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Alan Schwartz

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TOWARD A PATIENT RIGHT TO RECORD MEDICAL VISITS

ALAN SCHWARTZ*

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I. INTRODUCTION

In 2015, two patients in two separate instances recorded their doctors’ conversations during clinical procedures while the patients were unconscious.¹ The recordings revealed the physicians’ unprofessional

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1. Yanan Wang, *Patient Secretly Recorded Doctors as They Operated on Her. Should She be so Distressed by What She Heard?*, WASH. POST (Apr. 7, 2016, 5:24 AM), www.washingtonpost.com/news/morning-mix/wp/2016/04/07/patient-hid-recorder-in-her-hair-as-surgeons-operated-on-her-their-words-left-her-deeply-

behavior, including insulting comments, references to sexually assaulting the patient, and an intent (later realized) to record a false diagnosis.² One of those patients filed suit against the physicians and their practices; a jury found the physicians and their practice liable for defamation and malpractice, awarding the patient \$500,000 in damages.³

Beyond identification of unprofessional behaviors, patients often wish to record visits to enhance their memory or to share information with family, and many have done so.⁴ Indeed, the patient in the lawsuit had intended to record post-colonoscopy instructions that he was concerned he would not be able to remember.⁵ And yet, the legal framework permitting or prohibiting medical recording is based not on the needs of patients or their relationships with their physicians but on a patchwork of criminal eavesdropping statutes.⁶ Should patients be empowered to record their medical encounters as a matter of course?

distressed/ [perma.cc/6YRZ-X5QS] (describing case where patient intentionally concealed a recorder during surgery, and physicians made insulting comments and intimidated sexual assault); Tom Jackman, *Anesthesiologist Trashes Sedated Patient — And it Ends up Costing Her*, WASH. POST (June 23, 2015, 7:06 PM), www.washingtonpost.com/local/anesthesiologist-trashes-sedated-patient-jury-orders-her-to-pay-500000/2015/06/23/cae05c00-18f3-11e5-ab92-c75ae6ab94b5_story.html [perma.cc/Q82H-XXHC] (describing case where patient accidentally recorded his colonoscopy and physicians made insulting comments and falsely recorded a diagnosis of hemorrhoids in the patient's medical record).

2. In the first case, the recording included the surgeon saying, "I can touch her", another provider responding, "That's a Bill Cosby suggestion", and the surgeon asking, "Do you have photos?" and saying "[indiscernible] thought about it, but I didn't do it." Wang, *supra* note 1. In the second case, the anesthesiologist was recorded referring to the patient as a "retard", the patient's rash as syphilis or "tuberculosis in the penis" and saying "I wanted to punch you in the face and man you up a little bit". Jackman, *supra* note 1.

3. D.B. v. Ingham, M.D., No. CL20130016811, 2015 WL 10388424, at *1 (Va. Cir. Ct. July 27, 2015) (noting jury award against one physician and her practice group but dismissing the case with prejudice following a post-trial settlement between the parties).

4. Glyn Elwyn et al., *Patients Recording Clinical Encounters: A Path to Empowerment? Assessment by Mixed Methods*, 5 BMJ OPEN, no. e008566, 2015, at 1, 3 (Eng.) (finding in a survey of UK patients that 15% had covertly recorded a clinical visit, an additional 11% knew someone who had, 35% indicated they would consider secretly recording a visit, and an additional 34% would consider asking for permission to record); Paul J. Barr et al., *Audio-/Videorecording Clinic Visits for Patient's Personal Use in the United States: Cross-Sectional Survey*, 20 J. MED. INTERNET RSCH., no. e11308, 2018, at 1, 6, www.jmir.org/2018/9/e11308/ [perma.cc/NH3U-C2HV] (finding that 16% of 524 members of the U.S. public surveyed reported recording a clinic visit with permission, 3% reported doing so secretly, 19% knew someone who had, 7% indicated they would consider secretly recording a visit, and 59% would consider asking for permission to record).

5. Verdict and Settlement Summary, D.B. v. Ingham, M.D., JVR No. 1507060054, 2015 WL 4102900 (Va. Cir. Ct. June 18, 2015). The patient set his phone to record and left it in a plastic bag before the colonoscopy to have a record of post-procedure instructions; the bag unintentionally was brought into the procedure room.

6. Carol M. Bast, *What's Bugging You? Inconsistencies and Irrationalities of the Law of Eavesdropping*, 47 DEPAUL L. REV. 837, 843, 868-70 (1998) (describing state and federal recording laws).

This article argues for an affirmative patient right to record their medical encounters, rooted in the provider's fiduciary duty to the patient. It suggests this right should supersede any extant prohibitions on recording conversations and supplement any concomitant rights to record conversations in general. Part II reviews the prevalence of patient recording, and the reasons why patients and physicians might favor or disfavor patient recording, including covert recording. Part II also reviews the fiduciary nature of the patient-physician relationship, discusses patients' rights to their medical information, and explains the legal restrictions on electronic eavesdropping and recording.

Part III analyzes the implications of the foregoing laws and principles for patients seeking to audio record their medical encounters and identifies why existing recording statutes are not an ideal fit for the particular needs of patients and society. Part IV proposes a statutory right of patients to record medical encounters for their personal use. It explains why such a right, grounded in the physician's fiduciary duty, would be valuable even in states that already permit covert recordings by a party to an interaction. Part IV also discusses whether and how there should be statutory limitations on the use and disclosure of such recordings.⁷

II. BACKGROUND

Little case law has considered patient recording per se. Part II reviews research on the practice of patient recording and patient and

7. This article does not consider recordings made for the use of physicians, medical facilities, or third parties for research or other purposes. See Saul J. Weiner et al., *Patient-Centered Decision Making and Health Care Outcomes: An Observational Study*, 158 ANNALS INTERNAL MED. 573 (2013) [hereinafter Weiner et al., *Observational Study*] (employing patient-collected recordings with hidden recorders to study whether patients of physicians who identify life context during the visit have better health outcomes six to nine months later); Saul J. Weiner et al., *Evaluation of a Patient-Collected Audio Audit and Feedback Quality Improvement Program on Clinician Attention to Patient Life Context and Health Care Costs in the Veterans Affairs Health Care System*, 3 JAMA NETWORK OPEN, no. e209644, 2020, at 1, 6, jamanetwork.com/journals/jamanetworkopen/fullarticle/2768922 [perma.cc/S6AB-WH36] [hereinafter Weiner et al., *Evaluation*] (describing clinical and financial impact of a patient-collected recording program); Sherry L. Ball et al., *Implementation of a Patient-Collected Audio Recording Audit & Feedback Quality Improvement Program to Prevent Contextual Error: Stakeholder Perspective*, 21 BMC HEALTH SERVS. RSCH. 1, 5-8 (2021), bmchealthservres.biomedcentral.com/articles/10.1186/s12913-021-06921-3 [perma.cc/R95T-PQR6] (describing views of patients and providers toward a patient-collected audio recording program). This article focuses particularly on recordings by (or knowingly authorized by and delivered to) patients during a medical encounter, and not those that take place outside of treatment or by those to whom the physician does not owe a fiduciary duty, such as recordings of physicians delivering explanations to family members. See, e.g., *Smith v. Cleveland Clinic*, 968 N.E.2d 41, 43-44 (Ohio Ct. App. 2011) (affirming that a hidden recording of a hospital officer made by family members of a patient whose emergent condition led to death due to the hospital lab's delayed reporting of tests was not subject to peer review privilege and thus admissible in the estate's wrongful death suit).

physician attitudes toward patient recording. This Part also introduces the fiduciary relationship of physicians to their patients, the increasing legal and policy focus on patient rights to information about their care, and the patchwork of state and federal eavesdropping statutes that currently control the legality of patient recording.

A. *How Patients Record Visits*

Eighty-five percent of Americans say they own a smartphone—a pocket-sized recording device.⁸ Although research in the area is limited, studies in both the U.S. and the U.K. have found that 15-20% of patients already have recorded an encounter with physicians, and that 65-70% would consider either recording a visit secretly or asking for permission to record.⁹

Patients intentionally or unintentionally record medical encounters, with or without permission from the doctor.¹⁰ In cases when a patient asks for permission to record openly (“open recording”) but the physician withholds their consent, the patient might surreptitiously record without the doctor’s knowledge or consent (“covert recording”).¹¹ Anticipating the doctor’s resistance, some patients might instead proceed directly to covert recording without asking for permission.¹² Patients have also unintentionally recorded medical encounters by accidentally activating the recording function on their phone, and only later discovering that they had recorded the medical encounter.¹³

B. *Patient Attitudes Toward Recording*

An international review of studies in which patients were provided with recordings of their visits suggests that most patients will use recordings when they are available to them.¹⁴ Patients want to have recordings of their visits for several reasons.¹⁵ Perhaps most commonly,

8. *Mobile Fact Sheet*, PEW RSCH. CTR., www.pewresearch.org/internet/fact-sheet/mobile/ [perma.cc/LT88-ULLN] (last visited Sept. 17, 2021) (finding notably that 61% of those 65 years old and older, who are most likely to have health care encounters, report owning a smartphone).

9. Elwyn et al., *supra* note 4, at 3; Barr et al., *supra* note 4, at 6.

10. Elwyn et al., *supra* note 4, at 4-5.

11. *Id.*

12. *Id.*

13. *Cf.* CAL. PENAL CODE § 632(f) (West 2017) (“This section does not apply to the use of hearing aids and similar devices, by persons afflicted with impaired hearing, for the purpose of overcoming the impairment to permit the hearing of sounds ordinarily audible to the human ear.”). In fact, people use a variety of devices that they may not realize are listening or recording sound.

14. Maka Tsulukidze et al., *Providing Recording of Clinical Consultation to Patients – A Highly Valued but Underutilized Intervention: A Scoping Review*, 95 PATIENT EDUC. & COUNSELING 297, 299 (2014) [hereinafter Tsulukidze, *Scoping Review*] (finding that on average 72% of patients who recorded their medical encounters listened to their recording and 60% shared them with others).

15. *Id.*

patients often want to have recordings of conversations with their doctors to review the recordings and ensure that they understand and are following their prescribed treatment.¹⁶ Patients may want to share the recording with caregivers, family members, or other providers, for reassurance or assistance with their care.¹⁷ Recordings may also empower patients to formulate questions about their condition for future visits or identify medical jargon they wish to research further.¹⁸ Recognizing these potential benefits, the VA health care system is currently conducting a randomized trial of patients of recording their visits and having access to those recordings later.¹⁹

Studies also suggest that access to a recording results in greater patient recall of medical information.²⁰ Even patients with good

16. Elwyn et al., *supra* note 4, at 4; *see also* Thomas F. Hack et al., *Impact of Providing Audiotapes of Primary Adjuvant Treatment Consultations to Women With Breast Cancer: A Multisite, Randomized, Controlled Trial*, 21 J. CLINICAL ONCOLOGY 4138, 4142 (2003) (finding that women randomized to receive audio recordings of breast cancer consultations were better informed about side effects of adjuvant treatment than those who did not receive audio recordings, with no differences between women who did not receive recordings based on whether they knew that a recording had been made or not and no differences between women who received recordings based on whether they actively chose to receive the recording or not). *But see* E. Lobb et al., *The Use of Audiotapes in Consultations with Women from High Risk Breast Cancer Families: A Randomised Trial*, 39 J. MED. GENETICS 697, 700 (2002) (finding that women randomized to receive audiotapes of genetic consultations had less accurate risk perceptions than those randomized not to receive audiotapes, likely because the consultations themselves frequently did not include communication of risk figures by the doctor).

17. Elwyn et al., *supra* note 4, at 4.

18. *Id.* at 5; *see also* S. Ford et al., *The Influence of Audiotapes on Patient Participation in the Cancer Consultation*, 31 EUR. J. CANCER 2264, 2266 (1995) (Eng.) (finding that 77% of new cancer patients randomized to receive a recording of their first visit asked for clarification of information during the next visit, compared with 57% of patients randomized not to receive the recording); Pankaj Kumar Mishra et al., *A Randomized Controlled Trial to Assess the Effect of Audiotaped Consultations on the Quality of Informed Consent in Cardiac Surgery*, 145 ARCHIVES OF SURGERY 383, 386 (2010) (finding that heart surgery patients randomized to receive an audio recording of their consultation had higher knowledge and a greater internal health care locus of control than those randomized to receive a generic recording about the procedure or no recorded information).

19. U.S. National Library of Medicine, *Assessing Open Access Audio (OAA)*, CLINICALTRIALS.GOV, clinicaltrials.gov/ct2/show/NCT04452331 [perma.cc/R5T4-PT7G] (last updated Oct. 10, 2022) (describing a randomized controlled trial comparing health care outcomes and patient and provider behaviors when visits are recorded and (1) both patient and provider are aware a recording is made and both can access the recording after visit, (2) both patient and provider are aware a recording is made but neither can access the recording after visit, or (3) only patient is aware a recording is made but patient cannot access the recording after visit).

20. Tsulukidze, *Scoping Review, supra* note 14, at 299; *see also* Randall W. Porter et al., *Memory when You Need it Most: Review of Personalized Video Recording of Doctor-Patient Consultations at a Neurosurgical Institution*, 61 CLINICAL NEUROSURGERY 205, 205 (2014) (reporting that of 165 patients given access to a video recording of a consultation, 91% reported watching the video at least once, 64% reported sharing it, 50% reported feeling more at ease, and 66% reported that they could better remember instructions given by their physician after watching it); Andrew J. Meeusen & Randall

memories can have difficulty retaining all of the information packed into a typical 15-minute medical encounter.²¹ Memory is also malleable and selective.²² Moreover, sharing the recording with a third party (e.g. a partner, friend, or another provider for a second opinion) will allow the other person to hear the complete encounter as it occurred, rather than relying on the patient's recollection.²³ The value of a recording may be especially great when patients first receive news of a serious diagnosis, such as cancer; patients in this situation may be unable to take in relevant information due to the primacy of their emotional responses to their diagnosis.²⁴

Among older patients, memory impairment is also increasingly common, due to aging, dementia and related conditions, or both.²⁵ Furthermore, patients engage in more frequent medical encounters as they age.²⁶ Consequently, older patients and those with dementia simply

Porter, *Patient-Reported Use of Personalized Video Recordings to Improve Neurosurgical Patient-Provider Communication*, 7 CUREUS, no. e273, 2015, dx.doi.org/10.7759/cureus.273 [perma.cc/WF2H-UUEG] (finding that 74% of 333 surveyed patients reported they remembered more of what their doctor said during the visit after watching a video of their encounter, and about 20% of free-text comments in the survey mentioned memory benefits); E. Bruera et al., *The Addition of an Audiocassette Recording of a Consultation to Written Recommendations for Patients with Advanced Cancer: A Randomized, Controlled Trial*, 86 CANCER 2420, 2422 (1999) (finding that cancer patients randomized to receive an audio recording of their consultation scored higher on a 10-item true/false test of their knowledge related to their condition and treatment at a follow-up visit a week later than patients randomized not to receive the audio recording).

21. See, e.g., Valory Pavlik et al., *Association of Patient Recall, Satisfaction, and Adherence to Content of an Electronic Health Record (EHR)-Generated After Visit Summary: A Randomized Clinical Trial*, 27 J. AM. BOARD FAM. MED. 209, 209 (2014) (reporting study showing that adult primary care patients recalled only 52% of key clinical information two days following an outpatient visit).

22. Cf. Marc T. Kiviniemi & Alexander J. Rothman, *Selective Memory Biases in Individuals' Memory for Health-Related Information and Behavior Recommendations*, 21 PSYCH. & HEALTH 247, 247 (2006). More poetically, "We color in the outlines of our memories with our beliefs." NADIA OWUSU, AFTERSHOCKS 108 (2021).

23. Elwyn et al., *supra* note 4, at 5.

24. See Milou S.C. Sep et al., *The Power of Clinicians' Affective Communication: How Reassurance About Non-Abandonment Can Reduce Patients' Physiological Arousal and Increase Information Recall in Bad News Consultations. An Experimental Study Using Analogue Patients*, 96 PATIENT EDUC. & COUNSELING 45, 48-49 (2014) (finding that 21% of variance in information recall in patients receiving bad news could be explained by psychological arousal).

25. See Felicia A. Huppert et al., *High Prevalence of Prospective Memory Impairment in the Elderly and in Early-Stage Dementia: Findings from a Population-Based Study*, 14 APPLIED COGNITIVE PSYCH. S63, S71 (2000). Although the age-adjusted incidence of dementia has decreased over time, the concomitant increase in life expectancy may nevertheless lead to increased burden of care. Frank J. Wolters et al., *Twenty-seven-year Time Trends in Dementia Incidence in Europe and the United States: The Alzheimer Cohorts Consortium*, 95 NEUROLOGY e519, e524-25 (2020), dx.doi.org/10.1212/WNL.0000000000010022 [perma.cc/3SR8-FAHQ].

26. National Center for Health Statistics, *Percentage of Having a Doctor Visit for any Reason in the Past 12 Months for Adults Aged 18 and Over, United States, 2021*, NAT'L HEALTH INTERVIEW SURV., www.cdc.gov/NHISdataQueryTool/SHS_adult/index.html [perma.cc/UAX5-47WV] (select topic "Doctor visit" and group by "Age groups with

may not be able to recall the details of a doctor's visit.²⁷ An audio recording of the visit serves as an external memory and relieves the patient from the concern of forgetting or misremembering critical treatment requirements.²⁸

Less commonly, patients experiencing a loss of consciousness, either involuntarily because of a health condition or voluntarily through procedures involving anesthesia, may wish to have a record of the events that transpired around them during their unconsciousness.²⁹ Patients in these conditions may want to be sure they will recall instructions provided before or after their procedure.³⁰ Patients also may find a recording to be a comforting source of continuity between conscious periods, as well as a source of reassurance as to statements or decisions made about them during their unconsciousness.³¹

Finally, in contrast to the previously mentioned health-promoting purposes, some patients express an interest in recording medical encounters (typically covertly) to document evidence of poor practice by the physician, or to provide proof of visit events for evidentiary purposes.³² For example, one recording context relatively well-

65+") (last visited June 22, 2023) (reporting 94% of adults 65 and older in 2021 had seen a doctor within the preceding year); National Center for Health Statistics, *Percentage of Having a Hospital Emergency Department Visit in Past 12 Months for Adults Aged 18 and Over, United States, 2021*, NAT'L HEALTH INTERVIEW SURV., wwwn.cdc.gov/NHISDataQueryTool/SHS_adult/index.html [perma.cc/YLA3-NX43] (select topic "Hospital emergency department visit" and group by "Age groups with 65+") (last visited June 22, 2023) (reporting that 21% of those 65 and older in 2021 had visited an emergency room within the preceding year); *Table 40. Persons with hospital stays in the past year, by selected characteristics: United States, selected years 1997–2018*, CTRS. FOR DISEASE CONTROL & PREVENTION, www.cdc.gov/nchs/data/hus/2019/040-508.pdf [perma.cc/7CCM-LPTG] (last visited June 22, 2023) (reporting that 17% of those 65 and older in 2018 had been admitted to a hospital within the preceding year).

27. See Roy P. C. Kessels, *Patients' Memory for Medical Information*, 96 J. ROYAL SOC'Y MED. 219, 219–20 (2003) (Eng.) (reviewing reasons for age-related decline in memory for medical information).

28. See sources cited *supra* note 20.

29. Verdict and Settlement Summary, *D.B. v. Ingham, M.D.*, *supra* note 5.

30. *Id.*

31. Cf. Jean-Nicolas Gallant et al., *Patient Perceptions of Audio and Video Recording in the Operating Room*, 276 ANNALS SURGERY e1057, e1058–59 (2022), journals.lww.com/annalsurgery/Abstract/9000/Patient_Perceptions_of_Audio_and_Video_Recording.93758.aspx [perma.cc/5KDU-FCE8] (last visited Oct. 29, 2021) (showing that patients were interested in having an objective record of their surgeries, understanding the procedure, and being aware of what physicians and nurses might be saying and doing during the procedure). There have been legislative attempts in at least two states to champion a requirement to have surgical procedures in particular recorded by hospitals upon patient request; neither resulted in enacted law. ASSEMB. B. 255, 102D REG. SESS. (Wis. 2015); H. B. 633, 187TH GEN. CT. (Mass. 2011).

32. Elwyn et al., *supra* note 4, at 4–5. This purpose has some resemblance to the interest of citizens in recording their encounters with the police. See generally Alexander Shaaban, *Officer! You Are on Candid Camera: Why the Government Should Grant Private Citizens an Exemption from State Wiretap Laws When Surreptitiously Recording on-Duty Officers in Public*, 42 W. ST. L. REV. 201, 231–32 (2015) (noting that covert recording can be safer than confronting a person in power). The First

documented in case law is the desire of patients undergoing compelled exams (e.g. for insurance or employment purposes) to have recordings of the exams to prepare for, or contest, the legal consequences of their exam findings.³³ Some patients have asked their providers for permission to record, sometimes with unfortunate results, including refusal of treatment.³⁴

C. Physician Attitudes Toward Recording

Physician attitudes toward patient recording have received less study and vary substantially.³⁵ One study found that 28% of U.S. physician respondents record visits for a patient's personal use, and an additional 50% are willing to do so.³⁶

Some physicians, particularly oncologists, appreciate the value of an audio recording to patients' self-care and adherence to physician instructions.³⁷ Some also see benefits in terms of motivating better practice or protecting them against litigation brought by patients.³⁸ The knowledge that a patient is or might be recording a visit covertly could lead physicians to be more careful in their behavior and more precise in their communication with patients.³⁹ At least one U.S. clinic, the Barrow Neurological Institute, rewards physicians for permitting recordings through insurance benefits.⁴⁰ Over a 10-year period in which 40,000

Amendment right to record the police, however, is predicated on officers exercising their official governmental duties in public where there is no expectation of privacy, and thus has a different legal basis than a potential right of patients to record their medical encounters. *Cf. Project Veritas Action Fund v. Rollins*, 982 F.3d 813 (1st Cir. 2020), *petition for cert. filed*, No. 20-1598 (U.S. May 17, 2021) (holding that Massachusetts's wiretapping law was unconstitutional insofar as it criminalized covert audio recording of police exercising their official duties in public).

33. See Samuel D. Hodge, Jr., *Physicians Beware! The Patients May Be Secretly Recording the Encounter*, 23 QUINNIPIAC HEALTH L. J. 229, 247 (2020). Because compelled exams are not undertaken for the benefit of the patient themselves, however, they may not trigger a fiduciary duty toward the patient in the examining physician and are outside the scope of this article.

34. Glen Elwyn, "Patientgate" - *Digital Recordings Change Everything*, 348 BMJ g2078 (2014) (Eng.) (describing a patient who (nevertheless) covertly recorded a physician who denied her permission to record her visit openly, after which the physician berated the patient that recording disrupted the trust needed for the patient-physician relationship, and finally refused to treat her).

35. Tsulukidze, *Scoping Review*, *supra* note 14, at 302.

36. Barr et al., *supra* note 4, at 3 (finding that clinicians, oncologists, rehabilitation doctors, and psychiatrists were more willing than general physicians to be recorded by their patients in the future).

37. Tsulukidze, *Scoping Review*, *supra* note 14, at 302.

38. Maka Tsulukidze et al., *Patients Covertly Recording Clinical Encounters: Threat or Opportunity? A Qualitative Analysis of Online Texts*, 10 PLoS ONE, no. e0125824, 2015, at 1, 4 [hereinafter Tsulukidze, *Qualitative Analysis*]; Barr et al., *supra* note 4, at 6 (quoting physician who said, "If I detect a potentially litigious patient I would ask if the visit could be recorded.").

39. Elwyn, *supra* note 34, at g2078.

40. The Dartmouth Institute for Health Policy & Clinical Practice, *Can Patients Record Doctor's Visits? What Does the Law Say?*, SCIENCEAILY (July 10, 2017),

clinical visits were recorded, Barrow reported that no malpractice claims had been settled or paid against their physicians.⁴¹ Additional research by its staff has demonstrated that physicians who provided patients with (video) recordings received higher patient satisfaction ratings than those who did not.⁴² However, Barrow appears to be an exception in this regard; a 2017 survey of forty-seven of the largest U.S. health care organizations found that only two had a policy that could be applied to recording, twenty-two had no policy about recording, thirteen were unsure whether they had a policy, and ten left decisions to individual clinics or physicians.⁴³

On the other hand, some physicians, particularly surgeons, are wary of patient recordings, often out of concern that (visible) recording might inhibit discussion.⁴⁴ In addition, physicians frequently raise concerns about “professional rights” and “privacy”, particularly with regard to covert recording.⁴⁵ Some physicians have suggested that recordings could be used against them as evidence in malpractice cases, leading physicians to practice defensive medicine to the detriment of the patient and health care system.⁴⁶ Some physicians also feel that patients should be warned

www.sciencedaily.com/releases/2017/07/170710135301.htm [perma.cc/X5DV-BXST] (reporting that Barrow Neurological Institute provides \$1 million in additional malpractice coverage and a 10% reduction in the cost of defense to physicians who allow patient recording).

41. Komal Naeem et al., *Medico-Legal Implications of Video Recording Patient-Provider Communication*, 66 *CLINICAL NEUROSURGERY* 26, 26 (2019) (arguing also that the (a) availability of recordings as evidence in court may favor physicians, because juries may presume that patients better remember their visits than doctors and the recording is an objective source of truth, (b) a policy of provider-supported recording discourages covert recording, and (c) recording “helps with the development of [a] trustworthy relationship between the patient and the doctor.”).

42. Malika Bhargava et al., *Video Recording Patient Visits to Improve Patient Satisfaction and Hospital Consumer Assessment of Healthcare Providers and Systems Scores*, 66 *CLINICAL NEUROSURGERY* 79, 79 (2019) (reporting a study examining 3516 standard patient surveys at the Barrow Neurological Institute between 2016 and 2019). Ninety-six percent of patients with video recordings watched them, sometimes repeatedly, and many shared them with friends or family. *Id.* The video group rated their physicians most favorably in the categories “Communication with the Doctor” and “Doctor Explained [my treatment]” 91% of the time; the non-video group only 57-60% of the time. *Id.* The groups did not differ in their ratings of perceived “Physician Skill”. *Id.* Because patients were not randomized to receive recordings in this study, it is also possible that some or all the effect may have resulted from differences in the nature of physicians who preferred to provide recordings vs. those who did not.

43. Barr et al., *supra* note 4, at 7. Two health systems reported that their policies allowed for recording under certain conditions. The Henry Ford Health System requires consent and that the recording be stored in the electronic medical record. The Mayo Clinic requires consent and limits the purposes of recording to education for post-discharge care. *See also* Paula Span, *The Appointment Ends. Now the Patient Is Listening*, *N.Y. TIMES* (Aug. 18, 2017), www.nytimes.com/2017/08/18/health/recording-your-doctors-appointment.html [perma.cc/8AEN-JQRV] (reporting that the University of Texas Medical Branch at Galveston has provided recorders to cancer patients since 2009).

44. Tsulukidze, *Scoping Review*, *supra* note 14, at 302.

45. Tsulukidze, *Qualitative Analysis*, *supra* note 38, at 4, 6.

46. Barr et al., *supra* note 4, at 6 (quoting physician respondent who said “The

about the risks to patient confidentiality if the patient chooses to share the recording.⁴⁷

D. *The Physician's Fiduciary Duty*

The patient-physician relationship has been a focus of attention at least since the Hippocratic Oath.⁴⁸ In the modern patient-physician relationship, the physician is a fiduciary of the patient.⁴⁹ As fiduciaries, physicians hold the patient's interests above their own self-interest.⁵⁰

Physicians' fiduciary duty includes the usual duties of care,

recording of office visits would be used by lawyers to twist our words against us in court."); see also Michelle Rodriguez et al., *Ethical Implications of Patients and Families Secretly Recording Conversations With Physicians*, 313 JAMA 1615, 1616 (2015) ("Physicians may then feel more inclined to order additional tests and imaging than they otherwise would . . .").

47. Tsulukidze, *Scoping Review*, *supra* note 14, at 302.

48. *The Hippocratic Oath*, 317 BMJ 1110 (1998) (Eng.) (citing WILLIAM HENRY SAMUEL JONES, *THE DOCTOR'S OATH* 9-12 (1924)). Among other things, the Oath prescribes a duty to benefit and not harm patients ("I will use treatment to help the sick according to my ability and judgment, but I will never use it to injure or wrong them."), and a duty to maintain the privacy of patients ("Whatsoever in the course of practice I see or hear (or even outside my practice in social intercourse) that ought never to be published abroad, I will not divulge, but consider such things to be holy secrets.").

49. *Lilly v. Comm'r*, 188 F.2d 269, 271 (4th Cir. 1951), *rev'd on other grounds*, 343 U.S. 90 (1952) ("The relationship of patient and physician is to the highest possible degree a fiduciary one, involving every element of trust and confidence. . . . A doctor owes the duty of undivided loyalty to his patients . . .") (quoting STRYKER, *COURTS AND DOCTORS* 9 (1932)); *Nardone v. Reynolds*, 538 F.2d 1131, 1136 (5th Cir. 1976) ("Whenever a patient is treated by a series of surgeons and doctors the fiduciary relationship exists regardless of whether the patient is aware who is treating him. This Hippocratic duty is born out of the doctor's purpose to render professional service."); *Krukavick v. AARP, Inc.*, 458 F. Supp. 3d 1, 7 (D.D.C. 2020) ("Certain relationships, such as the attorney-client or doctor-patient relationship, automatically trigger fiduciary duties."); *Morris v. Consolidation Coal Co.*, 446 S.E.2d 648, 651 (W. Va. 1994) ("[A] fiduciary relationship exists between a physician and a patient.") (citation omitted); *Lockett v. Goodill*, 430 P.2d 589, 591 (Wash. 1967) ("The relationship of patient and physician is a fiduciary one of the highest degree. It involves every element of trust, confidence and good faith."); *Liebergessell v. Evans*, 613 P.2d 1170, 1176 (Wash. 1980) (en banc) ("A fiduciary relationship arises as a matter of law between an attorney and his client or a doctor and his patient.").

50. Am. Med. Ass'n, *Patient-Physician Relationships*, E-1.1.1 AMA CODE OF MEDICAL ETHICS (2016), www.ama-assn.org/delivering-care/ethics/patient-physician-relationships [perma.cc/LAL6-9H3Y] ("The relationship between a patient and a physician is based on trust, which gives rise to physicians' ethical responsibility to place patients' welfare above the physician's own self-interest or obligations to others, to use sound medical judgment on patients' behalf, and to advocate for their patients' welfare."); *Daniels v. Gamma W. Brachytherapy, LLC*, 221 P.3d 256, 270 (Utah 2009) ("Doctors stand in a fiduciary relationship with their patients. . . . [And,] the physician voluntarily and expressly undertakes to act primarily for the benefit of the patient.") (citations omitted) (quoting E. Haavi Morreim, *Medical Research Litigation and Malpractice Tort Doctrines: Courts on a Learning Curve*, 4 HOUS. J. HEALTH L. & POL'Y, 42-43 (2003)).

competence, and diligence in their relationship with the patient.⁵¹ As fiduciaries, physicians also have a duty to protect their patients' confidentiality, to communicate with other treating physicians to coordinate care, and to fully inform patients of medical findings and opinions.⁵² The duty to coordinate care in modern medicine implies a responsibility to correctly use electronic medical records.⁵³ The duty to fully inform patients is complicated by barriers to patient understanding.⁵⁴

E. Patient Rights to Information About Their Care

Physicians have traditionally taken a paternalistic approach to

51. See *Fiduciary*, BLACK'S LAW DICTIONARY (11th ed. 2019) ("Someone who is required to act for the benefit of another person on all matters within the scope of their relationship; one who owes to another the duties of good faith, loyalty, due care, and disclosure."); RESTATEMENT (THIRD) OF AGENCY § 8.08 (AM. L. INST. 2006) ("Subject to any agreement with the principal, an agent has a duty to the principal to act with the care, competence, and diligence normally exercised by agents in similar circumstances.").

52. 61 AM. JUR. 2D *Physicians, Surgeons, and Other Healers* § 141 (2021) ("[T]he physician-patient relationship is a fiduciary one, based on trust and confidence and obligating the physician to exercise good faith . . . Furthermore, it is the source of the protection of a patient against the disclosure by the physician of confidential communications between them."); *Hippocratic Oath*, *supra* note 48 at 1110; Health Insurance Portability and Accountability Act of 1996 (HIPAA), Pub. L. No. 104-191, 110 Stat. 1936 (codified as amended in scattered sections of 18, 26, 29, and 42 U.S.C. (2012)); *Morris*, 446 S.E.2d at 654 ("[I]n addition to the duty of secrecy, there arises the duty of undivided loyalty. Should a doctor breach either of these two duties, the law must afford the patient some legal recourse against such perfidy. We should not suffer a wrong without a remedy, especially when the wrong complained of involves the abuse of a fiduciary position.") (quoting *Hammonds v. Aetna Cas. & Sur. Co.*, 243 F. Supp. 793, 799 (N.D. Ohio 1965)); see also *Bass v. Barksdale*, 671 S.W.2d 476, 491 (Tenn. Ct. App. 1984) ("When two or more physicians treat a patient, they are required to coordinate their evidence and communicate 'in a manner that best serves their patient's well-being'"); *Piedmont Hosp., Inc. v. D.M.*, 779 S.E.2d 36, 39 (Ga. Ct. App. 2015) (distinguishing failure to inform as medical malpractice rather than ordinary negligence by virtue of the relationship of confidence between physician and patient); *Grubbs ex rel. Grubbs v. Barbourville Fam. Health Ctr., P.S.C.*, 120 S.W.3d 682, 687 (Ky. 2003), as amended (Aug. 27, 2003) (holding that the physician's duty of fidelity mandates that a physician "fully disclose his findings on examination and the opinions he holds."); *Schafer v. Lehrer*, 476 So. 2d 781, 783 (Fla. Dist. Ct. App. 1985) (holding that "given the fiduciary nature of the doctor-patient relationship, the doctor's duty extends beyond nonconcealment.").

53. See Dean F. Sittig & Hardeep Singh, *Rights and Responsibilities of Users of Electronic Health Records*, 184 CAN. MED. ASS'N. J. 1479, 1480-81 (2012) (detailing responsibilities of clinician users of electronic medical records, including responsibility to maintain accurate information and to obtain training in order to be proficient in system use).

54. See Marc Ginsberg, *Informed Consent and The Differential Diagnosis: How the Law Overestimates Patient Autonomy and Compromises Health Care*, 60 WAYNE L. REV. 349, 392-93 (2014) (noting patient health literacy and limited visit time as impediments to physicians explaining health conditions to patients). Access to a recording after the visit that the patient can share or use as the basis for self-directed learning may help overcome these impediments.

treating patients, but the more recent history of medicine in the United States has been characterized by an expanded concept of patient autonomy.⁵⁵ To act autonomously, patients must not only have choices between options but must also have information necessary to make those choices in ways that will serve their interests.⁵⁶ In particular, there has been interest in according patients both the ability and the right to access their own medical records.⁵⁷

Patient interest in being knowledgeable about their own care is the basis of the “OpenNotes” movement, which encourages physicians to document care using visible processes, e.g. letting patients see the computer screen while the physician is entering notes and orders into their charts, and to access that documentation later.⁵⁸ More generally, modern electronic health record systems often feature a “patient portal”—an electronic interface targeted to the patient to allow them to review records and lab results independently and on demand.⁵⁹

Although the Health Insurance Portability and Accountability Act (“HIPAA”) is most closely associated with a right to health information

55. See S. Allan Adelman, *The Evolution of Patient Rights: Individual Benefits and Provider Burdens*, 10 J. HEALTH & LIFE SCI. L. 66, 68-72 (2017).

56. Jaime S. King & Benjamin W. Moulton, *Rethinking Informed Consent: The Case for Shared Medical Decision-Making*, 32 AM. J.L. & MED. 429, 429 (2006); Marshall B. Kapp, *Patient Autonomy in the Age of Consumer-Driven Health Care: Informed Consent and Informed Choice*, 28 J. LEGAL MED. 91, 91 (2007).

57. Am. Med. Ass’n, *Patient Rights*, E-1.1.3 AMA CODE OF MEDICAL ETHICS (2016), www.ama-assn.org/delivering-care/ethics/patient-rights [perma.cc/92HY-VUUDT] (including the right “to obtain copies or summaries of their medical records”).

58. Tom Delbanco et al., *Open Notes: Doctors and Patients Signing On*, 153 ANNALS INTERNAL MED. 121 (2010) (introducing and describing OpenNotes); Jan Walker et al., *Inviting Patients to Read Their Doctors’ Notes: Patients and Doctors Look Ahead: Patient and Physician Surveys*, 155 ANNALS INTERNAL MED. 811, 811 (2011) (discussing the OpenNotes approach); Jan Walker et al., *OpenNotes After 7 Years: Patient Experiences with Ongoing Access to Their Clinicians’ Outpatient Visit Notes*, 21 J. MED. INTERNET RSCH., no. e13876, 2019, at 1, 4-6 (describing experiences of 23,710 patients of providers using OpenNotes over a seven-year period, and finding 97% had reviewed a note, three-quarters of those had read notes for a year or more, and almost 99% thought making notes available to patients was a good idea); see also OPENNOTES, opennotes.org [perma.cc/Z6M2-AEJU] (last visited Sept. 14, 2021).

59. See Alan Schwartz et al., *Impact of Unannounced Standardized Patient Audit and Feedback on Care, Documentation, and Costs: An Experiment and Claims Analysis*, 36 J. GEN. INTERNAL MED. 27, 31 (2020) (showing in a study of over 200 encounters at 14 practices that nearly 20% of behaviors documented in the medical record were not heard on audio recordings and nearly 15% of document-worthy communications heard on audio recordings were not documented); Saul J. Weiner et al., *How Accurate is the Medical Record? A Comparison of the Physician’s Note with a Concealed Audio Recording in Unannounced Standardized Patient Encounters*, 27 J. AM. MED. INFORMATICS ASS’N 770, 770 (2020) (identifying 636 documentation errors in 105 physician notes, including 181 charted findings not heard in audio recordings and 455 findings in audio recordings not recorded in the physician note). See generally Leslie P. Francis, *When Patients Interact with EHRs: Problems of Privacy and Confidentiality*, 12 HOUS. J. HEALTH L. & POL’Y 171, 174-79 (2012) (reviewing the history and features of patient portals). Even when patients have access to their electronic health records, visit recordings can be valuable, because research suggests that health records can poorly represent the activities of the visit.

privacy, it also creates a patient right to access their own medical records.⁶⁰ The right includes both the right to inspect protected health information maintained by a covered entity (e.g. a medical office) and a right to obtain a copy in a timely fashion.⁶¹ Because HIPAA applies to information “maintained, collected, used, or disseminated by or for a covered entity”, an audio recording made for a patient *by their physician* would represent protected health information for which a patient would have a right of access under HIPAA.⁶² More recently, a notable feature of the 2016 21st Century Cures Act is the addition of an anti-information blocking provision, which provides for civil penalties against health care providers who interfere with patient access to electronic health information, including provider notes, after October 2022.⁶³

Patients’ right of access to their medical records under HIPAA also encompasses the right of a personal representative to access that information.⁶⁴ Parents, guardians, and other surrogates with lawful authority to make health care decisions for a patient are treated as personal representatives, and personal representatives are treated as the individual with respect to disclosure of medical records.⁶⁵ However, if the health care provider reasonably believes treating the personal representative as the individual would endanger the patient, they physician may refuse disclosure.⁶⁶ Surrogate decision makers, like physicians, owe a fiduciary duty to the patient, and generally must make the decisions they believe the patient would have made.⁶⁷

60. Adelman, *supra* note 55, at 77; see 45 C.F.R. § 164.524 (2021) (implementing right to access of medical records under HIPAA).

61. 45 C.F.R. § 164.524 (2021). Exceptions to the right include psychotherapy notes and information compiled for use in a legal proceeding. Covered entities may also deny access for a variety of reasons, such as to protect the privacy of another person (but not another health care provider) or if access to the information would endanger the life or physical safety of another person. Proposed modifications to the HIPAA Privacy Rule would allow patients to take photographs or videos of their private health information as recorded by the covered entity, but does not extend to recordings of encounters themselves while they are taking place. Proposed Modifications to the HIPAA Privacy Rule to Support, and Remove Barriers to, Coordinated Care and Individual Engagement, 86 Fed. Reg. 6446-01 (proposed Jan. 21, 2021) (to be codified at 45 C.F.R. § 164.524(a)(1)(ii)).

62. 45 C.F.R. § 164.501 (2021) (emphasis added). An audio recording made by a patient would not be a record maintained by a covered entity and would not be subject to HIPAA’s right of access, but such an audio recording would already be under the control of the patient.

63. 21st Century Cures Act, Pub. L. No. 114-255, 130 Stat. 1033 (2016); 42 U.S.C.A. § 300jj-52 (West) (implementing anti-information blocking provision). However, until October 6, 2022, only a specifically defined subset of electronic data is protected from information blocking. 45 C.F.R. § 171.103 (2021).

64. 45 C.F.R. § 164.502(g)(1) (2023).

65. *Id.* § 164.502(g)(1)-g(3).

66. *Id.* § 164.502(g)(5).

67. See generally Thaddeus Mason Pope, *Legal Fundamentals of Surrogate Decision Making*, 141 CHEST 1074, 1077-78 (2012) (reviewing standards for surrogate decision making); Shana Wynn, *Decisions by Surrogates: An Overview of Surrogate Consent Laws in the United States*, 36 BIFOCAL 10 (2014) (summarizing states’ laws related to surrogate health care decisions).

F. State and Federal Eavesdropping Statutes as Applied to In-Person Conversations

Patients are routinely advised to take notes during visits with their doctor,⁶⁸ but state and federal law often makes it a crime to intercept or eavesdrop on conversations using electronic or mechanical devices in a variety of circumstances.⁶⁹ Electronic recording is always permissible under these laws when all parties to the conversation know and consent to the recording, so patients who ask and receive permission can record their medical encounters.⁷⁰ However, the legal status of covert electronic recording in the United States varies by jurisdiction.⁷¹ One set of distinctions is based on whether the consent of a single party to the conversation or all parties to the conversation is required to record.⁷² A second set of distinctions is based on the context in which the recording takes place.⁷³

1. Who Must Consent to Recording?

U.S. jurisdictions may have “one-party” or “all-party” consent laws. In “one-party” jurisdictions, consent of any party to the conversation is sufficient to permit covert recording.⁷⁴ Federal law, which applies to interstate communication and conversations on federal property, employs a one-party approach.⁷⁵ Under federal law, covert recording of conversations by private persons is permitted when performed by a party to the conversation unless done with wrongful intent.⁷⁶ Because federal law in this area preempts state law, state regulation of electronic

68. See, e.g., *Five Ways to Get the Most Out of Your Doctor's Visit*, NAT'L INST. ON AGING, www.nia.nih.gov/health/five-ways-get-most-out-your-doctors-visit [perma.cc/C3PF-X96Q] (last visited Oct. 29, 2021) (“Take along a notepad and pen and write down the main points or ask the doctor to write them down for you.”). This web page also suggests audio recording visits with the doctor's permission. *Id.* (“Recording is especially helpful if you want to share the details of the visit with others.”).

69. See Bast, *supra* note 6, at 868-70.

70. *Id.*

71. *Id.* at 851.

72. *Id.* at 869.

73. *Id.* at 888-90.

74. Cynthia A. Brown & Carol M. Bast, *Professional Responsibility: Making “Smart” Ethical Decisions While Making the Most of “Smart” Technology*, 48 CREIGHTON L. REV. 737, 744 (2015).

75. 18 U.S.C.A. § 2511 (West) (“It shall not be unlawful under this chapter for a person not acting under color of law to intercept a wire, oral, or electronic communication where such person is a party to the communication or where one of the parties to the communication has given prior consent to such interception unless such communication is intercepted for the purpose of committing any criminal or tortious act in violation of the Constitution or laws of the United States or of any State.”).

76. *Id.* The federal language permitting recording other than for committing a wrongful act is one common pattern for such regulations and has been adopted by many states. See D.C. CODE ANN. § 23-542 (West 2021); LA. STAT. ANN. § 15:1303 (2021).

recording can be stricter, but not less strict, than federal law.⁷⁷

Thirty-nine states and the District of Columbia are one-party jurisdictions.⁷⁸ Among the thirty-nine, Connecticut and Nevada are one-party states for recording in-person conversations, but require all parties to consent for recording telephone conversations.⁷⁹ Public policy rationales for broad rights to record without the consent of all parties center in individual interests in curiosity, social control, and social advantage.⁸⁰

In contrast, in “all-party” jurisdictions, recording is unlawful unless all parties to the conversation give consent.⁸¹ Ten states (California, Illinois, Florida, Maryland, Massachusetts, Montana, New Hampshire, Oregon, Pennsylvania, and Washington) are all-party states.⁸² An

77. *United States v. Feiste*, 792 F. Supp. 1153, 1154 (D. Neb. 1991), *aff'd*, 961 F.2d 1349 (8th Cir. 1992) (“The federal wiretap statute, 18 U.S.C. §§ 2510–2520, preempts state law pertaining to electronic surveillance . . .”); *State v. Rivers*, 660 So. 2d 1360, 1362 (Fla. 1995) (“Congress preempted the field of the interception of wire communications under its power to regulate interstate communications.”) (citations omitted); *State v. Siegel*, 285 A.2d 671, 681 (Md. App. 1971) *aff'd* 292 A.2d 86 (Md. 1972) (holding that state may require procedures more restrictive than federal law, but not less).

78. *Civil Rights Law – Protection of Rights: Surveillance, Recording & Interception (October 2020)*, LEXIS, plus.lexis.com/api/permalink/ac597d56-3882-4049-96e7-87acbf6c6704/?context=1530671 (last visited Sep. 9, 2021) (providing list of all U.S. eavesdropping statutes on the basis of which I classified each jurisdiction); see IND. CODE ANN. § 35-31.5-2-176 (West 2021) (defining “Interception” as “intentional recording or acquisition of the contents of an electronic communication by a person other than a sender or receiver of that communication . . .”); VA. CODE ANN. § 19.2-62 (West 2021) (“It shall not be a criminal offense under this chapter for a person to intercept a wire, electronic or oral communication, where such person is a party to the communication . . .”). Vermont alone has no statute related to private parties recording conversations, and its courts generally look to the federal law, making it effectively a one-party state. See Bast, *supra* note 6, at 863.

79. CONN. GEN. STAT. ANN. § 52-570d (West 2021) (“No person shall use any instrument, device or equipment to record an oral private telephonic communication unless the use of such instrument, device or equipment (1) is preceded by consent of all parties to the communication and such prior consent either is obtained in writing or is part of, and obtained at the start of, the recording, or (2) is preceded by verbal notification which is recorded at the beginning and is part of the communication by the recording party, or (3) is accompanied by an automatic tone warning device . . . while such instrument, device or equipment is in use.”); NEV. REV. STAT. ANN. § 200.650 (West 2021) (“[A] person shall not intrude upon the privacy of other persons by surreptitiously listening to, monitoring or recording, . . . any private conversation engaged in by the other persons, . . . unless authorized to do so by one of the persons engaging in the conversation.”). Thus, in these states, in-person and telehealth encounters may be subject to different recording restrictions.

80. Bast, *supra* note 6, at 890-99.

81. Brown & Bast, *supra* note 74, at 744.

82. Glyn Elwyn et al., *Can Patients Make Recordings of Medical Encounters? What Does the Law Say?* 318 JAMA 513, 513 (2017). Oregon’s statute contained an exception for public and private conferences where the recorder is visible and all parties are aware of the recording, whether they have been informed of the recording or not. OR. REV. STAT. ANN. § 165.540 (West 2021). However, Oregon’s statute was recently held to be unconstitutional as a content-based restriction on protected speech. *Project Veritas v. Schmidt*, 72 F.4th 1043, 1062 (9th Cir. 2023).

eleventh state, Michigan, has an ambiguous statute that has been read to permit one-party consent by its state appeals court and to require all-party consent by a federal district court in the state.⁸³ In these states, unauthorized recordings are felonious, and most of these states also provide a private right of action for damages.⁸⁴ Disclosure of unauthorized recordings is often criminalized, and in some states, unauthorized recordings are excluded from admission as evidence in trials.⁸⁵ The public policy rationale for all-party consent centers on the value of privacy, including interests in secrecy, anonymity, and solitude.⁸⁶

2. Which Conversations Are Protected?

Federal law and a majority of state laws refer to an expectation of privacy or not being recorded in defining relevant protected conversations.⁸⁷ An expectation of privacy involves both a party's subjective expectation, which may be demonstrated by actions that suggest they are seeking privacy, and an objective inquiry into whether the expectation was justifiable.⁸⁸ Thus, there is no expectation of privacy when conversations are loud enough to be overheard by others who would be expected to be present.⁸⁹ In the typical medical encounter, which takes place behind closed doors, an expectation of patient privacy is objectively justified by the existence of state and federal patient privacy

83. *Compare* Sullivan v. Gray, 324 N.W.2d 58, 59 (Mich. Ct. App. 1982) (holding that because the statute prohibits recording “the private discourse of others”, it does not apply to recordings made by a party to the conversation even though the prohibition applies to “any person who is present or who is not present”, MICH. COMP. LAWS ANN. § 750.539c (West 2021)), with AFT Michigan v. Project Veritas, 378 F. Supp. 3d 614, 620 (E.D. Mich.), order amended and superseded, 397 F. Supp. 3d 981 (E.D. Mich. 2019), leave to appeal denied sub nom. In re Project Veritas, No. 19-0109, 2019 WL 4667711 (6th Cir. Aug. 16, 2019) (“Sullivan’s construction contravenes the Legislature’s intent made clear by the plain, unambiguous language of the statute.”).

84. Elwyn et al., *supra* note 82, at 513.

85. *Id.*

86. See Bast, *supra* note 6, at 883 (citing Ruth Gavison, *Privacy and the Limits of Law*, 89 YALE L.J. 421, 424 (1980)).

87. *E.g.*, 18 U.S.C.A. § 2510 (West). (“(2) ‘oral communication’ means any oral communication uttered by a person exhibiting an expectation that such communication is not subject to interception under circumstances justifying such expectation, but such term does not include any electronic communication;”). The formulation “expectation that such communication is not subject to interception . . . under circumstances justifying . . . expectation” appears in 30 state laws (Alaska, Arizona, Colorado, Delaware, Florida, Idaho, Illinois, Kansas, Louisiana, Minnesota, Mississippi, Missouri, Nebraska, New Hampshire, Nevada, New Jersey, North Carolina, North Dakota, Ohio, Oklahoma, Oregon, Pennsylvania, Rhode Island, South Carolina, South Dakota, Tennessee, Utah, Virginia, West Virginia, Wyoming, Wisconsin) and the District of Columbia’s law. Maryland refers only to “private conversation”. MD. CODE ANN., CTS. & JUD. PROC. § 10-401 (West 2021). Illinois considers a conversation private if any party intended it to be “of a private nature under circumstances reasonably justifying that expectation.” 720 ILL. COMP. STAT. ANN. 5/14-1 (West 2021).

88. Kemp v. Block, 607 F. Supp. 1262, 1264 (D. Nev. 1985) (holding that there was no expectation of privacy in an argument loud enough to be overhead by others).

89. *Id.*

laws.⁹⁰ On the other hand, because the purpose of these laws is to protect the patient, some courts have held that physicians may not have a reasonable expectation of privacy from their patients for physicians' communications during medical encounters.⁹¹

Not every state's law is based, or solely based, on an expectation of privacy in the conversation. Instead, some states focus on where the conversation takes place. Georgia, Hawaii, and Maine statutes, and Vermont case law focus on a reasonable expectation of privacy in the place where the conversation originates.⁹² In states like these, the home is the quintessential place where privacy is expected.⁹³ Outside the home, courts have found that most other places do not provide a reasonable expectation of privacy, with public dressing rooms and bathrooms often a statutory exception.⁹⁴ One state, California, defines eavesdropping with

90. See Health Insurance Portability and Accountability Act of 1996 (HIPAA), Pub. L. No. 104-191, August 21, 1996, 110 Stat. 1936 (codified as amended in scattered sections of 18, 26, 29, and 42 U.S.C. (2012)); Cf. Thomson Reuters, Privacy and Confidentiality of Medical Conditions, 0110 REGSURVEYS 13, Westlaw (database updated July 2022). Violations of the duty of confidentiality are actionable against physicians. See *Fairfax Hosp. By & Through INOVA Health Sys. Hosps., Inc. v. Curtis*, 492 S.E.2d 642, 645 (Va. 1997) (holding that "in the absence of a statutory command to the contrary, or absent a serious danger to the patient or others, a health care provider owes a duty to the patient not to disclose information gained from the patient during the course of treatment without the patient's authorization"); *Morris*, 446 S.E.2d at 654 ("[I]n addition to the duty of secrecy, there arises the duty of undivided loyalty.") (quoting *Hammonds v. Aetna Cas. & Sur. Co.*, 243 F. Supp. 793, 799 (N.D. Ohio 1965)). Compare *Quarles v. Sutherland*, 389 S.W.2d 249, 251 (Tenn. 1965) (holding that Tennessee has not privileged doctor-patient communications and therefore the common law provides no action for disclosure of patient records) with *S.C. State Bd. of Med. Examiners v. Hedgepath*, 480 S.E.2d 724, 726 (S.C. 1997) (holding that although South Carolina does not have a statutory patient-physician privilege, physicians nevertheless owe a duty of confidentiality to their patients). See generally 48 A.L.R.4TH 668 § 2[a] (Originally published in 1986) (noting that although there is no common law protection of patient privacy, courts have generally found unauthorized disclosures actionable as either invasion of privacy or breach of the confidential patient-physician relationship).

91. See *Com. v. Alexander*, 708 A.2d 1251, 1255 (Pa. 1998) (holding that physician did not have an expectation of privacy in case where patient, cooperating with police, covertly audiorecorded doctor illegally prescribing narcotics during medical encounter, and noting that Pennsylvania patient-physician confidentiality statute protects patients, not physicians).

92. GA. CODE ANN. § 16-11-62 (West 2021); HAW. REV. STAT. ANN. § 711-1110.9 (West 2021); ME. REV. STAT. ANN. tit. 17-A, § 511 (West 2021); See *State v. Geraw*, 795 A.2d 1219, 1224 (Vt. 2002) (holding that there is an expectation of privacy in the home that protects against secret recording by the government); see also Suzanne M. Monte, *The Lack of Privacy in Vermont*, 24 VT. L. REV. 199, 200 (1999) (arguing that Vermont ought to protect expectations of persons more broadly than solely based on place).

93. See, e.g., *Geraw*, 795 A.2d at 1225 ("inside the home 'a person may legitimately expect the highest degree or privacy known to our society'") (quoting *Com. v. Brion*, 652 A.2d 287, 289 (Pa. 1994)).

94. See *Cox v. State*, 286 S.E.2d 482, 484 (Ga. App. 1981) (holding that common areas of an apartment complex are not reasonably private); *Nuckles v. State*, 853 S.E.2d 81, 89 (Ga. 2020) (holding that employees of rehabilitation facilities do not have reasonable expectations of privacy when in the rooms of residents of the facilities because they do not exercise control over those rooms); *State v. Strong*, 2013 ME 21,

reference to expectation of privacy while *also* specifically excluding situations where there is an expectation of recording.⁹⁵ California also uniquely criminalizes the disclosure of recorded *communications with a health care provider*—in particular, by anyone who makes such a recording in violation of the state’s eavesdropping law.⁹⁶

III. ANALYSIS

The existing legal and policy frameworks pose several challenges when applied to patient audio recording of medical encounters. Part III weighs the conflicting principles that surround patient recording, including the purpose of the medical encounter and public policy favoring patient access to information, and argues that the value to the patient of an accessible recording outweighs the value of the physician’s privacy. This Part also explains how eavesdropping laws are not well-aligned with the context of recording medical encounters regardless of whether the jurisdiction uses an all-party or one-party consent approach. It also analyzes the implications of patient recordings in evidentiary proceedings.

A. *Accessing Information about Patient Care is Subject to Conflicting Principles.*

The purpose of the medical encounter is the care of the patient by the physician, which often takes the form of communication of information between the two related to the patient’s diagnosis, treatment, or prognosis.⁹⁷ Physician preferences and state eavesdropping laws can prevent patients from the highest fidelity means of memorializing this communication accurately and completely: electronic

¶¶ 17-18, 60 A.3d 1286, 1291 (holding that the rationale for statutory language affording privacy in dressing rooms and bathrooms was based on justified expectations, rather than merely the fact of disrobing, and thus there was no reasonable expectation of privacy when visiting a prostitute).

95. CAL. PENAL CODE § 632 (West 2021) (“(c) For the purposes of this section, ‘confidential communication’ means any communication carried on in circumstances as may reasonably indicate that any party to the communication desires it to be confined to the parties thereto, *but excludes a communication made* in a public gathering or in any legislative, judicial, executive, or administrative proceeding open to the public, or *in any other circumstance in which the parties to the communication may reasonably expect that the communication may be overheard or recorded.*”) (emphasis added).

96. CAL. PENAL CODE § 632.01 (West 2021) (“(a)(1) A person who violates subdivision (a) of Section 632 shall be punished pursuant to subdivision (b) if the person intentionally discloses or distributes, in any manner, in any forum, including, but not limited to, Internet Web sites and social media, or for any purpose, the contents of a confidential communication with a health care provider that is obtained by that person in violation of subdivision (a) of Section 632.”).

97. See A. W. Childs, *The Functions of Medical Care*, 90 PUB. HEALTH REP. 10, 10 (1975) (describing components of medical visits).

recording of their medical encounter.⁹⁸ Although the practice of patient notetaking during the encounter is well-established, patients who mishear, misunderstand, or misspell medical terminology may record inaccurate information, and, because patients may not know at the time of the visit which information will be important later, patient notes may be incomplete.⁹⁹ Similarly, although patients have a legal right to access records created by their physician about their health and care, studies comparing physician notes with visit recordings have also demonstrated that physician-created records can be inaccurate and incomplete.¹⁰⁰

As with recording for personal use, sharing recordings for health care purposes is a benefit that has been recognized by providers but is also restricted by eavesdropping laws.¹⁰¹ Sharing the recording also implicates other concerns.¹⁰² Sharing potentially impairs the confidential nature of the medical information, reducing the patient's privacy.¹⁰³ In addition, patients' who have shared a recording may limit the ability of their physicians to assert patient/physician confidentiality as a privilege in a legal proceeding brought by another against the patient.¹⁰⁴ On

98. Cf. *Shloss v. Sweeney*, 515 F. Supp. 2d 1068, 1080 (N.D. Cal. 2007) (referring to "non-copyrightable fact works such as medical records"); *Muncey v. Eyeglass World, LLC*, 2012-NMCA-120, ¶ 14, 289 P.3d 1255, 1260 (holding that patient records created by optometrist lacked originality and did not have copyright protection). This analysis presupposes that a patient recording is legally the property of the patient who made it, and that, like other medical records, there is no copyright belonging to the physician in the recorded conversation.

99. See *Five Ways to Get the Most Out of Your Doctor's Visit*, *supra* note 68 (discussing notetaking); see also Consumer Reports, *Doctors' Use of Medical Terminology Can Leave Patients Poorly Informed*, WASH. POST (July 14, 2014), www.washingtonpost.com/national/health-science/doctors-use-of-medical-terminology-can-leave-patients-poorly-informed/2014/07/14/f440ae02-aac1-11e3-98f6-8e3c562f9996_story.html [perma.cc/EX7T-PGMK] (providing examples of patients confused by medical language); Kerry L. Kilbridge et al., *Lack of Comprehension of Common Prostate Cancer Terms in an Underserved Population*, 27 J. CLINICAL ONCOLOGY 2107 (2009) (finding frequent lack of knowledge or misinterpretation of medical language among men in low-income general medical clinics); R. L. O'Connell et al., *Patients' Understanding of Medical Terminology Used in the Breast Clinic*, 22 BREAST 836, 837 (2013) (Scot.) (finding a high proportion of incorrect or partially incorrect understandings of medical terms among women on first visit to a U.K. breast clinic).

100. See 45 C.F.R. § 164.524 (2021) (setting out right of access to records); Schwartz et al., *supra* note 59, at 31 (identifying limitations of physician-created records); Weiner et al., *supra* note 59, at 770 (demonstrating additional limitations of physician-created records).

101. E.g., 18 U.S.C.A. § 2511 (West) (making disclosure punishable by fine or imprisonment); see also TEX. PENAL CODE ANN. § 16.02 (West 2021) (making disclosure a felony of the second degree); MICH. COMP. LAWS ANN. § 750.539e (West 2021) (making disclosure of unlawful recording a felony).

102. Tsulukidze, *Scoping Review*, *supra* note 14, at 302.

103. *Id.*

104. Compare *Los Angeles Gay & Lesbian Ctr. v. Superior Ct.*, 125 Cal.Rptr.3d 169, 185 (Cal. Ct. App. 2011) ("Waiver occurs if the person holding the privilege, without coercion, discloses a significant portion of the communication or has consented to disclosure.") with *Leeds v. Prudential Ins. Co. of Am.*, 258 N.W. 672, 675 (Neb. 1935) ("It might, and often does, arise that a patient who cannot speak the English language

balance, however, because the benefits and risks of sharing recordings fall almost entirely on patients, they are best enabled to judge whether and with whom to share it.¹⁰⁵

Patients who choose to record covertly in an all-party jurisdiction expose themselves to civil and criminal liability.¹⁰⁶ But not all states are all-party states.¹⁰⁷ As a result, because the ability of patients to lawfully record varies by state, patients may be unsure as to the conditions under which they are allowed to make covert recordings.¹⁰⁸ Indeed, two states impose different conditions depending on the medium of the conversation, allowing any party to record an in-person conversation but requiring the consent of all parties to record telephonic conversations.¹⁰⁹ Given the increasing adoption of telehealth during the COVID-19 pandemic,¹¹⁰ patients in these states face uncertainty even when seeing the same provider. Absent a clear notification or norm about the acceptability and legal status of recording, this uncertainty may serve to discourage otherwise beneficial recording even in one-party states.¹¹¹

B. Accurate and Complete Medical Records Outweigh Privacy and Secrecy, Even in All-Party Jurisdictions.

In all-party jurisdictions, patients will only be able to record their medical encounter with the knowledge and consent of the physician.¹¹²

takes with her a close friend who can interpret between the doctor and herself. . . . It does not seem that the mere fact of the presence of a third person is a waiver of the confidential relations . . .”).

105. See Adelman, *supra* note 55, at 77.

106. See Bast, *supra* note 6, at 868-69.

107. *Id.*

108. *E.g.*, Md. Code Ann., Cts. & Jud. Proc. § 10-402 (West 2021) (requiring all-party consent); Va. Code Ann. § 19.2-62 (West 2021) (requiring one-party consent); D.C. Code Ann. § 23-541 (West 2021) (requiring one-party consent). A patient living in Maryland, an all-party jurisdiction, may be conveniently near a provider in Virginia or Washington, D.C., both one-party jurisdictions, or vice versa.

109. See sources cited *supra* note 79.

110. See Kyle Y. Faget, *Telehealth in the Wake of Covid-19*, J. HEALTH CARE COMPLIANCE, May-June 2020, at 5, 6 (describing broadening telehealth access in Medicare and Medicaid programs during the COVID-19 pandemic).

111. *Cf.* Patient Protection and Affordable Care Act, Pub. L. No. 111-148, 124 Stat. 119 (2010), amended by Health Care and Education Reconciliation Act of 2010, Pub. L. No. 111-152, 124 Stat. 1029 (2010) (codified as amended in scattered sections of 42 U.S.C.); Health Information Technology for Economic and Clinical Health Act, Pub. L. No. 111-5, February 17, 2009, 123 Stat. 226 (2009); Health Insurance Portability and Accountability Act of 1996 (HIPAA), Pub. L. No. 104-191, August 21, 1996, 110 Stat. 1936 (codified as amended in scattered sections of 18, 26, 29, and 42 U.S.C. (2012)). Although state laws frequently differ from one another in many areas, the value of uniform regulation of health care, along with the strong federal interest in health care quality for patients receiving federally-subsidized care, has spurred federal legislative action to create national standards in many areas.

112. See CONN. GEN. STAT. ANN. § 52-570d (West 2021) (providing partial exception by permitting recording with suitable notification to all parties, rather than requiring their affirmative agreement). In Connecticut, the patient recording openly but against the wishes of the physician is not acting unlawfully. However, absent an employer or

When physicians do not agree to be recorded, patients lose the many benefits associated with recording, including health benefits, increased knowledge and autonomy, and being able to review physicians' medical advice in detail later or with others who advise them in their medical decisions.¹¹³

Eavesdropping laws in these states allow a physician's objection to unconditionally prevent patients from recording the encounter, and thus effectively favor the physician's privacy over the public policy recognizing the value of patients' rights to information about their care.¹¹⁴ Legislatures in all-party jurisdictions may have consciously chosen to place a high value on the privacy of typical conversations. However, the public policy rationale is weaker here, where the conversation is for and about the patient and the record of the conversation may provide ongoing benefit to the patient. Patients benefit from accurate and complete information about their health care; the public benefits from empowered and engaged patients making cost-effective use of health care resources.¹¹⁵ In the medical context, these benefits outweigh the general public interest in privacy.

Moreover, the fiduciary relationship formed at law when the patient voluntarily undertakes an examination by a health care provider further supports the public interest by encouraging patients to rely on their physicians to act primarily for the patient's benefit.¹¹⁶ The patient's health interest in recording will generally be greater than the physician's general interest in not being recorded. In addition, the recording will primarily consist of the patient's own private health information. Thus, the patient's stake in the conversation is beyond that of a typical party, and a right of recording the visit should belong to the patient (or their legal guardian or surrogate acting on their behalf if the patient is incompetent).

Physicians may not want to be recorded, but it is not clear why their preferences should be controlling in these situations.¹¹⁷ Being subject to professional strictures that one would not otherwise prefer is common in

regulator requirement to allow the recording, the danger that the physician will simply refuse to treat the patient who insists on recording them is likely to be too great for a patient in need of care, especially one with a limited choice of providers. *See* Elwyn, *supra* note 34, at g2078.

113. *See* sources cited *supra* note 4.

114. *See* sources cited *supra* note 60. In addition, when providers practice with ancillary staff, such as nurses, physician assistants, or medical students, the consent of any staff member present during recording will also be necessary. Patients cannot always anticipate when these others will join or leave the visit, and thus even if the physician agrees to be recorded, the patient will need to interrupt their visit and obtain the consent of ancillary staff who enter the room.

115. *See* sources cited *supra* notes 55, 56.

116. *See* sources cited *supra* notes 51, 52.

117. *Cf.* Saul J. Weiner et al., *Evaluation*, *supra* note 7, at e209644, 6 (describing project in which physicians knew they were going to be recorded by at least some patients and patients had a choice of covert or open recording, and finding there was no difference in physician performance based on whether the recorder was concealed or revealed). Physicians may get used to the idea of being recorded and ignore the presence of a recorder.

many professions, including health care.¹¹⁸ The physician has already chosen to assume the fiduciary role, and it is the patient's privacy that is sacrosanct in a medical encounter.¹¹⁹ Concerns for physician privacy should weigh less than the value of the recording to the patient.

C. A General Right to Record One's Own Conversations is Not Sufficient.

Patients in one-party jurisdictions have a legal right to record conversations, including medical encounters, without the knowledge or consent of other parties present. However, this general right to record one's own conversations is not an ideal match to the medical encounter, because medical encounters implicate other values than the patient's curiosity, social control, and social advantage.¹²⁰ There are situations in all-party jurisdictions where the benefit to the patient of a covert recording of a medical encounter would outweigh the public policy interest in privacy or secrecy. Likewise, there can be situations in one-party jurisdictions where the potential harm to the patient outweighs the public policy interest in social control. For example, where the recording would itself pose a potential physical danger to the patient or other non-providers, the fiduciary duty would encourage the physician to discourage or prohibit recording, even in a one-party jurisdiction.¹²¹

In addition, some medical encounters take place while patients are unconscious.¹²² Whether a patient is a party to a conversation when the

118. See Centers for Disease Control and Prevention, *Immunization Administration Requirements For Influenza*, STATE IMMUNIZATION LAWS FOR HEALTHCARE WORKERS AND PATIENTS, www2a.cdc.gov/vaccines/statevaccsApp/AdministrationbyVaccine.asp?Vaccinetmp=Influenza [perma.cc/2K69-9S6G] (last visited October 24, 2021) (mandating flu shots for hospital employees); *Nat'l Treasury Emps. Union v. Von Raab*, 489 U.S. 656, 679 (1989) (holding that routine drug testing of Customs Service employees involved in interdicting drugs or carrying guns was constitutionally acceptable); *Williams-Yulee v. Fla. Bar*, 575 U.S. 433, 455 (2015) (holding that states may prohibit judicial candidates from personally soliciting funds for their election).

119. *Cf.* Application of Milton S. Hershey Med. Ctr. of Pennsylvania State Univ., 634 A.2d 159, 161 (Pa. 1993) (holding that patient health was a compelling need permitting medical center to disclose a surgeon's HIV status to patients potentially put at risk). The argument is even stronger in recordings of patient visits, where physicians themselves determine what they say to patients and are not required to disclose the physicians' private or personal matters in order to care for patients.

120. See Bast, *supra* note 6, at 890-99.

121. See *Curtis*, 492 S.E.2d at 645 (noting that provider duties, such as confidentiality, do not override a serious danger to the patient). Recording could be dangerous to a patient if the recorder itself poses a physical danger, as with a magnetic device concealed on the person of patient undergoing an MRI scan. See *How to Stay Safe When Getting an MRI*, YALE MED. (2017), www.yalemedicine.org/news/mri-safety [perma.cc/8QUA-UJD3]. Recording could also be dangerous in emergency rooms or delivery rooms if the recording process interferes with the ability of health care personnel to safely treat the patient or others. See Hodge, *supra* note 33, at 244-247 (discussing hospital policies related to video recording in delivery rooms).

122. See sources cited *supra* note 1.

conversation takes place when they are unconscious, and unable to overhear it with their own ears, is a question that has not received attention in case law.¹²³ Because current eavesdropping statutes do not contemplate unconscious parties, their application to these cases is uncertain, and their policy rationales are of limited guidance.¹²⁴

D. All-Party Consent May Be Used to Place Unfair or Inequitable Conditions on Patient Recordings.

In all-party jurisdictions, physicians can prohibit patient recording by declining to consent.¹²⁵ This power can be exercised inequitably. For example, physicians could only allow their less medically-complex patients to record encounters (for fear of being recorded in a misstatement), only allow their more-educated patients to record (out of a greater fear of the patient bringing a lawsuit in the future, in which the recording might protect the physician), or only allow their white, male, or straight patients to record (out of a general animus or prejudice).¹²⁶ Even if a physician routinely permits patients to record encounters, the physician may condition their permission on controlling which portions may be recorded or the subsequent use of the recording.¹²⁷ Any of these

123. *Cf.* *Thompson v. Dulaney*, 970 F.2d 744, 748 (10th Cir. 1992) (“[T]he wording of the statute, while broad, requires that interceptions be intentional before liability attaches, thereby excluding inadvertent interceptions.”); *People v. Ledesma*, 763 N.E.2d 806, 812 (Ill. App. Ct. 2002), *aff’d*, 795 N.E.2d 253 (Ill. 2003) (“Accidental overhears or recordings of a defendant’s conversation do not violate the eavesdropping statute.”). In the case of intentional recording during a procedure in which the patient is unconscious, a court might find that the patient is a party to the conversation because the patient is present and the physician knows the patient is present. On the other hand, if the physician reasonably believes the patient is unconscious and unable to perceive the conversation, and the physician thus never directs any conversation toward the patient, the physician may believe they have a reasonable expectation of privacy from the patient, and a court might find that the patient is not a party.

124. *See* Anthony G. Messina et al., *Anaesthetic Interventions for Prevention of Awareness During Surgery*, 10 COCHRANE DATABASE SYSTEMATIC REVIEWS. CD007272 (October 18, 2016), doi.org/10.1002/14651858.CD007272.pub2 [perma.cc/E82H-ZURH] (describing patient wakefulness during anesthesia or post-operative awareness of events during unconsciousness as a rare but well-known phenomenon). As a result, even the decision about whether the patient is in fact unconscious may be fraught.

125. *See generally* Bast, *supra* note 6, at 869 (explaining all-party consent).

126. *See* Helen R. Burstin et al., *Do the Poor Sue More? A Case-Control Study of Malpractice Claims and Socioeconomic Status*, 270 JAMA 1697, 1697 (1993) (finding that low-income and uninsured patients are less likely to sue physicians for malpractice than higher-income or insured patients, controlling for the severity of injury).

127. *See, e.g., The Voices of Patient Harm*, PROPUBLICA, www.propublica.org/article/patient-safety-voices-reporting-recipe [perma.cc/W9TZ-FBFBK] (last visited October 28, 2019) (providing a website allowing patients to report stories of harm resulting from health care encounters to journalists for potential investigation); *see generally* Alicia Y. Hong et al., *What Do Patients Say About Doctors Online? A Systematic Review of Studies on Patient Online Reviews*, 21 J. MED. INTERNET RSCH.

limits result in benefit-shifting from patients to the physician, in contravention of the physician's fiduciary duty to the patient, without running afoul of most eavesdropping laws.¹²⁸

A similar problem occurs in one-party jurisdictions when a patient proposes to record openly and with their physician's consent. Physicians who do not wish to be recorded may refuse to treat patients who insist upon (or even ask about) recording medical encounters; physicians might instead condition their willingness to treat patients in a recorded encounter on unfair grounds or subject to terms that reduce the benefit of the recording to patients.¹²⁹ In a one-party jurisdiction, this possibility, or the fear of it, may serve to discourage patients from recording openly, and lead them to employ covert recording, despite even greater physician opposition to covert recording.¹³⁰

E. Recording May Deter Malpractice or Benefit the Wronged Party in a Malpractice Action.

The availability of a recording may lead physicians to speak more carefully, reducing the risk of a misstatement or misunderstanding by the patient.¹³¹ It may also reduce the likelihood that even dissatisfied physicians will mistreat patients who avail themselves of the right to

e12521, 2 (2019), www.jmir.org/2019/4/e12521/ [perma.cc/7JEV-RQSM] (reviewing growth in patient online reviews of physicians and hospitals); Jing Liu et al., *What Do Patients Complain About Online: A Systematic Review and Taxonomy Framework Based on Patient Centeredness*, 21 J. MED. INTERNET RSCH. e14634, 7 (2019), www.jmir.org/2019/8/e14634/ [perma.cc/3U98-XLT4] (classifying 154,762 online complaints based on determinants of patient-centered care). California, in particular, criminalizes online sharing of health care recordings specifically. CAL. PENAL CODE § 632.01 (West 2021).

128. See, e.g., 18 U.S.C.A. § 2511 (West). Although many eavesdropping laws prohibit the making of recordings for criminal or tortious purposes, none prevent a consenting party from conditioning their consent to be recorded on any purpose, even a wrongful one, when the only parties involved are the recording party and the consenting party.

129. Cf. Elwyn, *supra* note 34, at g2078 (describing physician reprisal against patient seeking to record).

130. See DOUGLAS R. HOFSTADTER, *METAMAGICAL THEMAS: QUESTING FOR THE ESSENCE OF MIND AND PATTERN* 713-720 (2008) (describing game theoretic conditions for the Prisoner's dilemma). The collective action problem for patients and physicians is a variation of the Prisoner's dilemma. It can be illustrated by imagining a physician who prefers no recording to open recording to covert recording and a patient who prefers open recording to covert recording to no recording. Both would prefer open to covert recording, but the threat of retaliation by a physician against a patient who proposes open recording may lead the patient to adopt covert recording, which provides less value to both parties.

131. Cf. Catherine M. DesRoches et al., *The Views and Experiences of Clinicians Sharing Medical Record Notes With Patients*, 3 JAMA NETWORK OPEN e201753, 5-8 (2020) (reporting a survey of physicians asking about the impact of patient access to physician notes, and finding that physicians spent more time in documentation and used language less critical of patients when they knew that patients would be able to review the note).

record, because any mistreatment will be captured by the recording.¹³² Because these benefits depend on the knowledge or suspicion that the patient is recording, however, they may be less likely when patients record covertly than when they record openly.¹³³ This argues for a public policy of open recording or a policy that puts physicians on notice that any patient may legally use a concealed recorder.¹³⁴

In the event of an administrative or legal proceeding by the patient against the physician, the availability of an accurate and complete recording is likely to aid the tribunal and the injured party significantly.¹³⁵ Patient recordings can be evidence of the conversation itself and of the physician's behavior during the encounter.¹³⁶ In some cases, recordings are admissible evidence of the patient's condition.¹³⁷ Once introduced into evidence, an accurate and complete recording may support a more confident finding that the physician either met the standard of care or did not.¹³⁸ However, unlawfully made recordings will generally not be

132. *Id.*

133. *Id.*

134. *Id.* at 8. Some have argued that the potential for covert recording should create an incentive for physicians to be more cautious regardless of whether they are aware that recording is taking place. Naveed Saleh, *What to Do If Your Patient is Recording You*, MDLinx (May 21, 2019), www.mdlinx.com/article/what-to-do-if-your-patient-is-recording-you/lfc-3723 [perma.cc/JX2T-P9NL] ("Assuming that every patient is recording you will keep you on your toes.").

135. See *D.B.*, 2015 WL 10388424, at *1. See generally Nathaniel Morris, *Should Health Care Workers Press Charges Against Violent Patients?*, WASH. POST (Nov. 18, 2018, 8:30 AM), www.washingtonpost.com/national/health-science/should-health-care-workers-press-charges-against-violent-patients/2018/11/16/668ad5c0-d7b6-11e8-a10f-b51546b10756_story.html [perma.cc/G3BX-2EVV] (discussing prevalence of patient violence against health care providers and legal remedies).

136. *E.g.*, SAUL J. WEINER & ALAN SCHWARTZ, LISTENING FOR WHAT MATTERS: AVOIDING CONTEXTUAL ERRORS IN HEALTH CARE 157-162 (2016) (providing example of administrative evidentiary use of a recording). During an audio recording research project conducted at a VA Hospital, a nurse who objected to the project deliberately failed to call a patient for a doctor's appointment. The patient, who was carrying a hidden recorder for the project, complained. VA legal and ethical personnel determined that the audio recording was relevant information for disciplinary purposes, even though it was not collected with any intention to use it for such purposes, because VA personnel were obligated to report any evidence of patient harm by staff and because the recording would reflect the event accurately and protect any party that was not at fault.

137. See FED. R. EVID. 801 (defining hearsay as out-of-court statements presented for their truth). Patient recordings presented for the truth of the out-of-court statements of the physician would constitute hearsay evidence. However, the Federal Rules of Evidence permit the admission of statements of medical diagnosis and treatment as exceptions to the rule against hearsay. FED. R. EVID. 803(4). Several other hearsay exceptions may apply depending on whether the recording was made the patient or the physician, under what conditions, whose statement is being offered, whether the declarant is available to testify, whether the opposing party has notice of the intent to admit the recording, and the jurisdiction of the case. See FED. R. EVID. 803(5), 803(6), 803(7), 804(3), 807.

138. *Cf.* *Young v. Gastro-Intestinal Ctr., Inc.*, 205 S.W.3d 741 (Ark. 2005) (affirming trial court finding that physicians and nurses who procured patient signature documenting warning not to drive after a colonoscopy were not liable for patient's

admissible, delaying or subverting fact-finding or prompt settlement in all-party jurisdictions.¹³⁹

The availability of recorded evidence may have some drawbacks. Physicians may practice more defensive medicine in the belief that recorded overtreatment may immunize them from malpractice claims.¹⁴⁰ Defensive practice could lead to patient harm as well as increasing costs to the healthcare system, although evidence suggests that defensive practice is rare.¹⁴¹ Recordings introduced as legal evidence are likely to waive patient-physician privilege.¹⁴² Recordings used as evidence are also subject to concerns about tampering or selective editing, but in a trial context, this concern is minimized if the party requesting admission of the recording is available for cross-examination.¹⁴³ On balance, however, the

subsequent car accident and death as a result of acting against medical advice); *see also* Naeem et al., *supra* note 41. A recording could help an expert witness testify that the physician's practice was appropriate and that the patient was adequately informed of risks of treatment, or could show that the patient dismissed the physician's recommendations and may share responsibility for a subsequent injury caused by acting against medical advice, as in *Young*.

139. *E.g.*, 18 U.S.C.A. § 2515 (West) ("Whenever any wire or oral communication has been intercepted, no part of the contents of such communication and no evidence derived therefrom may be received in evidence in any trial . . . if the disclosure of that information would be in violation of this chapter."); N.Y. C.P.L.R. § 4506 (McKinney 2021) ("The contents of any overheard or recorded communication, conversation or discussion, or evidence derived therefrom, which has been obtained by conduct constituting the crime of eavesdropping . . . may not be received in evidence in any trial, . . ."); OR. REV. STAT. ANN. § 41.910 (West 2021) ("Evidence of the contents of any wire or oral communication intercepted: (1) In violation of ORS 165.540 shall not be admissible in any court of this state . . ."). *But see* *People v. Guzman*, 453 P.3d 1130, 1143 (Cal. 2019) (holding unconstitutional the exclusionary provision of California's Invasion of Privacy Act, CAL. PENAL CODE § 632(d) (West 2021), in light of state constitutional "Right to Truth-in-Evidence" provision).

140. *See* Rodriguez et al., *supra* note 46, at 1616.

141. *See* Michael J. Saks & Stephan Landsman, *The Paradoxes of Defensive Medicine*, 30 HEALTH MATRIX 25, 76 (2020) (reviewing empirical studies suggesting that defensive medicine very rarely occurs, and arguing that the concept is often misapplied to reasonable conservative medical practice in the face of uncertainty).

142. *See* *Cerro Gordo Charity v. Fireman's Fund Am. Life Ins. Co.*, 819 F.2d 1471, 1479 (8th Cir. 1987) (interpreting Minnesota law to conclude that disclosure of patient-physician communication in a legal proceeding waives the privilege in a subsequent proceeding). *See generally* 114 A.L.R. 798 (Originally published in 1938) (reviewing cases and suggesting that patient testimony about their injuries themselves generally does not waive privilege, patient direct testimony about communications with the physician generally does waive privilege, and patient involuntary testimony on cross-examination about communications with the physician generally does not waive privilege).

143. *See* *Masson v. New Yorker Mag., Inc.*, 501 U.S. 496, 517 (1991) (holding that a deliberate alteration in a quotation that results in a material change in meaning could represent knowledge of falsity for purposes of a libel action); *Karr v. Four Seasons Mar., Ltd.*, No. CIV.A.02-3413, 2004 WL 797728, at *4 (E.D. La. Apr. 12, 2004) ("Courts and commentators have recognized the danger of manipulation or selective editing of surveillance videotapes, which can, for example, compress hours of uneventful surveillance into a short tape . . ."); *see also* *United States v. Townley*, 472 F.3d 1267, 1274 (10th Cir. 2007) (holding that tape-recorded conversation was admissible because recorded parties testified at trial and were available for cross-examination).

American legal system strongly favors providing fact-finders with relevant and reliable evidence, and unaltered audio recordings are inherently reliable.¹⁴⁴

In summary, the current frameworks restricting the recording of conversations limit the ability of patients to obtain important benefits. These benefits outweigh the values enshrined in eavesdropping laws. Eavesdropping laws improperly privilege physicians in light of their fiduciary relationships to their patients. They are also poorly suited to advance the public interest in providing patients access to accurate and complete information about their health and health care.

IV. PROPOSAL

Because patient and public interests are served by permitting the making and use of recordings of medical encounters, and these interests are different from those addressed in current eavesdropping statutes, a new legal framework for recording medical encounters is needed. This Part proposes a framework based in the fiduciary principle and consistent with a policy seeking to increase patient access to information about their health and health care.¹⁴⁵ Because federal eavesdropping law partially preempts state law in this area, after reviewing the goals of the framework, the breadth of the proposed right, and potential limitations on the right, this Part proposes both an amendment to federal law and model state statutes intended to be adopted either in conjunction with the federal amendment or as unilateral state actions.¹⁴⁶

A. *Intended Goals of the New Framework*

The primary goal of providing a statutory right based in the fiduciary relationship is to improve patient health by providing patients with a source of verbatim information from their health care providers that they can review, on their own or with their caregivers, to better follow their provider's advice.¹⁴⁷ Secondary goals include reinforcing the autonomous patient as the principal in the patient-physician relationship and encouraging physicians to practice to a high standard of care with each patient.¹⁴⁸

These statutory changes may, in the case of one-party consent states, provide a second and independent basis for legally recording a medical encounter; they need not displace permissions accorded by these states'

See generally F. M. English, Annotation, *Admissibility of Sound Recordings in Evidence*, 58 A.L.R. 2d 1024, § 4 (1958) ("Sound recordings have almost universal approval as an acceptable form of evidence, providing a proper foundation is first established for their admission.").

144. *See* English, *supra* note 143, at §2.

145. *See* sources cited *supra* notes 52, 56.

146. *See* sources cited *supra* note 77.

147. *See* sources cited *supra* note 20.

148. *See* sources cited *supra* notes 56, 140.

existing eavesdropping laws.¹⁴⁹ Codifying the additional basis for patients recording medical encounters, however, will normalize the practice and provide constructive notice to physicians that their patients may record.¹⁵⁰ It may thus lead physicians to encourage open, rather than covert patient recording.¹⁵¹ In all-party consent states, these statutory changes will create an express exception to the all-party consent requirement, both legalizing and normalizing the practice of patient recording. Another consequence of enshrining a right is that it may encourage physicians to provide recordings to their patients routinely, making access to recordings more equitable.¹⁵²

B. Breadth of the Proposed Right

Consistent with the principle of patient autonomy, patients are best positioned to determine whether a visible recorder or a concealed recorder will better serve their needs.¹⁵³ Consensual recording is fully consistent with the primary purpose of this proposal, and permissible in every state under existing law. However, under the proposed framework the provider in an all-party state will no longer be able to prevent a recording by refusing to consent. Providers are singled out specifically because of the combination of their fiduciary relationships and the public policy interest in expanding patients' rights to access, retain, and use their medical information.¹⁵⁴

If the right to record is expressly granted to patients, providers should not be permitted to refuse treatment to a patient or otherwise retaliate against a patient who asks to exercise this right to record.¹⁵⁵ Patients who are concerned, however, that their providers will retaliate, or that their providers' awareness of recording will interfere with their

149. See Bast, *supra* note 6, at 931-42 (reviewing state statutes).

150. Cf. 42 U.S.C.A. § 300jj-52 (West) (implementing provisions prohibiting providers and others from blocking patient access to electronically stored information). Just as anti-information blocking regulations put providers and health systems on notice that patients may not be prevented from reviewing their medical records, a statutory right of patient recording puts providers on notice that patients may not be prevented from recording and reviewing their encounters with physicians.

151. See BRIT. MED. ASS'N, *Patients Recording Consultations* (June 2, 2021), www.bma.org.uk/advice-and-support/ethics/confidentiality-and-health-records/patients-recording-consultations [perma.cc/9MSZ-37RP] (recognizing that UK physicians likely cannot prevent patients from recording covertly and encouraging physicians to agree to open recordings in order to decrease the frequency of covert recording).

152. See Craig Klugman, *Why Doctors Should Audio Record Patient Encounters*, BIOETHICS.NET (Apr. 29, 2015), www.bioethics.net/2015/04/why-doctors-should-audio-record-patient-encounters/ [perma.cc/5TFY-U4UB] (last visited November 18, 2021) ("If physicians make their videos available to patients, then there would not be a need for patients to secretly or openly record.").

153. See sources cited *supra* notes 56, 60

154. See sources cited *supra* notes 52, 60.

155. Cf. 45 C.F.R. § 164.530 (prohibiting retaliation by health care entity against patient exercising HIPAA right to access records).

care, should be permitted to use a concealed recorder and make recordings without the actual knowledge or consent of the physician. Although this right to record permits patients to use a concealed recorder, by encouraging recording of medical encounters in general and increasing physician expectation of being recorded, it may in fact lead to more patients choosing to record openly who might otherwise have concealed a recorder.¹⁵⁶

Because patients must consent to any recording of their medical encounter, the benefits of recording are most easily secured when patients themselves make the recordings, and patient recording should be the primary focus of the right. However, some patients may not have a phone, or may forget their phone or fail to operate it properly as a recorder—and these may be the very patients for whom a recording would be most helpful.¹⁵⁷ Thus, another option for helping patients record is to place the provider in control of making the recording, upon the request (or lack of objection) of the patient.¹⁵⁸ Providers may prefer such a system, in fact, not least because it may discourage covert recording and give providers a greater sense of agency.¹⁵⁹

On the other hand, keeping control of the recordings in the hands of providers (or health systems), even with unmistakable patient consent, raises other concerns. Failure to successfully create and store the recording could itself subject the physician to liability under both statutory patient privacy duties and the fiduciary duty of confidentiality.¹⁶⁰ As a medical record, patients would have a legal right to obtain copies of the recording.¹⁶¹ However, they may also have more

156. See sources cited *supra* note 136. An established expectation of patient recording solves the collective action problem when physicians and patients both prefer open to covert recording. If the physician expects the patient to record covertly unless the physician encourages open recording, the physician's preferences are best fulfilled by encouraging open recording.

157. See sources cited *supra* notes 24, 25.

158. See Naeem et al., *supra* note 41, at 6; Bhargava et al., *supra* note 42, at 79; see also Ruby Lipson-Smith et al., *Co-Design of a Consultation Audio-Recording Mobile App for People with Cancer: The SecondEars App*, 3 JMIR FORMATIVE RSCH. e11111 (2019) (describing the development by the Peter MacCallum Cancer Centre in Australia of an app for patients that creates recordings that are automatically stored in the medical record); Span, *supra* note 43 (describing physician who offers to record visits for patients and provide access, and clinic that offers recorders to patients); Oliver Center for Patient Safety and Healthcare Quality, www.utmb.edu/olivercenter/perma.cc/P8MY-8CT3 (last visited October 24, 2021) (describing patient audio recording program with options for using own smartphone or provided recorders).

159. See Tsulukidze, *Qualitative Analysis*, *supra* note 38, at 6.

160. See, e.g., *Todeschi v. Sumitomo Metal Mining Pogo, LLC*, 394 P.3d 562, 576 (Alaska 2017) (discussing, in the context of negligent spoliation of evidence, the “well-recognized duty of a medical care provider to create and maintain medical records”). *But see Harris v. Wexford Health Sources, Inc.*, No. 15-CV-10936, 2017 WL 4467480, at *8 (N.D. Ill. Oct. 6, 2017) (holding Illinois statute that creates patient right of access to medical records does not create a duty in provider to preserve records).

161. See 45 C.F.R. § 164.524 (2021) (implementing HIPAA right to access of records but permitting a HIPAA-covered entity to require patients to make access requests in writing, so long as it informs the patients in advance).

difficulty doing so than if they had made the recording themselves, due to legal requirements (e.g. a signed written request) and technological challenges (e.g. accessing a patient portal or web site allowing them to download their own copy of the recording in a format they can later use).¹⁶² In addition, state mandatory retention periods for medical records would require the physician to maintain the recording even when the patient might prefer to destroy it after listening to it.¹⁶³ Patient recording obviates these concerns, and is preferable when possible, but extending the right to allow patients to permit their providers to create and maintain the recording on the patients' behalf would increase access to the right.

Under this framework, the right comes into play when the intended purpose of the recording is for patients (or their guardians or surrogates acting on their behalf) to review the communication of their providers to care more effectively for themselves. Thus, patients should be permitted to play all or part of the recordings to those whom they consult about their care decisions, including family, friends, or other health care providers.¹⁶⁴ This permission could be limited to playing the recordings in the patients' presence to reduce the likelihood that the recordings will be used for purposes other than helping the patient more effectively care for themselves.

C. Limitations on the Proposed Right

There are two primary exceptions to the right as framed in the fiduciary context. First, the right does not arise in the context of a compelled examination or when the "patient" is not actually seeking a care relationship, as in some kinds of activism or research projects.¹⁶⁵

162. See Joan F. Hilton et al., *A Cross-Sectional Study of Barriers to Personal Health Record Use by Patients Attending a Safety Net Clinic*, 7 PLoS ONE e31888 (2012), doi.org/10.1371/journal.pone.0031888 [perma.cc/U5TG-P3Y5] (finding that patients with limited computer skills had significant difficulty completing health surveys in web portals).

163. See Joy Pritts et al., *PRIVACY AND SECURITY SOLUTIONS FOR INTEROPERABLE HEALTH INFORMATION EXCHANGE: REPORT ON STATE MEDICAL RECORD ACCESS LAWS* (2009), www.healthit.gov/sites/default/files/290-05-0015-state-law-access-report-1.pdf [perma.cc/7N6F-MYFS] (last visited Dec. 28, 2021) (reviewing medical record retention requirements by state).

164. See Elwyn et al., *supra* note 4, at 4 (finding that patients often wish to share their recordings for these purposes).

165. Cf. *Planned Parenthood Fed'n of Am., Inc. v. Ctr. for Med. Progress*, 214 F. Supp. 3d 808, 816-17 (N.D. Cal. 2016), *aff'd*, 890 F.3d 828 (9th Cir. 2018), *amended*, 897 F.3d 1224 (9th Cir. 2018), and *aff'd*, 735 F. App'x 241 (9th Cir. 2018), *cert denied*, 139 S. Ct. 1446 (2019) (denying defendant's motion to dismiss suit arising from covert recordings of plaintiff's physicians and staff edited to misrepresent the plaintiff's procedures for fetal tissue donation); Saul J. Weiner & Alan Schwartz, *Directly Observed Care: Can Unannounced Standardized Patients Address a Gap in Performance Measurement?*, 29 J. GEN. INTERNAL MED. 1183-1187 (2014) (explaining the use of unannounced standardized patients, actors presenting incognito to physicians to study performance, which does not create a fiduciary patient-physician relationship). In *Planned Parenthood Federation of America, Inc.*, although the defendants were not

Second, in situations in which physicians reasonably believe that the recording process will create a substantially greater risk of harm to patients than if they did not record, the fiduciary duty may instead call for a prohibition on recording. This could occur, for example, if recording will be disruptive to the care team or increase the chance of infection or other patient harm.¹⁶⁶ Although many of these situations arise from the use of visible recorders, a concealed recorder with metal components could be dangerous to the patient during, for example, an MRI scan.¹⁶⁷ States enacting a broad right to record may wish to establish a rebuttable presumption that recording will be less risky than not recording. In contentious cases, the finder of fact can determine whether a physician's belief that recording would create a greater risk of harm than not recording is reasonable.

Additionally, the fiduciary relationship is not wholly one-sided.¹⁶⁸ Principals in a fiduciary relationship also owe some duties to their agents.¹⁶⁹ Thus, states may determine whether to permit or prohibit disclosures of recordings that would serve purposes other than assisting the patient in understanding and following the recommendations of the provider.¹⁷⁰ For example, states may prohibit disclosures by patients intended to persuade other consumers to choose or not choose a provider, as these disclosures do not serve the patient's health or understanding of the encounter and may harm the provider.¹⁷¹ Similarly,

recording medical encounters, even if they had recorded during a purported consultation, the factitious nature of such a consultation would not give rise to a fiduciary duty in the physician.

166. See Hodge, *supra* note 33, at 244-247 (discussing hospital policies related to video recording in delivery rooms).

167. See YALE MED., *supra* note 121.

168. See RESTATEMENT (THIRD) OF AGENCY § 8.15 (AM. L. INST. 2006) ("A principal has a duty to deal with the agent fairly and in good faith, including a duty to provide the agent with information about risks of physical harm or pecuniary loss that the principal knows, has reason to know, or should know are present in the agent's work but unknown to the agent.").

169. *Id.* In particular, the duty of good faith ought to restrict a patient from using a covert recording to harm the provider's practice.

170. *But cf.* Bartnicki v. Vopper, 532 U.S. 514, 515 (2001) (holding that laws prohibiting disclosure of an illegally recorded telephone conversation on a matter of public interest by one not involved in the recording violate the First Amendment right to freedom of speech). "Unlike the prohibition against the 'use' of the contents . . . [disclosure] is the kind of 'speech' that the First Amendment protects." *Id.* at 526-27. But the *Bartnicki* holding is a narrow one, involving matters of "unusual public concern", and unlikely to be relevant to most disclosures of routine patient recordings. See *id.* at 535-41 (Breyer, J., concurring).

171. See sources cited *supra* notes 32, 38. The availability of the (complete) recording would simplify any action for defamation or tortious interference against the patient by providing a factual basis for the patient's review. However, the proposed right need not encompass such patient disclosures, as they neither advance the patient health interest to which the physician's interest is subordinate in the patient-physician relationship nor seek to vitiate the fiduciary relationship in a malpractice or breach of fiduciary duty action. Thus, a state could prohibit such disclosures under this proposal, or condition the right to make such disclosures on the recording being made with the consent of the physician.

a state may permit or prohibit the public posting of a recording on social media, even in a group for patients with similar conditions, based on other policy goals of the state.¹⁷² States may also prohibit the distribution of edited recordings, if they are to be used for a purpose other than a patient's self-care, or if the editing has the effect of misrepresenting the physician's actions or advice.¹⁷³

Because the recording represents an independent and strong source of evidence of the behavior of the provider, patients should be permitted to introduce their unedited recordings as evidence in actions that relate to the purpose of the recording, subject to the usual evidentiary rules of relevance.¹⁷⁴ These actions will most frequently be actions for malpractice or breach of fiduciary duty to the patient. States may, but need not, allow disclosure of recordings in actions related to other aspects of the patient-physician contract, such as those related to medical billing.¹⁷⁵ If patients choose to introduce recordings in a legal proceeding adverse to their physicians, however, physicians should be permitted to insist that the entire recording be admitted.¹⁷⁶ Such a provision will best

172. *E.g.*, 2015 California Assembly Bill No. 1671: *Hearing Before the S. Comm. On Pub. Safety*, 2015-2016 Reg. Sess. (Cal. 2016) (noting impetus for CAL. PENAL CODE § 632.01 (West 2021), specially criminalizing internet disclosure of unlawful recordings with health care providers, included concern over posting of manipulated covert recordings that could endanger physicians).

173. *See Planned Parenthood Fed'n of Am., Inc.*, 214 F. Supp. 3d at 818 (describing case in which anti-abortion activists secretly recorded and allegedly edited conversations with Planned Parenthood employees to misrepresent the practices of the employees and organization).

174. *See generally* FED. R. EVID. 103, 401, 403 (defining relevance and admissibility). An action that relates to the purpose of the recording might be, for example, a malpractice action that turns on what the physician recommended during a visit.

175. Elwyn, *supra* note 34, at g2078 (noting that the UK General Medical Council now allows patient recordings to be introduced as evidence in assessment of professional practice); Niall O'Hara et al., *Setting the Record Straight: Patient Recordings of Consultations*, 17 CLINICAL MED. 188, 188 (2017). The proposed statutory right would encompass professional practice actions based on a provider's treatment of their patient. On the other hand, a UK court recently admitted covert recordings by a plaintiff of medical examinations conducted by defendant's experts as evidence in a personal injury trial. *Mustard v. Flower* [2019] EWHC 2623 (QB) [23] (Eng.), www.bailii.org/ew/cases/EWHC/QB/2019/2623.html [perma.cc/K8PA-ZH2H] ("The claimant acted on the advice of her solicitor and her motives were, in the context of adversarial litigation, understandable. Whilst her actions lacked courtesy and transparency, covert recording has become a fact of professional life."). The proposed statutory right would not extend to the *Mustard* case because no fiduciary duty arises between defendant's medical experts and the plaintiff undergoing the examination.

176. FED. R. EVID. 106 ("If a party introduces all or part of a writing or recorded statement, an adverse party may require the introduction, at that time, of any other part--or any other writing or recorded statement--that in fairness ought to be considered at the same time."); *E.g.*, *Beech Aircraft Corp. v. Rainey*, 488 U.S. 153, 172 (1988) ("[W]hen one party has made use of a portion of a document, such that misunderstanding or distortion can be averted only through presentation of another portion, the material required for completeness is ipso facto relevant and therefore admissible . . ."). Many states have adopted similar rules. *Rule of Completeness*, 1 WHARTON'S CRIM. EVIDENCE § 4:10 (15th ed.).

serve the fact-finder in the trial, who generally will already be weighing testimony from the parties that may be less credible than the verbatim recording, and will afford protection to physicians who practice to the standard of care.

D. Legislative Approaches to a Patient Right to Record

1. Enacting a Positive Right to Patient Recording

Legislatures can advance these public policies most forcefully by crafting a new statute enshrining a positive patient right to record, along with whatever disclosure permissions or prohibitions the state wishes to adopt.¹⁷⁷ Such an approach would be valuable even in one-party jurisdictions through normalizing the practice and providing constructive notice to physicians. It may thus motivate physicians to encourage patients to pursue open, rather than covert recording.¹⁷⁸ Key components of a positive statute as here envisioned include (1) connecting the right to the fiduciary relationship of the physician to the patient and the medical purpose of the encounter, (2) an intent to use the recording to further the patient's health care, and (3) patient control over whether and how the recording is made.

Federal law preempts state law in this area to the extent of limiting states from relaxing conditions on eavesdropping to be more permissive than federal restrictions.¹⁷⁹ Although federal law already permits covert recording by a party to the communication, adoption of an additional provision specifically focused on the patient right will normalize the practice, serve as a model for those states that have enacted legislation based on the federal model, and operate in any state that looks to federal law rather than state law.¹⁸⁰ An example of how 18 U.S.C. § 2511 could be modified to incorporate the proposed right might be the addition of a new section 2(k) modeled in part after 2(d):¹⁸¹

(k) It shall not be unlawful under this chapter for a person not acting under color of law to record a wire, oral, or electronic communication between a patient and:

(1) one or more physicians or licensed health care practitioners (as defined in 42 U.S.C.A. § 11151) at least one of whom stands in a fiduciary

177. See sources cited *supra* note 31 (reviewing prior unsuccessful state legislation supporting a patient right to record surgeries).

178. See BRIT. MED. ASS'N, *supra* note 151; Klugman, *supra* note 152.

179. See sources cited *supra* note 77.

180. See Bast, *supra* note 6, at 863 (noting that Vermont looks to federal law).

181. See 42 U.S.C.A. § 11151 (West) (defining "physician" to include surgeons and dentists, and "practitioner" to include licensed health care providers other than physicians). Although this article focuses particularly on encounters with physicians, where the fiduciary duty is most strongly established, legislatures will need to determine the breadth of practitioners who ought to be subject to a patient right to record. A maximally broad definition, limited by the fiduciary relationship, is most consistent with the principles motivating this proposal, and may be easier for patients, providers, and courts to apply.

relationship to the patient, or

(2) persons assisting or supervised by such a physician or licensed health care practitioner,

where the communication is one in which the patient is consulting the practitioner(s) for the purpose of diagnosis, treatment, or prognosis, and where the person recording the communication is:

(1) the patient recording the communication with the intent of furthering their own health care, with or without the consent of the practitioner(s), or

(2) a third party to the communication who would be regarded as the patient's personal representative (as defined in 45 C.F.R. § 164.502) recording the communication on behalf of the patient with the intent of furthering the patient's health care, or

(3) the physician or health care practitioner recording the communication on behalf of, and with the consent of, the patient or the patient's personal representative with the intent of providing access to the recording to the patient or the patient's personal representative to further the patient's health care, unless such communication is intercepted for the purpose of committing any criminal or tortious act in violation of the Constitution or laws of the United States or of any State.

To effectuate the right in all-party jurisdictions, their legislatures will also need to adopt amendments to their existing eavesdropping legislation. Legislatures in one-party jurisdictions should also adopt similar statutes or amendments to affirm the patient-specific right, particularly if their current framework has atypical variations (e.g. Connecticut and Nevada's distinction between oral and telephonic conversations, which could create confusion about the status of telemedicine visits), bases their rules on case law (Virginia), or imposes inconsistent prohibitions on use or disclosure.¹⁸² The nature of these statutes will vary state-to-state, but Florida and Illinois can serve as illustrative examples. Florida lists a set of permitted recording practices including recording with the consent of all parties.¹⁸³ The following new permission could be added:

(d) It is lawful under this section and §§ 934.04-934.09 for a person to record a wire, oral, or electronic communication between a patient and (1) one or more licensed health care practitioners (as defined in Fla. Stat. Ann. § 456) at least one of whom stands in a fiduciary relationship to the patient . . . where the person recording the communication is: (1) the patient . . . (etc.)

Illinois provides a list of exemptions from its prohibition on recording without the consent of all parties.¹⁸⁴ The list of exemptions could be amended to add an additional exemption as follows, for:

182. CONN. GEN. STAT. ANN. § 52-570d (West 2021); NEV. REV. STAT. ANN. § 200.650 (West 2021); Monte, *supra* note 92, at 200 (discussing Vermont framework).

183. FLA. STAT. ANN. § 903.04(2) (West 2021).

184. 720 ILL. COMP. STAT. ANN. 5/14-3 (West 2021).

(r) recording a wire, oral, or electronic communication between a patient and (1) one or more health care professionals (as defined in 225 Ill. Comp. Stat. Ann. 150/5) at least one of whom stands in a fiduciary relationship to the patient . . . where the person recording the communication is: (1) the patient . . . (etc.)

For the purpose of clarity, states may choose to enumerate exceptions to the patient's right to record consistent with the three key components, for example, clarifying that the right does not pertain when the physician has a reasonable belief that recording would be detrimental to the patient's health or health care.¹⁸⁵ It is also not inconsistent with the right for states to balance other public policy goals through restrictions on the use of permitted recordings. For example, one state might prohibit disclosure other than for the patient's health care benefit or in proceedings related to the physician's provision of care. Another state might permit some kinds of disclosures not related to the patient's health care benefit so long as the recording was made openly and has not been edited.

An advantage of enacting a positive right is that by grounding the right in the fiduciary relationship and the benefit to the patient's health, these statutes clearly delineate typical situations in which recording will be permitted. They establish boundaries for those situations (e.g., the right does not apply when there is no fiduciary relationship or the fiduciary duty would be to prevent recording for the protection of the patient), and provide direction to patients and physicians. A potential disadvantage may be that physicians may attempt to disclaim a fiduciary relationship or may argue that recording would cause (intangible) harms to the patient.¹⁸⁶ In exceptional situations, such arguments will trigger an inquiry by a fact-finder into the nature of patient-physician relationship or the balance of benefits and harms in a particular case. However, this kind of inquiry is one that most juries should be capable of undertaking, as factual questions about relationships and damages arise in medical negligence cases and are the subject of pattern jury instructions in many states.¹⁸⁷

2. *Amending Recording Laws to Create a Narrow Exception for Patient Recording*

A second option for legislatures in all-party jurisdictions is to create a narrower exception to eavesdropping laws to permit patient recording

185. See 45 C.F.R. § 164.524 (2021) (excepting psychotherapy notes from patient right to access medical records).

186. Cf. sources cited *supra* note 49 (describing holdings that the absence of a confidentiality statute is not dispositive as to whether the patient-physician relationship is a fiduciary one at common law).

187. See, 809.00A Medical Malpractice--Direct Evidence of Negligence Only. (Adopted January 2019), N.C.P.I.-CIVIL 809.00A; 1523 Right to Rely upon Health Care Provider, Ind. Model Civ. Jury Inst. 1523; Michigan Non-Standard Jury Instr. Civil § 24:32.

by excepting health care providers from expectations of privacy when conducting a medical encounter (but maintaining patient expectations of privacy during medical encounters).¹⁸⁸ For example, in the context of Florida's law, rather than enacting a positive permission (e.g. in Fla. Stat. § 903.04(2) (West)) the exception to privacy for public meetings could be extended to include in-person medical encounters:

(2) "Oral communication" means any oral communication uttered by a person exhibiting an expectation that such communication is not subject to interception under circumstances justifying such expectation and does not mean any public oral communication uttered at a public meeting, *any communication by a health care practitioner to their patient taking place during a medical encounter and intercepted by the patient themselves*, or any electronic communication.¹⁸⁹

Similarly, an Illinois exception might be introduced in the statutory definition of a private conversation:

(d) Private conversation. For the purposes of this Article, "private conversation" means any oral communication between 2 or more persons, whether in person or transmitted between the parties by wire or other means, when one or more of the parties intended the communication to be of a private nature under circumstances reasonably justifying that expectation. A reasonable expectation shall include any expectation recognized by law, including, but not limited to, an expectation derived from a privilege, immunity, or right established by common law, Supreme Court rule, or the Illinois or United States Constitution. *However, a health care practitioner shall not have a reasonable expectation of privacy from their patient during a health care consultation intended to benefit the patient.*¹⁹⁰

An advantage of the narrow approach is that it can be easily administered because it merely notifies physicians that they will not be

188. See Dep't of Health and Hum. Servs., *Can Health Care Providers Engage in Confidential Conversations with Other Providers or with Patients, even if There is a Possibility That They Could be Overheard?*, HIPAA FAQs FOR PROFESSIONALS, www.hhs.gov/hipaa/for-professionals/faq/196/can-health-care-providers-have-confidential-conversations/index.html [perma.cc/UD4Y-P5QD] (last visited Nov. 4, 2021) (explaining need for providers to take reasonable precautions to protect patient privacy). Medical encounters that take place in semi-private or public settings, such as shared hospital wards or mass vaccination sites, may complicate the application of exceptions in all-party states. If patients are restricted from recording encounters taking place where other patients might be incidentally overheard, providers who do not wish to be recorded may have a perverse incentive to conduct more care in less private settings. A potential response to this challenge might be to establish a presumption that encounters where the provider would be reasonably expected to take reasonable safeguards to protect patient privacy are acceptable for recording by the patient, but any communication captured incidental to the recording patient's encounter may not be used or disclosed by the patient. If patient recordings are permitted to be used as courtroom evidence, recordings that incidentally capture other parties could be reviewed in camera or edited to protect the other parties.

189. FLA. STAT. ANN. § 934.02 (West 2021) (proposed new language emphasized).

190. 720 ILL. COMP. STAT. ANN. 5/14-1 (West 2021) (proposed new language emphasized).

able to expect privacy from their patient during patients' medical encounters. The narrow approach requires minimal changes to the existing legislative framework. However, a substantial disadvantage is that by failing to ground the exception in the patient-physician relationship, the purpose of the exception is more arbitrary, and less likely to lead to physician promotion of patient recording as a positive benefit.

V. CONCLUSION

Allowing patients to record their medical encounters serves several valuable public goals, including enhancing patient health and adherence to physician recommendations, increasing access by patients to their health care records, and supporting patient autonomy. The practice of recording is also consistent with the fiduciary nature of the patient-physician relationship and can help physicians to better care for their patients. Current legal frameworks for recording based in privacy law are a poor fit to these goals and the medical context. A specific right to record medical encounters will lead recording to become more prevalent, accepted, and expected. As a result, patients will be more likely to choose to record openly, partially mitigating misgivings among some physicians, who may find that the practice does not damage their relationships with patients or subject them to greater liability. By enacting legislation that normalizes the practice of recording and imposes reasonable restrictions on the uses of patient recordings, particularly those made without the provider's consent, legislatures can encourage recording and embrace its benefits while addressing physician concerns.

