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Review Article

Intruding Medical Consultations: On Patients/Evaluees Recording Medical Encounters

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Abstract

The author relates reports of patients' surreptitious recordings of medical procedures. He opines that such recordings most often impact negatively on the medical encounter. The author suggests that clinicians should simply ask the patients/evaluees: Do you want to record the medical consultation? He proposes that such a simple question may allow the evaluees and the physicians to have a frank discussion on the related issues, and more appropriately respect a shared and collaborative decision-making process.

Keywords: *Medical Consultations; Evaluees; Medical Encounters*

Some triggering situations on the recording of the medical encounter

A few years ago, a C-L outpatient of mine wanted to record the medical session. I accepted and kept on file a copy of the recorded session. Three years later, she was going through a stormy divorce. She had lost the recording, but her ex-husband knew that I had a copy, and he asked the court to allow his lawyer to get a copy of that recording from me.

I now mostly practice forensic psychiatrist in Canada. At the beginning of an Independent Medical Examination (IME) session, an evaluee tells me that he already started to record the IME, without informing me first, and of course without requesting my consent. Was the evaluee kind of spying on me? I was angry and questioning the evaluee's real goal.

A few months ago, one of my colleagues' employee has put a picture of a patient and her on his facebook, without asking the patient, without asking her.

A few weeks ago, an evaluee was taking pictures in our waiting room, while other persons were waiting for my colleagues. I asked him why he was doing that, what he was going to do with the pictures, and I informed him about the others' rights to privacy and confidentiality.

Over the last few months, many articles about chaperones have been sent from different medical organizations, with some pros and cons of chaperones for the patients and/or for the physicians [1].

The presence of chaperones as well as the recording of medical sessions both raise many issues [2] on the doctor-patient, on the doctor-evaluee relationship. Here, I will concentrate on the recording of the medical encounter.

According to the Canadian Medical Protective Association, with the accessibility of new technologies the recording of medical consultations by patients (or evaluees) seems to become more frequent than it used to be [3] and it looks like that most often the patient does not ask for the professional's consent. The same has been observed in the United States and other countries [4-6].

Across Canada, patients (in the usual doctor-patient relationship) and evaluees (in the context of third-party evaluations) are allowed, by the law, to record the professional without his/her consent. However, a physician is not allowed to record them without the patient's/evaluee's consent. In the United States, it depends. In some jurisdictions it requires the consent of both parties, while in other jurisdiction, it is a one-party (patient/evaluee) decision [7].

I taught communication to medical residents for many years. I always told them what I have been taught myself i.e. "You can't not communicate". So, what is the communication message from patients' surreptitious recordings of medical procedures, a situation introduced by patients/evaluees? What do I have to understand from that, from a communication perspective? What does it translate about trust or mistrust?

What about the usual medical encounter?

A medical encounter is not a simple social day to day encounter. In the medical encounter, a person comes to see a physician (a health professional) about her medical problems. The person wants and accepts to share her preoccupations with the physician. The physician proceeds to an examination, proposes an investigation and/or a diagnosis, and/or proposes a treatment. So, the person shares her concerns, even intimate concerns, under the presumption of confidentiality, and accepts to be eventually physically touched for a physical examination by the physician (or to convey intimate preoccupations, for a mental state examination). The person then discusses the investigation or diagnostic alternatives, and the potential treatments. The expected professional climate is intended to support shared decision-making and collaborative care. Usually, it stays a rather private and confidential two-party matter, between a patient and a physician. But both parties may determine together the if-how-to whom-when-reason for the content of the encounter to be shared (or not). The patient confidentiality is de facto protected [8-12] but at times it may be legitimately breached, like in third party evaluations where the evaluee is informed of the objective of the evaluation and the transmission of some information to a specific third party.

When you know the intruder: The third-party evaluation

At times, patients want to be accompanied by a member of their family. Most of the time, it is because they are anxious, or they are afraid of forgetting what to say the physician, or to forget what the physician will tell them during the encounter [13]. But, at times, patients apparently do not trust the physician and want to get a form of evidence they could eventually be used, just in case. That last situation most often implies a form of suspicion, even an oppositional or adversarial atmosphere.

In the context of an IME, the evaluees are informed that the expert has received information about the evaluee's situation, that the encounter is not oriented toward a treatment of the evaluee's condition but is rather oriented toward getting the information allowing the expert to answer the questions of a mandate coming from a specified third party. They are informed that the report will be sent to that third party. The evaluee is also informed about issues like where the report will be confidentially kept and for how long, the transmission process of the report to the third party, and how he can get access to the report through the third party.

In many ways IME differs from the usual medical context, but it also shares many common aspects. The IME physician must still act as a physician. However, the IME physician will inform a third party about the evaluee. It implies that the expert must limit the shared information to what is essential to answer the questions at the mandate. The relationship is not the usual patient-physician relationship. This is not a therapeutic relationship. The main objective is not to protect the patient, the evaluee. Neither is it to harm the evaluee. The objective is to assess an evaluee's medical condition and to inform a third party, usually an employer, an insurance, a Tribunal or a Court

about a legal issue or potential medico-legal issue. The IME physician is not, per se, acting in a benevolent perspective toward a patient, but is asked to act in a fair perspective to the parties (the evaluee and the requesting third party). Accordingly, a forensic psychiatrist who treat a patient unfit to stand trial will eventually be in a position where he may opine that the patient, the evaluee, who he may be treating, is now fit to stand trial where he may be judged guilty and sentenced.

The IME physician must act with dignity and respect toward the evaluee. But he has a duty to a court, or a tribunal. The IME physician must strive for objectivity and honesty [14]. Nowadays, many jurisdictions even require the medical experts to declare that they will act to forts enlighten the court. For example, the Quebec Code [15] of Civil Procedure mentions: "Act 22. The mission of an expert whose services have been retained by a single party or by the parties jointly or who has been appointed by the court, whether the matter is contentious or not, is to enlighten the court. This mission overrides the parties' interests. Experts must fulfill their mission objectively, impartially and thoroughly".

Even if the expert's mission overrides the parties' interest, the evaluee may still not trust the expert, and may wish to record the session, anyway.

When you don't know the intruder

Some potential and unsuspected intruders: When a session is recorded, the patient, as well as an evaluee, may not necessarily know what will happen with the recording. When the patient or evaluee chooses to record the session, he may not realize it, but he may then introduce a potential unknown intruder. The recording can be used by the evaluee, but at times it is shared, by the evaluee, with a closed one. However, it could also be shared with co-workers, lawyers, union representatives. Some "new owner" of the recording could decide to put a part or all the session on a social network. So, the patient/ evaluee may herself infringe confidentiality and privacy principles not only in regard to the professional consulted but also about her own right to privacy (the right of an individual to keep his or her health information private) and her own right to confidentiality (the duty of anyone entrusted with health information to keep that information private) rights.

Recording: a tool for or a tool against

For the patient/evaluee: In the case of the patient recording the session with the professional consent, both can discuss the objective for recording the session, and how the recording will be used, and also where and how the recording will be saved.

In the case of the patient recording the session without the professional's consent: The patient may have for objective to use the recording as a way to reassure herself about the information mentioned by the physician, as a memory aid. It may be with an objective, for the patient, to secure himself against perceived potential harm. However, the potential harm may not be perceived as coming directly from the physician's attitude or behaviour but may also from what will be indicated in the conclusions of the report (e.g. in case of alleged malpractice, of disability), or how the physician's conclusions could be used by the third party requesting the IME.

For the physician, recording without the patient's would be unlawful and subject to a professional complaint. Recording with the patient's consent, like for educational objectives, should be specified and its used be limited, to avoid unexpected request to access the recording.

When the recording has been done by the patient without the physician's consent, this may have many suspected or unsuspected impacts. The physician may feel betrayed by the patient who did not trust the physician, who opened, consciously or not, a breach of the physician's privacy and right to confidentiality. That kind of situation is de facto far from a collaborative attitude from the patient. That attitude from the patient may have been dictated by a contextual imperative (related to work issues, to insurance claim issues, to litigation

issues) by the patients, his closed ones, his workers union, his lawyer, etc. That situation may impact on future communications with the physician who may be question the sincerity or transparency or truthfulness of the patient's discourse.

The physician may feel manipulated by the patient, or the evaluee, who may have asked oriented questions, using conscious or unconscious provocative strategies to essentially serve a patient's hidden agenda.

Are we missing the boat? A return of the pendulum?

For many years, physicians have been accused of a paternalistic attitude which did not respect the patient's autonomy. It is more and more recognized that the physicians are not alone to decide what is in the best interest of their patients. We have moved toward a paradigm favouring the importance of a collaborative shared decision-making [16].

The patient hiding to the physician the recording of a session may have done that from a protective perspective. But it still raises the question of the patient's mistrust or the possible biases coming from the patient (not only bias from the physician). It also puts the communication context in an adversarial position (i.e. for versus against) which holds off the patient usual encounter or the expected unbiased IME context.

Individual or societal imperatives: Obligations of patients

Of course, any medical encounter, like any IME consultation, may be subject to biases. Over the years, many professional organizations have advocated to improve training of clinicians and IME physicians about potential biases, and how to avoid them.

Also, over the years, physicians have been informed and trained about the importance of recognizing the patient's right to autonomy which may be expressed through a client-centered approach, a shared-decision making approach, a collaborative approach.

So, physicians are moving away from a paternalistic approach, and toward a collaborative approach. By recording medical sessions, at least for those who record the sessions without the physician's consent, are patients introducing a trend toward what could be called a narcissistic or individualistic approach? Are patients only have rights? Do patients also have obligations [17,18]? Do physicians have also a right to privacy and confidentiality?

When physicians feel threatened they tend, like most humans, to move toward a protective approach. Feeling threatened by patients or evaluees who record medical sessions without the physician's consent, may put physicians in a defensive approach, alienating instead of supporting an expected collaborative communication. Such a defensive attitude may have a negative impact on the medical encounter. The potential threat of a complaint, or of being sued, may put physicians in a position where every patient or evaluee becomes a potential aggressor, and suspiciousness becomes, in a way, appropriate. However, acting in a defensive mode is time consuming, and is costly, emotionally and financially.

Should we let things go, and see? Should we be proactive? Could we find a certain balance in the process?

Some authors have suggested to develop organizational policies, for their staff as well as for their patients [19,20]. I suggest that every physician should be proactive [21] about the issue.

Conclusion

Do you want to record the medical consultation?

Over the years, I introduced a simple question at the beginning of sessions with many of my patients. Now, as a forensic psychiatrist, it is part of my routine with evaluees. At the beginning of the session, while I am going through the consent process, I simply ask them: Do

you want to record the medical consultation? Asking the question, most of the time, allows the evaluee and I to have a direct discussion on issues related to the previously mentioned elements, to take together a shared decision approach on those aspects, and then to decide to record or not the session. I suggest physicians to seriously consider asking that initial question to their patients (as well as with the evaluees) and to document the answer in the session report. Including that process has the advantage to be clear and gives a certain tone of transparency to the encounter.

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