Ethical Problems of Recording Physician-Patient Interactions in Family Practice Settings

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Recordings of actual physician-patient interactions are an important tool for family medicine education and research. Their use, however, poses two sets of ethical problems: one dealing with privacy and confidentiality, and another related to limitations upon informed consent in the context of ordinary medical care. Experience with audiotaping and videotaping led to engaging in a "principle-based" method of ethical reasoning in which problems generated by difficult cases were examined in light of both current rules or guidelines and four fundamental ethical principles. Through this approach specific policies were developed for voluntary, informed consent and for protection of privacy, while recognizing that each case must be judged in the light of the physician's obligation to do the best for each patient.

Family practice training programs use audiotapes and videotapes extensively to investigate and teach about the physician-patient relationship. But taping makes one of the most private and intimate interactions between people—that between a patient and his or her family physician—a matter of permanent and public record. Providing access to the physician-patient relationship for teaching purposes endangers its integrity.

If family practice and medical ethics are, indeed, a "natural and necessary union,"[1] it is necessary to explore the dilemmas of its academic methods. This paper examines two sets of ethical questions that arise from the use of audio and video recordings of physician-patient interactions as commonly employed in family practice settings: (1) Are there violations of privacy and confidentiality when such recordings are used for teaching and research purposes? (2) Are there violations of true informed consent when recordings occur in the course of regular medical care by one's personal physician?

Concern emerged over a period of several years as one author (M.R.B.) videotaped routine office

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visits to teach about interviewing the physician-patient relationship. Three problems gradually became clear: (1) the richness of the data tended to obscure the importance of the violation of the interview's privacy; (2) procedures for protecting patients and their data were clumsy and inadequate, from the initial "informed consent" to the care and storage of the tapes; and (3) aside from Institutional Review Boards, which required consent procedures for research projects, there were no guidelines for the use of recordings for teaching purposes. Such training uses included playing the tapes to groups ranging in size from one person to 100 or more, involving many levels of clinical discipline from students to colleagues at national meetings.

Therefore, a search for procedures was undertaken that would protect patients on the one hand and the need to investigate and teach on the other. The process involved three steps: (1) identifying the problem, in part by studying the recordings themselves, (2) analyzing the problem by reference to ethical principles and moral reasoning, and (3) developing and implementing guidelines for consent and for the care and use of the tapes.

Identifying the Problem

Patients have the right to expect that "the information disclosed to a physician during the course of the relationship between physician and patient is confidential to the greatest possible degree. The patient should feel free to make a full disclosure of information to the physician so that the physician may most effectively provide needed services. The patient should be able to make this disclosure with the knowledge that the physician will respect the confidential nature of the communication."[2]

In reality, a wider circle of people have access to information about the patient,[3] from office staff who schedule appointments and screen laboratory data to colleagues at conferences or rounds who discuss "the case." Here the intent of the professional and the anonymity of the patient tend to protect the confidentiality of the information: staff are enjoined from perusal of the patient's record and from discussing the patient except insofar as is necessary to do their jobs on behalf of the patient, and names are never used in case presentations or published reports. Still, these protections are no guarantee against abuse; most physicians filter information so that intimate data are recorded in the written record in vague or cryptic form or not at all.

Recordings not only widen the circle of access, they provide unfiltered detail and potentially last forever; without editing, the intimate and identifying data sit alongside the mundane. The risk of third party identification is particularly great with video and with patients who are public figures or travel in the same circles as potential viewers. The "communities" of family health center patients tend to be small ones. Even in Pittsburgh, a city of one-half million people, two patients were quickly encountered who could be identified by viewers who knew them in a nonmedical context: a patient with an alcohol-related disorder who shared a part-time job with a medical student, and a patient with a sexually transmitted disease who was to become something of a local celebrity.

These experiences were disturbing, demonstrating what was, in retrospect, obvious: that certain patients and certain patient data are more private than others, and that recordings pose a risk of third party identification, which might do harm to patients by breaching the confidentiality of the physician-patient relationship. Patients were being asked to do something risky, and it was an unfamiliar risk: its incidence unstudied, its parameters impossible to measure, its implications uncertain.

Do present consent procedures consider this special kind of risk? "Informed consent" is a process whereby patients accept a certain risk, usually in exchange for some hoped for benefit, but it was not clear whether patients understood the risk and freely agreed to accept it. Written and oral explanations were vague and uninformative, and many consents that seemed straightforward at the time were really quite problematic. Existing written consents merely informed people that they

were being taped and that the tape would be used "only for educational purposes."

Analyzing the Dilemma

There are certain standards or rules governing the physician-patient relationship, such as confidentiality and informed consent, that derive from a limited number of ethical principles. One set of generally accepted ethical principles is as follows:

1. *Autonomy:* A person is autonomous if and only if he or she is self-governing. When one person acknowledges the importance of the principle of autonomy for another person, he is displaying respect for persons.

2. *Nonmaleficence:* This principle is based on the Hippocratic oath and means "do no harm," that is, prevent harm and remove harmful conditions.

3. *Beneficence:* This principle refers to a duty to confer benefits or to help others further their important and legitimate interests.

4. *Justice:* This principle means giving each person his or her "right or due." One is just toward a person if one gives that person what the person deserves or is owed.[4]

These principles, which derive from one or more general ethical theories, can be used in a dynamic way to derive guidelines or rules, which in turn help to decide individual judgments; but experience may then feed back to change the rules or possibly even the ethical principles or theories.

The confidentiality of patient records is a guideline that is well grounded on ethical principles.[4-7] The right to privacy and the notion of privileged communication are fundamental to the physician-patient relationship. These rights derive from the principle of autonomy: the right to control information about oneself with regard not only to what one says, but who knows it. Patients share things with their physicians—feelings, thoughts, parts of their bodies—that they do not share with others. People regulate their behavior according to who is watching, and as thinking beings, people want to know and choose who is watching. This position is basic to the concept of a person[8] and is defensible not only on general moral principles but also has a sound legal basis.[9-11]

Privacy and confidentiality are not absolute rights but can be overridden by other principles. Thus, a person could authorize access to information about his private life for medical education or research purposes. Then the issue becomes one of informed consent, and the physician must be morally certain that the patient understands to what he or she is consenting and that the patient is truly autonomous. There are good grounds for suspecting the patient often does not understand or is not functioning in truly an autonomous fashion. If this is the case, additional safeguards need to be developed to protect patients from placing themselves at risk.

It is some constraint upon this right to privacy that patients are asked to surrender when asked to permit recording the usually private activity of a visit with the physician. If the physical examination is recorded, the patient is also being asked to relinquish control over who has visual access to his or her body. When the patient gives up this right, he should know exactly what he is giving up and how the (private) information will be used. For research purposes, there are protocols that specify who will view the tapes, how the tapes will be used, and so on. However, use of tapes for "educational purposes" is much more open-ended and unpredictable, with greater potential for third party recognition and, thereby, for harm. If there is no chance that a third party could identify the patient, then privacy itself may not be infringed, but even so, the principle of autonomy would dictate that the person should have the opportunity to determine whether the visit is recorded. However, there is usually a small chance of some identification; therefore, the patient has a right to know what he or she is being asked to relinquish. This knowledge is the basis of informed consent.

At times it appears that the principle of autonomy comes into conflict with the principle of nonmaleficence, of not harming. One could argue that the physician wishing the best for his patient—and also wishing as a scientist to investigate—would not tell the patient he is being

taped so that the "true" nature of the interaction would be maintained. After all, the physician can do the best for the patient only if the patient is comfortable and uninhibited in giving information about himself. Moreover, not much can be learned about the "true" physician-patient relationship if study interactions are altered by the presence of the recording. Perhaps this concern is the basis for the physician-investigator's discomfort in asking patients to be recorded and for the "blanket" consent used by some settings in which patients agree that they can be recorded at any time without being informed in each instance that they are being recorded.

This dilemma illustrates the choice peculiar to the physician who is both healer and scientist or teacher: the choice between what has been termed the *individual ethic* and the *collective ethic,* between insuring the patient's best interest and the best interest of all future patients.[12,13] What guidelines can be developed to guarantee the autonomy of patients and the trust they place in their physicians while preserving a tool that aids physicians in understanding their patients?

Developing Ethical Guidelines

To preserve the physician-patient relationship, it is necessary to preserve the patient's autonomy, that is, the right to know and the right to choose who has access to information about himself. It is the principle of autonomy and the principle of nonmaleficence that dictate the need to (1) insure the voluntary and informed consent of the patient, and (2) prevent unauthorized access to the tapes and the information they contain.

The first concern is to insure consent that is both voluntary and informed. Arguing from the principle of autonomy and from the observation that patients quickly forget that they are being recorded, it is essential that patients always know at the time of the visit that they are being recorded. Consequently, "blanket" consents obtained, for example, on initially registering for care should not be permitted, even if they contain a statement that the patient may be recorded at any time. Furthermore, while it is essential for the patient to know and consent immediately before the visit that is to be recorded, it is equally essential that he or she be asked again immediately after the visit if the consent still stands. This procedure is recommended because patients may say something of an unexpectedly private nature, forgetting that a recording device is on. What such a procedure amounts to is a specific implementation of the standard guideline that "you can take back your consent at any time."[14] Such a "before" and "after" consent process goes a long way toward insuring that the patient knows he is being recorded and is actively choosing that option.

Arguing from the principle of nonmaleficence, there may be times when the risk of recording is too great to even make the request. Just as a clinical investigator might judge a patient too sick to undergo an experimental procedure, so might the physician-teacher exclude from taping a patient such as a public figure at too great a risk from invasion of privacy, even if he were to give consent. In this instance, nonmaleficence overrides autonomy. In other words, the patient agrees to be taped, but the clinician decides, in the best interests of the patient, that it is too risky.

In addition to a knowing choice, the choice must be voluntary and the patient competent to choose. To act voluntarily, the patient must not feel coerced. While physicians would not force a patient to do something against his or her wishes, there are coercive aspects of one's personal physician asking one to do what amounts to a favor; patients who have a great desire to please their physicians or who are unable to pay for their care may be at special risk. Likewise, arguing from the principle of justice, it would be unfair to ask only nonpaying patients to participate in recordings. To this end the physician must make it clear that the patient is free to say "no" and that his or her care will not be affected in any way. The physician should state the request matter-of-factly, making it clear that the patient's response is of no import to the particular visit at hand nor to his relationship with the patient. Some may feel that a request to record would be even less coercive if it comes, not

from the physician, but rather from someone else on the office staff or, as in the case of research protocols, from someone totally outside the care of the patient.

Aspects of competence may be even more subtle. A demented patient may clearly not be competent to give consent, but what of the patient who comes to the office feeling ill? It could be argued that such a patient, perhaps too sick to care, is not competent to give consent and that the consent is, therefore, not valid. How sick someone is and how that person feels interferes with his competence to give consent, a complex issue for which there is no simple answer. It can only be recommended that the physician be alert to this problem and make a judgment on a case-by-case basis.

What information does the patient need to know about the recording to make a reasoned choice? The patient certainly needs to know exactly what is being recorded: voice, picture, history, physical examination, getting dressed, getting undressed, and so on. The patient also needs to know who will see the tape and how it will be used. Only in this way can the person autonomously choose who has access to what information about his person. In this regard a statement that the tape will be used for "educational purposes" is inadequate; it must be specified, for example, that medical students and residents will see it. If the tape is for a research project wherein access is more limited, the patient can be asked to authorize additional (limited) access at the discretion of his physician, whom he trusts. It is also important to state exactly what the risk is, namely, that a person known to the patient might recognize him from the tape (especially likely with video) and that the patient will likely be disclosing information to the physician that he would not disclose to others (including prospective viewers of the tape).

When the physician records to benefit a particular patient, the task regarding consent is much easier. Such might be the situation, for example, when the physician is trying to resolve a difficult interaction and plans to use the tape to improve his relationship with the particular patient. Not only is the privacy issue simplified because access is limited, but direct benefit can be accorded to the patient over and above the selfless benefit to future patients. Thus, on a case-by-case basis the balance shifts somewhat so that patient and physician may be more willing to record intimate data if it is to the patient's advantage and will likely remain confidential.

All these precautions are inadequate unless the tapes are cared for as well as, and perhaps a good deal better than, any other medical record. Tapes should be stored in a safe place, and access should be limited to those with a legitimate interest. Tapes should be filed in such a way (for example, by number) that a person cannot get to a tape by looking up a name. Any data on the tape that might identify the patient or others who are frequently mentioned during clinical interviews (such as names of physicians) should be erased. It may also be desirable to limit the longevity of the tape by specifying a date after which the tape would be erased or destroyed. A real help in the effort to protect tapes has been the use of institutional rather than home equipment; 3/4-inch videotape cannot be used by a casual observer on home equipment. Moreover, audio should be used wherever possible, and video, only when absolutely necessary because of the obviously greater potential for third party identification with video. And as a final precaution it is essential to remind viewers that the information is confidential.

Implementing the Guidelines

Ethical theories and principles inform guidelines which, in turn, dictate specific actions that will be in keeping with the guidelines. Figure 1 illustrates an approach to solving the dilemmas of recording physician-patient interactions. The arrows represent a dynamic process of reasoning and adjudication between what may appear at times to be conflicting responsibilities. The basic components for insuring the patient's privacy include (1) develop criteria for whom and what to tape, (2) devise a consent document plus activities for oral consent, (3) define specific limitations on the uses of tapes, and (4) provide a secure area and

Ethical Theories	
↑ ↓	
Fundamental Ethical Principles	Autonomy Nonmaleficence Beneficence Justice
↑ ↓	
Derived Ethical Principles	Voluntary Consent Informed Consent Protection of Privacy Preservation of Confidentiality
↑ ↓	
Rules, Guidelines, Policies	Criteria (whom and what to tape) Consent procedures, written and oral Limitations on uses and viewers Care of tapes: storage, access, filing, institutional equipment
↑ ↓	
Particular Judgments or Actions	Is **this** patient too sick (demented, compromised) to consent? Would audiotape serve our needs in **this** case just as well? Is **this** patient at too great a risk of third party indentification? Is **this** information too sensitive? **If answers to these questions permit, then proceed with videotaping.**

Figure 1. A method of moral reasoning applied to the dilemmas of taping physician-patient interactions

filing system for storing the tapes. These basic components are then tailored to the individual patient as necessary; recording a physical examination may require an addition to the standard consent document, patients at greater risk of third party identification may be audiotaped only, some interactions may need to be limited to viewing by the patient's physician, or patients engaged in disability or malpractice litigation may not be recorded at all. Sometimes, if the interaction takes an unexpectedly intimate turn, it may be necessary to destroy the tape even when all other criteria appear to be satisfied. By clarifying the ethical foundation of alternative courses of action, it is possible to improve the selection of patients, the consent procedures and forms, and the care and use of tapes.

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