Hospital's Production of "Legal Medical Record" is a Glaring Red Flag for Deception

Healthcare entities are constantly looking for new ways to avoid producing a patient's complete medical record. In the era of electronic medical records, it can be difficult to discern which pieces of evidence might be missing. Thus, it has become increasingly important for plaintiffs' counsel to be on the lookout for devious ways in which some defendants conceal medical records from patients and their families. One of these tactics involves the production of what some hospitals now refer to as a "Legal Medical Record." "Fundamentals of the Legal Health Record and Designated Record Set." Journal of AHIMA 82, no.2 (February 2011).

There should be no debate as to what constitutes a "medical record." Ohio Revised Code § 3701.74(A)(8) defines a "medical record" as "…data in any form that pertains to a patient's medical history, diagnosis, prognosis, or medical condition and that is generated and maintained by a health care provider in the process of the patient's health care treatment." Although this definition seems nearly all-encompassing, many institutions have chosen to produce what they refer to as a "Legal Medical Record" in order to surreptitiously avoid production of certain information that could be vital to the plaintiff's case.

The Legal Medical Record is a product of hypertechnical definitions on the part of a healthcare provider as to what the provider will consider to be a discoverable medical record. A good example is an interpretation by the hospital's legal department that an original version of a subsequently edited or modified operative note, test result, or other record has been retroactively rendered non-existent and not part of the patient's medical records, even though that original version may still exist in electronic storage. In the face of possible litigation, only the edited and possibly sanitized version will be produced to the patient and family members, or their attorneys. This fiction that the edited document or entry replaced the original unedited version and thus eliminated it from the medical records creates a purported justification for providers to change an operative note or test report at any point after it is dictated and thereby make it less likely that the original dictation will ever being discovered.

By way of illustration, the following testimony was recently elicited in an actual pending case:

Q. When somebody asks for their records, and you've been in the record department most of your working life, does somebody make a decision whether or not to give them a draft as opposed to the final version or to give them both, does somebody make that decision?

A. Yes. So [the hospital's] stance on that is we do not produce the draft because that's not considered the medical record. Only the finalized copy of that report would be provided upon request.

Q. Who determined that stance?

A. I'm assuming our legal department probably did.

Thus, in assembling a Legal Medical Record for production, the hospital may unilaterally decide that certain documents are not part of the patient's medical record and therefore not subject

to production. These missing documents may be the very pieces of information that would best tell your client's story.

Of course, other types of mental gymnastics might also be used to re-define a discoverable medical record. For example, in a recent case, *Griffith v. Aultman Hosp.,* 146 Ohio St. 3d 196, 201 (Ohio March 23, 2016), the executor of decedent's estate filed a discovery action against the hospital seeking production of the decedent's complete medical records. The hospital eventually produced cardiac monitoring strips that it originally had withheld, but argued that the cardiac monitoring strips were not part of the patient's medical record because they were not physically kept in the medical records department of the hospital. The Ohio Supreme Court rejected this argument and held that any records which the healthcare provider decided to keep or preserve that were generated for the purpose of treatment and pertained to the patient's medical history were part of the patient's medical record regardless of where in the hospital they were kept.

Despite the above holding, some hospitals continue to redefine what they consider to be part of the Medical Records, feeling confident and justified in representing that they have produced the patient's complete medical record in good faith. This is true even when a hospital knows that an omitted document is highly relevant to plaintiff's case. Although hospitals should not be able to unilaterally create internal policies permitting the secret withholding of scrubbed or remotely stored documents, they can get away with it if unwary counsel do not press for everything to which plaintiffs are entitled.

Plaintiffs' counsel must exercise diligence and perseverance in pursuing the original and subsequent edited versions of all documents. Surgical notes are particularly likely to be amended, and the timing of the edit may be a tip to possible alteration in anticipation of litigation. A note dictated immediately after the procedure and subsequently edited several days or more later may be indicative of an attempt to conceal the actual details of the procedure. This could occur after root cause analysis or a morbidity and mortality meeting when it has become clear to the author of the note that his or her contemporaneous summary of events was a bit too descriptive under the circumstances. Under the aforementioned policy, the physician still has time to sanitize the language before the account becomes published to the patient, family members, and attorneys.

Bear in mind that one cannot rely on the hospital's good faith simply because discovery requests include language that specifically seeks production of all drafts, amendments, versions, edits, or other descriptive terms that seem to encompass dictated and unedited or unaltered documents in the patient's medical record. Defendants will produce voluminous records in response, casually representing that they have produced the entire Legal Medical Record. If pushed, they then will argue that the Legal Medical Record consisted of thousands of pages of documents, and they will attempt to paint the plaintiff's demand for drafts or originals of documents as a fishing expedition amounting to harassment. Meanwhile, the document you need to prove your case may remain hidden away in electronic form based upon a purely semantical game as to which records constitute "medical records" for discovery purposes and which do not. With the advent of the electronic medical record, this is easy for the defendants to accomplish. But automated processes permitting edits to records should not serve to exempt the hospital from producing the patient's complete record.

Not all notes are edited but it is imperative to recognize that the possibility exists and to act accordingly. In this regard, always look carefully to see whether physicians or other individuals have been courtesy copied on documents. In the event that your document has been forwarded to a primary care physician outside of the defendant hospital network, a request for records directed to that physician may result in the inadvertent production of the document concealed by the defendant hospital. Many previously unproduced documents ultimately surface through an alternate source that defense counsel may not have considered. Original unedited documents typically are found by accident.

Unfortunately, because truly punitive remedies for spoliation have recently all but been eliminated, defendants are now likely to become more emboldened in attempting to alter or hide evidence that could be detrimental to their case.

In *Moskovitz v. Mt. Sinai Medical Ctr.*, 69 Ohio St.3d 638, 651, 1994 Ohio 324, 635 N.E.2d 331 (1994), an alteration of records was discovered by plaintiff's counsel when the doctor's secretary sent copies of his office notes to the radiation oncology department. These records were later requested from and produced by that department. The defendant doctor's original entry with respect to a growing mass on decedent's ankle read, "We will therefore continue to observe." After the mass was diagnosed as a sarcoma, the offending doctor whited out that line of his notes and put in "as she does not want excisional bx [biopsy], we will observe." The physician, unaware that a copy of the original entry had been sent to radiation oncology by his secretary, falsely claimed that his original record had been lost. The defendant argued that since the plaintiffs now had the missing document, the patient had suffered no harm, but the Ohio Supreme Court rejected that argument, holding that under the circumstances, a separate claim for spoliation could be pursued even though plaintiff ultimately had obtained the original note. The Court held that the act of spoliation was a harm to the public and could provide grounds for an award of punitive damages.

However, in a 2018 decision, *Elliott-Thomas v. Smith*, 2018-Ohio-1783 (2018), the Ohio Supreme Court held that only physical destruction of evidence would qualify as actionable spoliation; intentional concealment of evidence was insufficient. The Court also indicated a preference for utilizing other remedies such as sanctions to deter and punish the parties and counsel for concealment of evidence. While the Court stopped short of deciding that an independent claim of spoliation could no longer be pursued, it left the impression that it might reach that point in the future.

From a public policy standpoint, there should be dire consequences when healthcare institutions conceal evidence from patients, and it is nothing short of outrageous to encourage such behavior by limiting the punishment that may await hospitals if they get caught. The Court in *Griffith* clearly set forth what records must be produced in response to a medical records request, yet it is clear that healthcare institutions continue to invent ways to avoid production of potentially damaging documents. Given the systemic propensity of hospitals to engage in these practices, plaintiffs' counsel must remain vigilant and should pursue all available means to obtain the discovery to which our clients are entitled.