

# Overt and covert recordings of health care consultations in Australia: some legal considerations

There are legal considerations for both clinicians and patients when recording health care consultations

Studies show that patients often have inaccurate recall of health care events and diagnoses.<sup>1</sup> Concentration during a medical consultation may be “hampered by unspoken anxieties or pain, making it difficult to recall detail”.<sup>2</sup> Audio recordings of consultations can be useful for patients and clinicians to assist memory and understanding. They have mainly been evaluated in oncology and paediatrics.<sup>3,4</sup> Patients report that listening to their consultation recording increases knowledge and understanding of their illness, and recordings can assist with treatment decision making, increasing a sense of empowerment.<sup>5</sup> Sharing recordings with family can facilitate support and understanding. Clinicians likewise recognise recordings’ benefits for patients and for improving the quality and efficiency of their care.<sup>6</sup>

Research in the United Kingdom found that 69% of patients wish to record consultations.<sup>7</sup> Increasingly, patients are using smartphones to record consultations, either with permission or covertly.<sup>7,8</sup> Recording systems have been developed by health services themselves, transformed by the ubiquitous use of smartphones and other flexible technologies.<sup>9–11</sup> Examples include the Open Recording Automated Logging System (ORALS) software in the United States<sup>9</sup> and telephone-based digital recording in Denmark.<sup>11</sup> In Australia, the Second Ears smartphone app, developed at the Victorian Comprehensive Cancer Centre in 2018, is designed to make recordings available to both the patient and the hospital health information management service.<sup>6,10</sup> Patients can choose whether to download and use the app (either before their appointment or in the clinic), access the recordings on their smartphone, and share them with family and friends.<sup>6,10</sup> Common design features of such health service-led recordings address data security, file storage and patient consent. Whether the clinician or the patient controls the recording process may differ across technology platforms; for instance, in the Danish example above, the clinician initiated the recordings, whereas with Second Ears the patient would do so.

The use of consultation recordings often raises legal questions.<sup>5,7,10,12</sup> In this article, we compare the legal implications of overt and covert recordings of health care consultations and address key concerns identified by clinicians, notably the requirement for consent to record and share the recording, and the use of recordings in negligence claims.<sup>8,13–15</sup> We distinguish between three recording types:

- Overt patient-led recordings: for example, a patient recording a consultation with the clinician’s

consent. These recordings are akin to a patient’s handwritten notes.

- Overt health service-led recordings: for example, the Second Ears app, where both clinician and patient consent (actively or impliedly) to the recording; the app is facilitated by the health service and the primary version of the recording stored on their system.
- Covert patient-led recordings: for example, a patient recording without the clinician’s knowledge or consent.

As each legal question is identified, we consider the law in the context of the Second Ears app. This article is general in nature and does not constitute legal advice. References to legislation are current at 13 October 2020. References to state or territory laws relate to the location of the recording or the place at which the sharing of the recording originated. We do not address the issue of intentional recording of private conversations by third parties, either overtly or covertly.

## Consent to record a consultation

### Clinician consent to patient-led recordings

Clinicians consider that their consent to be recorded is a key issue. Perhaps surprisingly, at law in many Australian jurisdictions, the patient need not obtain explicit consent from the clinician. In Victoria, Queensland and the Northern Territory, the law does not consider a recording of a conversation that is made by one of the parties (as opposed to a third party). In New South Wales, Tasmania and the Australian Capital Territory, patients can record their consultation without the clinician’s consent (or, by extension, their knowledge) if the recording is only for the patient’s own use (ie, to listen back to the recording later), or to protect their lawful interests (such as in a negligence claim). In South Australia and Western Australia, clinician consent is required (ie, two-party consent) for recording a consultation for later listening-back by the patient (Box 1).

### Patient consent to health service-led recordings

Where the recording is made on an app like Second Ears with data stored by the health service, this is an act of health information collection about an individual that requires the patient’s express or implied consent. The patient’s decision to download and install the app can act as implied consent; the app’s terms and conditions could also include a clear statement about patient consent.

Megan Pictor<sup>1</sup> 

Carolyn Johnston<sup>1</sup> 

Amelia Hyatt<sup>2</sup>

<sup>1</sup> Melbourne Law School, University of Melbourne, Melbourne, VIC.

<sup>2</sup> Cancer Experiences Research, Peter MacCallum Cancer Centre, Melbourne, VIC.

megan.pictor@unimelb.edu.au

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Podcast with Megan Pictor available at [mja.com.au/podcasts](http://mja.com.au/podcasts)

### 1 Patient-led recordings: when is consent from the other party required for the act of recording?

Jurisdiction	Patient makes recording for unspecified purpose	Patient makes recording intending it for personal use only	Patient makes recording that is reasonably necessary for the protection of their own lawful interests	Legislation
Victoria, Queensland, Northern Territory	Consent not required	Consent not required	Consent not required	<i>Surveillance Devices Act 1999</i> (Vic): no relevant provision <i>Invasion of Privacy Act 1971</i> (Qld), s 43(2)(a) <i>Surveillance Devices Act 2007</i> (NT): no relevant provision
New South Wales, Australian Capital Territory, Tasmania	Consent required	Consent not required	Consent not required	<i>Surveillance Devices Act 2007</i> (NSW), s 7(3) <i>Listening Devices Act 1992</i> (ACT), s 4(1)(b), (3) <i>Listening Devices Act 1991</i> (Tas), s 5(1)(b), (3)(b)
South Australia, Western Australia	Consent required	Consent required	Consent not required	<i>Surveillance Devices Act 2016</i> (SA), s 4 <i>Surveillance Devices Act 1998</i> (WA), s 5

#### Consent of other people captured incidentally in any overt recording

A consultation recording — whether patient-led or health service-led — might accidentally capture another conversation, for instance from the clinic's reception desk. No consent of the third party is needed in this case, because they are not a party to the recorded conversation. Typically, Australian surveillance device laws do not regulate recordings of conversations occurring in circumstances in which the parties ought reasonably to expect to be overheard, such as in public or an open hospital ward. This means that if a patient is overtly recording their own consultation while in a curtained cubicle, their inadvertent capture of another clearly heard conversation in the next cubicle would not require the consent of those having that conversation.

#### Consent when someone else joins any overt recording

If another person, such as the patient's relative or another clinician, enters a room where a consultation is being recorded, but does not join in the conversation, the new person is not a party to it and that person's consent is therefore not needed. However, if the new person does join the conversation, they become a party to it. [Box 1](#) indicates when that new party's consent to be recorded is required. In SA and WA it is usually required. In NSW, the ACT and Tasmania it is required if the patient makes the recording intending to share it with anyone else, but not if the recording is intended only for the patient to listen to. Consent, when required, can be either express or implied. An example of how this situation might be addressed could be a health service policy to have a door sign stating prominently that a recording is in progress and that by entering the room the new participant consents to be recorded. A person entering the room could then signal their non-consent by verbally requesting the

recording be stopped. This applies to health service-led and patient-led recordings.

#### Covert recordings by patients

Covert recording by patients is not uncommon; a survey conducted in the UK found that 15% of respondents self-reported recording clinical encounters without permission. A further 35% of respondents would consider covert recordings in the future.<sup>7</sup> In the US, a similar survey found that far fewer respondents recorded covertly (2.7%),<sup>8</sup> possibly because some health services routinely provided permission for recording. Currently, the proportion of Australian patients who record covertly is unknown; anecdotally, however, clinicians report that it is occurring.<sup>16</sup> Covert recording has been described as a topic of "significant legal ambiguity".<sup>17</sup> In Australia, as noted above, the law varies significantly by jurisdiction. Only SA and WA require two-party consent and thus prohibit patients covertly recording for their own use ([Box 1](#)).

#### Covert recordings: legal penalties

Not all consultation recordings require consent. In SA and WA, where two-party consent is required, a person making a covert recording for their own use is subject to legal penalties; for example, in SA, fines of up to \$15 000 or imprisonment for up to 3 years. In *Toth v DPP (NSW)* [2014] NSWCA 133, a case concerning a patient's illegal covert recording, the magistrate imposed an 18-month good behaviour bond.

#### Dealing with unwanted recording

If their consent is legally required but the clinician does not want to be recorded, they can simply ask the patient to discontinue the recording. Regardless of whether the act of recording legally requires their consent, a clinician's refusal to be recorded, or the exposure of covert recording by a patient, may lead to breakdown of the therapeutic relationship,<sup>14</sup>

## 2 Can a patient share their lawfully made recording with third parties for general purposes\* without the clinician's consent for the sharing?

Jurisdiction	Sharing with immediate family and friends <sup>†</sup>	Sharing with public at large	Legislation
Victoria, Northern Territory	No (clinician consent for sharing required)	No (clinician consent for sharing required)	<i>Surveillance Devices Act 1999</i> (Vic), s 11(2)(a) <i>Surveillance Devices Act 2007</i> (NT), s 15(2)(a)
Western Australia	No (clinician consent for sharing required)	No (not even with clinician consent)	<i>Surveillance Devices Act 1998</i> (WA), s 9(2)(a)(ii), (3)
Queensland, Tasmania, Australian Capital Territory	Yes <sup>‡</sup>	No (clinician consent for sharing required)	<i>Invasion of Privacy Act 1971</i> (Qld), s 45(2)(a), (d) <i>Listening Devices Act 1991</i> (Tas), s 10(2)(a), (d) <i>Listening Devices Act 1992</i> (ACT), s 5(2)(b), (e)
New South Wales, South Australia	Yes <sup>§</sup>	Yes <sup>§</sup>	<i>Surveillance Devices Act 2007</i> (NSW), ss 7(3)(b), 11(1). <i>Surveillance Devices Act 2016</i> (SA), ss 4(2)(a)(i), 12(1).

\* Legislation usually deals separately with the sharing of recordings for different purposes, such as "in the public interest", for protecting the "lawful interests" of the person who is sharing the recording, "in the course of legal proceedings", "in the performance of a duty", or as authorised by law. This table solely addresses when clinician consent is required for the sharing of a recording with a family member or with the public at large when the purpose of the sharing is not specified. This may include for the patient's health and wellbeing. It does not address sharing for other purposes. † This is typically expressed in legislation as: persons who have, or are believed on reasonable grounds by the person who is communicating or publishing the recording to have, such an interest in the private conversation (ie, the health care consultation) as to make the sharing reasonable under the circumstances. ‡ In these jurisdictions, the original recording may be lawfully made covertly by the patient for their own use, and then shared with family, without the clinician's consent. § Section 11 of the *Surveillance Devices Act 2007* (NSW) is silent about the sharing (publication or communication) of recordings that were made lawfully. A recording that is made by one party without an original intention that the recording be published or otherwise disseminated is lawful in NSW: section 7(3)(b)(ii). Section 12 of the *Surveillance Devices Act 2016* (SA) is silent about the sharing of recordings that were made lawfully, such as a recording made with the consent of both parties under section 4(2)(a)(i). ◆

necessitating transfer of care to another clinician as per the Medical Board of Australia's code of conduct (<https://www.medicalboard.gov.au/codes-guidelines-policies/code-of-conduct.aspx>). While discontinuing a relationship may be appropriate in the context of misuse of an audio recording or its use with malicious intent, it would be a drastic response to a simple request by the patient to record, given the benefits of doing so. Health service-led systems such as Second Ears may overcome this problem by incorporating clear frameworks around participation, consent and sharing.

### Sharing recordings with others

#### Health care organisations sharing recordings

Recordings made by the health service with the patient's consent (eg, via the Second Ears app) form part of the medical record and the organisation can lawfully share the recording in various ways, which are broadly similar across Australian states and territories. These include:

- with the person's consent;
- without the person's consent for a directly related purpose as long as the person would "reasonably expect" the disclosure (eg, in transferring care to another provider at the same service: *F v Medical Specialist* [2009] PrivCmrA 8);
- to defend a legal claim;
- for research in the public interest (if certain privacy guidelines are met, such as those set out by the National Health and Medical Research Council<sup>18</sup>); and
- with an immediate family member of the patient for compassionate reasons or to provide the patient with care when the patient is incapable of providing consent.

This mirrors other parts of the medical record such as written notes and scans.

If the recording is de-identified (which may be difficult because voice patterns are distinctive and health information discussed during consultations is often reasonably identifiable), it can usually be used without patient consent for communication training within the health service. Consent may provide a more appropriate legal basis for such use.

#### Patients sharing recordings

Apps such as Second Ears facilitate patients' sharing of recordings with family and others for treatment decision making and care. The law relating to such sharing of recordings with third parties varies between jurisdictions and also turns upon the question of whether the original recording was overt or covert. Separate legislative provisions address the act of recording compared with the recordings' subsequent use. Two-party consent is generally, but not always, required for patients to lawfully share recordings with third parties (Box 2). In Queensland, Tasmania and the ACT, there is a distinction between patients sharing a recording with immediate family (which can be done without the clinician's consent to share) and sharing with the wider world (which requires the clinician's consent). In NSW, unusually, a recording that is originally lawfully made with only one party's consent but with no intention to share can be subsequently shared without restriction (eg, on social media) (*Surveillance Devices Act 2007* (NSW), section 11).

Clear communication and consent remain the most desirable mechanisms to frame patients' expectations and choices around the sharing of recordings with others, even where consent is not legally required. For the avoidance of doubt, an agreement to create a recording — whether a clinician's oral agreement for a patient to record on their smartphone, or the terms and conditions built into an app — should explicitly address the extent to which a patient can share the recording with others. Such an agreement might, for

instance, permit the patient to share the recording with family but not publish it at large, for example, on public social media. This could override any legislative entitlement to share a recording openly. If a patient distributed the recording in violation of the terms and conditions, the health service could pursue a legal claim for breach of contract. We are not aware of previous such claims. Health services would need to weigh up the financial and reputational costs of pursuing such a claim.

### The use of recordings in legal proceedings

Recording the consultation does not change clinicians' medico-legal obligations to patients. Such recordings provide transparency of the discussion and could be used as evidence of appropriate information sharing with patients, thus meeting the clinician's required standard of care.

Clinicians have a duty to provide sufficient information on inherent risks of treatment and alternative treatments, to enable patients to exercise a meaningful choice. A claim may lie in negligence if the patient can demonstrate a "failure to warn", where the clinician did not meet the appropriate standard of care and the patient consequently made an uninformed choice about treatment which resulted in harm. The importance of patient-centred communication was highlighted in the UK decision of *Montgomery v Lanarkshire* [2015] UKSC 11 and the Australian case *Rogers v Whitaker* [1992] HCA 58.

In a claim for negligent non-disclosure, where the patient states that the clinician did not provide information concerning material risks about the proposed procedure, the recording could be used to provide evidence of the consultation. In most states and territories, whether the recording itself was taken with both parties' consent or by one party covertly does not affect its admissibility in court. In jurisdictions where covert recording is not lawful (Box 1), an exception typically exists permitting a person to covertly record a private conversation to protect their lawful interests. An example is where there is a serious dispute between two parties regarding different versions of an arrangement (*Georgiou Building v Perrinepod* [2012] WASC 72). The relevant lawful interest must exist at the time of the recording (*Marsden v Amalgamated Television Services* [2000] NSWSC 465). The recording's lawfulness is a separate issue to its admissibility.

It has been established that tape recordings are admissible to provide primary evidence of the conversation or sounds recorded on the tape. In the case of *Butera v Director of Public Prosecutions (Vic)* [1987] HCA 58, it was held that the tape is "a part of the machinery by which the evidence is produced". It would follow that the recording on an app such as Second Ears provides evidence of the conversation that took place between the clinician and patient. Such a recording is admissible in court if the content is relevant and otherwise admissible, the voices are properly identified, and the recording has provenance — it is authentic, accurate and has

not been tampered with. In this instance, the voices recorded would fall within the category of hearsay evidence — that is, representations made out of court that are led as evidence of the truth of the fact. As audio recordings fall within the definition of "document" in the *Evidence Act 1995* (Cth) (which is uniform with most state and territory Acts), they may be admissible if they conform to the statutory requirements.

As an example, in Victoria courts have the discretion to admit recordings as evidence if the evidence is relevant (*Evidence Act 2008* (Vic), sections 55 and 56) and if the desirability of admitting the evidence outweighs the undesirability of doing so (*Evidence Act*, section 138). The recording will form only part of the record of information flow between clinician and patient. Contemporaneous notes and other non-recorded conversations will also be relevant to determine if the standard of care has been met.

There is no evidence that audio or video recordings of consultations increase litigation.<sup>19,20</sup> A study evaluating the provision of consultation video recordings to patients found that in the high risk specialty of neurosurgery, none of the 2807 patients recorded used the video in a legal action.<sup>19</sup> Recordings might actually reduce conflict and litigation because they overcome differences in recollection between two parties.<sup>21</sup>

### Ownership of recordings

Traditionally, the law has not conceived of information as property (*Boardman v Phipps* [1967] 2 AC 46). In Australia, patients have no proprietary interest in a doctor's medical notes (*Breen v Williams* [1996] HCA 57) (although legislation provides a right to access them). Nor do doctors have any proprietary interest in a patient's handwritten notes, or by extension, an overt patient-led recording. However, a health service-led recording such as one made using the Second Ears app could be said to be jointly created. As there are two copies of it, one held by the patient and one by the health service, it could be argued that each has some proprietary interest. A recent exploration of this position posited that there may be multiple rights holders of health data.<sup>22</sup> This view has yet to be tested in the courts. It is appropriate to focus instead on the obligations of the different parties to protect and store the recording data.

### Data security and storage of overt recordings

A recording made on a system such as Second Ears forms part of the medical record and the organisation must take reasonable steps to protect it from misuse, loss and unauthorised access or disclosure. Any contract with a third-party organisation (eg, a cloud storage provider) should also reflect these requirements and address issues of security and access. Health records must be retained for a specified period; in Victoria, NSW and the ACT, this is 7 years after the patient last received care from the organisation, after which the records

should be destroyed if they are no longer needed. By comparison, patients need neither keep nor protect their own copy of a recording. If the recording is made using a third-party app, the terms and conditions of that app are relevant, adding further complexity in relation to custodianship and data protection.

## Conclusion

Health service-led recording technologies, of which Second Ears is an example, can draw on a framework that makes explicit all parties' rights and responsibilities, and ensure that an authenticated version of the recording is maintained securely. Such an approach promotes shared expectations between patients and clinicians and is likely to reduce miscommunication.

Our analysis found surprising diversity in Australian legislation pertaining to consultation recording, leading us to conclude that, to avoid confusion, expressly articulated permissions around

the act of recording and the extent of sharing recordings are desirable. While covert recording is not uniformly unlawful in Australia, transparency promotes trust and enhances the clinician–patient relationship. There is some evidence that concerns about a heightened litigation risk as a consequence of recording are unfounded; rather, the existence of a recording should minimise conflicting recollections and enhance a sense of collaboration. While the act of recording does not alter a clinician's duty to disclose relevant information to a patient, communication skills training may be a way to alleviate concerns about being recorded.<sup>10</sup>

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