SESLHD GUIDELINE COVER SHEET

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SUMMARY	This guideline aims to support staff with information about legal, professional and ethical obligations in relation to overt and covert audiovisual recordings of care encounters by patients and third parties. It focusses on matters raised in homes and other community settings.

SESLHD GUIDELINE
COVER SHEET

Health
South Eastern Sydney
Local Health District

Audiovisual recording of staff and patients in community care settings

Section 1 – Background

Community health clinicians have raised concerns about the use of audio and visual monitoring and recording devices in patient homes by carers, family members or other third parties. Clinical staff have reported instances of overt and covert recording of patients and staff during home visit consultations and treatments, sometimes in the context of surveillance systems that are constantly monitoring patients. These cases include circumstances where patients are not aware of or have not consented to audiovisual recording devices operating in multiple private spaces in their homes, as well as patients who are being surveilled by third parties in situations of violence and abuse. Some of these cases involve patients with cognitive impairment who lack capacity to consent to being recorded.

Clinicians are concerned about patient privacy, and confidentiality and safety, and some may need guidance and support in understanding their obligations to patients in this context. Staff may also need guidance around protecting their own safety and rights when being recorded, how to manage situations where patients or third parties want to record treatment and care services, and/or where staff become aware third parties are doing so covertly.

Community health teams comprise clinicians who provide specialist assessment, rehabilitation and support services to people in their homes, including older people, people with memory loss, younger people with disabilities, families and carers, and people discharged from hospital. Because they are situated outside health care facilities, and may be at times be alone and isolated, community patients and staff may experience health, safety and wellbeing risks that require assistance and support. At the same time, clinicians and patients do not have ready access to onsite procedures and spaces where they might seek safety and assistance, and practical alternatives to meeting in the client's home setting are limited. Current home visit risk assessment and consent forms do not include information or questions about audiovisual monitoring and recording that could be discussed with patients, families and carers.

Section 2 – Purpose

This guideline seeks to support staff with information about legal, professional and ethical obligations in relation to **overt and covert audiovisual recordings of care encounters by patients and third parties**. This includes staff rights and obligations in these situations, such as whether they must consent or can refuse, what to do if they are concerned about the patient, and what they can do if/when they find out that there has been a covert recording. While these issues are relevant to staff working both onsite in health facilities and offsite in community-based settings, **this guideline focuses on matters raised by the delivery of care in homes and other community settings**.

The guideline also aims to raise awareness among staff and management about the potential recording of consultations and treatments, which in many instances **is lawful and may benefit patients and clinicians**. It also seeks to clarify for staff, how and with whom organisationally they can direct issues to do with any uncertainty, distress and danger in this context.

Section 3 – Patient recordings of health care consultations: an overview

Patients are increasingly recording health care consultations or expressing a desire to do so (Elwyn 2015, Prictor 2021). The pervasive use of flexible technologies such as smart watches and phones and other recording devices means people have more opportunities to audio and/or video record health care encounters, either with permission or covertly (Prictor 2021, Farmer 2021). The phenomenon of patient recording has generated ambivalence and uncertainty among some clinicians (Tsulukidze 2015, Prictor 2021). Clinicians and management need to be aware of potential recording–overt or covert– and consider issues related to its use (Farmer 2021).

The following summarises key literature on recording in health care settings[1]:

- **Why are patients or third parties recording?**
  - To aid memory and understanding, and facilitate engagement in decision-making, particularly when anxiety, pain or care complexity is affecting memory and understanding. Also to facilitate carer support if a recording is shared with or made by family.
  - To identify mistreatment, abuse, neglect or other harms by service providers or other third parties.
  - Third parties may use surveillance to perpetrate abuse against a person, and health care consultations may be a focal or incidental aspect of that.

- **How are patients or third parties recording?**
  - Audio and/or visual recording applications can be used on a range of everyday personal electronic devices including mobile telephones, tablets and computers, in addition to specific surveillance devices such as home security cameras and voice recorders.
  - Where available, patients (and clinicians) can use recording systems developed by health services. Using an application on a phone or similar device, patients can initiate and access recordings that are collected and stored by the health service.
  - The proportion of Australian patients who record covertly is unknown. In a UK survey, 15% of patients self-reported recording clinical encounters without permission and a further 35% would consider doing so in the future. A US survey found 2.7% of people recorded covertly–this lower rate may be due in part to some health services routinely providing permission for recording.

- **What issues are raised by patients and third parties recording?**
  - Patients and clinicians report that recording clinical encounters can benefit patients and improve the quality of care. Clinician concerns include the stifling of candid discussions with patients due to litigation fears and an erosion of trust in health care providers, particularly in instances of covert recording. However, the evidence suggests that the existence of a recording may actually minimise

[1] Notably, Prictor et al (2021), Farmer et al (2021), Elwyn et al (2015) and Tsulukidze et al (2015), UK National Health Service (2016), UK Care Quality Commission (2022), British Medical Association (2021).

conflicting recollections and enhance a sense of collaboration. Explicit communication about the expectations of all parties and the processes related to recording may support this.
- Key legal considerations in patient or third party recordings include consent, use, storage and sharing, and privacy.
- Sometimes carers and other third parties may be unaware or uncertain about the implications of covertly recording patients and service providers, including whether or not it is in a patient's best interests.

Technology-facilitated abuse

As noted above, recording of health care consultations can be a feature of technology-facilitated abuse. Writing about recordings of telehealth encounters, Farmer et al (2021) noted: "The home setting allows for involvement of parties (seen and unseen) potentially contrary to the patient's best interests. Pertinent examples include family violence or elder abuse contexts, where presence of offenders may jeopardise the clinical encounter and may pose direct risks to the patient in the periconsultation period and subsequently via covert audio or video footage."

More than 99% of Australian victims of domestic and family violence have experienced technology-facilitated abuse, according to the Australian Government eSafety Commissioner. The main forms of this abuse–harassment, stalking, impersonation and threats–can include perpetrators using recording devices and software to monitor and surveil (eSafety Commissioner 2021). Research shows women with intellectual or cognitive disability can be particularly susceptible to technology-facilitated abuse, and perpetrators can include partners and ex-partners, children, parents, carers, strangers and service providers (eSafety Commissioner 2021).

Abuse in the context of technology and surveillance is not uncommon. For further information on how to manage suspected abuse situations, refer to the policies highlighted in Section 4 of this guideline, including: SESLHDPR/598 - Recognising and responding to abuse and violence of older people and SESLHDPR/491 - Domestic and Family Violence – Identifying and Responding: Mental Health Service.

Section 4 – Law and policy context: NSW

Legislation

The *Surveillance Devices Act 2007* (NSW) (the Act) regulates the installation, use, maintenance and retrieval of surveillance devices. The following information summarises relevant details about the Act based on general advice from members of the SESLHD Clinical Ethics Committee, the SESLHD Legal Unit (May and September 2021, August 2022) and from contemporary Australian health law research (see Prictor et al, 2021).

As a general principle, the law requires the consent of all parties to make an audiovisual recording. However, because the Act allows for some defences for a recording made without consent (as determined by a judge), the law around surveillance in specific clinical circumstances may be complicated and legally technical to determine. Some of the key legal points are summarised below:

A. The Act provides that **a person is prohibited from using a listening device to record a private conversation unless the parties to the conversation consent to the recording.**

- Under these legislative provisions, therefore, it is unlawful for a patient to record a health care consultation without a clinician's consent (or knowledge). However, a potential defence in court for a covert recording or one made without consent can include: if it is only for their own use (eg, to help recall or understand details) or to protect their lawful interests (eg, a judge may retrospectively determine it be lawful if, for example, it was conducted to document abusive treatment or to support a negligence claim).

- If a person is not a party to the conversation–that is, one of the people speaking or being spoken to–they must not install or use a listening device to overhear, record, monitor or listen without the consent of one or both parties. However, "unintentional" listening via a listening device is not an offence.

- While it may not be an offence for a person to make a recording to protect their lawful interests, this legal determination can only be made by a judge. Staff still have a legal right to decline to consent to being recorded. The practical implications of this in the context of their professional duties are detailed in Section 6 of this guideline.

B. The Act also provides that **a person may not install, use or maintain an optical surveillance device to record or observe activity without the consent of the owner or occupier of the premises/vehicle.**

- Under these legislative provisions, it is lawful for a patient to install and use surveillance cameras in their own homes and vehicles, or for someone else to do so with the owner's consent. There is usually an expectation there will be signage to inform people that there are surveillance cameras.

C. **Where a patient lacks decision-making capacity**, a substitute decision-maker would need to consent to a recording on behalf of the person of who lacked capacity. Consent to a surveillance device is not necessarily a health care decision. A substitute decision-maker might be a person who is able to make personal decisions on behalf of the person who lacks capacity, such as an Enduring Guardian appointed by the patient or a Public Guardian appointed by the NSW Civil & Administrative Tribunal.

D. Importantly for staff, **the legal rights and obligations of patients and third parties differ from those of clinicians and health services.**
   - If a health care professional makes a recording of a consultation or treatment, they are considered to be collecting health information about an individual. Under the *Health Records and Information Privacy Act 2002 (NSW)* (HRIPA) and NSW Health Privacy Principles, **express or implied patient consent is required to make a recording and the recording forms part of the medical record** (Prictor et al, 2021). If the patient doesn't have capacity (see s.7 of the HRIPA), then the authorised representative (see s.8) has to give consent to the collection, use and disclosure of the patient's health information.
   - In relation to a patient's or third party's recording, staff may note in the medical record that the consultation was recorded or monitored, whether they consented or asked for it to be turned off, and whether they expressed a preference about recording of future consultations. The HRIPA does not apply to individuals collecting their own information–only organisations and agencies–unless the staff member asks for a copy and "collects" it for the health record.

E. The use of audiovisual recording devices may also contravene other laws. For example:
   - Under the *Telecommunications (Interception and Access) Act 1979 (Cth)* it is unlawful to listen in to or record a telephone call or video conference (e.g., telehealth) without knowledge of one of the parties. **Covert recording of telehealth is always an offence** (Prictor 2021).
   - It could be a criminal offence if one person installs a camera to watch another person in a private context (e.g., the shower/bathroom), knowing that person had not given consent to being filmed in this way, or if it is used to cause harm or to harass a person captured in the recording.

It is important for clinical staff to note that they are not responsible for establishing whether a recording is lawful or taking action on legal issues. Where staff have concerns, they should seek the advice and support of management and Legal Services (further information at section 6 of this guideline). However, where there are concerns about patient safety and protection of their interests, staff may be required to act. This is detailed in section 6.

Policy

Staff and management are also directed to the following SESLHD and NSW Health policy documents which provide advice and support on related topics:

- SESLHDPR/598 - Recognising and responding to abuse and violence of older people
  - This procedure outlines the appropriate steps to be taken in the identification and response to suspected or alleged abuse of older people. It complements NSW Ministry of Health (MoH) policies and legislation.

- SESLHDPR/491 - Domestic and Family Violence – Identifying and Responding: Mental Health Service
  - This procedure has been developed to inform SESLHD Mental Health Service practice in effectively identifying and responding to domestic violence where this is encountered.

- SESLHDPR/323 - Working in Isolation Risk Management
  - This procedure is to assist managers and staff in identifying and managing risks to people safety when working alone and in isolation, either onsite or offsite.

- SESLHDPD/327 - Photography and Recording of Patients within the SESLHD
  - This policy is to provide clear and concise guidelines for obtaining consent to photograph, video or audio record patients and the subsequent taking and management of images and recordings.

- SESLHDPR/626 - Closed Circuit Television – management and operation of in SESLHD Facilities
  - Outline the purpose and objectives of utilising closed circuit television (CCTV) in South Eastern Sydney Local Health District (SESLHD) facilities, and to describe the role of Security personnel in the protecting and using of the surveillance material.

- NSW Ministry of Health Policy Directive PD2017_012 - NSW Health Public Communication Procedures
  - This document outlines the processes for consultation with the media, and includes a section on patient/visitor requests for filming or photography with mobile devices.

- NSW Ministry of Health Policy Directive PD2015_001 - Preventing and Managing Violence in the NSW Health Workplace–A Zero Tolerance Approach
  - This document outlines the requirements for identifying, assessing and eliminating or controlling violence related risks, and for providing an appropriate response when violence occurs.

- Virtual care: Embedding safety in practice
  - This NSW Agency for Clinical Innovation document outlines key principles and considerations related to virtual care. Further resources are available at https://aci.health.nsw.gov.au/statewide-programs/virtual-care

Section 5 - Responsibilities

Staff are responsible for:

- Recognising that there may be patient or third-party recording or surveillance of health care encounters and that at times this can be both lawful and beneficial.
- Prioritising the safety of patients, colleagues, and themselves in the context of recordings and surveillance, particularly patients with vulnerabilities such as impaired decision-making.
- In line with other relevant policies and guidelines, and in conjunction with colleagues and managers, identifying and responding to abuse and violence against patients.
- Adequately documenting in the medial record any discussions about recording or surveillance, including any concerns or unsettled questions.
- Escalating concerns or unresolved issues to management.

Managers are responsible for:

- Recognising that there may be patient or third-party recording or surveillance of health care encounters and that at times this can be both lawful and beneficial.
- Prioritising the safety of patients and staff in the context of recordings and surveillance.
- Overseeing staff involvement in processes that support patient best interests, including NSW Civil and Administrative Tribunal (NCAT) Guardianship Divisions matters and family and domestic violence services where required.
- Overseeing responses to abuse and violence against patients and/or staff.
- Ensuring staff follow relevant policies and procedures related to surveillance and recording incidents.
- Ensuring staff have training to understand their rights and obligations in relation to recordings and surveillance.
- Understand the complex issues that can arise in this context, legally and ethically, and provide guidance in situations of uncertainty, including facilitation of complex case discussions to better navigate patient best interests and how to meet those.
- Making decisions to refer an issue to Legal Services where there is legal uncertainty, complexity or advice required.
- Encouraging open and honest communication about recordings of health care encounters or surveillance in the home. Where covert recording aims to document potential mistreatment or other harms, encouraging patients and carers to raise concerns or complaints with staff and health service management.

Section 6 – In practical terms

A one-size-fits-all approach to guidance in this area is insufficient. However, the following points aims to assist clinicians navigating patient and third party use of audiovisual recording in community settings, including circumstances where there may be uncertainty, distress or danger.

Overt recordings

Where a patient or family member is overtly recording or asks to record a health care consultation or treatment.

- If a patient or third party is recording and you say nothing but continue to provide care then your consent is implied.
- You can refuse to be recorded and you do not have to say why.
- If you refuse being recorded and a person continues to do so, you then need to decide how and where to deliver care to your patient outside of the surveillance system if this can be arranged. (See “Recordings obtained without consent” below.)
- Depending on the circumstances you might use the disclosure as an opportunity to ask about their needs, what they are trying to achieve with the recording, and how the clinical team might help (eg, monitoring the patient’s safety at home, trying to keep abreast of complex clinical and related details, or because there has been prior mistreatment or other harms/trauma).
- In all of the above situations, you can make a note in the medical record about the disclosed presence of recording devices, any related discussions, your response and stated future preferences.

Covert recordings

Where a patient or family member is covertly recording a health care consultation or treatment.

- If you don’t know you or your patient are being recorded– or someone lies when asked about recording – then you cannot manage or control that unknown.
- If you become aware of covert recording, you can advise whether you do or do not consent. You do not have to say why.
- If you refuse being recorded and a person continues to do so, you do not have to continue with the consultation if you are uncomfortable. However, you then need to consider what your patient’s clinical needs are and how they may alternatively be met. (See ““Recordings obtained without consent” below.)
- Depending on the circumstances you might use the conversation as an opportunity to ask about their needs, what they are trying to achieve with the recording, and whether the clinical team can assist (eg, monitoring a vulnerable patient’s safety at home alone, trying to keep abreast of complex clinical and related details, or because there has been a prior instance of mistreatment or other harm). Opportunities for such discussions may be different in the context of covert recordings, where people might be defensive

or aggressive. Where possible, staff should avoid disputes or disagreements, and such matters should be referred to management.
- In all of the above situations you should make a note in the medical record about the recording, any related discussions, your response and stated future preferences.

Recordings obtained without consent

Patient and staff safety is a priority.

Recordings of patients obtained without consent

- Health care consultations and other aspects of a patient's daily life may be recorded or surveilled by third parties without their consent or under coercion.
- Where a patient does not have decision-making capacity to consent or refuse (eg, if a patient has dementia or a cognitive impairment), staff need to consider whether and how carers and/or substitute decision-makers are acting in their best interests with the recordings or surveillance.
- Patient best interests is a values based assessment, so people might defensibly come to different stances on a question. There may be differences between what a family member thinks is in a patient's interests and what a staff member thinks–you need to allow for that difference. You may still feel uncomfortable, in which case you should talk to colleagues and managers. Coming together as a team to deliberate and benchmark your thinking is crucial to determining next steps. You can also contact the Clinical Ethics Service for support to examine any issues of moral unease, uncertainty, or distress.
- As noted above, disclosure of recording may provide an opportunity for staff to engage with patients and carers about the reasons for recordings and options to best support the patient. It may also lead to people being defensive or aggressive. Staff should avoid disputes or confrontations and refer such matters to management.
- Where a patient does have decision-making capacity, staff may become aware they have had their refusal to be recorded overridden by a third party or they have been coerced into accepting being recorded or surveilled. Clinicians may need to act if patient abuse or harm is suspected. However, this should be done as a team and with management (see "Concern about harms" below).

Recordings of staff obtained without consent

- If a staff member's request for a recording or surveillance system to be turned off is refused then they should continue to act professionally, completing any urgent clinical service that may have been started, making a note of their refusal, and advising management.
- Management and/or Legal Services can communicate with patients and carers to manage complex care arrangements and unconsented recordings, including finding an agreed way forward at home visits or options for coming into the health service for care.

- Any responses to problematic recording and surveillance needs to ensure staff are not put further at risk by confrontation with a potentially dangerous person. Risk assessment and staff health and safety is the responsibility of management. See section 4 of this document for policies related to risk management for staff working offsite and identifying and responding to family and elder abuse and violence.

Concerns about harms

- Some patients may be made vulnerable to harms from recording or surveillance, such as people who lack or have impaired decision-making capacity, people reliant on others for safety and activities of daily living, and/or people subject to violence or abuse.
- People who are recording or surveilling others–including health care consultations–may be acting either with good intentions or may be doing so in the context of abuse or neglect. Some carers may not realise that recording systems might be problematic and could undermine a patient's best interests. Others may be perpetrating technology-facilitated abuse with their surveillance.
- Clinicians need to deliberate on the particulars of each situation, balancing among other issues their obligations to patients who may be vulnerable alongside assumptions that family and carers are acting in the patient's interests.
- As noted above, if you have concerns about potential harms to your patient from recordings and surveillance, document those issues and talk to colleagues and managers. Have a case discussion and benchmark thinking about whether there is abuse or something else going on.
- There are thresholds regarding potential abuse or harm. Clinicians may need to act, but don't do so on your own. Do it as a team and with management. See section 4 of this document for policies related to identifying and responding to family and elder abuse and violence.

Section 7 – Ethical and professional obligations

Overview

Patient and third party recording of health care encounters is a complex ethical area. Multiple and sometimes competing priorities may arise for clinicians to manage in each circumstance, such as patient autonomy, best interests, capacity, confidentiality, consent, dignity, privacy, security, trust and veracity.

Staff and management should note that there are multiple and sometimes contested definitions of these ethics related concepts. In addition, the interplay between these and other principles will have different implications depending on the specific patient context. This means that while all are important, certain principles may have greater relevance or significance depending on the circumstances.

Furthermore, while these ethics considerations are relevant to clinicians managing recordings onsite in health facilities and offsite in community settings, the nature of home and other community-based care can raise distinct issues. This is due in part to patients and clinicians being isolated and sometimes alone, as well as the additional insights about a patient's circumstances that a clinician gains by caring for a person in their home environment.

From the ethics perspective, key related concepts to consider are:

1. Respect for persons and autonomy: It is generally agreed that individual persons should be respected. This gives rise to related ideas such as the preservation of dignity and privacy, as well as respecting their ability to make decisions for themselves, aligned with their own goals, priorities and values. Based on this principle, consent should ideally be sought from all people involved for recordings and surveillance of any kind. Persons with impaired capacity to consent to recording, therefore, are particularly vulnerable in this context, and it's reasonable to carefully scrutinise instances of recording and surveillance where it involves people with impaired capacity.

2. Veracity: Veracity is about truth telling. It is integral to openness and trust. This is important because our professional relationship with our patients and their substitute decisions makers is trust based. Where surveillance or recordings are not disclosed, mistrust may arise, and this impacts the clinician-patient relationship.

3. Best Interests: As clinicians, our obligation to our patients is to act in accordance with their best interests. It is important to remember that this is a values based term, and can sometimes be therefore difficult to determine. Different people may come to different judgements about what is in the best interests of a person. From the clinician's perspective, this may lead to uncertainty around what our obligations may be to our patients in a particular context. It is important to remember that substitute decision makers and medical guardians also have an obligation to act in accordance with the patient's best interests when making to health care decisions. Where a person is being surveilled or recorded without explicit consent from the patient, we try to ascertain

whether it is overall in accordance with their best interests in order to decide what our obligations may be in the health care context.

Uncertainty around these moral ideas can lead to moral distress. Moral distress is defined as ethical unease or disquiet resulting from a situation where a clinician believes they have contributed to avoidable patient harm through their involvement in an action, inaction or decision that conflicts with their own values. Uncertainty or unease is not uncommon in surveillance and recording situations, which raise complex health, legal and social issues that often don't have clear cut answers.

Case examples

The following cases provide examples of the situations in which clinicians may encounter surveillance and/or recording by patients and third parties in the community setting, and highlight some of the ethical issues that may arise[2]. These cases are not an exhaustive account of all such circumstances or considerations, however they do serve to highlight some key challenges in clinical practice in this area.

Case example 1

An elderly male patient with mild dementia lives at home alone since his wife died a few months ago. His son has installed a web camera linked to his mobile phone to be able to check if his father is up and okay. The camera is located in the kitchen/dining area and has audio as well as video functions. The patient was agreeable to the camera being used in this way. Community health clinicians and other community care providers were informed of the camera installation and consented to being recorded when visiting. The son has Enduring Guardianship.

>> Key ethical considerations here include respect for a patient's autonomy, which includes their capacity and ability to make choices–such as consenting to the surveillance–according to their own preferences and beliefs. Supported- and substitute-decision-making involving a family carer arises here under the Enduring Guardianship, which should be focused on securing the patient's best interests. Carer openness about a camera installation provides opportunities for clinicians to collaborate with a patient and carer about the person's best interests, including how best to determine that now and in the future when health or other circumstances may change. It also provides opportunities to openly discuss other matters of both ethical and practical importance in the context of surveillance or recording systems, including how to ensure respect for the dignity and privacy of a person being surveilled or recorded.

[2] The cases are amalgams of de-identified clinical cases and examples from the literature.

Case example 2

A female patient with advanced dementia and high risk of falls was living alone at home. Her son has Enduring Guardianship and lives out of the area. To monitor her safety he set up video surveillance in multiple areas of the house, including her bedroom and bathroom. Visiting clinicians were aware of the surveillance and did not object to being recorded in their visits. However, they were concerned that the arrangements were not in the patient's best interests, based on the perception that this was a significant invasion of her privacy and dignity. The team discussed the case, and decided it would be best if she was in alternative safer accommodation that didn't involve being left alone under audiovisual surveillance. The mother was placed in an aged care home a few weeks later.

>> In the context of a patient with advanced dementia, it may be determined that they do not have legal capacity to make an autonomous choice about surveillance. The person nominated as an Enduring Guardian legally can make personal decisions such as these on their behalf. A clinician's obligations continue to relate to a determination of what is in a patient's best interests. This can sometimes be difficult to determine, particularly if patients have been made vulnerable by a lack of decision-making capacity, and if they depend on others for their security and well-being. In addition, sometimes caregivers and other third parties can be unaware or uncertain about the implications of recording patients (and service providers), including whether or not it is in a person's best interests. Key ethical questions may relate to respect for the privacy and dignity of a patient under any recording arrangements, particularly in private spaces such as bathrooms. Also, it may be prudent to consider the patient's security and well-being in circumstances where surveillance systems are being used as temporary or permanent substitute for other care and accommodation options. Where the patient themselves are not explicitly informed about surveillance, it can be important for clinicians to acknowledge its existence and open up discussion about these ethical issues. If it is not safe to do so, or if a clinician's concerns persist after an open discussion, it may be necessary to involve management and/or legal services for advice about appropriate next steps.

Case example 3

A middle aged male patient with an intellectually disability receives community health services following recent surgical debridement of a lower limb ulcer, as well as ongoing disability care services to support some of his daily activities. He is sometimes resistant to services, and also has a labile relationship with his mother who is his primary carer. Previously he had expressed a preference that his mother not sit in on his healthcare consultation. Instead, his sister sat in on a home visit by clinicians, and unbeknown to the patient or the clinicians, she recorded the consultation for her mother with her mobile phone. When it was later discovered that a recording had been made, the family defended recording as collecting necessary information for the mother in her carer role.

>> Respect for persons and their autonomy is presumed, and under the law we assume a person has capacity for decision-making unless we can clearly demonstrate otherwise. Importantly, persons with a disability are also accorded this presumption under law. Needing care or assistance in some domains does not necessarily mean the person does not have capacity for decision making in the specific circumstances. Capacity is time situation and decision specific, so a person may have capacity for decision making in some regards, and not in others. Careful assessment is required. If the person does not have capacity, involvement of a substitute decision-maker is appropriate. Remember, however, that the patient's wishes and preferences still have ethical weight, even where they lack legal capacity for decision making. Additionally, dignity, privacy, security, and confidentiality still remain important considerations. For further information on identifying an appropriate substitute decision-maker please refer to the NCAT Guardianship Division. Navigating these potentially competing claims can be difficult. Maintaining trust with the patient is imperative, and enabling their autonomy as far as able is considered best practice. Where family are legitimately trying to engage with complex medical information to support care for their family member, this may be an opportunity to identify ways to do so while centring the patient in those decisions.

Case example 4

An adult daughter is living in the home of her elderly parents, one of whom has dementia and is under the care of community health and social care teams. The couple have stated they are afraid of their daughter who intimidates her parents with verbal and psychological abuse, restricting their external relationships and activities. There was an episode of physical abuse by the daughter as well as suspected ongoing financial abuse. These issues were discussed between the couple and community clinicians at home visits, including giving advice about contacting elder abuse and domestic and family violence support and legal services.

Clinicians later became aware that the daughter had previously installed a surveillance camera in the room where these discussions took place. A subsequent visit by clinicians–who then attended jointly rather than alone–was conducted in another room. However, the sound range of the camera was uncertain. Acting on risk assessment information about guns in the house the parents were brought into the hospital to speak to police and family violence teams. Clinicians also raised with management their unease about being identifiable in the daughter's recordings.

>> A clinician cannot control situations where a recording or surveillance device is not disclosed or is denied. A third party covertly recording parties without their consent undermines respect for persons, including autonomy, privacy and self-determination in their health care encounter. Where patients are in situations of abuse and coercion, clinicians need to recognise that technology–such as recording and surveillance devices–may be part of that abuse. Clinicians cannot necessarily prove or prevent the use of technology in this way, but should be aware of the possibility and the related harms for patients from such abuse. In line with relevant guidelines, clinicians should work with management and legal service to take appropriate steps to respond to violence and abuse. Clinical teams should also determine appropriate health service arrangements that protect patient safety and security, and enable the provision of the necessary care that brought them to the patient in the first place. Clinicians may experience distress and unease about such situations, and their own exposure through any recordings. Concerns should be discussed with colleagues and, where appropriate, reported to management.

Section 8 – Resources

Acknowledgements

In the preparation of this document the SESLHD Clinical Ethics Service has consulted members of relevant clinical teams, POWCH Safety & Quality, SESLHD Legal Service Unit, and the SESLHD Clinical Ethics Committee. It has also been informed by presentations and discussions at a SESLHD Clinical Ethics Discussion Group and a Clinical Ethics Masterclass, which brought together clinicians, academics and community members to explore the research and law in this area. Dr Megan Prictor, Senior Research Fellow at the University of Melbourne Law School, presented recent relevant research to the Clinical Ethics Masterclass held in 2021.

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Section 9 – Version and Approval History

Date	Version	Version and approval notes
29 August 2023	1.0	Initial draft. Approved at the August 2023 Clinical and Quality Council.

Appendix A: Definitions

The following definitions from the *Surveillance Devices Act 2007* (NSW), the *Telecommunications (Interception and Access) Act 1979* (Cth), and the *Health Records and Information Privacy Act 2002* (NSW) explain and characterise some of the key terms relevant to audiovisual recording and monitoring of health care consultations.

Authorised representative

- in relation to an individual, means—
  - an attorney for the individual under an enduring power of attorney, or
  - a guardian within the meaning of the Guardianship Act 1987, or a person responsible within the meaning of Part 5 of that Act, or
  - a person having parental responsibility for the individual, if the individual is a child, or
  - a person who is otherwise empowered under law to exercise any functions as an agent of or in the best interests of the individual.

Communication:

- includes conversation and a message, and any part of a conversation or message, whether
- in the form of:
  - speech, music or other sounds;
  - data;
  - text;
  - visual images, whether or not animated; or
  - signals; or
- in any other form or in any combination of forms.

Listening device:

- means any device capable of being used to overhear, record, monitor or listen to a conversation or words spoken to or by any person in conversation, but does not include a hearing aid or similar device used by a person with impaired hearing to overcome the impairment and permit that person to hear only sounds ordinarily audible to the human ear.

Optical surveillance device:

- means any device capable of being used to record visually or observe an activity, but does not include spectacles, contact lenses or a similar device used by a person with impaired sight to overcome that impairment.

Party:

- to an activity–means a person who takes part in the activity, and
- to a private conversation–means a person by or to whom words are spoken in the due course of the conversation or a person who, with the consent, express or implied, of any

of the persons by or to whom words are spoken in the course of the conversation, records, monitors or listens to those words.

Principal party:

- in relation to a private conversation, means a person by or to whom words are spoken in the course of the conversation.

Private conversation:

- means any words spoken by one person to another person or to other persons in circumstances that may reasonably be taken to indicate that any of those persons desires the words to be listened to only--
  - (a) by themselves, or
  - (b) by themselves and by some other person who has the consent, express or implied, of all of those persons to do so,
- but does not include a conversation made in any circumstances in which the parties to it ought reasonably to expect that it might be overheard by someone else.

Record:

- includes the following--
  - an audio, visual or audio visual record,
  - a record in digital form,
  - a documentary record prepared from a record referred to in paragraph (a) or (b).

Surveillance device:

- means--
  - a data surveillance device, a listening device, an optical surveillance device or a tracking device,
  - a device that is a combination of any 2 or more of the devices referred to in paragraph (a), or
  - a device of a kind prescribed by the regulations.

Use:

- of a surveillance device includes use of the device to record a conversation or other activity.