AUDIOVISUAL RECORDING IN THE EMERGENCY DEPARTMENT: ETHICAL AND LEGAL ISSUES

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ABSTRACT

Emergency physicians, organizations and healthcare institutions should recognize the value to clinicians and patients of HIPAA-compliant audiovisual recording in emergency departments (ED). They should promote consistent specialty-wide policies that emphasize protecting patient privacy, particularly in patient-care areas, where patients and staff have a reasonable expectation of privacy and should generally not be recorded without their prospective consent. While recordings can help patients understand and recall vital parts of their ED experience and discharge instructions, using always-on recording devices should be regulated and restricted to areas in which patient care is not occurring.

Healthcare institutions should provide HIPAA-compliant methods to securely store and transmit healthcare-sensitive recordings and establish protocols. Protocols should include both consent procedures their staff can use to record and publish (print or electronic) audiovisual images and appropriate disciplinary measures for staff that violate them. EDs and institutions should publicly post their rules governing ED recordings, including a ban on all surreptitious or unconsented recordings. However, local institutions may lack the ability to enforce these rules without multi-party consent statutes in those states (the majority) where it doesn't exist. Clinicians imaging patients in international settings should be guided by the same ethical norms as they are at their home institution.

INTRODUCTON

Recording images of ED patients and staff members raises ethical and legal concerns while also offering significant benefits. Emergency department (ED) activities, personnel, procedures, test results, and patients have long been documented in photographs, on film (later

video), and in audio recordings.[1] Most often used for education,[2] transmission of clinical information among caregivers, scientific publication, personal use (e.g., yearbooks, memorabilia), or institutional publicity. Many EDs have used videos to help provide quality assurance for medical and trauma resuscitations and as security measures. Public media have also used these recordings.[3.4] Emergency physicians (EPs) have voiced concerns about recordings in Eds that include personally identifiable information.[5,]

With cellphones ubiquitous, ED personnel are increasingly concerned about the ethical and medicolegal implications of surreptitious recordings. Questions of consent under duress have also made recordings for commercial use controversial.[6]

ED personnel's concerns are somewhat analogous to those of law enforcement officers, who are frequently recorded when performing their activities.[7] Yet EM professionals note that the presence of police photographers and patrol officers with always-on body worn cameras (BWCs) in EDs also raises HIPAA concerns and increases potential legal dangers for patients.[8,9]

Recording in the ED offers novel opportunities to benefit patients and improve their ED experience. Clinicians in other specialties have used recordings to improve timely patient-physician interactions, particularly regarding understanding and recalling discharge instructions.[10] ED staff commonly record clinical images and test results (e.g., ECGs, radiographs) and, once de-identified, use them for academic purposes and for use by other treating clinicians, such as consultants, attending ED physicians and residents (with identifying information and transmitted via HIPAA-compliant modes).

Recording in EDs is a complex issue. This paper illustrates the concerns about and the benefits of ED recordings, highlighting ethical and legal issues surrounding the practice. While some successful efforts in limiting unwanted recordings are cited, clinicians, institutions and organizations should recognize that reducing unwanted recordings in the ED may have limited practicable solutions. One strategy is to advocate for effective state legislation where it doesn't exist.[11]

The following discussion is divided into sections related to who is doing the recording and who is being recorded.

DISCUSSION

Healthcare workers recording patients

ED healthcare workers or their institutions often record patients for legitimate reasons. These recordings may have healthcare-related indications, such as documenting information to assist with diagnosis and treatment; creating materials for education, research, or publication to benefit other healthcare providers or the public; or to augment quality improvement and assurance activities. Cases of physicians making voyeuristic recordings, which is illegal, are rare, but have occurred.[12]

Recordings that help diagnose and treat patients are of direct benefit to patients. Images may be sent to consultants who provide advice or follow-up care, to the patient's primary care clinician, or placed in the patient's chart to document disorders or treatment. Such recordings should protect patient privacy by complying with the Health Insurance Portability and Accountability Act (HIPAA) and they should be included in the general consent to treatment or

admission documents that patients sign—but rarely read. In addition, clinicians should inform patients when recordings are made, if possible, regarding the specific purpose.

Clinicians often use cell phones to make and send HIPAA-compliant recordings; patients may see this and be concerned about clinicians having recordings on their personal phones. Our experience is that using clearly labeled department-owned devices (phones or cameras), when possible, results in fewer patient privacy concerns or "the doctor was on their cell phone" complaints. When using a personal device, it is preferable to use secure applications that do not store copies of the recording, e.g. Haiku®. If this is not feasible, immediately delete recordings from the device following upload or transmission. Informing patients of this process generally relieves their anxiety. If clinicians must send recordings to other providers using other than HIPAA-compliant processes, they should inform patients and ask them to consent to this additional risk.

Recording patients to create educational materials benefits other healthcare professionals and, potentially, the public. However, these recordings do not directly benefit the individual patient, so significant precautions must be taken to protect his or her interests and uphold professional standards.[3] Clinicians should obtain and document verbal patient or surrogate consent and, when possible, obtain prospective written consent. Power differentials and the vulnerability of illness may place patients in uncomfortable positions when authority figures request their permission to make a recording. Clinicians wanting to record them should work to mitigate these power disparities. For incapacitated patients, subsequently asking patients or surrogates for permission to retain or use the recordings may be all that is feasible.

When recordings are being made for educational purposes, patients should be informed of the intended purpose and audience, and whether they can review the materials prior to publication or presentation or receive any compensation for their participation.[5] As is standard, patients should be informed that they can withdraw their consent at any time before its use. They should also be reminded that in our digital age, once something is published, its use can no longer be fully controlled.

EDs also use recordings for departmental or institutional quality improvement/quality assurance (QI/QA) purposes. Descriptions of these activities may be included in employment contracts and patient treatment agreements. Although used less frequently than in prior years, recordings may be used to document care in critical care areas for later clinical and educational review. These recordings (generally destroyed after use) and viewing situations (closed conferences) are done using HIPAA-compliant security. Remote video auditing, a developing QA technique that originated in the food preparation industry, uses low-resolution cameras and stringent security practices for real-time, remote auditing of and feedback for healthcare workers on procedures such as safety and turnover in operating rooms and handwashing in ICUs.[13,14] Institutions must ensure that appropriate policies and procedures are in place to protect both patient and staff member privacy and the integrity and confidentiality of the QI/QA process. It's also important to recognize that people are inclined to "assume that video is the event itself, when, in fact, it only is further evidence of the event" with inherent limitations on both perspective and technical capture.[7] Ethically, it is essential for both healthcare workers and patients in areas in which QI/QA recordings are occurring to be informed about the practice, what privacy and security measures are in place, and the opportunity to decline to be recorded.

When considering recording ED patients and staff members, three common, circumstances must be mentioned: 1. images without patient-specific identifiable information, 2.

situations precluding immediate (or any) consent, and 3. recording in international settings.

Imaging body parts to document illness, injury or treatment is common. Examples include a rash or wound on the skin, an injured extremity, or a dental or oral soft tissue problem. In isolation and, these images cannot be linked to a specific patient. When placed in a patient's chart, they provide useful information to the patient's other clinicians. Nevertheless, patient autonomy and simple courtesy suggests that clinicians should ask patients for permission to take such images. The situation is similar when imaging radiographs, ECGs, laboratory results and similar tests, if identifying data has been removed and nothing in the images connects them to the patient. If any of these images are transmitted, accompanying identifying information must comply with HIPAA requirements.

When patients with educationally useful findings present in circumstances precluding immediate patient consent, an ethical dilemma arises. As in other healthcare scenarios, a surrogate for children and adult patients without decision-making capacity can provide this consent. (The motivations and knowledge of surrogate decision makers has been thoroughly discussed elsewhere.[15,16 Ð]) In these cases, an ethical tension exists between providing professionally useful information and preserving patient privacy and, sometimes, confidentiality. If such imaging can be done without revealing patient-identifying information, recording is appropriate. If not, especially if recording must be done immediately to preserve the findings, the recording can be done, and patient permission subsequently obtained, if it becomes possible to do so. Providers must obtain consent as soon as possible and before the images are used in any manner. Providers must respect a patient's (or surrogate's) decision to withdraw consent.[17] The onus is on the clinicians to delete the images and ascertain that they do not appear in other formats, such as on social media. In addition, unless such permission is given or identifying information is erased, legitimate medical journals will not publish the images.

Recording patients in international settings for any purpose poses its own set of ethical dilemmas.[18] In these settings, clinicians encounter language barriers, observe novel (to them) clinical findings, appear to have a lax clinician-patient relationship, have significant authority discrepancies with their patients, and believe that they exclude any Western ethical or HIPAA restrictions. In addition to the respect that clinicians should show every patient, when working abroad they must realize that despite cultural differences, the same ethical strictures apply. U.S. clinicians who image patients while working internationally should be guided by HIPAA's principles and should offer patients the same protections as are offered to patients in the United States, even though its legal protections do not extend to them.[19] Moral values aren't variable and should not change regardless of setting. The providers duty must always be to the patient's welfare and best interests, whether in preventing, treating, or coping with illness regardless of the health care setting or patient characteristics.[18] As in the United States, the best course of action, and one adopted by many organizations, is to obtain and document verbal or written permission to take and use the photograph, and to work within local laws and bioethical standards of care.[19,20]

Healthcare workers or institutions recording staff members

There are multiple non-healthcare-specific reasons that ED staff members or their institutions may want to record other institutional employees. These often relate to ED and hospital organizational problems, such as systematic sexual and non-sexual harassment, wastefulness, illegal activities, or incompetence.[21] Such recordings may fulfill an ethical responsibility to document activities that harm patient care and run counter to good management

practices or the law. When done by security professionals, cameras in public areas may help deter or identify criminal behavior. However, clinicians or administrators making surveillance recordings, particularly in areas in which patients and staff have a reasonable expectation of privacy (e.g., patient care areas, bathrooms, and changing rooms), may put those making them at ethical and legal risk. Those initiating such recordings should recognize that potential positive impacts are counterbalanced by several risks. As high-profile cases involving such recordings have shown, these actions may alter workplace dynamics, breaking down trust by creating the fear that everything employees say may later be used against them. It may also compromise patient privacy and confidentiality.[22] For example, a San Diego, California women's hospital was recently sued for inadvertently filming nude women undergoing procedures while using hidden cameras to apprehend staff thought to be pilfering drugs.[23] While protecting staff and institutional reputations are laudable and necessary goals, the ethical imperative to protect patient privacy and confidentiality is most important. These types of investigations should normally be delegated to professionals who can guarantee that patients are protected.

Healthcare workers recording themselves

Outside the ED, providers can record themselves, within the bounds of societal norms, in a personal or professional capacity. Many providers use social media platforms to disseminate educational and general clinical information to other providers. These include podcasts, blogs, social networking (e.g., Facebook, LinkedIn), microblogging (e.g., Twitter, Tumblr), photo sharing (e.g., Instagram, Snapchat, Pinterest), and video sharing (e.g., YouTube, Facebook Live, Periscope, Vimeo).

Personal recordings on social media. Because social media is a widely used personal tool, the boundaries between personal and professional postings can become blurred, and may lead to confusion about the professional patient-provider relationship.[24] In addition, when providers' recordings are posted to public sites, they can be seen not only to other EM providers (which might be their intent) but also by the public, including those patients and families who were subjects of the recordings. Physicians should use caution to ensure that all posts (work-related and personal) are professional and appropriate.

Recordings on online education platforms. Another important professional online sharing platform is Free Open Access Medical Education (FOAM), a collection of resources that encourages interaction and creates a dialogue about healthcare.[25] The widespread availability of FOAM within the EM community reflects its usefulness for understanding and disseminating educational materials. Another example is the American College of Physicians' patient information center, where clinicians, institutions and organizations can post instructional videos for patients about common conditions.[26,27] Providers might also record themselves to help patients understand their health conditions. For example, videotaped discharge instructions may help to clarify the complex written instructions typically provided to patients, especially in cases in which the patient has little understanding of healthcare.[28] Recording personalized discharge instructions for patients helps them recall their visit and increases their understanding of home care instructions, medication dosing, and information about making follow-up appointments. When patients or family members overtly record ED providers answering questions about their ED visit or discharge instructions, they implicitly have the provider's permission. Studies show greater understanding and recall among those who receive provider recordings.[29] Covert recordings suggest pernicious motives for which provider consent would rarely be requested.

Because recordings can be a useful resource for both patients and providers, EM providers should be allowed to record in a professional manner without fearing repercussions. Yet providers worry about legal ramifications if care is perceived as incomplete or incorrect.[22, 24] EPs have raised concerns that recordings meant only for EM providers could expose judgment errors, missed diagnoses, or portray typical cynical medical humor that is perceived as crass or uncaring when publicly viewed.[30] One study showed that most patients support recordings made so that they could better recall discharge information, but about 11% said that they might use them in a malpractice claim.[28]

Patients, family or visitors recording other patients and staff

Family and caregivers sometimes record, overtly or covertly, the ED staff interactions with patients who they are accompanying. Before recording interactions with the patient's provider, they should obtain, if possible, the patient's permission, since the recording will contain private patient information. They should also take steps to prevent this information from being shared with outside parties. Laws and hospital policies permitting such recordings vary greatly.[5,30]

ED patients and those who visit them also sometimes use audiovisual devices to surreptitiously record staff and other patients who are strangers to them. These individuals may be unaware of the institution's rules and regulations or the pertinent law. Hospitals have difficulty curtailing these activities, since the patients and visitors involved are not subject to the controls they have over their employees, contractors, or volunteers. When patients and visitors are discovered to be recording against hospital policy they should be asked to stop recording and delete the recording. They also may be asked to leave the patient care area.

Covert imaging during the medical encounter is morally problematic because it undermines and damages the foundational trust of the doctor-patient relationship. Given its surreptitious nature, the frequency of this occurring is difficult to know. While there seems to be no ED-specific data on the frequency of covert recordings, a nationwide UK survey found that 15% of respondents indicated that they had secretly recorded a visit with a medical professional.[31] Surreptitious recording of well-known people can be particularly harmful. This behavior violates common social norms and the religious (Talmudic) maxim, commonly referred to as the "Golden Rule": "Whatever is hurtful to you, do not do to any other person."[32] Thankfully, this does not seem to be a common occurrence.

Patients and caregivers may also make covert recordings to document atypical provider or patient behavior. Patients or others sometimes record parts of their ED visit to post on social media or to share via e-mail. These may violate the privacy rights of caregivers, staff, or patients. Sometimes patients and visitors post recordings to complain about their wait time or treatment, or even to mock their caregivers or other patients. Such recordings may be rebroadcast or widely disseminated, whether the patients or caregivers want it or not.[33] These videos can be edited and may not include the whole visit or context.[34] Providers fear that these public videos may be used in malpractice and other adverse professional actions. For example, a California EP was overtly filmed in 2018 coaxing a patient to get him out of bed. The video was posted online, and became a national news story; eventually, the EP lost her job amid online demands to revoke her medical license.[35]

The American College of Emergency Physicians (ACEP) recommends that hospitals have regulations regarding this type of recording, including restrictions in areas where there is a reasonable expectation of privacy. This legal phrase, part of "intrusion" (tort) law, has been

upheld in courts.[36-38] Hospital policies restricting audiovisual recordings vary among institutions.[5] Some institutions, such as Cedars Sinai in Los Angeles and Vail Medical Center in Colorado, have policies that restrict most recording, even of family members who have given permission.[9] These policies often carve out exclusions for filming relative's births, if the mother gives permission to do so.

Privacy laws in most states allow a person who is part of a conversation or interaction, to record it because only one-party consent is needed.[30] That means that even if a person is not part of a conversation or interaction (for example a family watching a caregiver's interactions with a patient), they can record the interaction provided that one of the parties involved consents to it.[30] As of 2019, audiovisual recording without prior 2-party consent is illegal in at least 11 states, usually as part of their wiretapping laws. California law, for example, provides for up to a $2500 fine and up to a year in prison for a violation.[39] Hospital policies restricting audiovisual recordings vary among institutions.[5]

To discourage this activity, hospitals should post warnings at the registration area, in waiting rooms, and patient rooms. Because of the variability of privacy laws, emergency clinicians should act as if they are always being recorded, always maintaining a professional demeanor and communicating as clearly and effectively as possible.

Photographs present a different challenge. Because they don't involve audio recording, they are not restricted, even in states that require 2-party consent, unless specific statutes exist. However, they still may be restricted in private hospitals that have rules concerning photography. Transgressions might constitute breach of an individual's right to privacy and may result in HIPAA claims against a covered entity.[5,40-42]

When patients or third parties are discovered to have violated hospital policy or the law, whether intentionally or not, experience suggests that they are usually willing to delete videos or photos if asked. If they refuse, they cannot be forced to do so. But, unless it is a patient with an unstable medical condition, they can be removed from the premises if the institution is private property and their behavior is in violation of clearly posted hospital rules. In those cases, once EMTALA is satisfied, the patient can either comply with the request or be asked to leave the premises.

Despite the proposed remedies, technical advances like live streaming and uploading photographs or videos to the cloud make this activity impossible to completely control in our open society. Surreptitious filming, regardless of posted rules, is a problem for which there may be no solution, short of collecting cell phones at the door, which is not desirable or feasible. Regardless of whether it is legal or controllable, the authors consider this covert, unconsented recording of ED staff and patients to be unethical.[43]

Law enforcement recording staff and patients

Law enforcement officers often need to be in the ED to provide protection to staff, patients and visitors or to accompany or transport patients from accident or crime scenes. They may also come to investigate crimes. All these activities put officers in contact with patients and staff. Other than to perform the specific role for which they are in the ED, law enforcement officers should not be permitted to roam through the ED or to view other patients or patient care activities.[8,44]

EPs have voiced concerns about officers filming in the ED with body-worn cameras (BWC). However, no adverse outcomes have been reported from their use. Indeed, in a case that received national attention, an officer's BWC footage led to the release of an ED nurse (arrested for refusing to allow an illegal blood draw), demoting or firing the officers involved, and a financial settlement.[45]

ACEP policy states that "The unauthorized use of recording devices, including by law enforcement, should be regulated and restricted in areas of patient care or where there are reasonable expectations of privacy and confidentiality."[5] Specifically, they say that while law enforcement officers may use video or audio recording devices, they must have the consent of all parties to record "interaction or communication between ED patients and physicians or other ED staff."[46]

Law enforcement officers must obtain a patient's permission to record them except when they are in legal custody, when the officers have a temporary (emergency; *ex parte*) warrant, or where the law specifically allows it. Patients often give permission for officers to photograph injuries that may be later used to support prosecution against assailants. However, nearly all the 74 major U.S. police forces in one study now use BWCs, although as of November 2017, only 18 of the 74 had policies requiring vulnerable individuals to consent before they can be filmed. Some police forces now include limiting the use of facial recognition software in conjunction with BWCs.[47]

BWCs have the same limitations as all video. That is, they provide only a limited perspective, not showing (or providing audio for) events outside the camera's view or any events occurring before or following the video. As described in a proposed pro-officer BWC state law, "Video has a limited field of view and may not capture events normally seen by the human eye. The frame rate of video may limit the camera's ability to capture movements normally seen by the human eye."[7,48]

While individual institutions can work with their local law enforcement agencies to change BWC policies, Florida has addressed the issue in a statute. This law prevents disclosure of BWC recordings made "inside a private residence, healthcare, or mental-health or social-services facility, or any place where a person would have a reasonable expectation of privacy."[49] Just such an expectation of privacy exists in emergency departments. Promoting such legislation may be a tactic organized emergency medicine can take.

CONCLUSIONS

EPs and physician organizations should recognize the potential value of audiovisual recording in the ED and advocate for the adoption of consistent specialty-wide and local policies that emphasize protecting patient privacy. In ED patientcare areas, patients and staff have a reasonable expectation of privacy. Audiovisual recordings made without explicit consent may compromise patient and staff member privacy and confidentiality and generally should not be permitted. Particularly when recordings contain personally identifiable information, ED staff and patients should generally be required to give consent before being recorded and informed that identifying information will be removed. For ethical and legal consistency, surrogates should be able to provide consent for patients without decision-making capacity. Obtaining "retrospective consent" to record ED patients or staff is generally insufficient to ethically justify violating privacy and confidentiality. However, time-sensitive recordings of those patients without

decision-making capacity and who have no available surrogate may be made pending subsequent permission to retain or use the recordings.

Recording ED staff or patients should be a deliberate decision. The use of always-on recording devices, whether by hospital personnel, law enforcement, or other persons, should be regulated and restricted to areas where patient care is not occurring and where there is no reasonable expectation of privacy and confidentiality.

Emergency medicine organizations should work within their states with other medical organizations, law enforcement, hospitals, patient advocacy groups, and others to generate legal restrictions to body camera usage in the ED. Healthcare organizations and institutions should recognize that HIPAA-compliant audiovisual materials may benefit patients to advance educational purposes. They should maximize the use of premade audiovisual materials and encourage the cooperative (with consent) use of recordings to help patients understand and recall vital parts of their ED experience and discharge instructions.

Healthcare institutions should provide HIPAA-compliant methods to securely store and transmit healthcare-sensitive recordings. Healthcare organizations and institutions should recognize the potential value of recordings that are made with ethically and legally appropriate patient and staff safeguards. They should encourage their use for professional publication, education, research, and quality assurance/quality improvement.

Clinicians imaging patients in international settings should be guided by the same ethical norms as they are at their home institution.

Institutions and departments should establish protocols, that include consent procedures for making and publishing (print or electronic) audiovisual images in the ED as well as appropriate disciplinary measures for staff that violate them. EDs and institutions should post their rules governing ED recordings by the public, including a ban on surreptitious or unconsented recordings by any person.

Clinicians, institutions, and organizations in states without multi-party consent for recording laws (most states) will continue to face barriers in their efforts to limit covert or other undesired recordings and should consider legislative advocacy efforts to address this challenge.

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