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Release of Medical Records by Hospitals in North Carolina

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NOTES AND COMMENTS

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I. INTRODUCTION

The personal and confidential character of hospital medical records and their tripartite nature lead to sensitive questions concerning their release. The hospital medical record is the most complete documentation of an individual's confinement to a medical institution. Even though the record is made by the physician or at his direction, and deals with the course of a particular patient's hospitalization, it remains the property of the hopsital to which the patient has been admitted.[1]

The law governing the release of medical records by North Carolina hospitals is well settled with one exception, to wit, the release of medical information to law enforcement authorities to assist them in apprehending criminals. Typically, this problem arises when a physician in a hospital treats an individual whose injury is the apparent result of criminal activity. A question immediately arises regarding what, if any, duty is placed upon the physician or the hospital to report the suspected crime to the police.

First, the patient's right of privacy must be considered.[2] To justify the report to the police, a compelling state interest must outweigh individual privacy interests.[3] As will be seen *infra,* the North Carolina General Assembly has found such a compelling state interest in fourteen instances.

Admittedly, information leading to the arrest of a dangerous criminal would appear to be in the public interest; however, other factors must be assessed. It is conceivable that a reporting requirement would deter injured persons from seeking medical attention. The injured party may simply wish to avoid arrest, or if he is the victim of a crime, he may not relish the adverse publicity generated by the commission of the crime. In addition, it is possible that a report would cause the suspected criminal to take retaliative steps. For instance, a husband suspected of beating his wife might inflict more serious injuries on her if the initial beating is

1. E. HAYT, J. HAYT, & A. GROESCHEL, LAW OF HOSPITAL, PHYSICIAN, AND PATIENT 652 (2d ed. 1952); ASPEN SYSTEMS CORPORATION, HOSPITAL LAW MANUAL 11 § 2-1 (1973); E. HAYT AND J. HAYT, LEGAL ASPECTS OF MEDICAL RECORDS 84 (1964).

2. The right of privacy was first recognized to exist by Justice William O. Douglas in Griswold v. Connecticut, 381 U.S. 479 (1965), in the penumbra of the first, third, fourth, fifth, and ninth amendments.

3. Roe v. Wade, 410 U.S. 113 (1973).

reported. Finally, hospitals and physicians may resent the imposition of law enforcement responsibilities.

II. Requirement to Maintain Medical Records

A better understanding of the possible legal ramifications of disclosure of medical information in such cases requires a close examination of the hybrid "animal" called the patient's medical record. This calls for a review of the requirement placed upon hospitals to maintain medical records and the guidelines governing their content. Four institutions are involved in setting the relevant standards; the North Carolina Medical Care Commission, the Joint Commission on Accreditation of Hospitals (JCAH),[4] Medicare, and Medicaid.

The North Carolina Medical Care Commission is the agency responsible for regulation of licensure of hospitals in North Carolina.[5] Therefore, its regulations will be treated as having the greatest relevancy to this discussion. Accreditation of hospitals by the JCAH is strictly voluntary; however, since 111[6] of North Carolina's approximately 150[7] general hospitals were accredited in 1975, its standards become pertinent. Medicare and Medicaid impose standards upon hospitals which are entitled to receive reimbursement for the hospitalization of eligible beneficiaries.

The Medical Care Commission requires hospitals to write adequate and complete medical records for all patients admitted.[8] The JCAH requires hospitals to maintain an adequate medical record for every person admitted on an inpatient, outpatient, or emergency basis.[9] Medicare regulations require that medical records be maintained for every

4. In 1918, the American College of Surgeons established the Hospital Standards Program to adopt a uniform medical record format to facilitate accuracy in recording the patient's clinical course. The JCAH developed from the Hospital Standards Program through the work of the primary associations of North American medicine and hospitals. In 1951, they joined to create an organization to encourage voluntary attainment of uniformly high standards of institutional medical care. Under current procedures, the JCAH sends survey teams, at least one member of which must be a physician, to hospitals applying for accreditation. Based upon the results of the survey, a hospital is either denied accreditation or granted one or two-year accreditation. For further information on the history and procedures of the JCAH, *see* JOINT COMMISSION ON ACCREDITATION OF HOSPITALS, ACCREDITATION MANUAL FOR HOSPITALS 1970 1-13 (Updated 1973).

5. N.C. GEN. STAT. § 131-126.5 (1974), *as amended*, (Cum. Supp. 1975).

6. JOINT COMMISSION ON ACCREDITATION OF HOSPITALS, 1975 ANNUAL LIST OF ACCREDITED FACILITIES (Supp. Sept. 30, 1975).

7. This figure does not include ten psychiatric facilities which receive separate accreditation. AMERICAN HOSPITAL ASSOCIATION, HOSPITAL STATISTICS 106-107 (1975).

8. NORTH CAROLINA MEDICAL CARE COMMISSION, LAWS, REGULATIONS AND PROCEDURES APPLYING TO THE LICENSING OF HOSPITALS IN NORTH CAROLINA 39 (1964).

9. JOINT COMMISSION ON ACCREDITATION OF HOSPITALS, ACCREDITATION MANUAL FOR HOSPITALS 1970 107 (Updated 1973).

patient admitted,[10] and under the Medicaid program, standards for health care facilities are left to the states.[11]

III. CONTENT OF MEDICAL RECORDS

The duty of hospitals to maintain medical records is beyond dispute; however, in order to appreciate their confidential nature, one must examine the content of the typical medical record.

The Medical Care Commission's regulations are the most specific governing content of medical records. They require medical records to include identification data; date of admission; date of discharge; personal and family history; chief complaint; history of present illness; physical examination; special examination, if any; provisional or admitting diagnosis; medical treatment; surgical record including anesthesia record, pre-operative diagnosis, operative procedure and findings, post-operative diagnosis, and tissue diagnosis; progress and nurse notes; temperature chart including pulse and respiration; medications; final diagnosis; summary and condition on discharge; and, in case of death, autopsy findings, if performed.[12] For patients examined or treated in the emergency room, records must include date, name, address, age, place of injury, diagnosis, treatment and disposition.[13] JCAH standards are more general, but do add the requirement that medical records contain consent forms except when unobtainable.[14] Medicare guidelines are similar to those of the Medical Care Commission and add the requirement that consultations be included in the record.[15] Medicare outpatient records must be ". . . complete and sufficiently detailed relative to the patient's history, physical examination, laboratory and other diagnostic tests, diagnosis, and treatment to facilitate continuity of care."[16] Records for Medicare emergency room patients must contain patient identification; laboratory and X-ray reports, if any; diagnosis; record of treatment; disposition of the case; and, signature of a physician.[17] Medicaid allows state standards to govern the content of medical records.[18]

The extremely personal information contained in the medical record and the patient's constitutional right of privacy create a strong argument

10. 20 C.F.R. § 405.1026(a) (1975).
11. 42 U.S.C. §§ 1396(a)(9), (22) (1970).
12. NORTH CAROLINA MEDICAL CARE COMMISSION, LAWS, REGULATIONS AND PROCEDURES APPLYING TO THE LICENSING OF HOSPITALS IN NORTH CAROLINA 39-40 (1964).
13. *Id.* 32-33.
14. JOINT COMMISSION ON ACCREDITATION OF HOSPITALS, ACCREDITATION MANUAL FOR HOSPITALS 1970 109 (Updated 1973).
15. 20 C.F.R. § 405.1026(g) (1975).
16. 20 C.F.R. § 405.1032(d)(3) (1975).
17. 20 C.F.R. § 405.1033(d)(1) (1975).
18. 42 U.S.C. §§ 1396(a)(9), (22) (1970).

against the release of such data. However, as indicated *supra*, the North Carolina General Assembly has found a compelling state interest in certain circumstances to require disclosure.

IV. Limitation on Release of Medical Records

Although patients' medical records are the "property" of the hospital,[19] hospital authorities may not indiscriminately release such records to whomever may request them. The hospital's interest in a patient's record is custodial in nature, and it cannot be gainsaid that the patient retains an interest in its contents.[20]

North Carolina has granted statutory privilege to communications between a physician and his patient[21] which has the effect of encouraging full and frank disclosure by the patient,[22] and at the same time affords a means of protecting the patient's interest in his medical record. At common law, no such privilege existed, and communications between a physician and his patient could be fully disclosed.[23] The statutory prohibition against disclosure of privileged medical records, however, applies only to judicial or quasi-judicial proceedings.[24] In North Carolina, it is implemented at the superior court level.[25] Disclosure of the privileged communications in court will be allowed only where such disclosure is necessary for the proper administration of justice.[26]

The privilege granted by N.C. Gen. Stat. Section 8-53 extends only to the clinical portions of hospital medical records, that is, to that information acquired by the physician which is necessary for the physician to prescribe for the patient.[27] The statute applies to nurses, technicians, and others assisting or acting under the direction of a physician, provided the physician is covered by the statute at the time.[28]

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19. Note 1 *supra*.

20. Aspen Systems Corporation, Hospital Law Manual 11 §§ 2-1 to 2-2 (1973).

21. N.C. Gen. Stat. § 8-53 states:

> No person, duly authorized to practice physic or surgery, shall be required to disclose any information which he may have acquired in attending a patient in a professional character, and which information was necessary to enable him to prescribe for such patient as a physician, or to do any act for him as a surgeon: Provided, that the court, either at the trial or prior thereto, may compel such disclosure, if in his opinion the same is necessary to a proper administration of justice.

22. Yow v. Pittman, 241 N.C. 69, 84 S.E.2d 297 (1954).

23. *See, e.g.*, State v. Bryant, 5 N.C. App. 21, 167 S.E.2d 841 (1969); Sims v. Charlotte Liberty Mut. Co., 257 N.C. 32, 125 S.E.2d 326 (1962).

24. Aspen Systems Corporation, *supra* note 1 at § 2-3.

25. State v. Bryant, *supra* note 23.

26. N.C. Gen. Stat. § 8-53 (1969).

27. Sims v. Charlotte Liberty Mut. Ins. Co., *supra* note 23.

28. Cases cited note 23 *supra*; State v. Wooten, 18 N.C. App. 269, 196 S.E.2d 603 (1973).

Because the physician-patient privilege is that of the patient,[29] before the physician can divulge the protected communication, the patient must expressly or impliedly waive the privilege[30] or consent to the disclosure of the protected communication.[31]

The Medical Care Commission's regulations allow patients' records to be taken from the hospital only under a subpoena.[32] Likewise, the JCAH, recognizing the right of privacy which should be accorded hospital patients[33] indicates that medical records should be kept confidential and removed from the hospital only by court order, subpoena or statute.[34] Under the Medicare program's regulations, the patient's written consent is required for release of medical information[35] and medical records generally may not be removed from the hospital except under subpoena.[36]

The limitations on release of medical information discussed thus far have been in reference to court-related disclosures. This does not mean that hospitals are left with unbridled discretion in making such records available to relatives or friends of the patient, news reporters, etc. A patient whose records have been released in such an unauthorized manner may sue under either of two theories, defamation or invasion of privacy.[37]

V. Releases Required by Law

In numerous instances North Carolina law requires the disclosure of medical information by hospitals or medical personnel to appropriate authorities, presumably because the legislature has determined that, in these circumstances, the state interest in disclosure outweighs any rights to privacy that might be claimed by the patient. Statutes requiring disclosure necessarily eliminate any requirement to seek or obtain the patient's consent. Under presently applicable North Carolina law, disclosure to a designated authority (usually the local health director), is mandated in situations where a person dies in a hospital as a result of injuries apparently sustained in a motor vehicle collision;[38] where a

29. Cases cited note 23 *supra*.
30. Neese v. Neese, 1 N.C. App. 426, 161 S.E.2d 841 (1968).
31. Yow v. Pittman, *supra* note 22.
32. Medical Care Commission, Laws, Regulations and Procedures Applying to the Licensing of Hospitals in North Carolina 39 (1964).
33. Joint Commission on Accreditation of Hospitals, Accreditation Manual for Hospitals 1970 21-22 (Updated 1973).
34. *Id.* at 110.
35. 20 C.F.R. § 405.1026(a)(2) (1975).
36. 20 C.F.R. § 405.1026(a)(3) (1975).
37. Aspen Systems Corporation, *supra* note 1, at §§ 2-3 to 2-5.
38. N.C. Gen. Stat. § 20-116.1(f) (1975) *as amended*, (Supp. 1975).

professional has reason to suspect child abuse or neglect;[39] and where a physician (or other medical personnel) treats a case of venereal disease,[40] cancer,[41] tuberculosis,[42] rabies or exposure thereto,[43] or any of a lengthy compendium of diseases determined to be communicable to Regulations of the Commission for Health Services.[44] Persons attending childbirth are required to report any inflammation of the eyes of the infant,[45] and the hospital where such birth occurs must comply with additional reporting requirements.[46] In addition, certification requirements are imposed in regard to all fetal deaths occurring after gestation periods of twenty weeks or more;[47] in regard to all live births, regardless of gestation periods;[48] and in regard to all deaths.[49] An additional reporting requirement is imposed in the case of a death occurring as a result of a criminal act or suicide while the decedent was an inmate in a penal or correctional institution, or where death occurs under suspicious, unusual, or unnatural circumstances, regardless of situs.[50] Finally, any facts ascertained during the course of examining or attending an individual claiming Workmen's Compensation Act benefits are exempted from the physician-patient privilege.[51]

Each of the reports required by law appears to be of either a housekeeping (certification) or public health and safety nature. The patient's right of privacy is certainly outweighed by compelling state interests in all cases.

VI. SOLUTIONS

It is evident that the statutory requirements for reports of medical information do not include a requirement to report injuries apparently caused by crime, except in the case of death under unusual circumstances.[52] For instance, if an individual is admitted to a hospital through the emergency room with gunshot wounds in the back, except as hereinafter mentioned, there is no duty on the physician or hospital to report the suspected crime to local law enforcement authorities.

39. N.C. GEN. STAT. §§ 110-118 to -119 (1975) *as amended,* (Supp. 1975).
40. N.C. GEN. STAT. § 130-95 (1974).
41. N.C. GEN. STAT. § 130-84 (1974).
42. N.C. GEN. STAT. § 131-57 (1974).
43. N.C. GEN. STAT. § 106-380 (1975).
44. N.C. GEN. STAT. § 130-81 (1974). Regulations of the Commission for Health Services currently declare 44 specific diseases to be reportable.
45. N.C. GEN. STAT. § 130-107 (1974).
46. N.C. GEN. STAT. § 130-108 (1974).
47. N.C. GEN. STAT. § 130-43 (1974), *as amended,* (Cum. Supp. 1975).
48. N.C. GEN. STAT. § 130-50 (1974).
49. N.C. GEN. STAT. § 130-46 (1974), *as amended,* (Cum. Supp. 1975).
50. N.C. GEN. STAT. § 130-198 (1974).
51. N.C. GEN. STAT. § 97-27 (1972), *as amended,* (Cum. Supp. 1975).
52. N.C. GEN. STAT. § 130-198 (1974).

In 1971, New Hanover and Alamance counties were successful in having local acts passed by the North Carolina General Assembly which require physicians and other medical personnel to report ". . . every case of a bullet wound, gunshot wound, powder burn or any other injury arising from or caused by, or appearing to arise from or be caused by, the discharge of a gun or firearm, every case of poisoning or illegal drug usage, every case of a wound or injury caused, or apparently caused, by a knife or sharp or pointed instrument if it appears to the physician or surgeon treating the case that a criminal act was involved, and every case of a wound, injury or illness in which there is grave bodily harm or grave illness if it appears to the physician or surgeon treating the case that the wound, injury or illness resulted from a criminal act of violence."[53] The report is to be made to the police of the city or town where the place of treatment is located or to the sheriff if the place of treatment is not in a city or town. The person making the report is given immunity from civil or criminal liability which might otherwise arise from making such report.

On December 2, 1975, the city of New Bern, North Carolina enacted an ordinance which requires physicians and other medical personnel to report to the police department any treatment or requests for treatment "to a person who is suffering from a bullet wound, gunshot wound, knife wound, or any other injury arising from or caused by, or appearing to arise from or to be caused by an act criminal in nature."[54] The obvious difference between the New Bern ordinance and the statutes of Alamance and New Hanover counties is the omission from the ordinance of the grant of immunity to the person making the report. Without immunity, the reporter is faced with the choice of either making the required report and subjecting himself to possible liability to the patient for invasion of privacy or defamation[55] or not making the report and being guilty of violating the ordinance.

New Bern's failure to grant immunity in its reporting ordinance was probably intentional as it is certainly outside the bounds of the city's authority to infringe upon private rights of action. The local acts of New Hanover and Alamance counties may grant such immunity because the state, as sovereign, may cut off such rights.

53. Session Laws 1971, Ch. 4 (New Hanover County); Session Laws 1971, Ch. 594 (Alamance County).

54. New Bern, North Carolina, An Ordinance to Require Physicians and Other Medical Personnel to Report Certain Wounds and Injuries to Their Attention, Dec. 2, 1975.

55. ASPEN SYSTEMS CORPORATION, *supra* note 1, at §§ 2-3 to 2-5; Letter from William W. Melvin, Special Deputy Attorney General of North Carolina to Fred M. Carmichael, Attorney for Craven County Hospital, Oct. 13, 1975.

VII. CONCLUSION

The ordinance of New Bern was definitely in the interest of its citizens. The required reports could possibly mean the swift apprehension of dangerous criminals. Thus, it was within the ordinance-making power of the city.[56] However, because of the limitations placed upon that power, local ordinances are not the solution for the problem. A state statute is necessary to achieve the appropriate result. New Hanover and Alamance counties have effectively protected their health care communities from possible serious consequences for well-intentioned actions. New Bern has not been as successful in its attempt to do the same. North Carolina's medical contingent must take the initiative in preparing proposed legislation for consideration by the General Assembly. A state statute, uniform in application and interpretation, and capable of granting immunity to the individual making the report, is necessary for the protection of a segment of the population that is so vital to North Carolina's welfare.

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An Historical Analysis of Mandatory Capital Punishment

The case and statutory history of the death penalty in the United States is well documented.[1] Its continued constitutionality is, however, a matter of debate. In one-hundred and eighty years since the passage of the eighth amendment,[2] the United States Supreme Court has not once held the death penalty unconstitutional;[3] yet there has unquestiona-

56. N.C. GEN. STAT. § 160A-174 (1972).

1. H. BEDAU, THE DEATH PENALTY IN AMERICA (1967 rev. ed.); E. BERKSON, THE CONCEPT OF CRUEL AND UNUSUAL PUNISHMENT (1975); DAVIS, THE MOVEMENT TO ABOLISH CAPITAL PUNISHMENT IN AMERICA, 1787-1861, 23 (1957); Forman, *Capital Punishment: "Evolving Standards of Decency"*, 19 LOYOLA L. REV., 81 (1972-73); Grannucci, *Nor Cruel and Unusual Punishment Inflicted: The Original Meaning*, 57 CALIF. L. REV., 839 (1969); P. Makcey, *The Inutility of Mandatory Capital Punishment: An Historical Note*, 54 B.U.L. REV., 30 (1974); Passell, Deterrent Effect of the *Death Penalty: A Statistical Test*, 28 STAN. L. REV., 61-80 (1975); Note, *Capital Punishment in Virginia*, 58 VA. L. REV., 97 (1972); Note, *Constitutional Law—Capital Punishment*, 41 FORDHAM L. REV., 671 (1973); Note, *Discretion and the Constitution of the New Death Penalty Statute*, 87 HARV. L. REV., 1690 (1974); Comment, *Supreme Court and Capital Punishment from Wilkerson to Witherspoon*, 14 ST. LOUIS L.J., 463 (1970).

2. U.S. CONST. amend. VIII.

3. State v. Waddell, 282 N.C. 431, 194 S.E.2d 19 (1973).