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Smartphone standoff: a qualitative study exploring clinician responses when a patient uses a smartphone to record a hospital clinical encounter

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ABSTRACT

Objectives Patients are initiating recordings of their clinical encounters using a smartphone. While this is an important, universal issue, little is known about the clinician viewpoint. Understanding clinician perspectives and behaviours is key to ensuring the protection of patient and clinician interests. This study aimed to gain a deep understanding of clinician attitudes and behaviours to patient-led recordings of hospital clinical encounters.
Design Semistructured interviews were conducted with 20 hospital clinicians. Participants were recruited using a combination of purposive and snowball sampling. Interviews were digitally recorded and transcribed. Transcripts were analysed using thematic analysis.
Setting This study took place at two hospitals in the metropolitan area of Gold Coast, Australia.
Participants Participants included clinicians with varying levels of experience, or clinical managers in the roles of: medical, nursing and midwifery, and allied health staff.
Results The 20 participants interviewed were from a range of health disciplines and clinical areas and most had experienced a patient-led recording. Three themes emerged when exploring participant attitudes. First, that recording was a significant and controversial topic. Second, that experiences often informed clinician attitudes and many clinicians held conflicting views. Finally, a perceived loss of control was a significant stressor. A further three themes emerged relating to clinician behaviours when a patient asks to record. Decision-making involved balancing multiple factors often in pressurised situations. Shared decision-making was shaped by power dynamics and, finally, decision-making was not informed by hospital policy.
Conclusions While patient-led recordings were viewed as beneficial, clinician welfare and patient safety may be at risk when a patient records a clinical encounter. Current safeguards, such as hospital policies, are not used and may not meet the needs of clinicians when decision-making is complicated by power dynamics. More research is needed to better understand how clinicians can be supported in this critical domain.

Strengths and limitations of this study

► A qualitative methodology focused on understanding the phenomena of clinician attitudes and behaviours in relation to patient-led recordings.
► The use of semistructured interviews, which allowed for exploratory discussion while also yielding quality, comparable data were a clear strength of this study.
► The blend of purposive and snowball sampling enabled a variety of clinician views and experiences.
► A limitation of this study is that findings are not generalisable given the small sample of clinicians in just two hospitals.

using their smartphones. These are called patient-led recordings.[1] Clinicians are increasingly working under a critical public lens and the healthcare sector is exposed, resulting in an imperative to develop policies and practices that meet patient needs, while protecting the interests of clinicians and the health service.[2–10] Previous studies have shown that up to 93% (n=37–360) of doctors[2 4 11] and 47% of nurses (n=92–119) had experienced a patient-led recording.[2 4] There is a substantial body of research that investigates the provision of audio recordings of clinical discussions to patients.[12–14] However, there are limited studies that have sought to understand the clinician perspective when a patient initiates a recording within a variety of clinical scenarios in hospital. More research is urgently needed across the broad spectrum of clinicians and clinical encounters to help inform practice.[15]

In Australia, recording clinical encounters (defined as the point at which transactions between patients and clinicians take place)[16] is legislated according to state or territory.[1] In Queensland, where this study took place, it is legal for a person to record a conversation they are part of, such as an encounter with their clinician. Consent or knowledge of the

INTRODUCTION

Evidence suggests that patients are increasingly initiating both audio and audiovisual recordings of their clinical encounters

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other parties to the conversation is not required; however, there are limitations regarding setting and use.[1 17–19]

Previous research has called for hospital policies to guide clinician practice when a patient asks to record.[2 3 6] In the hospitals where this study was undertaken, the distinct policies for medical and birthing contexts place the onus on clinicians to consent to a recording or not, based on appropriateness, use of the recording for private purposes and with the consent of all relevant parties. The policy outlines decision-making considerations, including impact on care or interference with health service delivery, workplace health and safety, privacy of others, withdrawal of consent, and restrictions on use in designated places.[20 21] There is no guidance in the policy relating to how to manage multiclinician encounters, such as family meetings or joint therapy sessions. Given the decision-making burden falls to clinicians, understanding their attitudes and behaviours to patient-led recordings is key to support practice.

There is a large scholarship on the use of service-led recordings (recordings initiated by the clinician or health service[1]). Most of these studies have focused on the effects of facilitating an audio recording of a clinical conversation with patients (such as diagnosis and treatment discussions),[12–14 22] and the implementation barriers within the service.[13 23] Overall, service-led recordings have been found to be beneficial to patient's understanding of health issues and satisfaction with service.[12–14 22] However, clinicians have been found to be hesitant to adopt this practice, with the main concern being perceived medico-legal risks.[13 24]

These studies provide a background to understanding patient-led recordings. Given the evidence for the potential benefits for service-led recording, patient-led recording may also be of benefit for patient understanding of health issues and adherence to treatment. The obvious distinction between service-led and patient-led recordings is the broad range of clinical encounters in which a patient might initiate a recording (audio or audiovisual) within a hospital setting and whether the recording is undertaken with consideration to the legislative and ethical limitations described above. More research is needed to better understand patient-led recordings across a range of hospital contexts.

Emerging evidence suggests that patient-led recordings may benefit patient recall of the conversation or procedure and information discussed and enhance patient satisfaction overall.[2 3] Improving recall is of significant value, as patients may forget up to 80% of medical advice due to anxiety or cognitive deficits, impacting health outcomes.[25] Despite these benefits, clinicians report concerns relating to medico-legal issues, including privacy: confidentiality, potential uses of the recordings and challenges relating to consent.[2 4–6 11] Research on patient-led recordings has been mainly focused on physicians and nursing[2 4 6 11] and centred in oncology.[4 11] Previous research has also been limited to specific clinical contexts, such as medical procedures or discussions with physicians.[2–4 6 11] There is

less evidence regarding the perspectives of allied health professionals, experiences within a multiclinician setting and responses of clinicians when a patient records an encounter other than a clinical discussion.

One recent study explored multidisciplinary perspectives to the use of a smartphone app designed to record clinical conversations (the SecondEars app).[26] These recordings are initiated by the patient; however, the app is facilitated by the health service and the main copy of the recording is stored on the hospital system therefore controlling some of the confidentiality and ethical issues for patient-led recordings.[1] The study found clinicians were supportive of the app, particularly in its potential to mitigate medico-legal concerns.[26] However, due to limits in knowledge about the clinician perspective to different types of patient-led recordings, it is unclear whether the efficacy of this tool is limited to the recording of clinical discussions.

There is an imperative to better understand clinician perspectives to patient-led recordings, to inform quality policy, education and practice. This research aimed to respond to evidence–practice gaps, by furthering our understanding of clinician perspectives and behaviours to patient-led recordings across a broad range of clinical disciplines, areas and scenarios in a tertiary health service.

METHODS

This was an explorative study centred within a social constructivist paradigm.[27] The objective of this study was to explore clinician experiences and response when patients (including their family, friends or carers) initiated a recording (audio or audiovisual) of their clinical encounter. This study was conducted at two established hospitals within the one health service on the Gold Coast, Australia: A university, tertiary-level hospital (930 beds) and a major regional hospital (448 beds). Together, these hospitals deliver: emergency, medical, paediatric, maternity and palliative care to approximately 700 000 people.

Participants

Participants (n=20) were recruited from the Gold Coast Hospital and Health Service. Semistructured interviews are ideal research instruments for exploratory designs where there is limited prior knowledge about the participants' perspectives.[28 29] Participants included clinicians or clinical managers with varying levels of experience and in the following roles: medical, nursing and midwifery, and allied health staff (social workers, physiotherapists, occupational therapists, psychologists, dieticians and speech pathologists).

Participants were recruited using a combination of purposive recruitment and snowball sampling through advertisements and features placed on internal hospital news feeds, social media and internal forums. Targeted recruitment was undertaken via the investigators' network by email. Participation was voluntary.

Table 1 Participant characteristics

	Participants, n (%)
Profession	
n	20
Physicians	3 (15%)
Nursing and midwifery	4 (20 %)
Allied health	13 (65%)
Social work	3
Physiotherapist	2
Occupational therapist	3
Speech pathologist	2
Dietician	2
Psychologist	1
Level of experience	
Junior (0–3 years)	2 (10%)
Mid-senior (3+ years)	14 (70%)
Leadership	4 (20 %)
Clinical areas*	
Intensive care unit	3
General and specialist medicine	10
Emergency (ED)	1
Rehab	2
Newborns, women and children	3
Leadership	1
Outpatient	4
Previous experience of patient-led recordings	
Yes	16 (80%)
No	4 (20%)

*Total number of clinical areas exceeds 20 as some clinicians worked in multiple clinical teams.

Interviews

Semistructured interviews were conducted in person or via videophone and were 30–60 min in duration. An interview guide was used to explore participant experiences of patients recording clinical encounters, consent processes and clinician decision-making (see online supplemental file). Participants were invited to describe their current job position and professional background, including years of experience (see table 1).

The interviews were conducted by two members of the research team (a clinical social worker and a PhD-qualified research fellow). Participants were made aware of the interviewers' professional backgrounds and goals of the study and provided written consent through a participant's information and consent form. Both interviewers had received training in qualitative research and interview techniques. While both interviewers had formed some understandings of this topic based on their involvement in this project and professional experiences, neither held strong beliefs about the topic that would significantly impact the interview process.

The guide was piloted using internal testing[30] and no significant changes were made. Interviews were digitally recorded and transcribed (intelligent verbatim). Participants were given the option to review the transcripts for accuracy prior to analysis. A reflective journal was completed after each interview to enhance rigour.[31]

Data analysis

Interview data were analysed thematically, using Braun and Clarke's[18] six-step guide to thematic qualitative analysis: (1) transcripts were uploaded to NVivo, and two researchers read and reread transcripts to become immersed in the data; (2) one researcher generated initial codes; (3) that same researcher searched for themes according to code similarity and significances, ensuring all data was represented; (4) a second researcher reviewed and reorganised codes and considered their relevance and coherence to potential themes/subthemes; (5) both researchers revised and refined the descriptions and labels for each theme/subtheme until all data were adequately represented; and (6) a write-up of findings was developed with compelling participant quotes supporting each subtheme. The demographic data, including the participant's professional position and years of experience, were collected at the interview and have been presented as number and percentage in table 1.

RESULTS

A total of 20 participants were interviewed: 16 prospective participants were approached directly; 12 agreed to be interviewed; and 4 did not respond. A further seven prospective participants responded to adverts: four were interviewed; one was ineligible; and two withdrew from the study prior to interview. Four participants were interviewed via snowball sampling. Information regarding participant background characteristics and experience of patient-led recordings was obtained during the interview and reported in table 1. The sample included participants from a broad range of clinical disciplines, clinical areas and clinical experience, although there was a focus on allied health and mid-senior level clinicians.

When exploring participant attitudes to recording, three major themes emerged: (1) recording was perceived as a significant and controversial issue; (2) experiences informed clinician attitudes, and there was evidence of inner conflict as clinicians navigated patient recording; (3) participants reported significant concerns related to patient recording, and these were often linked to loss of control. In relation to participant behaviours, three further themes emerged; (4) clinicians were often forced to make difficult decisions relating to patient-led recording, and the associated practical and ethical considerations, under pressure; (5) shared decision-making was

often influenced by power dynamics; and (6) policies were not used.

CLINICAN ATTITUDES
Theme 1: recording as a significant and controversial issue
Almost all participants had a personal experience of patients recording a clinical encounter, although some experienced this more regularly than others. It was generally recognised that healthcare has become more digitally and technologically advanced, and most viewed this issue as important. Patient-led recording was a divisive issue, with some participants holding strong views in support and others in opposition to recording. However, most held mixed sentiments. All participants could identify both potential benefits and risks to themselves as clinicians, their patients and the health service (table 2).

Patient-led recordings were presented as a multifaceted tool, which could benefit patients in a variety of circumstances. Examples were given of recordings being used as visual aids to improve participation in therapy, used by patients in crisis to improve recall of important clinical discussions, and initiated to improve the communication of health issues and treatment to others within the patient's social network. Participants felt this both improved the patient's experience of the heath service and increased their understanding of health issues and clinician recommendations. This was linked with greater adherence to treatment plans and improved health outcomes.

Participants recognised that patient-led recordings could improve the quality and efficiency services. For example, participants reflected on how recordings reduced the need to repeat information such as when a patient's family requested information or with patients who had poor memory of information already provided. Some viewed patient-led recordings as a means of ensuring that care was inclusive and equitable for people with different modes of learning and additional needs.

Several risks and concerns were highlighted regarding patient-led recordings. Participants reported concerns about confidentiality of the patient's medical information being stored on their personal device (rather than the hospital system) and about the confidentiality risks to other patients, if accidentally included on the recording. There was also unease about the threat to clinician confidentiality. Strong fears were raised regarding the potential uses of patient-led recordings, which warranted a distinct theme and are discussed later in this paper (Theme 3). Some participants reflected on how patient-led recordings changed the relationship dynamic. They felt the act of recording formalised communication, which improved clarity, but hampered rapport building. This shift in communication and relationship dynamic had the potential to impede patient understanding and experience of the health service, as it centred clinical matters rather than a holistic approach. Participants viewed recordings as a source of evidence which may be protective or a

threat, or both. Some welcomed this perceived accountability, others feared prejudicial editing, recordings being taken out of context or the potential for mistakes to be recorded and shared.

> Filming and having documentation can act like a double-edged sword really. It can work in your favour to show events, but it might also not show that you've done things. It's just hard having evidence there that might put your organisation at risk as well as you personally. (P19)

There were reports that patient-led recordings may be a distraction when managing clinical encounters and had the potential to impact patient care and safety during critical moments, such as resuscitations or emergencies during childbirth. In addition, participants reported that it was difficult to withdraw consent if something unexpected were to happen during the encounter.

> It's just so many things going on, so many balls up in the air, that a recording could just add another fuel to the fire. It's just another ball they'll have to deal with that could topple all the other balls. So, it could impact on nurses' care. (P07)

Theme 2: experiences informing attitudes and inner conflict
Participants drew on their experiences of patient recordings to inform their perspectives. Those who held positive views had often initiated recordings for their patients or perceived the recording to lead to an improved patient experience or outcome.

> I haven't had any occasions where people have wanted to record conversations, or difficult conversations and those sorts of things, which I think I might have a different attitude towards… I think, for me, I find it a really positive thing and a really powerful tool for patients and families. (P20)

In contrast, negative views were often expressed when a participant had faced difficult experiences or had heard of adverse incidents via colleagues or in the media. Negative incidents of recording included conflict prompted by or leading to a breakdown in the clinician–patient relationship or where consent to record was not sought in advance.

> I guess that I've mostly only seen them used in a covert, negative way. So, my initial response is that I don't necessarily agree that it is a great thing. (P01)

There was evidence of inner conflict as participants articulated their position on patient-led recordings, often struggling to weigh up perceived benefits, risk considerations, as well as ethics and rights.

> But I think in that moment, being able to record it, for them is a good tool to get through. I just think for us, we're scared. We're scared of what the implications are of what we say. (P02)

Table 2 Perceived benefits and risks of patients recording clinical encounters

Perceptions	Quotes
Benefits	
Improved patient engagement, understanding, experience and health outcomes	1. With split families it could be beneficial if you're sharing – like with mum and dad being separated or carers separated. (P05) 2. It can be actually really helpful for some patients to watch it back themselves and then we can point things out, where we say, you know when we're telling you to do X, this is what it looks like, and this is what we want you to do [during therapy]. (P10) 3. Elderly people where they've got some cognitive issues or… or other people that have been quite highly distressed and are having difficulty absorbing information and interventions. (P17)
Improved clinical and communication efficiency	1. They could play it back to their family members, to alleviate the family members ringing us 100 times to try to get the information, where they've heard it from the horse's mouth. (P07) 2. It made my job a lot easier to explain things to him. That was obviously less work for me, so that's always a win. (P12)
Evidence of service to protect clinician and patient	1. The recording can actually show that that's not what was said or that's not how it was intended. (P01) 2. I think if people are genuinely getting a poor level of care, I can see why that would be beneficial for patients. (P10)
Equitable uptake of service via inclusive practices	1. So literacy levels were a challenge and then they were very attached to their phones. We discussed with them that that was a great way to support their memory. (P14) 2. Say if someone is vision impaired, for example, and with the brochure, it's not really user friendly for someone with a vision impairment. Having a voice recording of that could be beneficial. (P18)
Risks	
Ownership and confidentially (for patients and clinicians)	1. The gym is a public space and there are others in the background on these videos, and that is often not considered. (P04) 2. The conversation that I have with that patient is private and confidential, and with a recording being made of that conversation, it's no longer safely private or confidential, even if it is in the patient's possession. (P11)
Use and personal, professional, and legal consequences (including social media, news)	1. So you would be forever thinking, okay, well, if this ends up in the paper, I could lose my job. I could lose my registration. I could lose the respect of my colleagues. (P02) 2. As a clinician I should be caring and compassionate thinking that sometimes you're overloaded with the information. But my first thought is for myself and for the backlash that I might get if it's recorded. (P07) 3. That they would use it in a negative way, or they'd put it on the internet and I wouldn't have any control over how that information was used. (P08)
Negatively impacts relationship, dynamic	1. But when you have someone recording you, you feel like you want to be quick and easy, let's just get the recording done, then go through the rapport-building afterwards. I guess that's a negative, that you can't get that – the fluff is sometimes important. (P03) 2. But I think people do speak differently when they're on camera or if they're being recorded, so it might sort of put up a barrier between the patient and the clinician of free and open communication, because you've always got things in the back of your mind about what could be misinterpreted or misconstrued, or what the patient might not understand fully. (P16)
Impairs patient understanding, well-being, or experience of service	1. We try and keep it very clinical. So we're not actually supporting them emotionally as much as we would do if they weren't recording. (P02). 2. If instead a recording was used and all of that clutter of conversation leading up to that was what information was potentially being derived from, it could lead to a lot of mess. (P11)
Evidence of service, to expose clinician or health service	1. I just think it's me feeling that it could be used against me if I haven't done the right thing. (P07) 2. Then yeah, the idea that you might say something and not necessarily misspeak, but it's a true thing at that time, that might not be true down the track and people try to [hold you] to it. (P04)

It does add a bit more pressure on because, obviously, it's that accountability. But at the same time, we should be held accountable anyway. (P13).

Theme 3: fear and control

Despite some participants holding strong positive attitudes to patient-led recordings, the majority expressed fear and anxiety. They articulated concerns about: (1) the use of the recording; (2) the potential of it being uploaded to social media or sent to news outlets; and (3) the professional and medico-legal consequences.

I just have this dread of winding up on the internet. I don't know who would be interested in what I am saying, but you see all of these videos of these snippets of things that are out of context, and you just get to see

that and it goes on the internet, and then it's there forever. (P06)

Loss of trust and control was a common theme. Participants ruminated on the difficulty in controlling content once a recording had commenced, restricting the use of the recording and managing the perception of the recording by others. Loss of control provoked feelings of worry and discomfort. One participant reflected on a double standard where patients are required to trust clinicians. However, that same trust is not always reciprocated.

Because they have to trust us. As much as I have to trust them, they have to trust me that that photo I've taken is now going into their notes and not into some kind of presentation. (P07)

CLINICAN BEHAVIOURS
Theme 4: difficult decisions under pressure
Decision-making relating to patient-led recording was influenced by multiple factors and several subthemes emerged (see table 3). Key factors were whether the patient had asked for consent to record and if there was a clear purpose and use of the recording. Protecting the confidentiality of the primary patient, clinician(s) and other patients was another important factor. Examples were provided of restricting recording in public or multipatient areas, such as the rehabilitation gym or hospital corridors (where therapy can occur). The type and predictability of encounter also influenced decision-making. Participants conveyed they were more likely to consent to a recording of patient education and demonstrations as opposed to when clinical assessments, procedures, complex clinical reasoning or more difficult discussions were occurring. In the latter, participants were concerned about patients owning evidence of clinical mistakes or footage of their dissatisfaction with the health service.

Patient risk and safety considerations drove the consent process for some participants. For example, a recording might be refused if it were assessed as being distractive to a clinician during a procedure or activity (eg, during difficult mobility transfers). Conversely, that promoted patient safety and well-being (eg, documenting recovery milestones) were more accepted. For a few participants, recordings were the option of last resort, when other formats (such as written notes) were unsuitable. Decision-making was often influenced by clinician confidence and competence. For example, some participants credited skills they had acquired during their careers with empowering them to refuse patient-led recordings, such as competencies in de-escalation techniques or abilities in navigating difficult conversations. However, none of the participants referred to any specific skills, which would assist them with integrating recordings into practice.

Personal factors were strong influencers in decision-making and dwarfed other aspects. For example, certain participants stated they would always consent or always refuse a patient-led recording, no matter the situation, due to personal disposition. For example: that's just my personality (P03). Furthermore, general perceptions and beliefs about recordings and technology were cited as influential. Participants were more willing to consent if there had been a longstanding or trusted relationship between themselves and the patient. Where consent was given, there was often limited discussion between participant and patients about confidentiality or the potential uses of the recording. It was trusted that patients would use the recording in a way it was intended.

Just trusted that they were going to listen to it and then delete it when it was no longer needed – just trusted that completely. (P03)

The challenge of making complex consent decisions while undertaking clinical responsibilities was raised. Participants recounted experiences of patients requesting or starting recording during critical or high-risk points of care.

The dad, while we were resuscitating, got the phone out and started recording… (P16)

In these circumstances, the decision-making process itself was a distraction and occasionally forced retrospective decision-making (after the recording had occurred), which was a source of stress. Participants reported fear of damaging the relationship, and the potential impact to the patient's health experience and outcomes, if consent was declined or withdrawn.

I don't want them to question my ability or my care in the moment that I say I don't want you videoing me. (P19)

Theme 5: shared decision-making and power dynamics
The consent process in a team environment or in a multidisciplinary encounter (in dual-therapy or family meetings) was also explored and was more complex than the individual process. Some participants reflected on specific issues, such as the pressure to consent if another clinician had consented. Many experienced family meetings as an encounter where patients wished to record due to the meeting being both information dense and emotionally charged. However, some participants spoke of the mistrust and discomfort they faced with recording family meetings. Family meetings were regarded as points in service where difficult conversations were likely to occur or where fractures in the patient–clinician relationship might emerge. Participants shared experiences of patient-led recordings of family meetings, where they suspected the patient had nefarious intent, or where families engaged in covert recording. Participants spoke about their fear of misinterpretation and that recordings may be taken out of context.

The ones that I've had is the sneaky – like asking in a family meeting because they want to make sure that

Table 3 Factors which influence decision-making

	Factors	Quotes
1	Consent requested by patient	So I guess, for me, I wouldn't necessarily be against it being recorded if I was aware of it and consenting, and it was an agreed thing. (P01)
2	Purpose and use of the recording	If there's a clear reason and a clear purpose, I guess, then I'm all for it. (P13)
3	Confidentiality of patient, clinician, or other patients	We made it very clear, especially in a busy gym environment, that they can only record if there weren't other patients present in the background. (P20)
4	Type and predictability of encounter	Yeah I think [giving] instructions, it's pretty black and white, and I'm happy. But the other ones are more about like where it's reasoning and then that's a little bit more of your own clinical decision-making and your own clinical reasoning, and that's what I don't want on record. (P15)
5	Risk and safety/value considerations	I always think about what the risks are first and then make decisions from that. (P12)
6	Suitability and feasibility of alternative modes (including audio vs video recording)	I will offer the families the CD first and foremost, because we have a system for giving them the images. If they say, 'Oh I just want to show Dad tonight, I don't think I can wait to pick up the CD next time I'm in,' generally that's when the radiographer will give consent. (P14)
7	Personal factors, such as personal disposition, values, beliefs and usual behaviours	I'm set in my ways about what is okay and what isn't okay, but they're based on my values and my feelings and my – because of my – the years of practice, not necessarily because that's the way it is or should be. (P05)
8	Clinician–patient relationship considerations	It depended on the relationship I had with the person. I think that's the biggest thing. (P07)
9	Clinical confidence and competence	I understand as a new grad or when you're very fresh new or if you had a difficulty expressing those concerns, that would be really hard to say no. (P03)
10	Deferred consent and corruption of hospital policies	Someone else in the room said, 'Well actually no you can't,' and then that was it. (P04)

when they listen back, you're all on the same page or they want to know what you're saying because the doctor has said something different or – it's the ones whose intent isn't for the benefit of the patient. (P15)

There were mixed accounts relating to the consent process in relation to family meetings. Participants reported they had been in family meetings where requests to record were met with a blanket decline or a unanimous decision-making approach. Others described encounters where the medical consultant or another clinician made the decision on behalf of the team, either without consulting others, after a brief pre-encounter discussion or implied consent or non-verbal agreement. While some participants took refuge in deferring decision-making to others, others expressed tensions relating to power, hierarchy and peer pressure in this setting.

It would be tricky if they (the consultant) said, 'Oh yeah, that's fine. We're happy. Is everyone happy with that?' It'd be really hard to say no. Because they're essentially the bosses. (P14)

Participants recognised the complexity of obtaining free and uncoerced consent; however, there was little consensus about how this process might be better managed in multiclinician encounters. A few believed a formal tool (consent form) and clear guidance was crucial in improving the consent process. Others thought an informal meeting prior to multiclinician encounters was sufficient. Some did not desire a specific policy or guideline for multiclinician encounters, as they felt their working environment was policy and process saturated.

Theme 6: unused policies

There was uncertainty about the legal status and hospital expectations of clinician behaviour for patient-led recordings. No participants had used the current hospital policies to inform decision-making and most were unaware of the policies. Several participants were adamant there was no relevant policy in place. Others felt there was likely to be a policy but had not sought it out. Ironically, many participants thought hospital policies would be helpful to support decision-making, with some recommending policies for specific clinical areas. Some participants either unintentionally used aspects of the workplace policies (considering factors such as confidentiality and purpose), while others or their colleagues misquoted policy to support their practice (eg, saying all recording was prohibited) (table 3). In contrast, most participants were aware of the hospital policy pertaining to clinicians recording patients using their own personal smartphone with references to discipline-specific guidance.

Generally, decision-making was informed by factors not stated within the policy, such as personal or clinician–patient relationship factors. One participant felt they did not have the option to refuse, as patient-led recordings were deemed to be the norm in their clinical area

(maternity), despite the policy advising it was the clinician's choice to consent.

DISCUSSION

Six key themes were identified in this study, which enhance current understandings of clinicians' attitudes and behaviours when a patient records a clinical encounter in hospital. In keeping with previous studies,[2 4 11] our study found that most participants had experienced a patient-led recording. Our findings also showed that patient-led recordings are occurring in many types of clinical encounters outside of the clinical discussion. The findings supported current understandings that this is both an important and contentious topic. As previous studies have shown, our findings re-enforced that patient-led recordings illicit strong, polarising and mixed perspectives.[2 4–7] However, our findings build on this knowledge by suggesting that mixed perspectives also lead to inconsistent responses by clinicians when a patient initiates a recording.

The study reproduces previous findings that clinicians are generally cautious about the loss of control and potential ramifications of a recording.[2 4–6 11] This appears to impede a clinician consenting to a recording. These concerns have been identified in both research into service-led recordings[13] and discussion in the literature on patient-led recordings.[7] However, our research deeply explores these concerns and behaviours in relation to patient-led recordings across a broad range of clinical disciplines and clinical encounters. In addition, we identified further factors that influence decision-making to consent to the recording, include the type and predictability of the encounter, personal factors and the quality and the duration of the patient–clinician relationship.

It would therefore appear that multiple factors need to be satisfied and aligned for clinicians to consent to the recording. This is indicative of a culture of hesitancy to patient-led recordings. Participants explained that they used skills to support them to refuse recordings but made no mention of skills supporting acceptance of recordings. Previous literature has discussed clinician hesitancy in relation to patient-led recordings.[2 4 6 7 11 32] Our findings suggest that clinician hesitancy persists and impedes integration of this potentially beneficial tool into practice across a broad range of clinical settings.

Some studies have identified strategies to overcome clinician barriers to recordings.[23 26] The SecondEars Smartphone App may ameliorate clinician hesitancy in certain contexts such as a clinical discussion.[26] However, to what extent the SecondEars app effects the decision-making factors found in our study remains uncertain. For instance, would consent be given to a SecondEars app recording within a fractured patient–clinician relationship, during a complex assessment, or where a clinician had a personal aversion to recording? More research is needed to understand effective strategies, which harness the potential benefits of recordings[13] and mitigate the

risks within a broader range of settings where patient-led recordings occur. This is also key to reducing patients recording covertly due to fear of or realised refusal.[3 7 9]

Interestingly, despite the range of clinician concerns about patient-led recording, when consent was given, there was little consideration of the use of the recording. This signifies that trust underpinned clinician concerns. The literature on service-led recordings[22] and recordings in the primary care setting has proposed that clinicians can build trust with patients by consenting to a recording, thereby offering full transparency.[7] Our findings suggest that recordings may also indicate that a clinician has trust in their patient. This raises questions about which patients are trusted and how equity is ensured. More research is required to fully understand the role of trust.

Patient-led recordings may negatively impact patient and clinician safety and well-being. Most previous studies have explored patient-led recordings within the confines of specific encounters such as a conversation with a clinician. In these settings, both the clinician and patient are prepared and able to have a discussion. Despite this, studies have still raised the potential of patient-led recordings distracting clinicians from their practice.[2 4 11] Our findings build on this knowledge and show that both the recordings themselves and the decision-making process can distract clinicians and cause stress. Most concerning is the potential for a patient-led recording to distract a clinician during critical clinical care, such as a resuscitation. While patient safety issues appear to influence whether a clinician consents to the recording or not. Clinicians are not always safely able to consider and respond to the request for patient-led recording. This means that patient safety may be at risk while clinicians respond to the recording or clinicians may be at risk of being recorded without their consent. Our findings infer potentially significant risks to patient care and clinician well-being, which warrants further investigation.

Despite concerns, when compared with most previous studies on patient-led recordings, the findings showed clinicians to be less sceptical about the benefits of recordings for patients.[5 6] Most participants could recognise some benefits, with some viewing it as an inherently positive tool. The inclusion of allied health clinicians and diversity of clinical settings may explain this difference, although further studies into the allied health perspective is indicated. Furthermore, our findings highlighted that, despite the risks to themselves and fear of losing control, some clinicians viewed recording as increasing accountability and saw the potential to improve patient care. Improved care has been associated with patient-led recordings in the literature, although not formally investigated.[2 7] The role of patient recordings in achieving a greater level of transparency should be further considered as this is aligned with global initiatives to advance accountability in healthcare.[33]

New learnings from this study surrounds the challenge of the consent process in multiclinician encounters, such as family meetings. In this setting, complex decision-making is also impacted by power dynamics. This study's findings have shown instances of senior clinicians consenting on behalf of others. The combination of tensions that exists in this scenario means, it is unsurprising that clinicians may take a non-consent approach. However, this approach could have detrimental effects on patient understanding and care if they are unable to record an information-dense encounter.[25] Patient perception that recording will be denied is likely to lead to a greater level of covert recording.[37] There is an imperative for training and tools to ensure effective decision-making in this difficult landscape.

Finally, previous studies have called for the development of policy or guidelines to both inform and empower clinicians to manage patient-led recordings.[2 4 6 15] However, they have not accounted for the challenges of implementing policies when power dynamics are at play. Our findings suggest that clinicians are not using the existing health service policies to inform decision-making or behaviour. Further investigation is needed into the role of policy in supporting clinicians when a patient records, with consideration given to policy accessibility, efficacy and other tools, which may support policy implementation.

Strengths and limitations

This is a qualitative study that interviewed a small sample of clinicians in two hospitals within a single tertiary health service and is, therefore, not generalisable. As with any study that uses semistructured interviews, data quality may be affected by dishonesty, inaccuracy or reliability due to context, time or the influence of the interviewer. Further research on the issues raised in this study is warranted.

Despite these limitations, the qualitative approach is a reliable method for initial exploration of a topic.[28 29] Our study is the first to explore patient-led recordings using this approach. Previous studies have not sought to understand clinician decision-making in depth, perhaps as these have primarily used survey design,[2 4 6] rather than qualitative interviews, which allow participants to reflect intensely on a topic.[28 29] A combination of purposive and snowball sampling facilitated a wider diversity of opinions and experiences across a range of clinicians. The use of semistructured interviews rather than structured interviews or quantitative surveys was a strength, as it allowed for free flow of discussion while also producing rigorous data that was comparable.[29]

CONCLUSION

This is the first study to explore the clinician perspective and behaviours to patient-led recordings from a broad range of clinical disciplines and clinical areas in a tertiary hospital setting, providing greater insight into the hospital clinician position. Key learnings are that while there are benefits to patient-led recordings, clinicians are facing multiple challenges when a patient records, which impacts both clinician and patient well-being. This study challenges previous assertions that policy will support

clinicians and protect patients' interests, since findings suggest that policy is not used. Also, policies are unlikely to respond to issues such as power dynamics. More research is urgently needed to investigate the usefulness of policy and other mechanisms of support to ensure the safety of both patients and clinicians when patients record encounters in hospitals.

Patient and public involvement Patients and/or the public were not involved in the design, or conduct, or reporting, or dissemination plans of this research.

Patient consent for publication Not applicable.

Ethics approval This study involves human participants, ethical approval was obtained from Gold Coast Hospital and Health Service, Human Research Ethics Committee (HREC/2020/QGC/63753 (LNR)). Research governance approval was granted by Gold Coast Hospital and Health Service (SSA/2020/QGC/63753). Participants gave informed consent to participate in the study before taking part.

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