Malaysian Medical Council

AUDIO AND VISUAL RECORDINGS
GUIDELINE OF THE MALAYSIAN MEDICAL COUNCIL

MMC Guideline 003/2023

PRELUDE

This Guideline complements, and should be read in conjunction with the Code of Professional Conduct of the Malaysian Medical Council (MMC).

In this Guideline, the words “Doctor”, “Physician”, “Medical practitioner” and “Practitioner” are used interchangeably, and refer to any person registered as a medical practitioner under the Medical Act 1971. The word “Hospital” and “Healthcare Facility” are used interchangeably and refer to any premises in which members of the public receive healthcare services. Words denoting one gender shall include the other gender. Words denoting a singular number shall include the plural and vice versa.

Adopted by the Malaysian Medical Council on 20/06/2023

CONTENTS

Guidelines for Audio and Visual Recordings in Medical Practice

A. Introduction

1. Technological advancements have made it easier to record, copy, store and transmit recordings of patients. These technologies have been and continue to be used to improve diagnosis and treatment, and in the process, improve communication and the quality of care.

2. Practitioners need to always bear in mind that such recordings form a part of the patient's medical record and are subject to the same standards of confidentiality and consent.

3. The Malaysian Medical Council's (MMC) "Code of Professional Conduct" states "A practitioner may not improperly disclose information which he obtained in confidence from or about a patient."

4. Details of this duty are found in the MMC's guidelines on "Confidentiality" which states *"Patients have the right to expect that there will be no disclosure of any personal information, which is obtained during the course of a practitioner's professional duties, unless they give consent. The justification for this information being kept confidential is that it enhances the patient-doctor relationship. Without assurances about confidentiality, patients may be reluctant to give doctors the information needed in order to provide good care.*

   The professional duty of confidentiality covers not only what a patient may reveal to the practitioner, but also what the practitioner may independently conclude or form an opinion about."

5. The Principles of Confidentiality are:

   a. *When a practitioner is responsible for confidential information, the practitioner shall ensure that the information is effectively protected against improper disclosure when it is disposed of, stored, transmitted or received;*

   b. *When patients give consent for disclosure of information about themselves, the practitioner shall ensure that they understand what will be disclosed, the reasons for disclosure and the likely consequences;*

c. *The practitioner shall ensure that patients are informed that information about them are likely to be disclosed to others involved in their health care, and that they have the opportunity to withhold permission;*

d. *The practitioner shall respect requests by patients that information should not be disclosed to third parties, except in exceptional circumstances (for example, where the health or safety of others would otherwise be at serious risk);*

e. *The practitioner shall only disclose such relevant confidential information for a specific purpose;*

f. *Any information given to health care providers or any concerned third party is done on the understanding that it is given to them in confidence, which must be respected;*

g. *The practitioner shall anonymise data where unidentifiable data will serve the purpose.*

h. *The practitioner shall seek patients' expressed consent to disclosure of information, where identifiable data is needed for any purpose other than the provision of care or for clinical audit, save in the exceptional circumstances described in this guideline. Any disclosure of confidential information shall be in accordance with the requirements of statute and common law.*

i. *If a practitioner decides to disclose confidential information, the practitioner must be prepared to explain and justify the decision.*

These principles apply in all circumstances."

6. Valid consent has to be obtained prior to the capturing, copying, storing and transmission of recordings of patients. The components of valid consent are:

    a. The patient must be competent;
    b. Consent must be given voluntarily; and
    c. The patient must be given sufficient information to make a decision.

7. This guideline provides more detailed advice about the compliance to the principles of confidentiality and consent when making or using visual or audio recordings of

patients. It covers all audio and visual recordings made in healthcare facilities or services in Malaysia or abroad. It applies equally to new technologies and to the more conventional processes of recording and transmitting images of patients.

8. The practitioner may be subjected to disciplinary action if there is failure to adhere to this guideline.

B. Recording

9. The word “recording” means the originals or copies of audio recordings, video recordings, photographs and other visual images of patients made by any recording device, which includes mobile telephones and webcams.

C. Principles of Audio and Visual Recordings

10. The practitioner shall respect the patient's autonomy whenever recordings are made or used. This means that the following apply in respect of:

    a. Patients

        i. The recording shall not compromise a patient’s privacy or dignity;
        ii. The patient shall be provided with information he or she wants or needs to know about the purpose of the recording;
        iii. The recording shall only be made after valid consent has been obtained except in the circumstances listed in this guideline;
        iv. Good medical practice dictates that consent should only be obtained for a specific single purpose and not an overarching general purpose. The patient shall be informed whether the recording is for investigation and/or treatment and will be part of the medical records only; or teaching, training or research; or publication or for medico-legal purposes. The consent form shall specify the purpose of the recording.
        v. A patient shall not be subjected to any pressure to consent to the recording.

    b. Practitioners

        i. The recording shall not be made against a patient’s wishes;
        ii. The recording shall not be used for purposes outside the scope of the original consent unless the patient has given further consent

prior to the additional use of the recording;

iii. The recording shall not harm a patient;

iv. The recording shall be stopped immediately upon a patient's request or if it appears to be having an adverse effect on the patient's management;

v. The recording shall be stored in a secure environment;

vi. The practitioner shall not participate in any recording made against a patient's wishes

11. The practitioner shall be responsible for obtaining the patient's consent to the recording. It is good practice to obtain written consent but where this is not practicable, the patient's consent shall be documented in the patient's medical records.

12. After a recording has been made, the patient should be given the opportunity to view it, and to withdraw consent for its future use or to specify the kinds of contexts in which it may be used.

13. The practitioner shall accede to a patient's request for a copy of the recording.

14. When a recording is requested by a patient or the patient's representative, any health care facility or any other body, except those whose authority to record is granted by existing statute, it shall only be done with the expressed consent of the practitioner.

15. Any recording given to a patient or patient's authorized representative shall be duly acknowledged by the patient and/or the patient's authorized representative.

D. Recordings that are part of the medical records in the care or treatment of a patient

I. Recordings for which separate consent is not required

16. Where a practitioner has obtained a patient's consent for care or treatment where recordings are part and parcel of the services, separate consent is not necessary. Example of such recordings include:

a. x-rays, ultrasound and other images;
b. endoscopy images;
c. images of pathology slides; and
d. Recordings of organ or foetal function e.g. electrocardiogram, cardiotocograph.

It is good practice to inform a patient that such recordings are being made as part of care or treatment.

17. There may be recordings of the care or treatment of a patient that can be used for teaching, training or research. Such recordings can be used without a patient's additional consent provided the patient had given prior consent as part of care, and the recordings are anonymised, before use, by the removal of any patient identification.

II. Recordings for which separate consent is required

18. Except for the type of recordings listed in paragraph 16, the practitioner shall obtain a patient's consent to make any recording as part of the care or treatment of a patient. The practitioner shall provide an explanation to a patient why a recording would assist their care or treatment, what form it will take and an assurance that it will be stored securely.

19. As recordings made for clinical purposes constitute part of a patient's medical record, it should be treated in the same way as any other part of the medical record. The MMC's guidelines on *Confidentiality* shall be complied with whenever recordings are disclosed or published especially when the patient can be identified. In addition, the practitioner shall obtain the patient's consent prior to any disclosure or publication. Wherever practicable, the practitioner shall inform the patient of any secondary uses of the recording when consent is sought. The practitioner shall document the discussion with the patient in the patient's medical records.

E. Recordings for purpose of teaching, training and research

I. Planned recordings

20. The practitioner shall obtain consent from a patient prior to making recordings for teaching, training or research, other than in the circumstances described in paragraphs 16 and 33 to 41.

21. The information to be provided when the practitioner seeks consent from a patient will vary according to the nature of the recording and the concerns of the individual patient. The practitioner shall provide an explanation to the patient about:

    a. the purpose of the recording; and
    b. how the recording will be used; and
    c. how long the recording will be kept; and
    d. who will have access to the recording.

22. The practitioner shall inform the patient that the quality of care provided will not be affected irrespective of whether consent is given for the recording or not.

23. The practitioner shall also inform the patient that he or she may withhold consent, or withdraw consent during or immediately after the recording.

24. The information provided to patients shall be in a manner that they can understand. The patient's questions shall be answered as honestly and as fully as is possible.

II. Unplanned recordings

25. There may be situations when no recording has been planned but an unexpected event occurs, the recording of which would be of educational value. Wherever possible, consent should be sought from the patient or another person who has legal authority to act on behalf of the patient.

26. If consent cannot be obtained e.g. the patient is unconscious, semi-conscious or is under sedation and no person of legal authority is available, the recording may be made but the patient must be informed as soon as is possible about the recording and his or her consent sought before its use. The recording should be stopped immediately if the patient's partner, relative or other person close to the patient makes such a request.

27. After making such a recording, the practitioner shall ensure that:
    a. the patient is given an opportunity, as soon as it is practicable, to view the recording in the form that it will be shown;
    b. obtain the patient's consent for its use;
    c. the recording is used solely for the specific purpose for which the patient has given consent;and
    d. the recording is erased or destroyed as soon as possible if the patient withholds or withdraws consent.

28. If the patient does not recover capacity, the practitioner shall seek consent from a person with the legal authority to act on behalf of the patient for the recording to be used.

29. If there is no one with legal authority to make decisions on behalf of the patient, the recording may be used provided it is anonymised.

III. Existing collections used for teaching and training

30. Some practitioners have collections of recordings which were made prior to the issuance of the first version of this guideline in 2010 and which are used solely for the teaching of medical students, nurses and other health care professionals. The recordings in these collections may be invaluable for educational purposes but there may be no record of whether consent had been obtained.

31. Such recordings may be used provided they are anonymised. Where practicable, they should be replaced as soon as possible with recordings where consent has been obtained.

32. The practitioner shall not use recordings where:
    a. it is clear from the context that consent had not been obtained, or
    b. the patient can or may be identified.

F. Recordings of patients who lack capacity

I. Recordings made as part of the medical records in the care or treatment of a patient

33. If a patient lacks the capacity to decide about care or treatment, which involves a recording, the practitioner shall obtain consent from anyone who has legal authority to make a decision on the patient's behalf prior to making the recording.

34. If no one has legal authority to make a decision on a patient's behalf, recordings may be made provided they form an essential part of care or treatment.

II. Recordings for research purposes

35. The practitioner may make a recording of a patient who lacks capacity as part of research related to the patient's incapacity, or conditions associated with the patient's incapacity and which may either benefit the patient, or contribute to the knowledge or understanding about the patient's incapacity.

36. The practitioner may record patients receiving emergency care, where the recording is an essential part of research into procedures or treatments used in emergencies provided consent has been obtained from the patient or a person with legal authority to consent on the patient's behalf.

III. Recordings for the purposes of teaching or training

37. The practitioner may record a patient who lacks capacity for the purpose of teaching or training provided that:
    a. a recording of a patient who has the capacity to consent would not fulfill the same purpose; or
    b. less intrusive means of information collection are not available.

38. Prior to making the recording, the practitioner shall obtain consent from the person who has legal authority to make decisions on the patient's behalf.

39. Wherever practicable, the practitioner shall explain to the patient what is going to happen. The practitioner shall stop the recording if the patient objects verbally or indicates so, or if the practitioner believes, or someone close to the patient states that the patient is distressed.

40. The practitioner shall ensure that all reasonable steps are taken to anonymise the recording prior to the disclosure of the recording. The practitioner shall ensure that access to the recording is limited to the least number of people compatible with the purpose and that there is protection of the recording from further or inappropriate disclosure.

41. The practitioner shall not participate in making recordings of patients who lack capacity where the patient may be harmed or distressed by the making of the recording; its disclosure or use.

G. Recordings involving a Child or Younger Person

42. The Child Act 2016 defines a child as a person under the age of 18. It also allows only parent(s) and court Legal Guardians to give consent.

43. When making recordings of a child, consent must be obtained from the Parent(s) or legal Guardian. In addition, a child aged 7 years and above must also give assent. If the child declines to give assent, no recordings should be made, although the Parent/Legal Guardian may have consented.

44. An exception to 43 can be allowed if the child has diminished capacity to understand, example with mental retardation or severe Autism.

H. Deceased patients

I. Recordings made when the patient was alive

45. The practitioner shall comply with the patient's wishes regarding the use of the recording, if it is known. For example, if a patient, when alive, gave consent to a recording for a specific purpose, like teaching or training, the recording may be used in accordance with the patient's consent.

46. If a recording gets into the public domain, and the patient is identifiable, the practitioner shall consult the patient's family. Where the recording includes information about a genetic condition, or about the patient's family, they may have a right to stop its use. It is good practice for the practitioner to seek legal advice in such a situation.

II. Post mortems

47. Recordings form an essential part of a post mortem and separate consent is not needed for the taking photographs of organs, body parts, or pathology slides. The images should be anonymised before use for any purpose outside of any medico-legal indication for the post mortem.

I. Recordings for use in the print and electronic media

48. The practitioner shall obtain consent from the patient prior to making recordings, where the recording will be publicly accessible, irrespective of whether the patient is identifiable from the recording or otherwise.

49. The practitioner, who is involved in recording a patient for use in the print and electronic media, shall satisfy himself or herself that patient's consent has been obtained in accordance with this guideline.

50. The practitioner shall confirm with the patient that he or she understands that, once the patient has agreed to the recording, he or she may not be able to withhold consent for its subsequent use. If the patient wishes to restrict the use of material, he or she should get written agreement from the film producer and/or the owners of the recording, prior to commencement of the recording.

51. The practitioner should be especially vigilant in recordings of patients who may be vulnerable to intrusions in their privacy and dignity e.g. patients who are physically or intellectually challenged. If the practitioner believes that the recording is intrusive or damaging to the patient's interests, the practitioner shall raise the matter with the patient and/or the producers, although the patient has consented to the recording. If

concerns remain, the practitioner should do his or her best to stop the recording and withdraw co-operation.

Patients who lack capacity to consent

52. Where a patient lacks capacity to decide about a recording, paragraphs 33 to 41 should be adhered to.

53. The practitioner shall satisfy himself or herself that disclosure is in the public interest, if there is no person who has legal authority to consent on the patient's behalf. This means that the benefits to an individual or to society of the disclosure outweigh both the public and the patient's interest in keeping the information confidential.

J. Covert recordings

54. Covert recordings are prohibited unless there is no other way of obtaining information that is necessary to protect someone from serious harm or to investigate or prosecute a serious crime.

55. If covert recordings are considered, the practitioner is advised to obtain consent from a person who has legal authority, if possible; to seek legal advice and to discuss this with senior colleagues.

K. Telephone calls

56. The practitioner shall not secretly record telephone calls from patients.

57. If the practitioner wants to make recordings, the practitioner shall inform patients and callers that their telephone calls are being recorded and the reasons for the recording, how long the recordings will be kept and how they can be accessed.

58. It is good practice to maintain a record of the means by which callers have been informed.

L. Recordings made by patients or accompanying persons

59. With the ubiquitous camera in mobile phones, it is becoming increasingly common for patients or accompanying person(s) to make recordings of their consultations. Such recordings by itself do not breach patient confidentially ethical guidelines if performed by the patient, or with the patient's knowledge and permission.

60. Such recordings may be done secretly, or in the open. While such actions does not

breach patient confidentiality, it does involved a counter party, the medical practitioner, who is also entitled to his own privacy. If the practitioner feels uncomfortable about potential secret recordings, he can put a notice to advice patients and accompanying persons that there is no objection, but they should indicate they are making recordings. From a patient confidentiality point of view, it is within the patient's right to make such recordings, which help them in remembering details of the consultation. However, it should be done with consensual agreement. If the practitioner suspects a patient is covertly recording, the practitioner should discuss the issue with the patient and explore the reasons for the recording. If the practitioner feels uncomfortable with the continued recording, he can request the patient to stop the recording, or if the patient insists, terminate the consultation and refer on the patient appropriately.

61. These recordings may however also capture information about other patients, and this can potentially compromise their confidentiality. The practitioner should make sure such breach does not happen when patients make recordings by ensuring adequate privacy during the consultation. If such breaches cannot be assured to be avoided, the practitioner may decline the patient's request to record the consultation.

62. It is wise for the practitioner to request a copy of such recordings, and it be placed with the patient's medical records.

References

1. Malaysian Medical Council (1987) Code of Professional Conduct
2. Malaysian Medical Council (2001) Good Medical Practice
3. Malaysian Medical Council (2008) Confidentiality
4. General Medical Council (2002) Making and using visual and audio recordings of patients.
5. General Medical Council (2009) Making and using visual and audio recordings of patients. Consultation document.
6. The Child Act 2001 (2016)
7. https://www.bma.org.uk/advice-and-support/ethics/confidentiality-and-health-records/patients-recording-consultations

Acknowledgements

General Medical Council for permission to use excerpts from its guidance Making and using visual and audio recordings of patients (2002) and its Consultation document, Making and using visual and audio recordings of patients (2009).

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The review of all guidelines shall not exceed five (5) years.