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Beyond Recording the Clinical Discussion: A Qualitative Study into Patient-Led Recordings in Hospital

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Abstract

Patient-led recording occurs when a patient records a clinical encounter with their smart device. Understanding patient-led recording is important in ensuring a safe and patient-centered response to this behavior. This exploratory study provides insight into the patient perspective of patient-led recordings. We conducted 20 semistructured interviews with hospital and health service patients. The interview data was analyzed using thematic analysis. We identified three themes relating to patient-led recordings, including patient engagement, psychosocial, and health service. Findings suggest that health services move beyond querying the permissibility of recording and consider how to maximize the benefits of recording while reducing the risk of harm. Patients and clinicians need to be made aware of the potential broader psychosocial benefits of recording a clinical encounter during hospital admission. These results point to an urgent need for health services to develop policies and resources that support clinicians to work within a culture of recording.

Keywords

recording clinical encounters, sharing health journeys, covert recording, social media and hospitals, technology changing healthcare

Introduction

Smartphone technology enables patients (and their friends, families, and carers) to initiate a video or audio recording of a hospital clinical encounter to which they are party. This behavior is known as patient-led recording.[1] Patient-led recording is becoming a common feature in modern hospital clinical encounters. A recent survey of 360 oncologists, found that almost all (93%) had experienced a patient-led recording, with 85% experiencing patient-led recordings one to five times a month.[2] However, the reasons why patients record their hospital encounters, including the potential benefits and risks of recording from the patient perspective, are not fully understood, indicating the need for further research into this topic to enable clinicians and health services to respond to this behavior.

Patient-led recordings have been found to improve patient understanding; enable shared listening; and be of therapeutic benefit.[3,4,5] For example, patient-led recordings enable patients to listen back to what was discussed in the clinical encounter, which helps them to both remember and understand medical information.[3,5,6] Recordings can be shared with family and friends to support patients in communicating their medical issues.[5] Finally, recordings have been found to support patients therapeutically by enabling them to revisit the emotions of the clinical encounter. This is viewed as important in processing what has occurred.[5] Additional benefits include data ownership, proof of service, and a memento of a significant experience.[3,4,5,7] Patient-led

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recordings have been linked to increased patient empowerment and accountability from the clinician.[3,5]

Despite a developing understanding of the patient perspective of patient-led recordings, there remain gaps in knowledge. Previous studies have tended to focus on audio recordings of discussions between clinicians and patients,[4,5,8,9] rather than exploring patient perspectives of different types of recordings (eg, audio-visual recordings or photographs) across diverse hospital clinical contexts and scenarios. There is an imperative to build knowledge about patient-led recording as while clinicians recognize some of the benefits of patient-led recording, they are concerned about the impact on rapport building, patient safety, the fact recordings might be shared publicly (eg, via social media), and potential medico-legal issues, which are all barriers to the acceptance of recordings in practice.[1,2,7,9,10] Understanding patient attitudes and intentions is therefore necessary to create patient-centered health services.

Legislation relating to patient-led recording changes depending on the jurisdiction and setting. The legislation is complex and not well understood by staff or patients, and policies change across organizations.[1,10,11] In Australia, where this study was undertaken, patients can record their clinical encounters without the consent of a clinician. However, patients usually do need clinician consent to play or share this recording with others (unless a legal exception applies).[1] Given the law empowers patients to record, there is a need for studies which illuminate patient motives for recording and the situations in which patients may initiate a recording. It is also important to better understand the benefits and risks attached to this behavior.

This study responds to a need to better understand recording practices and focuses on answering the research question: what are patient attitudes and experiences regarding patient-led recording of a hospital clinical encounter? This is the second stage in a multistage study. The first stage was a qualitative study which explored the experiences and attitudes of clinicians to patient-led recording.[10,11] This study explores the perspectives of the patient or consumer on patient-led recordings in more detail. The qualitative design was selected in order to discover processes and meaning in practice.

Method

This study used a social constructionist paradigm for understanding recording practices, which assumes that there is no objective reality and that reality is constructed through the collective meanings that humans place on phenomena.[12] In order to understand reality, we must therefore investigate people's understandings, feelings, and meaning-making.[12] The aim of the study was to explore patient attitudes to and experiences of patient-led recordings in hospital through semistructured interviews. In this study, the term "patient" is extended to include the patient's social support people, such as their friends, family, or carer.

This study was conducted at two hospitals (with approximately 1000 beds across both sites) in a large Australian city. It was decided to undertake this study within the hospital setting, as there are ample opportunities for patients to initiate a recording with multiple disciplines and across varying clinical scenarios, wards, and departments.[10] Since the legislation and policies are not well understood,[10,11] there is organizational vulnerability regarding patient safety, privacy, and confidentiality, with associated operational risk.

A health service consumer was involved throughout the research life cycle and is a named author of this article. The consumer research partner was recruited through the health service's consumer advisory group. The consumer research partner attended all the team meetings and was involved in the design of the study, interpreting the data, and writing the manuscript.

The research team recruited 20 participants. The sample size allowed for sufficient richness of data to answer the research questions while being practical. Participants were either patients or support people to patients (eg, family members, friends, or carers) at the health service, over 18 years old, and able to speak in English on this topic. Participation was voluntary. Recruitment involved the use of digital advertisements and paper flyers exhibited in public areas of the hospital and on the health service's social media accounts. Invitation letters were also handed out by a member of the research team to patients in public areas of the hospital (such as the lobby, food court, and waiting rooms) and to patients on the wards. Participant information and consent forms (PICF) were provided to eligible and interested parties. The PICF included information about the project aim, team members and what was involved. Verbal and written consent was obtained. Of all the indivdiuals that consented to be involved in the study, only one withdrew (reason was not provided) and the rest were interviewed.

Semistructured interviews lasted for approximately 45 minutes. Semistructured interviews were selected as they ensure that the data retrieved is relevant to the research question while allowing participants the freedom to raise related topics not predetermined by the research team.[13] The interview location was decided by the participant. They were offered the option of meeting in person or virtually on MS Teams. If they opted to meet in person, then the meeting took place in a meeting room or in a private hospital room (again based on the participant's preference). An interview guide was developed with questions and prompts, and internally piloted prior to use with participants. Questions elicited participant experiences of and attitudes related to recording their hospital encounters. Interviews were conducted by one of the researchers (a female, hospital social worker, with a Masters' degree) who had experience in qualitative interviews. Interviews were digitally audio-recorded using a recording device and sent to a transcription service that transcribed the recordings (intelligent verbatim).

The interviewer had an understanding of the topic and wrote a reflective journal to reduce bias during the study.[14] Participants were invited to appraise the transcripts for accuracy before analysis. Six participants opted to review their transcripts, and the transcripts were emailed to them with a timeframe of 2 weeks to provide feedback. There were no major changes made following this review.

Interview data was analyzed using Braun and Clarke's (2006) thematic analysis. It is a method which enables the exploration of research participants' perspectives by revealing cohesion and distinction and generating unanticipated learnings.[15,16] The transcripts were uploaded to NVivo. Two members of the research team separately read through the transcripts and organized the data by identifying codes based on significant or patterned data, ensuring all relevant data was considered. Next, they individually organized these codes into potential themes. The same two researchers worked together, through discussions and emails, to label and define themes, resolving any differences in opinions. Finally, a report was generated (with supporting participant quotes) and sent to the rest of the research team for final analysis, which included meetings to discuss any discordance.[13,14]

Results

There were 20 participants who consented to be interviewed. The demographics of participants are reported in Table 1. Participant behavior and perceptions of the social interaction involved in obtaining permission to record have previously been reported.[11] This paper reports on general attitudes to recording, including the uses and perceived benefits, concerns, and risks, which can understood through the following three themes: *patient engagement* (Table 2), *psychosocial* (Table 3), and *health service* (Table 4).

The patient engagement theme describes patient perspectives on the impact of recording on their understanding of health issues and their participation in their health care, including the quality of that care. The psychosocial theme describes patient attitudes relating to the effect recordings can have on their psychological and social status. Finally, the health service theme describes patient views on how recordings can influence wider health service considerations, such as navigating the complaints process or their potential to impact clinicians.

Patient Engagement Uses and Benefits

Participants perceived several uses and benefits of patient-led recordings relating to patient engagement. Most participants recognized the value of recordings to help improve understanding and recall of health information. Participants gave examples of recordings being viewed during the clinical encounter to support their understanding of clinician instructions, such as viewing a recording of themselves completing an exercise during a physiotherapy session. Other participants had recorded clinical discussions and viewed them at home, allowing them to digest information and to educate themselves about medical terms. This led to a greater sense of control and participation, and reduced stress in clinical discussions.

Participants found recordings useful in sharing medical information and education with their social network. Specific to the hospital admission, participants reflected on how acute health issues (malaise, fatigue, and the impact of

Table 1. Participant Demographics.

Participant	Gender	Age	Patient or social support person	Types of recordings made previously
1	F	36	Patient	Photo and video
2	F	49	Patient	Photo
3	F	39	Patient	Video
4	F	68	Patient	Not previously recorded
5	M	40	Support person	Photo and video
6	M	51	Patient	Photo
7	M	29	Support person	Not previously recorded
8	M	38	Support person	Not previously recorded
9	F	53	Patient	Photo
10	F	64	Patient	Photo
11	M	44	Patient	Photo, video, and audio
12	M	35	Patient	Photo
13	F	44	Patient	Photo and video
14	M	50	Patient	Not previously recorded
15	F	63	Patient	Not previously recorded
16	F	Not disclosed	Patient	Not previously recorded
17	M	61	Patient	Not previously recorded
18	M	66	Patient	Not previously recorded
19	M	43	Patient	Not previously recorded
20	M	26	Patient	Not previously recorded

Table 2. Patient Engagement.

Patient engagement		
Uses	**Benefits**	**Quotes**
As an education or memory tool for the patient.	• Improves information exchange. • Enhances experience of the clinical encounter. • Improves patient capacity to participate in their care.	*"Because I know when the doctors come in and they're telling you all about what happened and that, things can get a bit overwhelming at first and then if you've recorded it, you can play it back later and you might get a better understanding."* (P19) *"We've had many meetings and if I'd recorded most of them now, I would probably be able to reflect back and go this is what he said during this time and everything."* (P7) *"Yeah, because my knees hyperextend, and so they were just giving me pointers on how not to allow them to hyperextend."* (P3)
To enable shared listening within the patient's social network.	• Improves information exchange with patient's social network. • Reduces pressure on the patient to communicate health status/plan to others. • Improves the opportunity for shared decision making and support from social network.	*"It's very helpful to family members as to what's happening because doctors aren't always available when family come in."* (P1) *"If I'd recorded it, I could have then gone to my niece who's a nurse and gone in real words 'what does this mean?'"* (P09)
To facilitate patient control over their health issues and care.	• Greater sense of empowerment within the heath journey. • Improves quality of the clinical encounter by patients being able to better communicate their medical status and background. • Provides clarity for patients and clinicians when there is a dispute.	*"Just to have that recording for later use. I never expected that video to be used so much as what it has been by multiple specialists afterwards."* (1) *"So, it does help to monitor my disease, and helps to share what is happening, with other specialists."* (P2) *"Because you're not always going to have the same physio so you can ask them 'hey, can we record this so if I ever need this sort of thing done again I could show them what you did'."* (P14) *"I think, with nurses and doctors, because sometimes things get said and then different things come back. So I've been instructed by my mother, if you're not happy with someone, I'm recording this conversation."* (P11)
To hold clinicians accountable.	• Improves quality of the clinical encounter.	*"If they know that they're recorded, like I said before they will hopefully give more elaborate and proper answers and take you more seriously, even next time when you see them."* (P2)
Concerns	**Risks**	**Quotes**
That recordings will replace current practices.	• Impedes information exchange. • Negatively impacts experience and quality of the clinical encounter. • Reduces patient capacity to participate in their care.	*"I'm not really [technology] literate, you might say, doing that kind of thing."* (P18) *"Probably something written, yeah. Now thinking on it, yeah, that would probably be the way to go."* (P7)

medications) hindered participation in, and recall of, clinical encounters. "*Especially when the drugs they give you, you've got to try to process that as a normal human while you're doped up to your eyeballs; some of it just does not go in… maybe they need to leave a recording"* (P13). This limited their own knowledge of their health status and treatment plan, as well as prevented them from sharing this information with their social network. Participants were uncertain when a clinician (eg, a treating doctor) would attend the ward, making it difficult to coordinate their support person being present for clinical discussions. Participants were, therefore, meeting the clinician without a social support person, putting pressure on them to understand and retain the information and to communicate health updates to family and other supports. Participants found this stressful and fatiguing, and recordings were viewed as a solution to these issues. "*Because when you're in hospital you're already tired, if you're telling 100 people when they come to visit you the same story, the time you get to 99 you're done. So, whereas if you had it on recording this is what they said"* (P9). By involving their family in their healthcare journey, participants were able to obtain assistance in understanding their health issues and access decision-making support.

Table 3. Psychosocial.

Psychosocial		
Uses	Benefits	Quotes
To document and share notable life events.	• Enables nostalgia, legacy or enjoyment through spectacle for patients and their social network.	*"Recordings just to capture those moments that don't exist again if you haven't got it on camera."* (P5) *"I'd only record interesting things. I'd record my cannula going in just because that to me is, ah, here's an interesting thing, I'd like to record it."* (P12)
To connect patients with social network during hospital admissions.	• Boosts patient morale. • Enables continuation in relationships. • Provides reassurance to patient's social network.	*"They're in Scotland, but they wanted a visual because my mum was really worried because I was in surgery for 13 hours and she knew I'd be under for about 10, and when it went longer and she didn't hear anything, I just needed to reassure her that I was alive."* (P9) *"I recorded a video to my daughter saying good night and stuff like that."* (P12)
As a reflection tool.	• Promotes patient's psychosocial recovery.	*"Yeah, conversations, not to fix anything, just sort of to remember what I went through and how I beat that physically and mentally at the time."* (P14) *"Yeah, it [the recording] is a healing process."* (P11)
Concerns	Risks	Quotes
That viewing/listening to recordings could be traumatic.	• Disturbs patient mental health/ emotional status.	*"I imagine some people might get upset if they look back at that, but then again, don't look back at it, if doing so makes you feel bad you should stop."* (P12)
That confidentiality could be breached if device is compromised.	• Disturbs patient mental health/ emotional status. • Security risks associated with personal/ medical information leak.	*"Well, all depends on the nature of what it was. Like yeah, if it was really, really bad news you might not want anyone to know."* (P19)

Table 4. Health Service.

Health service		
Uses	Benefits	Quotes
Recording can be used as evidence of service received.	• Greater sense of empowerment for consumers within the health service. • Improves health service. • Supports patients and clinicians during complaint, compliment, or legal processes.	*"But it can also benefit that if something goes wrong, they've got evidence, or you've got evidence."* (P1) *"I think it does give a power to the patient, to me, I think. Because again I don't have to retell what someone says, I can actually be confident that if anyone wants proof, I've got it."* (P2) *"If there's someone that doesn't have the best experience or for legal reasons."* (P16)
Concerns	Risks	Quotes
Recording can be used as evidence of service received.	• May damage the clinician's career or health service reputation	*"Or if you saw something that wasn't quite right that maybe a medical professional was doing, they could jeopardize their career, yeah, that would not be good."* (P5) *"You end up with a court case, sort of thing. Even on Facebook, people have been saying things and—caught out and they've lost their job. I know a person who's lost his job because he made an opinion. It got back to the council. They deemed it racist, and he lost his job."* (P18)

Recordings of clinical encounters had been helpful in self-monitoring health issues and self- coordinating their care. Participants had used the recording to monitor health trajectories. For example, one participant had self-monitored a wound healing by recording different nurses attending to his wound care. The recording gave participants a sense of control over their health and enabled better communication with clinicians (both within and outside the health service) about their symptoms, medical history, and involvement of other clinicians in their care. "*It's made it easier I suppose when you're talking to another specialty to show documentation of the journey, and words can't always describe what a picture or a video can"* (P1). This was seen as particularly beneficial when patients had complex health issues or dealt with multiple treating clinicians. The recording allowed participants to reflect upon, reconcile, or action perceived conflicting information and clinical opinions.

A final patient engagement use was that the act of recording could lead to greater clinician accountability and improve the quality of the clinical encounter for patients. Participants reflected on previous poor experiences with clinicians and felt they would have experienced better care if the clinician was aware the encounter was recorded. For example, one participant reflected on a negative experience of a clinical encounter and considered how a recording may have been helpful in that instance. "*I think that I'm entitled to have my own doubts and fears. I should be able to talk about them not just be spoken to like you're an idiot, which is how I felt. He was quite rude. A fat idiot. I am too fat. But you know, that's obviously something he wouldn't want to have been recorded. Maybe if he knew he was being recorded, he would have been more polite"* (P15).

Patient Engagement Concerns and Risks

Most participants did not feel that recording would negatively impact their ability to engage in the clinical encounter. The main concern was that recording could replace current practices. For example, few participants were concerned that recording could be substituted for written records, which could impede their understanding and participation in their health care. "*I wouldn't like any more of a barrier put between the lady that's actually delivering the health service to me, and I want to make sure that she's 100 per cent comfortable in treating me because I want the best services I can get"* (P6). This was evident for those who reported they preferred written information or were not technologically literate. Participants were also aware of the potential deleterious impact of recording on the patient–clinician relationship. A couple of participants felt that recording could make the clinician feel uncomfortable or distract them, which could negatively impact their care or experience of the health service. However, overall participants favored audiovisual recording over other information formats (verbal or written), as they felt they were a more accurate representation of what was discussed or viewed it as more convenient "*because we got a lot of paperwork at home and none of it actually makes sense"* (P10).

Psychosocial Uses and Benefits

Participants reflected on several psychosocial uses and benefits of recording clinical encounters. Some participants were motivated to make recordings as a keepsake or to share notable moments of their lives, such as recording a birth or an injury. These recordings were made for pleasure and interest, with anticipated future psychosocial benefits, such as nostalgia, legacy, or for spectacle. "*Some with my wife and the little one, there were some with the staff in the background, because I wanted to remember them because they did a great job, being there to help out and they are part of the journey*" (P5).

Another psychosocial use of recordings was that they promoted social connection. On a hospital admission when people are separated from their social support people, visual recordings (rather than texts and emails) were viewed as important for staying connected. Some of these recordings were of clinical encounters and some were the participant alone. The content was shared through social media (via public and private networks) and through direct messages. Participants had used these recordings to update their social network about their general well-being (rather than to educate or involve them in their health issues) in the hospital and to maintain social relationships. Recordings provided reassurance to concerned parties and boosted the patients' morale through responses to these recordings. *"We've recorded my movements of walking with my frames, without my frames, which I've posted on social media so everyone can see. Sent it to mum in Melbourne for my own personal encouragement"* (P11).

A theme that came up repeatedly in interviews was the value of creating a digital journal (multiple recordings) to reflect on health experiences during treatment and/or recovery. Participants viewed recordings as helpful in clarifying what had occurred and a timeline of key events; evidence of what they had survived, including their physical transformation; and visual reminders of who had supported them along the way (inclusive of clinicians). "*Think for me it's all about me being able to look back. I know what I went through, and it's just every now and again, I just look back and go, 'oh my gosh, I really look like that'"* (P9). These recordings were perceived to be a source of hope for their future, both inside and outside of the hospital context, and a tool to help them communicate their experiences (rather than medical information) to others. This perceived benefit was distinct from the other benefits described, since it was less about taking action or galvanizing support to cope with a health issue but more about the process in which they transitioned from patient back to person, made meaning of their experiences, and shared this period of their life with others.

Psychosocial Concerns and Risks

'There were a few psychosocial concerns associated with patient-led recordings identified by participants. Although most participants viewed recordings as healing rather than causing distress, one participant anticipated that viewing certain recordings could cause distress. Confidentiality was also raised as a concern by a few participants, should their smart device be lost or stolen, which could cause angst or lead to risks associated with unsanctioned people obtaining that information. Most participants did not have serious concerns about the safety of recordings on their smart devices. Most participants felt that they carried a high level of personal information on their phones and accepted a certain level of risk with this behavior, regarding this as normal. "*I don't particularly want photos of me bleeding everywhere out there … but put it this way, if my phone got stolen, they wouldn't be the ones that would immediately come to mind, it would more be like old friends and special occasions and stuff like that, that'd be like, I don't really want someone having that"* (P12). Some explained the safety measures they had taken for the security of their phone. Some participants also felt that the recordings would be safer in their care than in the hospital system. A few participants highlighted confidentiality concerns about being recorded in the hospital by other patients.

Health Service Uses and Benefits

There was one main health service use associated with recordings. Participants highlighted how recordings could be used as evidence of the care they had received. While none of the participants had previously used recordings as evidence, participants gave examples of how evidence of the service they had received could be used to advocate for themselves within the health service or for legal action. Obtaining evidence of the service, particularly a poor service, was viewed as empowering. "*I think it does give a power to the patient, to me, I think. Because again I don't have to retell what someone says, I can actually be confident that if anyone wants proof, I've got it"* (P2). Some of the participants who had previous negative experiences with the health service discussed the inadequacy of the complaints service in managing their grievances. They considered how "independent evidence" (eg, the recording) could help, particularly when it is a patient's word against one or multiple clinicians. Participants also saw recordings as potentially improving the quality of care through complaints or allowing patients to acknowledge the quality service they received.

Health Service Concerns and Risks

Some participants considered how evidence of clinical encounters could negatively impact the clinician and health service. "*… if you saw something that wasn't quite right that maybe a medical professional was doing, they could jeopardize their career, yeah, that would not be good*" (P5). Participants worried about the professional and legal impacts on clinicians if a recording was made of a low-quality service. Participants drew on examples in their own professional lives where recordings had led to negative consequences for colleagues. These participants appeared to identify with the clinician and prioritize the clinician's well-being over acting against possible wrongdoing or improving health services.

Discussion

This study extends current knowledge surrounding patient perceptions of patient-led recording via the uses, concerns, and related benefits and risks across the domains of *patient engagement*, *psychosocial,* and the *health service*. The study identified new opportunities and uses for patients in recording their hospital clinical encounters. For example, patients admitted to the hospital can use recordings to improve their connection with loved ones who are not there with them. The study illuminated the broad and varied reasons a patient may choose to record their hospital clinical encounter as well as patient concerns and risks relating to recording.

Previous studies have focussed on how recordings impact patient engagement and the experience of specific hospital clinical encounters (usually discussions or procedures) between patients and clinicians, with a focus primarily on care received from doctors or nurses both in Europe and the United States of America.[4,5,9] Elywn et al (2015) interviewed 18 members of the public about their experiences of recording both community and hospital health professionals in the United Kingdom. They found 4 common uses of recordings: (1) to relisten to medical information, (2) to enable shared listening, (3) for proof of service received, and (4) for therapeutic purposes. Elwyn's study also identified the following benefits of recording: improvement in the quality of the clinical encounter (including increasing clinician attention) and enhanced patient control and sense of empowerment.[5] Our findings support these findings and show broader uses and benefits for recording clinical encounters within the hospital environment.

In modern life, people record and share significant moments using a smart device.[17] Since hospitals are places where a range of life events plays out, it is unsurprising that our findings show this recording behavior has penetrated our health services. Previous studies have begun to discuss this connection.[7,18] However, our study has provided greater insight into the culture of recording activity in a hospital environment. A previous suggestion to help clinicians take control of the recording process is to offer patients the option to record.[8,9,19] However, it may be that while health services have considered their policy position on recording practices, patients have continued initiating recordings, thereby taking the lead. While offering a recording still has value (particularly in supporting access to this potentially beneficial intervention and in enabling early discussions

about content and use),[8,20] some patients may feel that they are being offered an option already available to them.

One of the key findings from this study is that patient-led recordings have several psychosocial uses and benefits, both during care and long after the patient has left the hospital. As discussed, prior studies have centered around recordings as a tool for patient engagement.[4,5,8,21] However, previous studies have found some psychological[5,22] and social[7] benefits of recording. Dommershuijsen et al's systematic review of the value of audio consultation recordings for people over the age of 55 years, reviewed some of the evidence surrounding the psychological impact of recordings. They discussed one qualitative study that found recordings helped patients adjust emotionally and psychologically to their illness. In addition, they found one randomized control trial that indicated an improvement in anxiety scores following the provision of an audio recording. However, there were a further seven studies discussed which found no significant difference in the levels of anxiety or depression following the provision of a recording.[22] Oyedokun et al conducted a survey of patients in a Canadian hospital emergency department and found that 29% of 55 respondents were motivated to record as they found it interesting, and 38% wanted a memento.[7] Though this is a contested topic, these studies indicated that patients may benefit from recording clinical encounters for psychosocial benefits.

Our study is the first to develop a deeper understanding of the psychosocial uses and benefits of patient-led recordings. Our findings indicated that recordings could have a role in both relieving stress during the clinical encounter and supporting a patient's long-term psychological recovery following illness. Furthermore, our findings have shown that sharing patient-led recordings enhances a patient's social connections during an admission. This has a dual impact: it enables the patient's social network to be informed and reassured about their well-being and provokes responses which aid in the comfort and motivation of the patient. It could be that the psychosocial uses and benefits of recordings are more important within the inpatient domain, whereas previous studies have focused more on outpatient appointments or the emergency department.[7,22] However, more research is required into the use of recordings by inpatients to better understand this relationship. It would be easy to regard the psychosocial benefits of recording as secondary to patient engagement outcomes. However, our findings show that recordings have a fundamental role in patient care since they promote coping on the admission and adjustment after illness, they also enhance the well-being of the support people who in turn scaffold a person's recovery.

Previous studies have tended to frame recordings being used as evidence for legal purposes against clinicians as a potential negative outcome.[5,7,18] Medico-legal concerns have resulted in clinician discomfort around recording.[2,10,21] Indeed, our findings somewhat support this perspective, as some of our participants considered recording for legal purposes. However, others worried about the professional and legal consequences to clinicians should wrongdoing be recorded. Our findings also show the potential of recordings being used as evidence: within the legal system, in hospital complaints procedures, and in discussions with clinicians with the purpose to improve the health service (rather that to punish the clinician). As one participant pointed out, the recording can also be used as evidence of quality care, to better educate others about patient needs, and to celebrate a clinician's work. Some previous studies have found that clinicians remain hesitant to offer a recording or accept a recording when a patient initiates one, including some clinicians who refuse to be recorded.[2,4,7,9,10] A shift in attitude and the discourse around recording as evidence may reduce clinician concerns and lead to more acceptance of recording.

This is a small qualitative study within a constructionist paradigm which has provided insight into the constructed realities of participants. Findings are, therefore, not transferable to all contexts. However, the findings of this study may help in understanding the benefits and risks of recording in other Australian hospitals and community health services. Given some of the similarities in the findings of this study with previous studies conducted outside of Australia,[4,5] our findings could have value to clinicians and policymakers outside of the Australian context.

There were some limitations to the study which need to be considered when evaluating the findings. We excluded participants who were under 18 years old and those who could not undertake an interview in English. Further, we were unable to recruit anyone over the age of 68 years old. Interviewing participants from other age groups and with different languages may have led to more varied data. Another limitation is that interviews were undertaken by a researcher from the health service where the study took place. While participants were informed that there were no negative consequences to participating, concerns for any implications to their care may have influenced their responses.

Conclusion

To understand recording practices in hospitals, we must view hospitals as not only acute health centers but as places where human lives unfold. In the digital age, this means clinician's must consider being recorded using a smart device. This study has shown that recording is occurring in the hospital environment for a variety of reasons. It may be that the debate today is not whether the recording should be allowed but how the benefits of recording can be maximized, while the risks to patient care and negative impacts on clinician wellbeing are minimized.

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Author Contributions

Laura Ryan and Robyne Le Brocque conceptualized the study. Laura Ryan, Robyne Le Brocque, Kelly Weir, Jessica Maskell, and Lily Bevan designed the study. Laura Ryan collected the data. Laura Ryan and Robyne Le Brocque analyzed the data. Laura Ryan, Robyne Le Brocque, Kelly Weir, Jessica Maskell, and Lily Bevan contributed to the interpretation of the data. Laura Ryan drafted the manuscript with input from Robyne Le Brocque, Kelly Weir, Jessica Maskell, and Lily Bevan. All authors gave approval for the final version.

Declaration of Conflicting Interests

The authors declared no potential conflicts of interest with respect to the research, authorship, and/or publication of this article.

Ethics

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