Clinical implications of covert recording: A rejoinder

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We find the review by Elwyn and colleagues (this issue) very interesting and timely. As researchers and teachers, we have recorded many interviews and consultations. Sometimes we have used video recordings and sometimes audio recordings. Of course, in all these instances, we have informed all those participating and have obtained written consent. When the purpose of the recording has been research, an external agency has also evaluated and approved the recording protocol beforehand.

As recording has become easier and as the quality of our cameras (i.e., mobiles) has improved, it has become commonplace in many settings. Conferences, meetings and lectures are now quite often recorded and posted online. We use our mobiles to record and store videos from social occasions such as weddings, parties, travels, dinners and happy moments from our day-to-day lives with family and friends, pets, etc.

In this light, it may be quite natural that some patients would want to record their consultations – for instance, to better remember or to document what was said. When the purpose of the recording has been research, an external agency has also evaluated and approved the recording protocol beforehand.

As far as we can gather, a private individual may legally record conversations that she or he partakes in, and this can also be done in secret (Datatilsynet 2022). No apparent distinction is made between different communication technologies (audio, video, chat, etc.). However, the distribution/publication of the recording might be subject to different regulations, depending on content. We think most Norwegian doctors would be likely to agree to being recorded provided that they were satisfied with the reason given by the patient. In our experience, however, such requests do not occur very often.

Elwyn and colleagues mention the issue of litigation. This is fortunately rarely an issue in Norway, with its public National Health Service (NHS) -type service (Myklebust et al. 2017), with little tradition of legal action. This does not mean, though, that recordings cannot be problematic. Elwyn and colleagues primarily discuss legal perspectives. However, as we see it, the clinical implications are equally important.

If a patient records a consultation covertly, this obviously might impact the doctor–patient relationship negatively, especially if the doctor at some point discovers that he/she has been recorded unknowingly. Recording someone without telling them is impolite, by most standards. When a doctor is recorded unknowingly and told afterwards, the doctor is likely to wonder why this was done. In a way, this type of covert recording increases any
sense of insecurity experienced as a doctor or therapist. Covert recording of clinical encounters may be due to patient distrust (Tsulukidze et al. 2015); from the clinician’s perspective, however, covert recording might also lead to distrust, a loss of empathy and negative feelings towards the patient, consequently damaging the therapeutic relationship (Wynn 1998, 2005; Littauer et al. 2005; Tsulukidze et al. 2015).

In what follows we recount two anonymised (composite) anecdotes about covert recording. In contrast to typical clinical case reports (Nissen and Wynn 2014), the purpose here is not to give a detailed and accurate clinical description but to shed light on the topic of covert recording.

On the first occasion, it was a patient known for some time. The patient, who had struggled with mental illness, informed the doctor about the recording after the event. The patient’s mental condition had worsened, which might explain the act of secret recording. While this incident was perceived by the doctor as a bit awkward, the alliance was good, and the doctor–patient relationship was fortunately not much shaken by the incident. The patient had, after all, informed the doctor about the recording – which could be seen as reassuring and, maybe paradoxically, as an expression of confidence in the doctor and her ability to handle the covert recording without becoming too upset.

The second incident was a first consultation with a patient with many challenges. In this sense, it was unlike the first instance, where the patient had an ongoing relationship with the doctor. The purpose of the consultation was to establish the doctor–patient relationship and to start the process of jointly examining the patients’ needs and challenges. As the clinic consultation progressed, the patient became increasingly angry with the doctor, which put its mark on the interaction. Accordingly, the session did not achieve much, as the patient and the doctor were unable to reach the level of trust required to discuss the patient’s challenges in a constructive manner.

Afterwards, the patient informed the doctor about having recorded the consultation and threatened to publish it on social media with commentary added. One might only speculate about the purpose of this action. Although not a pleasant experience, publication on social media seemed unlikely as it was unclear what the patient would stand to gain from this. Actually, it is not clear if a recording had in fact been made and, if so, whether anything was ever posted online.

These two anecdotes illustrate that covert recording poses a challenge for the relationship between doctor and patient and may be problematic to varying degrees, depending in part on the strength of the doctor–patient alliance.

As also mentioned by Elwyn and colleagues, video recording may involve the unintentional capturing of other co-present patients and providers, for instance in busy hospital wards. While this problem in most cases can be easily avoided, sometimes those making the recording may not be sufficiently sensitive to the needs of others, for instance in acute psychiatric wards (Bordvik 2019). Our experience is that most hospitals in Norway discourage or forbid video recording in communal areas in the inpatient wards, in order to protect the privacy of other patients.

Legal matters notwithstanding, we believe it is important to consider the purpose of making a recording and its clinical implications. Obviously, the open (i.e. not covert) recording of a consultation might help some patients remember what has been said. Some patients might find it helpful to listen to the recording at home together with, for instance, a family member, in order to digest and better understand the interaction and advice that was given. If the clinician is informed beforehand and agrees to the recording, the clinical implications are more likely to be positive.

Some doctors might not like being recorded in any case, because they are unaccustomed to being recorded or because they are worried about being criticised if something they said is taken out of context. Therefore, the patient and the doctor should consider whether recording is likely to disrupt or influence the consultation in some way, e.g. the doctor becoming more guarded or uncomfortable, which might reduce the quality of the interaction or even influence the outcome of the interaction.

In summary, covert recordings should be avoided altogether, as they are likely to promote distrust and thereby have a negative effect on the doctor–patient relationship. Although the practice may be legal, it might not be wise to record your doctor in secret. The take-home message should be, in our opinion, that everyone present should...
know if a recording is being made, and if so, exactly why.

References


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