How can the law better enable consultation recording? A rejoinder

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1. Introduction

Research investigating the implementation and impact of consultation recording has been undertaken since the 1970s, with clear benefits evidenced for patients, clinicians and healthcare services (Pitkethly et al. 2008; Rieger et al. 2018). As highlighted by Glyn Elwyn and colleagues (this issue), innovative approaches have been developed by academics, health services and private enterprise (Barr et al. 2017; Wolderslund et al. 2017), including our SecondEars smartphone app (Lipson-Smith et al. 2019; Hyatt et al. 2020). However, despite the simplicity, documented benefits and range of technological solutions for consultation recording, it is not routinely implemented as part of usual patient care. Widespread adoption of this technology has effectively stalled, despite concerted effort globally. Our work in Australia has echoed that emphasised by Elwyn and colleagues – that legal concerns identified by clinicians and patients regarding making, sharing, storing and using recordings may constitute the single biggest barrier to uptake (Tsulukidze et al. 2014; Hyatt et al. 2020).

2. A legal patchwork

Elwyn and colleagues’ paper aptly emphasises the complexity in the legislative landscape for health consultation recording in nine countries, spanning hemispheres and legal systems. The law in this field is, described generously, a ‘patchwork’. The authors have identified significant variations both within and between countries on the question of consent: one-party consent is sufficient across the UK and in Canada and most Australian and US states, whereas two-party consent is necessary in France, Germany, Mexico, India, Brazil and a minority of US and Australian states. Telehealth attracts different rules. For instance, in Australia, face-to-face clinical encounters are regulated by state and territory listening-devices laws (variously stipulating one-party and two-party consent), whilst telephone- and internet-enabled conversations fall under the federal legislation (requiring two-party consent). In short, the legal landscape lacks consistency and is exceptionally difficult for those without legal training to navigate.

Importantly, the legal opacity and complexity identified by Elwyn and colleagues is not confined to the question of consent for recording alone, but extends into every aspect of the life-cycle of each recording, from its initiation to storage, to sharing, publication and multiple re-uses in different contexts. As noted in the paper, Elwyn and colleagues’ review did not examine the subsequent admissibility of recordings into evidence in court. Nor did it explore legal limitations on who may listen to a recording in different circumstances – a question that occupies both clinicians and patients (Hyatt et al. 2020). Our own research has found...
that a range of factors, such as whether the original recording was made with necessary consent, who the recording is to be shared with and for what purposes and (in Australia) the specific state or territory jurisdiction in which the individual is located, all affect the legal parameters for sharing a recording (Prictor et al. 2021).

Further, the medico-legal outcomes of consultation recording are unknown. Being able to point to evidence answering the question of ‘Am I more likely to be sued?’ might improve clinician acceptance of recording practices and technologies. Our current research seeks to illuminate this matter, at least in the Australian context. Overall, legal opacity and complexity at present act as almost overwhelming constraints on the uptake of this highly effective clinical tool (Tsulukidze et al. 2014).

3. A legal solution?

The critical question is: what legal reform or other changes are needed to resolve these issues? Geographic standardisation might be a starting point in the US and Australia, where bringing wiretapping / surveillance device legislation into line between the states, for instance through a uniform or model law, would improve consistency and may instil user confidence. As Elwyn and colleagues emphasise, the laws that apply to consultation recording were never designed to do so, but instead were largely developed to regulate law enforcement entities and to prevent inappropriate eavesdropping by private citizens. Hence it may be appropriate to consider solutions such as bespoke legislative schemes, or relocation of consultation recording from the wiretapping regulatory space into the health records and information privacy sphere. The clinical benefits of consultation recording demand regulation that enables the activity, with suitable protections, rather than unduly constraining it.

4. The clinician approach to understanding law

A further strength of Elwyn and colleagues’ paper is their method of identifying the relevant law. We feel that the study design, which rejected a formal legal analysis in favour of approaching the issue in the manner of an informed and motivated clinician, allowed a realistic and pragmatically informed understanding of how and what law on this topic would be identified, and what this would mean for clinicians. Notably, this approach highlights the necessity of expertise in determining the application of relevant law applying to consultation recording in an operational healthcare setting. Accessing suitable legal expertise would likely be cost prohibitive to many (particularly in public healthcare). This further deters the uptake of consultation recording by interested parties. By highlighting how access to the law is problematic, Elwyn and colleagues’ work underlines the need for user-friendly guidance on the use of consultation recording in healthcare.

5. Discussion and conclusion

Legal concerns amongst clinicians inhibit routine consultation recording; law reform does not seem imminent; and relevant legal advice is difficult to obtain, understand and use. How, then, might beneficial consultation recording practices be promoted and implemented? In consultation with consumer advocates and health professionals at Peter MacCallum Cancer Centre, and with the Office of the Victorian Health Complaints Commissioner, we are developing lay summaries describing how Australian law applies in situations where a patient asks to record a medical encounter. These summaries will be directed to both patients and health professionals and will cover key issues associated with consent, sharing and storage of recordings. Our goal, through the summaries, is to enable access to the law and so reduce confusion, improve confidence and provide reassurance for all parties.

Beyond this, investigation is also needed into the health service policy landscape, which remains opaque. Individual institutional policy may, perhaps reactively, restrict patient-led or -facilitated recording and fail to be aligned with relevant law. Understanding whether health professionals and/or patients can refer to relevant policies and charters to guide good practice is important. Equally, determining whether these policies align with relevant legislation is essential to ascertain
whether the right advice is being provided to guide lawful use of consultation recordings. We are
endeavouring to map this landscape in Australia, as a precursor to developing standardised policy
recommendations, informed by the clinical evidence on consultation recording and relevant legal
and ethical considerations. This work is likely to be useful and relevant not only in Australia, but
internationally.

Removing perceived barriers to routine use of consultation recording is important given the
demonstrated benefits of the practice to health professionals, patients and health services. Elwyn
and colleagues’ study promotes knowledge of the international legal landscape and highlights the
need to reduce complexity and improve citizens’ understanding. Building on this work to further
clarify the law and create clear policy and practical recommendations guiding use in all healthcare
settings is vital.

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