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COUNCILS FOR ENGLAND AND WALES

Recording and Video-taping of Patient Consultations

- The Legal Position

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RECORDING AND VIDEO-TAPING OF PATIENT CONSULTATIONS, EXAMINATIONS AND TREATMENTS - THE LEGAL POSITION

1. Legal Context

Legal and ethical issues arise when medical practitioners and other health professionals:

(i) video-tape medical examinations, consultations and procedures, or

(ii) tape patient telephone conversations,

with or without the patients' knowledge or consent.

Similar issues arise when patients surreptitiously record conversations with medical practitioners.

There are several sorts of circumstances in which the making of these recordings may arise, e.g. GP out-of-hours services may record incoming and outgoing calls from and to patients; ambulance services (and other emergency services) routinely record conversations with callers; medical procedures may be video-recorded for the purpose of training doctors or to assist in appraisal of their work. It appears that a few doctors are so litigation-conscious that they routinely record consultations with patients and even examinations of patients.

None of these activities is strictly illegal. Criminal proceedings are unlikely to follow, although in the recent case of Vigon v Director of Public Prosecutions, a market trader was convicted under s5 of the Public Order Act 1986 after having recorded women trying on swim-wear by use of a concealed video-camera.

There are a number of other legal and ethical considerations of concern to patients and doctors. These include issues of confidentiality, data protection and professional codes of practice.

2. Data Protection Legislation

Data Protection Act 1984

The Office of the Data Protection Registrar have confirmed that the provisions of the Data Protection Act 1984 (DPA) would apply to such recordings - and registration under the Act would be required - only when the recordings (or information taken from them) are stored electronically and the system used is capable of retrieving information by reference to an individual. This would apply, for example, where video equipment's automatic search facility can search for and locate the block of time when a doctor saw a particular patient. It is probable that ambulance services and GP out-of-hours organisations will store information in a computerised fashion, in which case the current Data Protection Principles will apply.

The **first data protection principle** is that information shall be obtained and processed fairly and lawfully. It is likely that unless callers are made aware that calls are being recorded and why, then the process of information gathering is unfair.

The **fifth data protection principle** requires that the personal information that is recorded and stored must be accurate. Included within this is the necessity to use good quality tapes, clean them prior to re-use and replace them regularly.

The **sixth data protection principle** is that *'Personal data held for any purpose or purposes shall not be kept for longer than is necessary for that purpose or those purposes'.* When any information is stored in this fashion, the data holder is required to justify the period of storage.

The **seventh data protection principle** confers rights of access to the stored material, independent of the rights of patients under the Access to Health Records Act 1990 (see later).

If there is doubt as to whether practitioners or organisations are complying with the provisions of the DPA, then a complaint can be made to the Data Protection Registrar.

Data Protection Bill 1998

In October 1998, a new Data Protection Act will bring into force European Directive 95/46/EC covering data protection issues. This will expand the scope of data protection and personal privacy protection in line with Article 1 of the EU Directive, which states that *'Member States will protect the fundamental rights and freedoms of natural persons and, in particular, their right to privacy with respect to the processing of personal data'.* Whereas the old Data Protection Act only governs the use of personal data held in certain computerised forms, the new Act will also apply to data held in other forms, *including taped material*, where these are held as part of a structured filing system, even when not computerised. The legislation with cover the collection of data, its storage, processing and disclosure and the data protection principles will usually apply at each stage.

The new data protection regime will differ significantly from the present legislation. The most fundamental repercussions on taped material held by medical professionals are likely to be:

(i) the fact that holders of such material (and, indeed, more conventional records) will be required to register as data controllers

(ii) Under Schedule I Part II, for the purposes of the first data protection principle, personal data are not to be treated as processed fairly unless in the case of data obtained from the data subject, the data controller ensures so far as practicable that the data subject has, is provided with, or has made readily available to him, the following information (inter alia):

a) the identity of the data controller

b) the purpose or purposes for which the data are intended to be processed, and

c) any further information which is necessary, having regard to the specific circumstances in which the data are or are to be processed, to enable processing in respect of the data subject to be fair

In effect, processing of data obtained from the patient will be unlawful unless the data subject has been notified. It remains unclear how the phrases "so far as practicable" and "readily available" will be interpreted. In principle, notice to the patient, on first consultation, that recordings may be made and the purpose for which they will be used may be sufficient, but there are as yet no clear guidelines.

(iii) the new first data protection principle states that such data *may not be processed* unless at least one of the criteria in both Schedule I and Schedule II are fulfilled, the most relevant ones in this context being:

a) the data subject has given his consent or the processing is in his vital interests (Schedule I), and

b) the processing is necessary for medical purposes (Schedule II).

If, as is quite likely, "vital interests" is construed narrowly, to mean the preservation of life, this provision will add the force of data protection legislation to the requirement that patients' consent be obtained before they are taped or filmed, or indeed before any data contained within the recordings is disclosed, in any situation which is not actually life threatening.

3. Telecommunications legislation

The recording of telephone conversations is within the scope of the Telecommunications Act 1984. Class licences issued by the Secretary of State under s7 of the Act apply automatically to anyone using a telephone system and impose certain conditions, most relevantly:

"7.3 The Licensee shall make every reasonable effort to inform parties to whom or by whom a live speech telephone call is transmitted before recording, silent monitoring or intrusion into such call has begun that the live speech telephone call is to be or may be recorded, silently monitored or intruded into."

Whilst there is nothing illegal in recording conversations, the party doing so is under an obligation to make every reasonable effort to inform other parties to telephone conversations and also required to keep a record of how this is done, so that in the case of a dispute they would be able to show how the parties were made aware of the recording.

4. Confidentiality

In the UK there is no general legislation protecting privacy and confidentiality. However, over the years the courts have built up a series of common-law principles to provide protection against breaches of confidentiality. The common-law, together with rights enshrined in the European Convention of Human Rights, does provide protection to individuals against unauthorised release of personal information. It is very probable that the courts would consider that video-tapes of medical examinations, consultations and procedures and taped telephone conversations about personal medical concerns, do amount to confidential personal information, particularly when the individual can be identified from any of the information held. Thus, whether or not the information is stored electronically, the holder of the information would have a duty to ensure that information is not disclosed without authority, and should certainly have systems in place to prevent such disclosure. As a general rule, recordings are subject to the same protection as the original conversation or examination and attract the same degree of confidentiality. Additionally, NHS employees are bound by clear contractual obligations with respect to patients' confidentiality.

Should such information be made available to other health professionals? The law does allow disclosure to other medical staff, on a "need-to-know" basis, on the assumption that health professionals work as a team and that patients give implied consent to the sharing of information in order to facilitate their diagnosis and treatment. The notion of implied consent could be undermined, however, if the patient is not aware that the conversation, examination or treatment is being recorded. It could be argued that even where the patient was told that information was being recorded, their need for medical assistance was such that any implied consent could be held to have been obtained by duress and so invalidated.

Publication of recordings without consent would be deemed unlawful processing under the data protection legislation, since this would breach the law of confidence that exists between doctor and patient .

5. Professional Ethics

Health professionals are under professional and moral obligations to keep patients' confidences. The General Medical Council's guidance to doctors is in the process of revision and more information will be available when the new guidance is published. The present guidance requires them:

(i) to respect patients' privacy and dignity, and

(ii) to respect the rights of patients to refuse treatment or take part in teaching or research.

The GMC's principles of confidentiality include:

(i) making sure that confidential information is effectively protected against improper disclosure,

(ii) ensuring that patient consent to disclosure is informed and

(iii) ensuring that patients have the opportunity to withhold permission whenever it is likely that confidential information about them would be disclosed to others.

In September 1997 the GMC produced guidance for doctors on "Making and Using Visual and Audio Recordings of Patients". It appears that any doctor who video-records confidential personal information (and perhaps any doctor recording telephone conversations), without the permission of the patient, may be in breach of his or her professional obligations. If there is any breach of confidentiality arising from the practice, then a complaint to the GMC should be treated seriously. It may be appropriate, in some cases, to make a complaint about the practice of making recordings without consent, even when there is no disclosure to a third party.

In a recent publication, the Medical Defence Union noted that the practice of routinely inserting messages, warning that the conversation may be recorded, is "consistent with a doctor's desire to be open and honest with patients". They recommend a notice in a doctor's surgery to the effect that the practice records incoming telephone calls in the interests of patients. Such a notice would probably be sufficient to cover any potential liability for breach of the conditions which govern the use of telecommunications equipment (see below) .

6. Medical Records

No guidance has been issued on how video-recordings and taped telephone conversations relate to medical records. If conversations are transcribed into the records, or referred to within them, then they will clearly become subject to the same requirements as any other medical record. The definition of health records contained within s1(1)(a) of the Access to Health Records Act 1990 is wide enough to encompass recordings. The recording would have to be made by or on behalf of a health professional and be in connection with the care of the individual to be accessible under the provisions of the Act. Care is defined as including, 'examination, investigation, diagnosis and treatment'.

Possible areas of concern include whether such recordings would be passed on along with the patient's written file to the health authority and future GPs and whether the patient had explicitly consented to that form of disclosure. It seems likely that recordings would be treated in this respect in the same way as more usual health records. Other relevant questions include how video recordings of intimate examinations can be protected from unauthorised viewing and for how long recorded information should be stored.

The Data Protection Bill, as drafted, conflicts with the rights conferred on patients and their representatives under the Access to Health Records Act 1990. The most serious discrepancies relate to:

(i) the correction of inaccuracies and omissions in records - the 1990 Act is wider in its scope and gives patients the right to have notice of their views appended to their records, even if the data controller disputes them,

(ii) access to records on behalf of minors and persons lacking capacity - the Bill does not replicate the express provisions contained in the 1990 Act, giving right of access to parents and guardians,

(iii) the length of notice required before access is given - the Bill could in some cases virtually double the time it takes to obtain copies of records.

Representations have been made on these and other provisions in the Bill and clarification is awaited.

7. CHC Guidelines

When CHCs receive enquiries or complaints of this type they may want to ask questions of the doctor or other medical practitioner or organisation concerned, including:

(i) Was consent obtained and in what manner. For what uses did the patient give consent to the recording. Was the patient's consent recorded in their notes?

(ii) How is the recorded information stored?

(iii) Why are calls recorded and to what use is the information put?

(iv) If the information is stored electronically, they should be asked to provide details of their registration under the DPA, including details entered on the Register as to the 'specified purposes' for which information is to be put.

(v) Whether information is stored in its original form, or whether just partial records are retained and if so what information is kept?

(vi) For how long is the information stored?

(vii) Who has access to the records and in what circumstances?

(viii) What arrangements they have in place to allow individuals access to any recorded conversation or video-tape or to details stored from the same? (In compliance with the seventh principle of data protection.)

(ix) What systems are in place to protect patient confidentiality?

(x) Whether any information from recorded conversations finds its way into the patient's medical records, particularly where the information recorded does not relate to care, for example recordings made in the conduct of non-therapeutic research.

Marion Chester, June 1998

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