Association of Anaesthetists guideline: audio/visual recording of doctors in hospitals

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What other guidelines are available on this topic?

General guidance on making audio/visual recordings of patients has been produced by the General Medical Council, and some general guidance on being recorded during consultations has been produced by some of the medical defence organisations.

Why was this guideline developed?

This guidance was developed in response to enquiries from members of the Association of Anaesthetists regarding an increasing trend for patients and their relatives or friends to wish to record clinical procedures and discussions with anaesthetists or intensivists.

How and why does this statement differ from existing guidelines?

Available guidance is non-specific and does not cover the sorts of clinical encounters involving anaesthetists or intensivists.

Introduction

This guidance has been produced by an Association of Anaesthetists Working Party in response to members' enquiries. The process has been led by the Association of Anaesthetists and so is primarily applicable to anaesthetist, intensivist and pain specialist members, but may be applicable to other doctors and even to non-doctor healthcare workers; the term 'doctors' is used below to refer to all relevant groups. The guidance covers both overt and covert recording (still or moving image, and audio) of doctors in hospitals by the following:

- patients and their families or friends.
- Trust agents or advisors e.g. during incident reviews, grievance/disciplinary/complaint panels, medicolegal case conferences, etc.
- media allowed or invited into hospital, e.g. for television or radio documentaries, news items, etc.

Please note that the following is based on legal opinion, but many of these issues have not been tested in the courts.

Background and scope

Anecdotally, recording of doctors and other staff in hospital by patients or relatives appears to be occurring more frequently, for example during discussions with patients or parents and during procedures under local or regional anaesthesia (e.g. caesarean section). The recording may be covert or overt, and with or without the permission of the doctor(s). Whilst some general discussion/guidance is available, it mostly refers to covert recording of consultations [1-4]. There are also other situations in which doctors may find themselves recorded, as above. (N.B. situations in which there may be recording of *patients* by *doctors* are specifically excluded from this guidance).

Summary of legal background

There are three main areas of law that apply to the recording of patients/doctors:

i) Confidentiality

A major focus of the law has been on protecting patients' rights to confidentiality. A patient can waive his/her right to confidentiality, for example by recording aspects of his/her care (including discussions and consultations) and showing it to others at home. Doctors are not able to prevent this on the grounds of protecting patient confidentiality. However, Trusts do have an obligation to protect the confidentiality of all of their patients, for example if a recording made by one patient includes another patient in the background (n.b. this is unlikely to apply to staff in the background, carrying out their normal work).

ii) Data protection

Like the old Data Protection Act 1998, the new General Data Protection Regulations (GDPR) and the accompanying Data Protection Act 2018 do not apply to processing "*by a natural person in the course of a purely personal or household activity*" [5]. A patient does not need anyone's permission to process his/her own personal information. Thus, data protection rules would not apply to a recording made by a patient that is viewed only at home. However, data protection rules may well apply to recordings that are widely shared, posted online or on social media if they include identifiable persons (for example doctors) without their permission, depending on the nature of the material and the extent of the dissemination, and whether such use can no longer be considered for 'purely personal' reasons. If it cannot, then the posting would have to be justified, by, for example, obtaining the doctor's consent, or by relying upon other specific legal justifications.

iii) Privacy

Rules over privacy are still evolving in the UK, under the influence of the European Convention of Human Rights. An important factor is the 'reasonable expectation of privacy' – i.e. a patient might reasonably expect his/her interaction with a doctor to be private. Staff might reasonably expect to be treated with appropriate respect regarding privacy *by their employers*, for example not having covert recordings made, or recordings shared publicly without their permission. Patients are unlikely to be under the same obligation to staff unless there are aggravating circumstances, for example if staff are being harassed or recordings are being made for inappropriate purposes. Disclosure of private information must be sufficiently serious to cause substantial offence to a person of 'ordinary sensibilities'.

Implications and recommendations

a) Trusts should draw up guidance for the taking/making of overt and covert photographs/recordings on its premises, by both staff and patients or relatives. All staff should be made aware of such guidance, for example on staff induction and Trust information networks, and patients or relatives should also be

informed of it, e.g. by use of notices or information leaflets. It is acknowledged that enforcing rules may be difficult in practice.[1]

b) Trusts should also draw up and make available guidance for recording by Trust agents or advisors e.g. during incident review panels, complaint reviews, medicolegal case conferences, etc., and for recording by television/radio and other media allowed or invited into hospital, e.g. for television or radio documentaries, news items, etc. This guidance should be aimed both at those doing the recording and at those being recorded.

c) If a patient or relative asks for permission to record a conversation for their own personal use and reference, consent should generally be given, as within the current legal framework it is difficult to see why consent could be refused, unless there are real concerns that it would impact on patient safety and care.

d) If relatives wish to record a conversation concerning the management of a patient without capacity, for example around treatment decisions or end-of-life care, consideration should be given to discussing confidentiality obligations with them. In most situations, family members are not entitled to release medical information about a relative who lacks capacity into the public domain, so it is important that they should understand their own obligations to the patient if recordings are to be released into their possession. In difficult or contentious situations, or when disclosures concerning children are at stake, clinicians are advised to seek legal guidance from their employing organisations – including about the role of the Court of Protection. It is recommended that both parties to the conversation should retain copies of any recording, and a formal and transparent recording process should be considered, such as a simultaneous dual-CD or other digital recording system, with copies for the patient or relatives and health records.

e) The priority for care should always be the safety and quality of treatment; a doctor who has concerns that intrusive filming, for example (by patients/relatives or external media company), may be overly distracting and/or impair his/her ability to provide safe care, should explain these concerns to the person making the recording and the patient. It is hoped that patients or relatives would be likely to listen to such an explanation and respect the doctor's wishes, even if there may be no legal obligation to desist. In such situations, senior clinical and/or managerial staff should be consulted if time permits, and attempts made to resolve any conflict without compromising care. It is recommended that these discussions are documented in the clinical records.

[1] A number of Trusts have produced policies regarding recording in their premises; for example, see:

- https://www.kch.nhs.uk/news/public/news/view/23135
- https://www.southernhealth.nhs.uk/_resources/assets/attachment/full/0/155775.pdf
- https://www.guysandstthomas.nhs.uk/news-and-events/filming.aspx
- http://www.royalberkshire.nhs.uk/patients-and-visitors/filming-in-the-hospital.htm (all sites accessed 17/06/2019).

However, many refer only to recording by external media companies. It should also be noted that some of these policies' suggestion, that patients simply cannot record without permission, does not reflect the breadth or subtlety of the current legal situation, which we have tried to present in the current document.

f) The legal situation regarding staff members who do not wish or do not give permission to be recorded by patients is unclear; however, rather than simply withholding care they should seek other colleagues to provide care instead. If a willing colleague cannot be found, then this should be recorded in the notes but ultimately, concerns about recording would be very unlikely to justify withholding necessary medical care and treatment.

g) In general, Trusts should not make covert recordings of staff, unless there are serious concerns over wrongdoing, etc, to justify covert recording. Rather, Trusts should inform their staff what is being monitored and what is being shared or disseminated, and to whom. Similarly, staff should not be included in media recordings without giving them a free choice, i.e. a real option to 'opt out'.[2]

h) Legal advice should be sought should staff or a Trust become aware of a complaint or claim involving a covert recording. There may be grounds to object, particularly if the information is publicly shared and/or is inaccurate or defamatory. However, it is likely that such a recording may be viewed or listened to as evidence, even if covert, depending on the nature of the complaint or claim and the circumstances of the case.

Private sector

The situation in the private sector may be different, in that care is based on contract rather than the obligations of a public body. Private institutions may therefore have greater legal freedom to impose contractual terms that prohibit recording without express consent, and to withhold treatment (except in an emergency situation) if those conditions are not respected. However, it is recommended – on ethical grounds, if not legal – that the same principles as those above should apply to both private and public sectors as appropriate.

Commentary

The above text represents what the Working Party believes is the best advice available regarding the current legal situation relating to recording of doctors in hospitals. The Working Party acknowledges that the primary message, that there does not seem to be a sound legal argument for refusing requests (whether overt or implied) to film or record a patient's care, may not be popular amongst clinicians, who may feel uncomfortable when asked or when being recorded. However, it is important that doctors and others are aware of the legal situation, in order to help avoid conflict and/or misplaced objections. As with many other difficult areas of practice, it is not always possible to give a clear direction of what is and isn't permissible, to cover all circumstances, but it is hoped that this document will be helpful, not least in helping departments and Trusts

[2] N.B. the GMC's guidance *Making and Using Visual and Audio Recordings of Patients* refers to covert recordings of patients rather than staff, but gives the legal basis for this and may also be of interest; it may be found at https://www.gmc-uk.org/ethical-guidance/ethical-guidance-for-doctors/making-and-using-visual-and-audio-recordings-of-patients (accessed 14/01/2019).

draw up appropriate local guidance. It is strongly encouraged that anaesthetists involve themselves in this process.

Acknowledgement

The Working Party is indebted to Eleanor Grey QC, who has been involved throughout the development of this guidance.

Competing interests

No competing interests declared.

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