Defining covert recording: A qualitative study exploring the experiences of clinicians when a patient records a hospital clinical encounter using a smartphone without consent

Laura Ryan¹, Kelly A Weir¹,², Jessica Maskell³, Lily Bevan⁵ and Robyne Le Brocque⁶

Abstract

Background: Patients use their smartphones to covertly record their clinical encounters in hospital. However, this issue is poorly understood. Insight into the clinician perspective will help inform policies and practices that deliver safe environments for patients and clinicians.

Objective: This study aimed to gain a deep understanding of clinician attitudes and behaviours when a patient covertly records a hospital clinical encounter using a smartphone.

Methods: Semi-structured interviews were undertaken with 20 hospital clinicians. Participants were recruited via purposive and snowball sampling. Interviews were conducted in person or via Microsoft Teams. Interviews were digitally audio recorded and transcribed. Data was analysed using thematic analysis.

Results: Most of the 20 participants reported they had either suspected or experienced a patient covertly recording a clinical encounter. Covert recordings occurred across a broad range of clinical disciplines and contexts. Themes were identified from participant perspectives, including discernment of patient intention, likeliness to consent to the recording if asked, anticipated risks and potential benefits associated with the covert recording. These themes have led to the categorisation of three forms of covert recording: (1) Intentional Covert Recording (2) Inadvertently – Covert Recording, and (3) Beneficial Covert Recording.

Conclusion: Clinicians have varied experiences and responses when a patient covertly records a clinical encounter. Findings indicate that nuanced strategies may be required to support clinicians to manage covert recording, whilst balancing the needs of patients.

Keywords

Smartphone, mobile phone, health communications, qualitative, self-efficacy, personalised medicine

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Background

Covert recording in hospitals occurs when patients make recordings on their smartphones without the consent or knowledge of the clinician.¹⁻³ Covert recording can be understood within the broader context of recording clinical encounters. Sometimes the patient seeks consent from the clinician prior to recording (termed overt, patient-led recording). When consent is not sought from the clinician,
it is called covert recording. Recordings may be used by the patient for a variety of purposes, such as improving patient recall, understanding of the clinical encounter and for litigation. Whilst the recording has the potential to increase transparency in the health sector, covert recording may have a harmful impact on the clinician and health service. Despite the significance and controversy associated with covert recording, there is limited research which explores this phenomenon from the clinician’s perspective.

A British study (2015) surveyed 168 members of the public and found that 15% had secretly recorded a health professional and 11% were aware of someone who had secretly recorded a clinical encounter. Interestingly, 69% of respondents were motivated to record their clinical encounters, split equally between wanting to do so covertly or with permission. Further research is needed to understand the frequency and magnitude of this issue in the Australian context.

The legality of covert recording is dependent upon the Australian state or territory. In Queensland, under the Invasion of Privacy Act 1971 (Qld), if a person makes a recording of a conversation they are involved in, they are not required to obtain the consent of the other parties in the conversation. However, there are some limitations regarding setting and restrictions for use (e.g. relating to sharing).

A recent study, into patient-led recordings in the United States, found that of 49 large health systems, none had a dedicated policy for sharing clinic recordings. With limited guidance, the integration of patient-led recordings depends upon the individual clinicians consenting or not to the recording. In the hospitals where this study was undertaken, there are relevant policies, that state that consent must be verbally obtained from the clinician. However, no explicit guidance as to how to proceed when a patient records without the consent or knowledge of the clinician is provided, other than to contact legal services. Clinicians are, therefore, required to make difficult decisions and take actions with limited direction or training.

Patients are motivated to record a clinical encounter to improve their understanding of the clinical discussion, facilitate shared listening, for therapeutic benefits and to obtain evidence of the clinical encounter. Previous studies on covert recording have found that patients choose to covertly record intentionally, with several motives: (1) due to lack of trust and poor previous experience of the health services; (2) fear of permission (to record) being denied, (3) fear about losing access to care; and (4) to increase clinician accountability.

Patient concerns regarding clinicians rejecting recordings maybe valid. There is a history of restricted mobile phone use in hospitals, the primary concern being phone interference with medical equipment. However, restrictions to mobile phone use in hospitals have eased, due to limited evidence about the significant risks to patient safety. Despite the relaxation of restrictions, there is an enduring fear among clinicians regarding patients using their smartphone cameras to record hospital experiences. Some clinicians may decline a recording due to their own preference not to be recorded, others due to the recording being a distraction or putting the confidentiality of others at risk. Covert recording is of particular concern to clinicians, who are reported to hold mainly negative attitudes due to medico-legal implications, fear regarding loss of control of the encounter and material, and confidentiality issues. Policy makers and hospital leaders need to consider how to support patient access to recordings, as a valuable intervention, whilst also considering risks to patient safety and the well-being of the clinicians.

Previous literature has focused on recording clinical discussions with physicians. Whilst there is an emerging understanding of the attitudes of patients, dental advisors, lawyers, and general health professionals to covert recording, further research is needed into the perspectives of all relevant stakeholders, within a range of clinical contexts. Additional research would inform the development of quality policies and working environments. Hence, this study explored clinician reactions to patient-led recordings, including the potential use of covert recordings, across a broad range of clinicians, hospital settings, and clinical contexts (such as therapy sessions or family meetings).

The long-term goal of this study is to explore perceptions of clinicians and patients regarding recording behaviours in hospital, including attitudes to covert recording. While this study explores the clinician’s perspective, the second stage of this study will report on patient perspectives. The research question addressed in this paper was “What are the experiences and attitudes of clinicians when a patient covertly records a clinical encounter?”

Methods

This study was undertaken within a social constructionist paradigm which is concerned with how human interactions construct social reality. The aim of the study was to explore clinician attitudes and experiences toward patients and their families (including carers and friends) covertly recording their clinical encounters using a smart device. This study is the first stage of a wider, multi-stage study. The second stage of the study will explore patient attitudes and experiences with covert recording. The study reported here, was undertaken at two public hospitals within a single public health service on the Gold Coast, Australia.

Participants

Twenty participants were recruited from the Gold Coast Hospital and Health Service. Inclusion criteria were that participants must be a hospital clinician (or clinical
manager) and employed by Gold Coast Health in a medical, nursing, midwifery or allied health position. Participants were clinicians or clinical managers in the following positions: medical, nursing and midwifery, and allied health staff (social workers, physiotherapists, occupational therapists, psychologists, dieticians, and speech pathologists). Clinicians with differing levels of professional experience were interviewed. Twenty participants were selected to enable sufficient data to answer the research question, and for the topic to be explored deeply.15

A mixture of purposive recruitment and snowball sampling was used to recruit participants. The investigators undertook targeted recruitment via their network by email and placed adverts on social media, internal forums, and internal hospital news feeds. Participation in the study was voluntary. Participants were provided a participant information and consent form, which advised them of the interviewer’s professional background and study information, including the aims of the study. Participants provided written consent.

There were 13 prospective participants who were approached directly about the study. Of those approached directly, nine were interviewed and four declined to be involved or did not respond prior to enrolment. There were 11 responses to the adverts, of which eight were interviewed, two withdrew prior to enrolment and one was excluded due to ineligibility (as they did not hold a clinical role). Finally, a further three prospective participants approached the research team directly to participate in the study through snowball sampling and were interviewed.

**Interviews**

Semi-structured interviews were selected as they are useful tools for initial exploration of an issue.14 Each participant attended an individual, semi-structured interview lasting approximately 45 minutes. Interviews were conducted in person or via video conference (Microsoft Teams) based on participant preference. An interview guide was created through discussions by the research team which included (academics, clinicians, and clinical leadership). Questions and prompts were designed to retrieve rich data which would address the research questions and allow participants the opportunity to direct aspects of the interview.15 The interview guide was internally piloted prior to use with participants. Interviews were conducted by two female members of the research team (a clinical social worker and a PhD-qualified research fellow) trained in qualitative research and interview techniques. The interviewers were aware of the relevant literature on this topic. However, they did not hold strong beliefs about patient-led recording. Interviews were digitally audio recorded and transcribed (intelligent verbatim) by a transcription service. After each interview, a reflective journal was completed to improve rigour.16 Participants were given the option to review the transcripts for accuracy before analysis. Seven participants opted to review the transcript. Only one participant revised the transcript (with minor revisions).

**Data analysis**

Braun and Clarke’s (2013) six-step guide to thematic analysis was adopted to analyse data: using NVivo, (1) two researchers independently read the transcripts, multiple times to acquaint themselves with the data; (2) the principal researcher generated initial codes; (3) both researchers collaborated to organise themes based on code similarity and cohesion, ensuring all data was represented; (4) themes were reviewed; (5) researchers generated labels and descriptions for each theme, re-evaluating until all data was sufficiently represented; and (6) a report of findings complied with relevant participant quotes representing each theme.17

**Results**

There were 20 participants interviewed (refer to Table 1), including 13 allied health clinicians, four nursing and midwifery clinicians and three physicians. Participants came from a broad range of clinical areas including general and specialist medicine, intensive care, emergency, rehabilitation, newborns, women and children, outpatient clinics and leadership teams. Most participants (n = 14) were mid-level clinicians (with over three years of experience). However, there were two participants who were junior clinicians (less than three years of experience) and four participants working in leadership roles. There were other themes identified which related to consensual recording.9 However, the focus of this report is on the themes identified when discussing covert recording.

**Frequency and context**

Many participants had experienced covert recording or suspected they had been covertly recorded. Whilst participants felt it was difficult to determine the frequency of covert recording, many felt it was likely to be happening more than they were aware. Those without specific experiences of covert recording felt it was possible or likely they had been covertly recorded, as stated by one participant: ‘I’m sure they [patients] have, but never to our knowledge’ [P11]. The perception of high likelihood and frequency was linked to ubiquity of phone use within the hospitals. One participant, who worked in paediatric wards, referred to parents’ use of phones: ‘Phones are always present. All the time … It’s rare that you see – walk into a room and there’s not a parent on the phone or the phone next to them. So you couldn’t tell really’ [P14]. Some participants commented that rates of covert recording were more frequent within younger cohorts of patients as stated by
this participant: ‘So we have super young patients who Instagram their entire thing’ [P04].

Participants reported incidents of covert recording in adult, maternity, and paediatric services, and across multiple clinical areas, including emergency departments, acute wards, and rehabilitation settings. Participants raised a wide range of clinical encounters in which they had experienced or suspected covert recording, including during resuscitations, childbirths, allied health therapy sessions (e.g. physiotherapy), telehealth encounters, nursing care episodes, family meetings, outpatient appointments, clinical procedures such as inserting nasogastric tube, and information sessions. Participants also gave a range of examples of how they discovered a covert recording had occurred, including patients disclosing during or after the recording had occurred, by observing the patient’s behaviour, being informed by another clinician, or discovering the recording on social media.

Three forms of covert recording

An exploration of topics raised by participants was undertaken and themes were created from the data based on participant experiences, views, and responses towards covert recording. Themes included: the manner in which the recording was made (concealed or not), discernment of patient motives for failing to obtain clinician consent, reflections on whether consent would be given if asked, and the perceived risks and benefits associated with the recording. These themes have allowed for the categorisation of three forms of covert recording. There was debate determining definitions, due to the lack of discourse on this topic in the literature. However, it was agreed that following three definitions best reflect participant perspectives: (1) Intentional Covert Recording, (2) Inadvertently Covert Recording and (3) Beneficial Covert Recording. The relation between these themes and forms can be seen in Table 2 and Figure 1.

Intentional Covert Recording

Intentional Covert Recording described recordings which participants felt were deliberately undertaken without the consent or knowledge of the clinician. Participants perceived that the patient had intentionally not sought consent and were either concealing the recording or continuing to record when consent had been refused. These recordings were viewed as having limited benefits to the patient’s care and health outcomes, carrying high risks to the patient (e.g. by negatively impacting the patient–clinician relationship), the clinician, and health service (e.g. through medico-legal and publicity ramifications), and that they were unlikely to have consented to these recordings. Incidents of Intentional Covert Recordings were sub-categorised into:

- **Type A – Confrontational**: recording without participant consent but with the participant’s knowledge, i.e. the patient continues to record despite the participant or another clinician stating they do not consent to the recording: ‘They were quite blatant, literally like cameras in faces recording nursing staff attending to mum’s personal cares and things like that’ [P 18].
Type B – Concealed: recording without the participant’s knowledge and consent. Participants either suspected a recording has occurred or learnt of the recording at a later point in time: ‘I could see a phone kind of awkwardly hanging out of a bag but didn’t know … But then when I left the room and the physio said I think they may have been recording that, I felt really uncomfortable’ [P15].

Examples from participants about Intentional Covert Recording were where family members or carers initiated the recording on behalf of the patient, rather than the patient themselves. Most participants experienced or suspected Intentional Covert Recording had occurred when there was dissatisfaction with services, or where there was breakdown in the relationship, or loss of trust: ‘Quite often it’s covert recording in those situations. They’re not going to ask you. The people that record at the bedside tend to be the families that aren’t happy with either levels of care or outcomes’ [P02]. Some participants viewed these recordings as entrapment; that patients were hoping to record service issues or inconsistencies in care: ‘It was more of a “we’re going to trick you because we’ve got all of this – like everything you’ve just said has just been recorded, so this is going to be a problem for you.” It was presented to us in that way’ [P04].

Intentional Covert Recordings were viewed by participants as both stressful and difficult to manage. One participant’s feelings about Intentional Covert Recordings mirrored the majority’s: ‘Disrespected, uncomfortable, devalued, questioned’ [P07]. Participants expressed concerns about the recording being used for medico-legal action or disseminated via social or mainstream media. Part of the challenge of managing Intentional Covert Recording (Type B – Concealed) was the uncertainty about whether the recording had occurred or not, as expressed by this participant: ‘So there have been instances recently with the increased use of telehealth that we have no idea what they’re recording, because they can potentially be recording on their iPhone and you can’t even see’ [P05].

Multiple participants were uncertain about the legality of these recordings, their rights or whether there was a relevant hospital process or policy. Some sought support from their line managers or nurse unit managers to address Intentional Covert Recordings, and one considered contacting the health service legal team: ‘I did want it deleted but I didn’t really want to go into conflict, or I didn’t know where we sat. I didn’t know like do you get security up and make them delete it? I didn’t know what to do. So, I just handed it over to the Nurse Unit Manager’ [P15].

Some participants felt they were prepared to respond to Intentional Covert Recordings due to their personality or professional experience and skills. For example, personal and professional confidence was linked to competency in navigating discussions to cease recording: ‘I think it’s about experience and confidence. I definitely think age is an issue as well. Life experience that you bring will play a difference’ [P07]. When participants did confront patients about Intentional Covert Recordings, they reported that they often faced aggression, threatening behaviour, or

Table 2. Three forms of covert recording.

<table>
<thead>
<tr>
<th>Themes</th>
<th>Intentional covert recording:</th>
<th>Inadvertently covert recording</th>
<th>Beneficial covert recording</th>
</tr>
</thead>
<tbody>
<tr>
<td>Manner of recording</td>
<td>Not concealed</td>
<td>Concealed</td>
<td>Concealed or not concealed</td>
</tr>
<tr>
<td>Discernment of patient motives to make a covert recording</td>
<td>Intentional</td>
<td>Intentional</td>
<td>Intentional or inadvertently</td>
</tr>
<tr>
<td>Consent considerations</td>
<td>Consent refused</td>
<td>Clinician would have refused recording</td>
<td>Likely to have consented</td>
</tr>
<tr>
<td>Perception of risk associated with recording</td>
<td>High risk</td>
<td>High risk</td>
<td>Medium-low risk</td>
</tr>
<tr>
<td>Perception of benefits associated with recording</td>
<td>Limited benefits</td>
<td>Limited benefits</td>
<td>Likely to be of benefit</td>
</tr>
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**Previous definition of covert patient-led recording is a patient recording without the clinician’s knowledge or consent.”**

Ryan et al.
further clinician–patient relationship degradation: ‘I mean obviously we didn’t have a great therapeutic relationship before that moment, but it certainly got much worse after that’ [P04]. When asked to do so, some patients deleted the recording, some continued to record throughout the encounter or admission (Type A – Confrontational), and some denied the recording had occurred leading to further distrust: ‘[the patient’s] saying, “no, I didn’t, I was just - I had my phone up that way”’. But we didn’t believe that person’ [P07].

Even when they had requested that the recordings were deleted, participants continued to have concerns: ‘So, really, even though I saw her delete it, I don’t know whether there were copies sent there’ [P12]. Despite these concerns, no participants had experienced a medico-legal issue that had arisen from an Intentional Covert

Figure 1. Three forms of covert recording.
Recording. However, clinicians disclosed that there had been threats made by patients and families to use the recordings for legal action and to share with mainstream media. These threats caused further stress and uncertainty as to what actions to take: ‘[The family said] “We are going to take this to Channel Nine basically … what you have done is negligence, you’re horrible….” So I do know that they recorded’ [P18].

**Inadvertently – Covert Recording**

Inadvertently – Covert Recordings describe participant reports where patients ‘inadvertently’ failed to obtain consent from the clinician prior to recording. Whilst consent was not obtained, participants viewed these recordings differently from Intentional Covert Recordings. Participants believed that it was not the patient’s intention to make the recording covertly (without the consent or knowledge of the clinician) due to the recording not being concealed, their understanding of the patient or context, or because of the patient’s response when confronted. Examples of Inadvertently – Covert Recordings included paediatric patients who were viewed as too young to understand consent issues, patients for whom recording their lives was the norm, or for maternity patients where recording of clinical encounters (e.g. births) is common and accepted in the clinical community. One participant reflected: ‘I have had experience where I haven’t realised they were videoing when they were, but it wasn’t intentional. Like they weren’t trying to do it in a backhanded way, they just thought it was okay to start videoing and I didn’t know about it’ [P19].

Inadvertently – Covert Recordings were not viewed by participants to carry significant risks to themselves or the health service, as it was discerned that the recording would not be used as evidence against them: ‘It may be an innocent kind of thing where they just, you know, they’re a bit scattered’ [P17]. However, these recordings were often not perceived to directly benefit health outcomes or care. Participants also noted enduring concerns about the possible risks, such as the potential of the recording distracting the clinician, or the consequences of patients possessing a recording if an adverse or unexpected incident were to occur: ‘Look, I get that they want it and I want to facilitate it, but I want to facilitate it in a safe way that keeps me safe, my colleagues safe, and the organisation safe’ [P19].

Some participants reflected they may have consented to the recording if asked and therefore did not take action to stop the recording. Other participants did not consider asking patients to cease or delete the recording, as they did not view the risks associated with the recording as sufficiently concerning. A few did confront patients about the recording and asked them to cease or delete it. Unlike the interactions described for Intentional Covert Recordings, these communications were portrayed as calm and amicable, with patients understanding the clinician perspective, often apologising or ceasing the recording when asked: ‘So, I explained the situation and normally … people [patients] sort of stand back and say, “Oh, gosh, okay, yeah, I totally get that”’ [P10].

**Beneficial Covert Recording**

Beneficial Covert Recordings were the least common covert recording raised by participants. Beneficial Covert Recordings describe participant perspectives of recordings where consent was not obtained either intentionally or inadvertently. Further these covert recordings could have been concealed or not. However, in contrast to Intentional Covert Recordings or Inadvertently – Covert Recordings, these recordings were viewed by clinicians as being of potential benefit to patient care and health outcomes, with limited or justifiable risks. Participants would have likely consented to these recordings if asked: ‘I can see how that’s a really powerful moment for patients and families. So, I guess, personally for me, I don’t really have a big issue with it’ [P20]. Examples of Beneficial Covert Recordings included situations where a patient was experiencing poor service, potential malpractice, or significant moments in care or recovery.

Participants who gave examples of Beneficial Covert Recordings were often in favour of patient recordings in general, were understanding of why consent may not have been sought, or were unconcerned about their practice being recorded: ‘It doesn’t really bother me, to be honest I think they’ve probably got their reasoning for doing it’ [P13]. Whilst there were no participants who had directly experienced a covert recording of poor service, a few participants viewed covert recording in this setting to be both understandable and of potential benefit, which is why it is included in this category.

Participants reported that they responded to Beneficial Covert Recordings by retrospectively consenting to the recording or asking the patient to cease or delete the recording. In instances where participants asked for recordings to be deleted, this was due to other considerations (such as other patients’ confidentiality, when another patient may have been recorded in the background). These discussions were not usually seen as stressful or negatively impacting the clinician–patient relationship: ‘So, it’s sometimes a conversation that needs to happen after the event’s actually happened …. I haven’t had any issues; people have been quite understanding’ [P20].

Some participants did not associate benefits with covert recordings and viewed all forms of covert recording as problematic, particularly with regards to covertly recording experiences of poor care as expressed by this participant: ‘I think covert recording tends to imply that they think something’s not right, we’re not doing a good enough job. I’d rather address those issues if they do feel like that. I’d
rather address those issues than have them sit and think about it. Then, there’s also the impact of where that recording will end up as well.” [P02].

Discussion

This study is the first to explore, in-depth, the experiences of a broad range of hospital clinicians when patients used, or were suspected of using, a smartphone to covertly record their clinical encounters in a hospital setting. The findings have led to the categorisation of covert recordings from the clinician’s perspective. Tsulukidze et al. (2015) previously highlighted the complexity attached to motivations of patients who covertly record (through analysing online texts about covert recording).1 Our study has built on these findings and suggests that covert recordings are both viewed, experienced, and dealt with in different ways, depending upon clinician perceptions. These include discernment of patient intent, risk considerations, whether the clinician would have consented to the recording if asked, and whether the clinician perceived potential benefits to patient care and health outcomes.

Prior to this study, there have been limited attempts to define covert recording. As a result, the definition has been restricted to the ‘absence of consent or knowledge’.2 Previous research has focused on situations where patients have intentionally recorded without the consent of clinicians.1,3 Through the experiences and attitudes of participants of this study, we have found that covert recording may exist in different forms including the: Intentional Covert Recording, the Inadvertently – Covert Recording, and the Beneficial Covert Recording. We do not assert that all covert recordings will neatly fit into these categories, nor that every type of covert recording is represented here. However, this is another step in understanding covert recording as a multi-faceted phenomenon from the clinician perspective.

Covert recording behaviour could be reflective of power dynamics within the patient–clinician relationship. Elwyn and colleagues (2015) described varying patient reasons to covertly record including: permission being denied, a lack of trust in care, and increased accountability; and linked these to discourse surrounding the patient–provider power imbalance. They argued that covert recordings are indicative of patients attempting to empower themselves within an asymmetrical relationship.3 On the one hand, our study supports this perspective, since our findings show that clinicians interpret these motives and appear to experience discomfort regarding the loss of control. However, our findings also suggest that policy ignorance (e.g. assuming clinician consent due to the clinical context, such as in the birth suite), issues relating to capacity to consent (e.g. paediatric patients) or cultural norms (e.g. recording day-to-day life for social media) may be mechanisms which increase the prevalence of covert recording. To date, these motives have not previously been raised in the literature. The findings infer that post-structural understandings of power may better explain the power dynamics at play. Post structural definitions of power tend to view power as fluid and multi-directional rather than as purely hierarchical.18 For example, our findings imply that cultural norms surrounding smartphone use may supersede previous tendencies to submit to an authoritarian power dynamic.19 Further research into patient perspectives is needed to determine the validity of the three described forms of covert recording and the links to power.

Our findings indicate that covert recording in the hospital environment is experienced by clinicians from multiple disciplines, in a multitude of clinical contexts. Whilst this study suggests that covert recordings are perceived to be an increasingly common phenomenon encountered by participants, further research utilising quantitative methodologies (such as a large-scale survey to investigate clinicians’ reports of instances of covert recording) would be required to determine the true prevalence in the hospital context.

In the absence of clear directives on how to manage covert recordings, the stress experienced by clinicians in managing these issues, the acknowledged risks to health services, and the perception that covert recordings are being made more often, is concerning. This has now become an urgent issue for policymakers to address, and policies should be developed that integrate emerging evidence. Previous studies have stressed the importance of policy for managing patient-led recordings.6,20 Our findings show there is a clear need for support, education, and protection. This study indicates there is both uncertainty, and inconsistency in clinician responses to this phenomenon, which has the potential to impact patient care, clinical well-being, and health service reputation.

Policymakers and educators should consider the findings of this study to ensure that patients and clinicians have appropriate support and protection. Whilst guidance is needed to safely facilitate patient-led recordings, consideration should be given to the management of covert recording. Different approaches may be required to manage the different forms of covert recording. For example, Inadvertently – Covert Recordings may be avoided with better communication of hospital policy. Whereas some Beneficial Covert Recordings may be reduced by safely offering patients the opportunity to record. Further research is needed to examine existing and potential protection for clinicians when a patient covertly records.

Finally, whilst none of the clinicians in this study had experienced medico-legal action, our findings highlight that threats to legal action are being made. This, along with the increased frequency of covert recording suggested, makes the risk of legal consequences more likely and the need to protect clinicians and health services more urgent.
**Strengths and limitations**

This study is limited by sample size which included only 20 clinicians across two hospitals within the same health service. Thus, findings are not generalisable to other contexts. A larger sample and quantitative design would strengthen findings. Another limitation is the use of interviews, meaning that findings are dependent upon the participants speaking honestly and accurately and data is shaped by interview conditions.

A strength of this research is that it is the first study to our knowledge which attempts to deeply explore the experiences of clinicians when a patient covertly records in the hospital setting. The explorative, qualitative approach is therefore appropriate for raising this topic and gaining an initial understanding of this phenomenon. The inclusion of a health consumer (from the hospitals where this study took place) in the research team, who contributed to the data analysis and manuscript development improves the study quality and strengthens this research.

Whilst this is a starting place in which to both understand hospital clinician perspectives and begin defining this phenomenon, a quantitative study would allow for further investigation into prevalence and definitions as well as distinctions and commonalities across professional disciplines. Additionally, it is important to consider the patient perspective. The next stage of our multi-stage study is underway and aims to understand the patient perspective to recording clinical encounters, including covert recordings, which will further provide further insight into this important matter.

**Conclusions**

Our study provides novel insights into the clinician perspective when a patient records a clinical encounter. Our findings suggest that covert recording is occurring frequently across a broad range of clinicians throughout the hospital setting. The emergence of three forms of covert recording is an important finding and furthers our understanding of the clinician perspective of this phenomenon, which should be considered by policymakers and future researchers.

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The corresponding author had full access to all of the data in this study and takes complete responsibility for the integrity of the data and the accuracy of the data analysis.

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**ORCID iD:** Laura Ryan https://orcid.org/0000-0001-6127-0053

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