

# Medico-legal implications of audiovisual recordings of telehealth encounters

The COVID-19 pandemic has necessitated rapid uptake and use of telehealth, unmasking a number of concerns potentially not previously contemplated by clinicians, patients and legislators

In the physical distancing climate of coronavirus disease 2019 (COVID-19), the ubiquity of virtual communications in medical practice generates a number of challenges. Consultation via telehealth allows for creation of audiovisual documentation of the clinical interaction as well as observation by unseen parties from each participant's perspective, either in real time or subsequently via review of any recordings. It is necessary for clinicians to i) obtain informed consent for clinician-led recordings, ii) be aware of potential patient-generated recordings (both declared and undeclared), and iii) meet legal, privacy and storage requirements pertaining to health information arising from a virtual consultation.

## Consent to participation

Observing next of kin or third parties to a virtual telehealth consultation must be introduced to the treating clinician in a manner consistent with an in-person consultation, whereby such an individual would, with the patient's consent, attend the consultation with the patient.

In considering the clinician's screen, consent for clinician participation is implied, but should be specifically broadened where appropriate to allow for the presence of clinical observers. Indeed, the clinician's duty of confidentiality still applies to telehealth consultations, necessitating awareness of others within earshot or visual proximity to the consultation.

## Implications of virtual participation

The benefits of a virtual consultation include participation and collaboration with members of the patient's family previously unable to participate, as well as increased access to health care for patients with particular physical challenges or vulnerabilities, including vulnerability to infection with COVID-19. Interviewing a patient in their home adds rare insights for a clinician not typically engaged in home visits, including opportunities for environmental observation, which may be of clinical value.

The home setting allows for involvement of parties (seen and unseen) potentially contrary to the patient's best interests. Pertinent examples include family violence or elder abuse contexts, where presence of offenders may jeopardise the clinical encounter and may pose direct risks to the patient in the periconsultation period and subsequently via covert audio or video footage. A 2020 article provided insights on screening questions for detecting and navigating

potential abuse during telehealth consultations in the setting of a COVID-19-related domestic violence epidemic secondary to government-imposed social restrictions.<sup>1</sup>

Beyond clinical value, novel forms of documentation (including audiovisual recording) generated within the consultation may benefit research, education, billing and coding, subject to appropriate ethical and consent obligations. The content of a traditional clinical consultation episode is limited to the parties in the room and, to a defined extent, other parties (via review of written documentation). In the telehealth context, a wide audience can potentially review video footage of the consultation, as if they were there, for an indefinite period. This may have implications for the practicalities and duration of storage required of such material, its latent role as discoverable documentary evidence in future litigation (particularly given the persuasive nature of audiovisual documentation), and in substantiation of episodic care funding. Clinical interactions may incorporate questions or discussions that, while appropriate sequentially, may appear inappropriate, deficient, discourteous or misleading if taken out of context or distilled to a single statement or query. Recordings, and their potential edits, could be used by patients in a maladaptive manner, engender abnormal illness behaviour, or make a participant consciously or unconsciously feel the need to perform or otherwise change clinical interactions.

## Recordings by the patient

The likelihood of a patient recording a clinical encounter is much higher in the age of telehealth, when secret recording is increasingly possible. The legality of recording a private conversation without consent depends on the state or territory where the person undertaking the recording resides, as surveillance legislation is largely a matter for these jurisdictions (Box 1).

In New South Wales, South Australia, Tasmania, Western Australia and the Australian Capital Territory, it is an offence to record a private conversation. This was upheld in NSW in *Toth v Director of Public Prosecutions*, where it was held that a patient secretly recording a consultation with a general practitioner was an offence.<sup>2</sup> However, in Victoria, Queensland and the Northern Territory, it is lawful to record a private conversation without consent if you are a party to the conversation.<sup>3-5</sup>

In all jurisdictions, it is generally not permissible to publish or communicate information secretly recorded. However, exceptions exist; for example, in Victoria, the prohibition on publication or communication

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## 1 Legislation governing covert recordings

State or territory	Legislation pertaining to recording
Australian Capital Territory	<i>Listening Devices Act 1992</i> (ACT)
New South Wales	<i>Surveillance Devices Act 2007</i> (NSW)
Northern Territory	<i>Surveillance Devices Act 2007</i> (NT)
Queensland	<i>Invasion of Privacy Act 1971</i> (QLD)
South Australia	<i>Listening and Surveillance Devices Act 1972</i> (SA)
Tasmania	<i>Listening Devices Act 1991</i> (TAS)
Victoria	<i>Surveillance Devices Act 1999</i> (VIC)
Western Australia	<i>Surveillance Devices Act 1998</i> (WA)

of information secretly recorded does not apply to subsequent use in the course of legal or disciplinary proceedings.<sup>6</sup> Courts may be more receptive to the notion of undisclosed recordings for defensive purposes where there is a reasonable belief that a recording might be necessary to address a substantive harm.

Thus, in certain jurisdictions, patients can secretly record a consultation without the consent of the clinician and this recording may be used in legal or disciplinary proceedings. These risks are best described as emerging given the widespread use of telehealth and the paucity of reported examples of recording.

It should also be stressed that when practitioners are behaving professionally and meeting the appropriate standard of care, the medico-legal risk of patient recordings is minimal.

Practical measures to prevent patients from secretly recording screens include disabling the in-built recording functions in telehealth platforms, using platforms lacking this recording option, and employing programs preventing screen recording or superimposing watermarks including publication preclusion. However, such measures will not prevent another party from recording a consultation with an additional device.

Provision of documented restrictions to the patient at the time of any patient-generated recording and co-recording by the clinician (to ensure record integrity) may be of value. However, an automated message before consultation commencement expressly stating the clinician does not consent to screen recording (intending to effect a licence agreement or permit a gag order) is unlikely to achieve this in jurisdictions allowing patients to record without the clinician's permission.

### Recordings by the clinician

Key to understanding and managing both consent and any recordings is the status of these recordings at law.

The definition of health information as defined by the *Privacy Act 1988* (Cth) s 6FA is broad, including not only information pertaining to someone's health but also personal information collected to provide,

or in providing, a health service to an individual.<sup>7</sup> Interpreted literally, any information pertaining to a patient that is recorded, irrespective of consent, may be considered health information with requirements for storage in compliance with the relevant state or territory health records and/or freedom of information legislation (Box 2).

In Australia, under the *Privacy Act 1988* (Cth) as well as relevant state and territory legislation, a patient's medical records will generally be held and owned by the clinician or health care organisation, but patients are entitled to access and take a copy of their records. However, concepts of data sovereignty are changing.<sup>8</sup> Patient-driven and centralised health records (such as collaborative digital hospital files and My Health Record) are contemporary examples of this, with reduced clarity about the roles and responsibilities of potential contributors (including the patient) to a medical record as well as the ownership of that information.

Various jurisdictions within Australia legislate minimum periods for medical record-keeping, generally 7 years from the date of the last record entry for adults and until the age of 25 years for children. Many variations exist, based on state or territory, whether the records reside in a public or private institution, or relate to public health, quality improvement, disability, implants or artificial devices, sexual assault counselling, or child protection.

Efficient and safe storage of electronic health information by clinicians, including telehealth recordings, is increasingly challenging. Considerations include provisions regulating onshore versus offshore and cloud-based storage technicalities, including encryption inherent in the platform of choice, preventing evolving real-time threats to health information security (including via insurance and strategic risk mitigation), and compliance with legislated security requirements. The omnipresence of personal digital devices, including smartphones, has irrevocably altered the role and prevalence of clinical photography, videography and digital team communication tools, constantly generating much data, not all of which are routinely stored by health services or clinicians relying on them to guide clinical decisions.

## 2 Legislation governing health information management

Jurisdiction	Legislation governing health information management (not including legislated regulations)
Federal	<i>Privacy Act 1988 (Cth); Personally Controlled Electronic Health Records (Consequential Amendments) Act 2012 (Cth); My Health Records Act 2012 (Cth); Freedom of Information Act 1982 (Cth)</i>
State or territory	
Australian Capital Territory	<i>Health Records (Privacy and Access) Act 1997 (ACT)</i>
New South Wales	<i>Health Records and Information Privacy Act 2002 (NSW)</i>
Northern Territory	<i>Health Services Act 2014 (NT); Information Act 2002 (NT)</i>
Queensland	<i>Information Privacy Act 2009 (QLD); Right to Information Act 2009 (Qld); Public Records Act 2002 (QLD)</i>
South Australia	<i>Freedom of Information Act 1991 (SA); State Records Act 1997 (SA)</i>
Tasmania	<i>Personal Information Protection Act 2004 (TAS); Right to Information Act 2009 (TAS)</i>
Victoria	<i>Health Records Act 2001 (VIC); Privacy and Data Protection Act 2014 (VIC); Freedom of Information Act 1982 (VIC); Public Records Act 1973 (VIC)</i>
Western Australia	<i>Freedom of Information Act 1992 (WA); State Records Act 2000 (WA)</i>

Clear documentation of consent to recording of digital information by clinicians is important, and that consent should extend to the purpose of the recording. When the patient provides their consent, the use of the recording should be limited to that purpose.<sup>9</sup>

Recording of telehealth discussions between health care workers, including multidisciplinary meetings and case conferences, engenders further challenges. Recordings may be helpful for updating absent clinicians, minute taking, education or documentation. However, such recordings constitute health information, necessitating compliance with management and storage requirements applicable to a virtual consultation. In the public sector, patients may have access to recordings under freedom of information legislation, potentially resulting in significant alterations to the dynamic and tone of the discussion. This is a complex area of law which varies among jurisdictions but is worth keeping in mind. Where there is uncertainty, proactive discussion with medical indemnity providers may be invaluable, especially given the heterogeneity of legal obligations upon clinicians across jurisdictions.

### Conclusion

In Australia, the COVID-19 pandemic has necessitated rapid uptake and use of telehealth. This has

unmasked a number of concerns potentially not previously contemplated by legislators, patients and clinicians, particularly concerning the recording of clinical consultations and thereby the creation of health information, with extensive associated data management and security compliance challenges.

Recording of clinical conversations or processes may enhance patient and clinician participation, self-reference, research, education and funding. In certain jurisdictions, however, clinical consultations or meetings may be lawfully recorded with or without participants' knowledge, and may later be accessible to the patient, including for use in future legal or disciplinary proceedings, potentially stifling candid discussion. This and the challenging obligations relating to data management technicalities represent real risks for clinicians and health services. It is incumbent upon health care providers and lawmakers alike to consider these issues in a practical context, ensuring that telehealth is not only a useful tool but a safe and effective one.

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- 4 Invasion of Privacy Act 1971 (QLD).
- 5 Surveillance Devices Act 2007 (NT).
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