no argument that success in this medical-records case appeal will give her anything she does not already have.

Second, appellant's argument offers no workable alternative to the statutory interpretation Aultman Hospital used with regard to medical records. She complains that the hospital identifies patient medical records within a discrete system that is comprised of something less than the universe of patient information. Her jurisdictional memorandum, however, says nothing as to how she thinks the system should be changed, but only complains that Aultman's system is somehow flawed.

Appellant's decision not to suggest an alternative meaning for a patient's "medical record" is telling. If, as it appears, she is asking this Court to define a patient's "medical record" to include, without any filtering, every piece of patient-specific information located within, or available to, a hospital, and, thereby, require hospitals to produce records in that plenary fashion to requesting patients, the burden on hospitals would be, in a word, impossible. The volume of electronic information pertaining to patients, generated through medical equipment and data entry, is staggering. Any attempt by a hospital to meet such a

duty and capture and maintain all patient information would sharply raise the cost of patient care.

That increased cost, moreover, would be needless. The sense of appellant's argument is that it is somehow necessary to redefine the process of maintaining medical records to prevent hospitals from "manipulating" and "concealing" patient information. Appellant, however, does not show any evidence of such concealment or manipulation, either here, or in any other case. She is arguing an imagined threat.

The third reason the Court should not grant jurisdiction is that the suggested ambiguity over the meaning of the medical-records statute is fabricated. There is nothing unclear about the statute: it defines the patient's medical records as those records created and maintained by the provider. The qualifier "maintained" presumes that the provider has selected data from the complete body of patient information and stored it in a manner useable by the patient and his or her caregivers. Appellant is asking the Court to rewrite the statute to exclude the qualifying language the legislature used.

In short, the case is not of great or general public interest. Appellant does not indicate any other case where the meaning of "medical record" was ever considered. It does not even affect the parties to this action. Finally, her argument requires the Court to deny effect to the plain language of the statute.

STATEMENT OF THE CASE AND FACTS

The dispute before the Court involves a complaint against a hospital brought under R.C. 3701.74 to produce a medical record. The complaint alleged that Aultman Hospital failed to produce the medical record of appellant's decedent, Howard Griffith.

With the complaint, appellant submitted a request for admissions that asked Aultman to admit it had failed to produce a complete copy of the record upon her request following the death of her decedent. Aultman admitted the matter. Appellant also

submitted a request for production, asking Aultman to produce a complete copy of the medical record, and Aultman provided a certified copy of the record in response.

After Aultman produced the record, it filed a motion for summary judgment. Appellant opposed the motion, arguing that she needed to depose the director of the medical records department to confirm that the complete record had been produced.

The trial court deferred consideration of the summary judgment motion to allow the deposition. After the deposition, the court held a hearing on appellant's motion for summary judgment. The court granted summary judgment to Aultman, holding that the complaint was moot since Aultman had produced the medical record.

The Stark County Court of Appeals, Fifth Appellate District, affirmed the judgment, and then denied appellant's motion for reconsideration of the ruling. Appellant filed her notice of appeal from the judgment.

ARGUMENT

- II. **The medical record of a patient consists of medical data and information concerning the patient that the provider has determined to maintain as the medical record.**

The term "medical record" is defined at R.C. 3701.74 as "data in any form that pertains to a patient's medical history, diagnosis, prognosis, or medical condition that is generated and maintained by a health care provider in the process of the patient's health care treatment." The definition recognizes a selecting function by the provider in deciding what constitutes the patient's "medical record." If it did not envision such a selecting function, the legislature would have omitted the qualifying language "maintained by a health care provider...." By including that language, the legislature made clear that medical information becomes part of the patient's medical record only when the provider determines to "maintain" the information by managing it as the "medical record."

Appellant's argument against this reading of the statute never discusses the provider's activity in "maintaining" the medical record. Evidently, it is her view that any information held by, or available to, the provider is the patient's medical record, i.e., it is "maintained" by the provider simply by virtue of its existence. One of her amici runs headlong with this notion, stating the view in plain terms: "In short, a medical record is anything that pertains to the patient's medical history, diagnosis, prognosis or medical condition that was generated in the process of the patient's treatment," leaving out the inconvenient qualifier that the information be "maintained" by the provider.¹

Appellant's interpretation violates the settled rule of statutory construction that language used by the legislature is presumed to have some purpose. See, e.g., *City of E. Liverpool v. Columbiana County Budget Comm'n.*, 105 Ohio St.3d 410, 412, 2005-Ohio-2283, ¶8 ("In construing statutory provisions, we have long recognized that we will apply the plain meaning of the statute"); *State ex rel. Bohan v. Indus. Comm.*, 147 Ohio St. 249, 251, 34 O.O. 151, 70 N.E.2d 888 (1946) ("It is the duty of courts to accord meaning to each word of a legislative enactment if it is reasonably possible to do so. It is to be presumed that each word in a statute was placed therefore a purpose.") The statutory definition of a medical record as information "maintained" by the provider must be given some meaning. Appellant reads the statute as if the word was not included.

Further, courts presume the legislature intended words used in a statute be given their ordinary meaning, unless the statute specifies otherwise. See, e.g., *Jones v. Santel*, 164 Ohio St. 93, 95 (1955) ("In the absence of special definition, it is presumed that the legislature uses a word in its common and ordinary meaning, since in the construction of a

¹ Brief of Amici Stark County Association for Justice, and Miami Valley Trial Lawyers Association, at p.7.

unless the statute indicates a contrary or different meaning, words are given their ordinary meaning.”)

R.C. 3701.74 defines a medical record to be information “created and maintained” by the provider. Webster’s defines maintain, in pertinent part, as follows:

1. to keep or keep up; continue in or with; carry on; 2. a) to keep in existence or continuance [food maintains life] b) to keep in a certain condition or position, esp. of efficiency, good repair, etc; preserve [to maintain roads]

Webster’s New World Dictionary (1984) 854.

The word signals a measure of management, i.e., something maintained is “kept in a certain condition or position, especially of efficiency, good repair.” Black’s Law Dictionary defines the word “maintain” in similar terms:

The term is variously defined as acts of repairs and other acts to prevent a decline, lapse or cessation from existing state or condition; bear the expense of; carry on; commence; continue; furnish means for subsistence or existence of; hold; hold or keep in an existing state or condition; hold or preserve in any particular state or condition; keep from change; keep from falling, declining, or ceasing; in good order; keep in repair; keep up; preserve; preserve from lapse, decline, failure or cessation; provide for; rebuild; repair; replace ; supply with means of support; supply with what is needed; support; sustain; uphold....

By definition, a medical record is a collection of data and information that is maintained, purposefully, as a discrete set. It is, necessarily, a selected collection of information. And, obviously, it excludes information that has not been selected for inclusion.

This understanding comports with the provisions of the Ohio Administrative Code, which requires health care facilities to “maintain a medical record for each patient that documents, in a timely manner and in accordance with acceptable standards of practice, the patient’s needs and assessments, and services rendered.” OAC 3701-83-11(A). At subsection D), the administrative code requires health care facilities to “maintain an adequate medical

record keeping system and take appropriate measures to protect medical records against theft, loss, destruction, and unauthorized use.”

Under the Administrative Code, Aultman Hospital is required to have a “system” for maintaining medical records. It has a medical records department for that purpose. The OAC does not require that every piece of medical information pertaining to a patient be preserved, but only that information and data that the provider has determined to document “the patient’s needs and assessments, and services rendered.”

The statute and the Administrative Code make clear that the set of records constituting the “medical record” of a patient is something less than the universe of patient medical information held by, or available to, the hospital. It is data and information that the provider has decided to maintain from that universe of information.

Aultman Hospital’s medical records department manages the medical records of hospital patients. While appellant complains that this management involves “self-selecting” of data and information by the provider, and that the resulting collection that constitutes the medical record is somehow “incomplete,” those complaints are unconnected to the plain language of the statute and the provisions of the Administrative Code.

At pages 9 through 11 of her brief, appellant raises for the first time a legislative-history argument, suggesting some distinction between a “finalized medical record” (as defined in the original version of the R.C. 3701.74, as adopted in 1985 under HB 433), and the term “medical record,” as defined by the present language under HB 508 in 1999. Appellant argues that by removing the words “finalized medical record,” the legislature intended the medical record to mean “the entire medical record without qualification.” (Brief, p.10.)

Aultman agrees that the term “medical record,” as now defined by statute, includes the “entire medical record.” It disagrees, however, that the “entire medical record” is

something different from the medical record as selected and maintained by the provider. Under appellant's reading, any medical information concerning the patient somehow qualifies as the medical record, regardless of whether it has been selected for inclusion in that set of materials. The 1999 amendment to the statute in 1999, removing reference to a "finalized medical record," did not change the law in the way suggested by plaintiff, i.e., it did not change a patient's medical record from a selected set of data and information to a limitless reference covering all medical information and data concerning the patient. The amended statute still defines medical record as materials maintained by the provider.

While appellant argues this is a case of public or great general interest, she does not cite any other case where a court has addressed the issue of what constitutes a medical record. One of her amici² argues that the decision below conflicts with that in *S.S. v. Ruddock*, Eighth Dist. No. 100281, 2014-Ohio-2270. The issue in that case was whether a plaintiff's complaint for production of her medical record was barred based on a release she signed with the provider. It did not involve the issue raised here as to what constitutes the medical record.

In her conclusion, appellant suggests that Aultman Hospital produced a "sanitized" medical record that excluded "inculpatory" information that was deliberately separated from the medical record. To prop up that claim of misdealing, she presents a carefully-worded suggestion (brief at p.4) that Aultman concealed the fact that her decedent was off-monitor when he was discovered, and that she learned of that circumstance only by filing her complaint for the medical record.³ That is not true. Plaintiff came to the hospital immediately after her decedent was discovered off monitor, and was told by hospital

² Stark County Association for Justice and Miami Valley Trial Lawyers Association.

³ Appellant writes, "It was discovered by Mr. Griffith's surviving family that Mr. Griffith had been off of his cardiac monitor for approximately forty minutes during which alarms sounded or should have sounded, and no one had checked on him during such time until the two x-ray technicians found him nonresponsive."

personnel of that circumstance at that time. The monitor strip documenting that Howard Griffith had been off-monitor for forty minutes only confirmed what plaintiff had already been told. It was not part of the medical record because it was printed at the direction of Aultman's Risk Management Director— not a care provider—who kept the printout in her office.

Finally, appellant argues that the evidentiary burdens on plaintiffs in medical negligence cases make it necessary for the Court to construe medical records to mean all patient information whether or not it is maintained by the provider. She makes no attempt, however, to connect that claimed need with the facts of this case. Appellant brought a medical negligence case against Aultman Hospital while the medical records case was pending; any change in the meaning of “medical record” as defined in R.C. 3701.74 would have had no effect on her claim.

Moreover, the fact that the medical record consists of something less than the universe of patient specific information does not mean that a patient who requests his or her medical record is barred from obtaining patient information outside the medical record. As appellant did in this case, a patient can obtain additional relevant records and information through discovery.

CONCLUSION

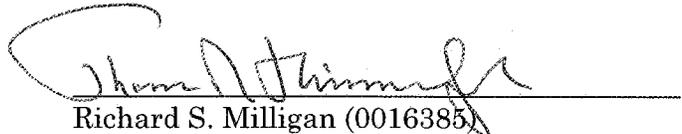
This case will not affect the parties; appellant, as plaintiff in a separate medical negligence action, has pursued, without hindrance, her discovery in that action, and any decision by this Court changing the law as to what constitutes a medical record will not give appellant any additional information to litigate her claim.

Appellant's claim is founded on an imagined need to prevent misdealing by hospitals in maintaining medical records. There is no evidence of such misdealing here, or anywhere else.

Appellant has not indicated any other case addressing the question of what constitutes a medical record. It is not a matter of great general interest or concern. There is no need for the Court to grant jurisdiction to address the issue here. Appellee requests that the Court deny appellant's motion for jurisdiction.

Respectfully submitted,

MILLIGAN PUSATERI CO., L.P.A.

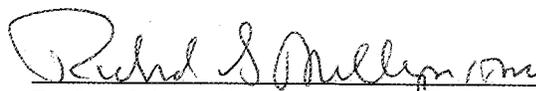


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CERTIFICATE OF SERVICE

A copy of the foregoing *Memorandum of Appellee, Aultman Hospital, Opposing Jurisdiction* was sent by regular U.S. mail this 21st day of July, 2014, to the following:

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