OHIO LEGISLATIVE SERVICE COMMISSION

Bill Analysis

Aida S. Montano

H.B. 7

132nd General Assembly
(As Introduced)

Reps. Cupp, Becker, Hambley, R. Smith, Huffman, Schaffer, Stein

BILL SUMMARY

Qualified immunity for health care providers in a disaster

- Generally grants qualified civil immunity to a physician, physician assistant, dentist, optometrist, or hospital (hereafter health care provider) that provides emergency medical services, first-aid treatment, or other emergency professional care as a result of a disaster.

- Provides that the bill does not create a new cause of action or substantive right against a health care provider and does not affect any civil immunities or defenses to which a health care provider may be entitled in the provision of those services or that treatment or care.

- Provides that the bill does not grant immunity from tort or other civil liability to a health care provider for actions that are outside the provider's authority and does not affect a provider's legal responsibility to comply with any applicable Ohio law or agency rule.

- Specifies that the immunity under the bill does not apply to a tort action alleging wrongful death against a health care provider who provides emergency medical services, first-aid treatment, or other emergency professional care as a result of a disaster.

Immunity for behavior of mental health patients

- Grants immunity to certain health care professionals or hospitals for failing to discharge from a facility a patient whom the professional or hospital believes in the good faith exercise of professional judgment according to appropriate standards of

professional practice has a mental health condition threatening the safety of the patient or others.

- Grants immunity to certain health care professionals or hospitals for discharging a patient whom the professional or hospital believes in the good faith exercise of professional judgment according to appropriate standards of professional practice not to have a mental health condition that threatens the safety of the patient or others.

Medical Malpractice Law

- Clarifies the definition of "medical claim" and applies the provisions described in the following dot points to civil actions based on a medical claim.

Complaint

- Specifies the manner of sending, prior to the expiration of the limitation period for the claim, to a person who is the subject of a medical claim the written notice under current law of the claimant's intent to bring that claim.

- Specifically requires the plaintiff to file with the complaint, pursuant to Civil Rule 10(D), an affidavit of merit as to each defendant or a motion to extend the period to file such affidavit.

- Permits the parties, within 180 days after filing the complaint, to seek to discover potential medical claims or defendants not included in the complaint.

- Permits the plaintiff within that 180-day period to join any additional claim or defendant if the one-year limitation period for that claim had not expired prior to the filing of the original claim or the amendment to the complaint is filed within 180 days after service of the notice of intent to file that additional claim.

- Prohibits a plaintiff from joining additional claims or defendants after the expiration of the 180-day period unless the claim is for wrongful death and the limitation period of the wrongful death claim has not expired.

Evidence

- Renders inadmissible as evidence of an admission of liability a health care provider's, employee's, or representative's statements expressing error or fault made to the victim of an unanticipated outcome of medical care or the victim's relative or representative that relate to the victim's suffering, injury, or death.

- Generally renders inadmissible as evidence any communications between a health care provider, employee, or representative and a victim, victim's relative, acquaintance, or representative following an unanticipated outcome of medical care and made as part of a good faith review into the cause of the unanticipated outcome.

- Provides that any guideline or standard under the "Patient Protection and Affordable Care Act" or the "Social Security Act" dealing with Medicare and Medicaid cannot be construed to establish a health care provider's standard or duty of care owed to a patient and is not admissible as evidence in a medical claim.

- Provides that any insurer's reimbursement policies or determinations or regulations of the United States Centers for Medicare and Medicaid Services or the Ohio Department of Medicaid regarding the health care services provided to a patient are not admissible as evidence and may not be used to establish a standard of care.

- Requires the plaintiff, to recover damages in a medical claim, to establish by a preponderance of the evidence that the defendant's act or omission in rendering medical care or treatment is a deviation from the required standard of medical care or treatment and the direct and proximate cause of the injury, death, or loss to person.

- Provides that any loss or diminution of a chance of recovery or survival by itself is not an injury, death, or loss to person for which damages may be recovered in a civil action on a medical claim.

- States the findings of the General Assembly that the application of the so-called loss of chance doctrine improperly alters the requirement of direct and proximate causation, and abrogates the decision in *Roberts v. Ohio Permanente Medical Group, Inc.*, 76 Ohio St.3d 483 (1996), which adopted the loss of chance doctrine.

- Provides that in an action on a medical claim, a written bill or relevant portion of it that itemizes the charges for the defendant medical provider's or hospital's medical services is not admissible as evidence of the reasonableness of those charges.

- Provides that an amount accepted as full payment for the medical services rendered to the patient is admissible as evidence of the reasonableness of the charges, and current law on the evidence of collateral benefits does not apply to exclude that evidence.

Peer review proceedings

- Permits a peer review committee to share proceedings and records within the scope of the committee with governmental agencies that are prosecuting, investigating, or

adjudicating alleged violations of applicable statutes or administrative rules, and provides that such sharing will not affect their confidentiality under continuing law.

TABLE OF CONTENTS

HEALTH CARE IMMUNITIES 4
Qualified immunity for health care providers in a disaster 4
Conditions 5
Exception for wrongful death actions 5
Immunity in disasters – definitions 5
Immunity for behavior of mental health patients 6
Immunity for behavior of mental health patients – definitions 7
MEDICAL MALPRACTICE LAW 7
Application of bill's provisions to medical claims 7
Notice of intent to bring an action on a medical claim 8
Complaint asserting a medical claim 8
Discovery and joinder of additional medical claims or defendants 9
Nonjoinder of additional medical claim or defendant 9
Background – affidavit of merit 10
Applicability 10
Unanticipated outcome of medical care 10
Defendant's expressions of error or fault 10
Communications made in a review 11
Unanticipated outcome – definitions 11
Standards in federal laws not admissible as evidence in medical claim 12
Insurer's reimbursement policies not admissible as evidence in medical claim 13
Insurer's policies – definitions 13
Damages not recoverable for loss of chance of recovery 13
Findings 14
Evidence of reasonableness of charges in medical bills 14
PEER REVIEW PROCEEDINGS 15
Sharing of peer review proceedings with governmental agencies 15

CONTENT AND OPERATION

HEALTH CARE IMMUNITIES

Qualified immunity for health care providers in a disaster

The bill generally provides that a "physician," "physician assistant," "dentist," "optometrist," or "hospital" (hereafter health care provider) that provides emergency medical services, first-aid treatment, or other emergency professional care, including the provision of any medication or medical product, as a result of a "disaster" is not liable in damages to any person in a "tort action" for injury, death, or loss to person or property allegedly arising from the health care provider's act or omission in providing those services or that treatment or care if the act or omission does not constitute "reckless disregard" for the consequences so as to affect the life or health of the patient

(see "**Immunity in disasters – definitions**").[1] This provision is subject to the third bullet point under "**Conditions**," below.

Conditions

The bill provides the following conditions and exceptions regarding the above immunity of health care providers:[2]

- It does not create a new cause of action or substantive legal right against a health care provider.
- It does not affect any immunities from civil liability or defenses established by another section of the Revised Code or available at common law to which a health care provider may be entitled in providing emergency medical services, first-aid treatment, or other emergency professional care.
- It does not grant immunity from tort or other civil liability to a health care provider for actions that are outside the provider's scope of authority.
- It does not affect any legal responsibility of a health care provider to comply with any applicable Ohio law or Ohio agency rule.

Exception for wrongful death actions

The immunity provided by the bill does not apply to a tort action alleging wrongful death against a health care provider that provides emergency medical services, first-aid treatment, or other emergency professional care, including the provision of any medication or medical product, that allegedly arises from the provider's act or omission in providing those services or that treatment or care as a result of a disaster.[3]

Immunity in disasters – definitions

The bill defines "dentist," "optometrist," "physician," and "physician assistant" as persons who are licensed or authorized to practice their respective professions under the applicable licensing or regulatory statutes.[4] It defines "hospital" and "medical claim"

---

[1] R.C. 2305.2311(B).

[2] R.C. 2305.2311(C).

[3] R.C. 2305.2311(D).

[4] R.C. 2305.2311(A)(1), (4), (5), and (6) by reference to R.C. 2305.231 and R.C. Chapters 4725., 4731., and 4730., respectively.

as in the existing Medical Malpractice Law, as modified by the bill (see "**Application of bill's provisions to medical claims**," below).[5]

The bill further defines the following terms:[6]

"**Disaster**" means any occurrence of widespread personal injury or loss of life that results from any natural or technological phenomenon or act of a human, or an epidemic.

"**Reckless disregard**" as it applies to a given physician, physician assistant, dentist, optometrist, or hospital rendering emergency medical services means conduct that such a health care provider knew or should have known, at the time those services were rendered, created an unreasonable risk of injury, death, or loss to person or property so as to affect the life or health of another and that risk was substantially greater than that which is necessary to make the conduct negligent.

"**Tort action**" means a civil action for damages for injury, death, or loss to person or property other than a civil action for damages for a breach of contract or other agreement between persons or governmental entities, and includes an action on a "medical claim."

Immunity for behavior of mental health patients

The bill provides that, notwithstanding any other provision of the Revised Code, a "physician," "physician assistant," "advanced practice registered nurse," (hereafter health care professional) or "hospital" is not liable in damages in a civil action, and cannot be subject to disciplinary action by any entity with licensing or regulatory authority, for doing either of the following (see "**Immunity for behavior of mental health patients – definitions**"):[7]

- Failing to discharge or to allow a patient to leave the facility if the health care professional or hospital believes in the good faith exercise of professional medical, advanced practice registered nursing, or physician assistant judgment according to appropriate standards of professional practice that the patient has a mental health condition that threatens the safety of the patient or others;

[5] R.C. 2305.2311(A)(3).

[6] R.C. 2305.2311(A)(2), (7), and (8).

[7] R.C. 2305.51(D).

- Discharging a patient whom the health care professional or hospital believes in the good faith exercise of professional medical, advanced practice registered nursing, or physician assistant judgment according to appropriate standards of professional practice not to have a mental health condition that threatens the safety of the patient or others.

These immunities from civil liability and disciplinary action are in addition to and not in limitation of any immunity conferred on such health care professional or hospital by another section of the Revised Code or by judicial precedent.[8]

Immunity for behavior of mental health patients – definitions

The bill defines "advanced practice registered nurse," "physician," and "physician assistant" as persons who are licensed or authorized to practice their respective professions under the applicable licensing or regulatory statutes.[9] It defines "hospital" as in the Peer Review Committee Law.[10]

MEDICAL MALPRACTICE LAW

Application of bill's provisions to medical claims

The bill's provisions modifying the Medical Malpractice Law primarily pertain to civil actions based upon a "medical claim," defined in current law as modified by the bill. Current law defines "**medical claim**" as any claim asserted in any civil action against a physician, podiatrist, hospital, home, or residential facility or an employee or agent of such person or facility, or against a licensed practical nurse, registered nurse, advanced practice registered nurse, physical therapist, physician assistant, emergency medical technician-basic, emergency medical technician-intermediate, or emergency medical technician-paramedic, and that arises out of the medical diagnosis, care, or treatment of any person. "**Medical claim**" includes the following, as modified by the bill:[11]

- Derivative claims for relief that arise from the medical diagnosis, care (instead of plan of care in current law), or treatment of a person;

- Derivative claims for relief that arise from the plan of care prepared for a resident of a home (added by the bill);

---

[8] R.C. 2305.51(E).

[9] R.C. 2305.51(A)(1)(g), (i), and (j), by reference to R.C. 4723.01 and 4730.01 and R.C. Chapter 4731.

[10] R.C. 2305.51(A)(1)(h).

[11] R.C. 2305.113(E)(3).

- Claims that arise out of the medical diagnosis, care (instead of plan of care), or treatment of any person or "claims that arise out of the plan of care prepared for a resident of a home" (clarified by the bill) and to which both types of claims either of the following applies: the claim results from acts or omissions in providing medical care; or the claim results from the hiring, training, supervision, retention, or termination of caregivers providing medical diagnosis, care, or treatment;

- Claims that arise out of the plan of care, medical diagnosis, or treatment of any person and are brought under the grievance procedure for violation of the rights of a nursing home resident;

- Claims that arise out of skilled nursing care or personal care services provided in a home pursuant to the plan of care, medical diagnosis, or treatment.

Notice of intent to bring an action on a medical claim

Current law provides that, if prior to the expiration of the one-year period of limitations for filing an action upon a medical, dental, optometric, or chiropractic claim a claimant who allegedly possesses such a claim gives to the person who is the subject of that claim written notice that the claimant is considering bringing an action, that action may be commenced against the person notified at any time within 180 days after the notice is given.[12] The bill requires a claimant who allegedly possesses a "medical claim" (see above definition) and intends to give to the person who is the subject of that claim the written notice described above, to send the notice by certified mail, return receipt requested, addressed to any of the following: the person's residence, the person's professional practice, the person's employer, or the address of the person on file with the State Medical Board or other appropriate agency that issued the person's professional license.[13]

Complaint asserting a medical claim

The bill specifies that at the time of filing a complaint asserting a "medical claim," the plaintiff must file with the complaint, pursuant to Civil Rule 10(D) (see "**Background – affidavit of merit**," below), an affidavit of merit relative to each

[12] R.C. 2305.113(B)(1).

[13] R.C. 2305.113(B)(2).

defendant named in the complaint or a motion to extend the period of time to file an affidavit of merit.[14]

Discovery and joinder of additional medical claims or defendants

The bill provides that the parties may conduct discovery as permitted by the Rules of Civil Procedure. Additionally, for a period of 180 days following the filing of a complaint asserting a medical claim, the parties may seek to discover the existence or identity of other potential medical claims or defendants that are not included or named in the complaint. All parties must provide such discovery in accordance with the Rules of Civil Procedure.[15]

Within 180 days following the filing of the complaint, the plaintiff, in an amendment to the complaint pursuant to Civil Rule 15, may join in the action any additional medical claim or defendant if either of the following applies:[16]

- The original one-year period of limitation applicable to that additional medical claim or defendant had not expired prior to the date the original complaint was filed; or

- The amendment to the complaint was filed within 180 days after service of the written notice described above in "**Notice of intent to bring an action on a medical claim**," applicable to that additional claim or defendant.

The plaintiff must file an affidavit of merit supporting the joinder of the additional claim or defendant or a motion to extend the period of time to file an affidavit of merit pursuant to Civil Rule 10(D) with the amendment to the complaint. The provisions described in the preceding paragraph and dot points and in this paragraph do not modify or affect and are not to be construed as modifying or affecting any provision of the Revised Code or rule of common law that applies to the commencement of the period of limitation for medical claims that are asserted or defendants that are joined after the expiration of that 180-day period.[17]

Nonjoinder of additional medical claim or defendant

After the expiration of 180 days following the filing of a complaint asserting a medical claim, the bill prohibits the plaintiff from joining any additional medical claim

[14] R.C. 2323.451(B).

[15] R.C. 2323.451(C).

[16] R.C. 2323.451(D).

[17] R.C. 2323.451(E).

or defendant to the action unless the medical claim is for wrongful death and the period of limitation for the claim under the Wrongful Death Law (generally within two years after the decedent's death) has not expired.[18]

Background – affidavit of merit

Under Civil Rule 10(D), a complaint that contains a medical claim, dental claim, optometric claim, or chiropractic claim generally must include one or more affidavits of merit relative to each defendant named in the complaint for whom expert testimony is necessary to establish liability. Affidavits of merit must be provided by an expert witness, and must include all of the following:

- A statement that the affiant has reviewed all medical records reasonably available to the plaintiff concerning the allegations in the complaint;
- A statement that the affiant is familiar with the applicable standard of care;
- The affiant's opinion that the standard of care was breached by one or more of the defendants to the action and that the breach caused injury to the plaintiff.

Applicability

The bill provides that its provisions pertaining to the above procedures upon filing a medical claim applies to a civil action based on a medical claim that is filed on or after the act's effective date.[19]

Unanticipated outcome of medical care

Defendant's expressions of error or fault

The bill expands current law by providing that in any civil action brought by an alleged victim of an "unanticipated outcome" of medical care or in any arbitration proceeding related to such civil action, any and all statements, affirmations, gestures, or conduct expressing error or fault that are made by a health care provider, that provider's employee, or a "representative of a health care provider" to the alleged victim, the victim's relative, or a "representative of the alleged victim," and that relate to the discomfort, pain, suffering, injury, or death of the victim as the result of the unanticipated outcome of medical care are inadmissible as evidence of an admission of

[18] R.C. 2323.451(F).

[19] Section 4.

liability or of an admission against interest. (See "**Unanticipated outcome – definitions**.") Current law provides that in any civil action or arbitration proceeding described above, any and all statements, affirmations, gestures, or conduct expressing apology, sympathy, commiseration, condolence, compassion, or a general sense of benevolence made by a health care provider or provider's employee to the alleged victim or the victim's relative or representative, and that relate to the discomfort, pain, suffering, injury, or death of the victim as the result of the unanticipated outcome of medical care are inadmissible as evidence of an admission of liability or of an admission against interest.[20]

Communications made in a review

The bill provides that when made as part of a "review" conducted in good faith by the health care provider or the provider's employee or representative into the cause of or reasons for an unanticipated outcome of medical care, the following communications are inadmissible as evidence in any civil action brought by an alleged victim of such unanticipated outcome, any related arbitration proceeding, or any other civil proceeding, unless the communications are recorded in the victim's medical record:[21]

- Any communications made by a health care provider or the provider's employee or representative to the alleged victim, the victim's relative or acquaintance, or the victim's representative;

- Any communications made by an alleged victim, the victim's relative or acquaintance, or the victim's representative to the health care provider or the provider's employee or representative.

The above provisions do not require a review to be conducted.[22]

Unanticipated outcome – definitions

The bill expands the definition in current law of "**unanticipated outcome**" to include any outcome that is adverse or not satisfactory to the patient. Current law defines "**unanticipated outcome**" as the outcome of a medical treatment or procedure that differs from an expected result.[23]

---

[20] R.C. 2317.43(A).

[21] R.C. 2317.43(B)(1).

[22] R.C. 2317.43(B)(2).

[23] R.C. 2317.43(C)(6).

Current law, retained by the bill, defines "**health care provider**" as a hospital, ambulatory care facility, long-term care facility, pharmacy, emergency facility, or health care practitioner.[24] The bill also retains the current definition of "representative" and clarifies that the defined term is "representative of an alleged victim" to distinguish it from the new defined term "representative of a health care provider" below.[25]

The bill defines the following additional terms:[26]

"**Representative of a health care provider**" means an attorney, health care provider, employee of a health care provider, or other person designated by a health care provider or employee to participate in a review conducted by a provider or employee.

"**Review**" means the policy, procedures, and activities undertaken by or at the direction of a health care provider, the provider's employee, or person designated by the provider or employee with the purpose of determining the cause of or reasons for an unanticipated outcome, and initiated and completed during the first 45 days following the occurrence or discovery of an unanticipated outcome. A review must be initiated by verbal communication to the patient or a relative or representative of the patient by the health care provider, the provider's employee, or person designated by the provider or employee. The verbal communication must be followed by a written document explaining the review process. A review may be extended for a longer period if necessary upon written notice to the patient or the patient's relative or representative.

Standards in federal laws not admissible as evidence in medical claim

The bill provides that any guideline, regulation, or other standard under any provision of the "Patient Protection and Affordable Care Act," or Title XVIII or XIX of the "Social Security Act" (Medicare and Medicaid) cannot be construed to establish the standard or duty of care owed by a "health care provider" (defined as any person or entity against whom a medical claim may be asserted in a civil action) to a patient in a "medical claim" and is not admissible as evidence for or against any party in any civil action based on the medical claim or in any civil or administrative action involving the licensing or licensure status of the health care provider.[27]

---

[24] R.C. 2317.43(C), by reference to R.C. 2317.02(B)(5), which is not in the bill.

[25] R.C. 2317.43(C)(3).

[26] R.C. 2317.43(C)(4) and (5).

[27] R.C. 2317.44.

Insurer's reimbursement policies not admissible as evidence in medical claim

The bill provides that any "insurer's" "reimbursement policies" or "reimbursement determination" (see "**Insurer's policies – definitions**") or regulations issued by the United States Centers for Medicare and Medicaid Services or the Ohio Department of Medicaid regarding the health care services provided to the patient in any civil action based on a "medical claim" are not admissible as evidence for or against any party in the action and may not be used to establish a standard of care or breach of that standard of care in the action.[28]

Insurer's policies – definitions

The bill defines the following terms for purposes of the above provisions:[29]

"**Insurer**" means any public or private entity doing or authorized to do any insurance business in Ohio, and includes a self-insuring employer and the United States Centers for Medicare and Medicaid Services.

"**Reimbursement determination**" means an insurer's determination of whether the insurer will reimburse a "health care provider" (see definition in "**Standards in federal laws not admissible as evidence in medical claim**," above) for health care services and the amount of that reimbursement.

"**Reimbursement policies**" means an insurer's policies and procedures governing its decisions on the reimbursement of a health care provider for health care services and the method of reimbursement.

Damages not recoverable for loss of chance of recovery

The bill provides that in any civil action on a "medical claim," in order for the plaintiff to recover any damages resulting from the alleged injury, death, or loss to person, the plaintiff must establish by a preponderance of the evidence that the defendant's act or omission in rendering medical care or treatment is a deviation from the required standard of medical care or treatment and the direct and proximate cause of the injury, death, or loss. Such direct and proximate cause is established by evidence showing that it is more likely than not that the defendant's act or omission was a cause in fact of the injury, death, or loss to person. Any loss or diminution of a chance of

[28] R.C. 2317.45(B).

[29] R.C. 2317.45(A).

recovery or survival by itself is not an injury, death, or loss to person for which damages may be recovered.[30]

Findings

The bill states that the General Assembly finds that in civil actions based upon a medical claim, the negligent act or omission of the responsible party must be shown to have been the direct and proximate cause of the injury, death, or loss to person complained of. The General Assembly also finds that the application of the so-called loss of chance doctrine in those actions improperly alters or eliminates the requirement of direct and proximate causation. Therefore, the Ohio Supreme Court decision adopting the loss of chance doctrine in *Roberts v. Ohio Permanente Medical Group, Inc.*[31] is abrogated by enacting R.C. 2323.40.[32] (See **COMMENT**.)

Evidence of reasonableness of charges in medical bills

The bill provides that in an action for damages based on a "medical claim," a written bill or statement or any relevant portion of the bill or statement that itemizes the charges and fees for the medical services rendered by the defendant medical provider or hospital is not admissible as evidence of the reasonableness of the medical charges and fees. Any evidence of an amount accepted as full payment for the medical services rendered to the patient is admissible as evidence of the reasonableness of the medical charges and fees for the medical services rendered, and current law described below regarding evidence of collateral benefits does not apply to exclude that evidence.[33]

The law regarding collateral benefits provides that in any civil action upon a medical, dental, optometric, or chiropractic claim, the defendant may introduce evidence of any amount payable as a benefit to the plaintiff as a result of the injury, death, or loss suffered, except if the source of the collateral benefits has a mandatory self-effectuating federal right of subrogation or a contractual or statutory right of subrogation. If the defendant introduces such evidence, the plaintiff may introduce evidence of any amount the plaintiff has paid to secure the right to receive the benefit. A source of the collateral benefits of which evidence is introduced cannot recover any amount against the plaintiff or be subrogated to the plaintiff's rights against a defendant.[34] The bill provides that the above law does not apply to exclude evidence in

---

[30] R.C. 2323.40(B).

[31] 76 Ohio St.3d 483 (1996).

[32] Section 3.

[33] R.C. 2317.421(B).

[34] R.C. 2323.41(A), (B), and (C).

an action on a medical claim of any amount accepted as full payment for the medical care or treatment of the patient, which evidence is admissible to prove the reasonableness of the charges and fees rendered for the medical care or treatment.[35]

Under current law, in an action for damages for personal injury or wrongful death, a written bill or statement or a relevant portion of it, itemized by date, type of service rendered, and charge, if otherwise admissible, is prima-facie evidence of the reasonableness of any charges and fees stated in the bill or statement for medication and prosthetic devices furnished, or medical, dental, hospital, and funeral services rendered by the issuer of the bill or statement, but only if the party offering it delivers a copy or relevant portion of it to each adverse party's attorney not less than five days before trial. The bill modifies that law by limiting its applicability to "dental" medication and prosthetic devices and to dental and funeral services.[36] The bill's provisions regarding evidence of charges and fees for "medical services" rendered by a medical provider or hospital are described in the preceding paragraphs.

PEER REVIEW PROCEEDINGS

Sharing of peer review proceedings with governmental agencies

The bill permits a peer review committee to share proceedings and records within the scope of the committee, including documents regarding patient and medical care provided by physicians and nurses, with law enforcement agencies, licensing boards, regulatory agencies, and other governmental agencies that are prosecuting, investigating, or adjudicating alleged violations of applicable statutes or administrative rules. That sharing of those proceedings or records will not affect the confidentiality of proceedings and records under continuing law. Any recipient of the records that are provided as described above must take appropriate measures to maintain the confidentiality of the information in the records.[37]

COMMENT

The "loss of chance doctrine" was adopted in *Roberts v. Ohio Permanente Medical Group, Inc*.[38] The syllabus of the Court states the following:

[35] R.C. 2323.41(D).

[36] R.C. 2317.421(A).

[37] R.C. 2305.252(C).

[38] 76 Ohio St.3d 483 (1996).

1. In order to maintain an action for the loss of a less-than-even chance of recovery or survival, the plaintiff must present expert medical testimony showing that the health care provider's negligent act or omission increased the risk of harm to the plaintiff. It then becomes a jury question as to whether the defendant's negligence was a cause of the plaintiff's injury or death . . . .

2. The amount of damages recoverable by a plaintiff in a loss-of-chance case equals the total sum of damages for the underlying injury or death assessed from the date of the negligent act or omission multiplied by the percentage of the lost chance.

3. To ascertain the amount of damages in a case of lost chance of survival or recovery, the trial court must instruct the trier of fact to consider the expert testimony presented and (1) determine the total amount of damages from the date of the alleged negligent act or omission, including but not limited to lost earnings and loss of consortium; (2) ascertain the percentage of the patient's lost chance of survival or recovery; and (3) multiply that percentage by the total amount of damages.

HISTORY

ACTION	DATE
Introduced	02-01-17

H0007-I-132.docx/ks