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Clinical Photography in UK Podiatric Practice A Narrative Review of Consent, Confidentiality and Safe Image Handling

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Review

Clinical Photography in UK Podiatric Practice A Narrative Review of Consent, Confidentiality and Safe Image Handling

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Abstract

A clinical photograph can show changes that are difficult to describe in words. In podiatry, images help document wounds and skin lesions, support referrals and compare progress over time. They also create a lasting record that may identify the patient, even when the face is absent. This narrative review brings together UK legislation, professional guidance and selected literature to explain how photographs should be taken, stored and used. The starting point is the intended purpose. Agreement to a photograph for care does not automatically permit teaching, research, publication or promotion, and the patient's agreement is distinct from the organisation's data-protection basis for processing the image. The proposed framework covers the patient discussion, image capture, record linkage, storage, secondary use and audit. Its practical message is simple: a clinical photograph needs the same care as the rest of the patient's health record.

Keywords: clinical photography; consent; confidentiality; UK GDPR; health records; smartphones; podiatry; patient images

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Key messages

- Start with the purpose of the photograph, then apply the relevant legal duties, professional guidance and local policy.
- Explain the proposed use and record the patient's decision. The organisation must separately document its Article 6 lawful basis and Article 9 condition.
- Photographs taken as part of care belong in, or must be reliably linked to, the clinical record.
- Do not assume that agreement to photography for care permits teaching, research, publication or promotion. Assess each proposed use and record the permission or other valid authority it requires.
- Check the whole route from camera to record. An approved device is only one part of a secure process.

Introduction

A good clinical photograph often conveys what a paragraph of notes cannot. It can show the shape of a lesion, the extent of a wound or the appearance of a surgical site, and give a colleague useful context for an onward referral. Serial images are particularly helpful when reviewing diabetic foot ulcers, postoperative wounds, Charcot neuroarthropathy, nail pathology, toe deformity and vascular change. Their value depends on taking comparable views rather than simply accumulating pictures. Digital ulcer measurement has been studied directly, although these studies do not establish the value of every indication listed here [1,2].

The current ease of taking a photograph can obscure what happens to that image next. An image may remain in a phone's camera roll, enter a personal cloud backup or be forwarded through a messaging service. Excluding the face does not guarantee anonymity: a tattoo, scar, unusual deformity or detail in the room may identify the patient [3-7]. These risks need to be considered before capture, while the clinician can still control the frame and the route into the record.

Clinicians asking what they may photograph will not find the answer in a single UK rulebook. It depends on the purpose, the storage system, the audience and any proposed later use [8-17]. Data-protection law, confidentiality, professional standards and records policy all apply. This article draws those requirements together; unusual or disputed

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cases may need advice from the organisation's information-governance lead, data-protection officer, Caldicott Guardian or legal adviser.

Terminology Used in This Article

- Agreement to photography: the patient's informed decision to allow a photograph for the stated clinical purpose
- Data-protection lawful basis: the Article 6 basis identified by the organisation for processing personal data
- Special-category condition: the Article 9 condition identified for processing health information
- Consent for secondary use: purpose-specific permission for teaching, publication or promotion where required

Methods and Scope

This article draws on a targeted narrative review of UK legislation, official regulatory and professional guidance, and selected peer-reviewed literature relevant to clinical photography. Authoritative sources were sought through legislation.gov.uk, the Information Commissioner's Office (ICO), the Health and Care Professions Council (HCPC), the General Medical Council (GMC), NHS England and the International Committee of Medical Journal Editors. PubMed and Google Scholar were searched using combinations of terms for clinical or medical photography, consent, confidentiality, health records, smartphones, UK General Data Protection Regulation (GDPR), information governance, podiatry, diabetic foot, wound photography and digital wound measurement. Reference lists of key guidance and review articles were also checked. No publication-date restriction was applied at the search stage; the final selection was limited to English-language material that was directly relevant to the article's legal, professional or practical scope. Searches were completed on 20/21 September 2026. The GMC provisions on care recordings and public-media consent were checked again during article revision on 9 October 2026.

The review prioritised current UK legislation and guidance from statutory bodies and professional regulators. Peer-reviewed studies were selected to illustrate clinical, technical and patient-perspective issues rather than to estimate an intervention effect. Where NHS operational guidance was specific to England, this is stated, and readers are directed to the corresponding national requirements in Scotland, Wales or Northern Ireland. This was not a systematic review: no protocol was registered, duplicate screening was not undertaken, and no formal risk-of-bias assessment was performed. The following discussion focuses mainly on still photography, although many principles also apply to video capture. Covert surveillance, forensic work, police requests and documentation following sexual assault fall outside its scope. Research governance is not reviewed in detail, but research remains in the purpose framework because reuse of clinical images requires a distinct pathway. The proposed framework supports local policy; it does not replace advice on a particular organisation or case.

The Governing Framework in the United Kingdom

Data Protection

An identifiable clinical photograph is personal data under the UK GDPR and Data Protection Act 2018. An image that reveals health information is also special-category data [8-11]. The Data (Use and Access) Act 2025 amended parts of the framework without replacing those laws; organisations should check current ICO guidance and its update notices. Some ICO guidance remains under review following the Act [10,11,18]. The controller therefore needs both an Article 6 lawful basis and an Article 9 condition. These are organisational decisions. They are separate from the clinician's conversation with a patient about whether a photograph may be taken for care. For necessary processing for diagnosis, treatment or the provision or management of healthcare, Article 9(2)(h) may apply, alongside Schedule 1, paragraph 2 of the Data Protection Act 2018 and the professional-secrecy safeguards in Article 9(3). An appropriate Article 6 lawful basis must still be identified separately [8,9,11].

Signing a form does not settle how the image should be handled. Fairness, transparency, purpose limitation, data minimisation, retention, security and accountability still apply [9-11]. Patients need a clear explanation of the proposed use and accessible information about how their images will be managed [12-15].

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Confidentiality and Professional Duties

The common-law duty of confidentiality applies where information is given in circumstances that create a reasonable expectation of confidence. Regulators reinforce that obligation. HCPC standards require registrants to obtain valid consent or other appropriate authority, maintain confidentiality, keep full, clear and accurate records, complete records promptly and protect them from loss, damage or inappropriate access [12,13]. HCPC standards provide the directly applicable regulatory framework for HCPC-registered podiatrists. GMC guidance is used here as a detailed professional reference on patient recordings, rather than as a standard issued by the podiatry regulator. It distinguishes recordings made as part of care from recordings intended for another purpose and addresses consent, privacy, dignity and secure handling [14,15]. These professional standards do not replace legislation, but they help define acceptable conduct and may be relevant in fitness-to-practise proceedings.

Records Management and Organisational Accountability

In England, the Records Management Code of Practice 2021 is the main NHS reference for managing health and care records. GMC guidance states that a recording made as part of care forms part of the medical record and should be treated in the same way as other records [14-16]. It should therefore be stored within, or reliably linked to, the health record. Unless stated otherwise, NHS operational guidance cited here is drawn principally from England. Readers in Scotland, Wales and Northern Ireland should apply the relevant national records-management, information-governance and capacity requirements. Local policy should define responsibility for devices, capture software, transfer, storage, backup, deletion, incidents and disclosure.

Purpose Determines the Governance Pathway

Table 1 summarises the principal governance pathway for each purpose; local services should adapt it to their legal setting and policy [8-17,19].

Purpose	Typical justification	Minimum permission and governance	Principal caution
Direct clinical care	Diagnosis, monitoring, treatment planning, referral or continuity of care	Explain purpose and intended sharing; record agreement or other appropriate authority; use approved capture and record systems	Do not assume that a care image may be reused for teaching or publicity
Clinical governance	Audit, incident review, complaint or service evaluation	Use the minimum necessary information; prefer robust anonymisation where feasible; where identifiable, establish a valid authority and follow local governance arrangements	Governance use may still be identifiable processing
Education and assessment	Teaching clinicians or students, examinations, portfolios	Prefer genuinely anonymised material where it can meet the purpose. If only de-identified or pseudonymised, assess identifiability, confidentiality and data-protection requirements; obtain specific consent or another valid authority where required [9-11,14,25].	Cropping may not prevent recognition from rare features or context
Research	Research protocol, dataset development or validation	Follow the approved research protocol, information-governance arrangements, transparency requirements, data-management plan and applicable ethics or research approvals; identify an appropriate Article 6 basis and Article 9 condition	Consent to clinical photography alone does not authorise research use

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Purpose	Typical justification	Minimum permission and governance	Principal caution
Publication and presentation	Journal, conference, textbook or professional website	New public-media recordings: usually written consent, whether identifiable or not, subject to specified exceptions. Existing care recordings: consent if identifiable or potentially identifiable; genuinely anonymised recordings may be published when seeking consent is impracticable. Follow publisher and local requirements [14, paragraphs 37-38; 20].	Withdrawal may not retrieve copies already disseminated
Marketing and social media	Promotion, testimonials, campaigns or public posts	Obtain separate, freely given, specific permission; follow organisational communications approval and approved-platform requirements	Power imbalance and public re-identification make this high risk

Research Use

Clinical images used for research should follow an approved protocol and the organisation's research and information-governance arrangements. The controller should identify the relevant Article 6 lawful basis and Article 9 condition, provide appropriate transparency information, define access, retention and data-management controls, and obtain ethics or other research approvals where applicable. Agreement to photography for clinical care does not by itself authorise inclusion in a research dataset, and de-identification should be assessed in the context of the data and linkage risks [9-11,20].

Patient Agreement, Consent and Capacity

Before reaching for the camera, explain why the photograph would help and what it will show. Tell the patient who is likely to see it, where it will be stored and whether it will be shared outside the organisation. Explain the consequences of declining, if any, without putting pressure on the patient [12-15]. Record the purpose, the decision and any limits. A note that says only "consent obtained" leaves the next clinician guessing what was agreed. This clinical discussion is distinct from the organisation's documentation of its lawful basis and special-category condition [8-15].

Capacity relates to the particular decision at the time it is made. In England and Wales, clinicians must follow the Mental Capacity Act 2005 when an adult may lack capacity; different statutory frameworks apply elsewhere in the UK. The photograph should be necessary and proportionate to the person's care or another authorised purpose, and any best-interests decision should be recorded. A relative cannot consent for an adult merely because of the relationship; the person must have the relevant legal authority [21,22]. With children and young people, clinicians should consider the child's competence, parental responsibility, the child's views, safeguarding and the sensitivity of the body area and intended use [23].

Patients should know what changing their mind can achieve. They can decline further photography and withdraw permission for a proposed secondary use. A photograph already forming part of the clinical record may still need to be retained for care, accountability or legal reasons [14-16]. Once an image has been published, it may be impossible to retrieve every copy. Explain these limits before asking for a decision [14,20].

Capture Devices Transfer and Storage

A well-designed system sends the image from an approved camera or clinical app into the correct patient record, without leaving copies in a personal gallery, cloud backup or messaging history [4,6,14,16,24]. Device ownership alone is a poor guide to safety. The service needs to know what happens at each stage, including transfer and deletion. One emergency-department app study cannot establish the safety of personal-device photography in general [6].

Use transfer channels approved for clinical images. Before approving a system, check who can see the photographs, where copies are held, how long they remain and how deletion or an incident will be handled [16,17,24]. Encryption is

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useful, but it does not answer these other questions. Camera rolls, recently deleted folders, backups and chat histories all need attention.

A Minimum Standard for Clinical Image Capture

The following steps provide a practical capture standard based on the duties discussed above [3,4,12-17,19,24].

1. Confirm patient identity using the organisation's usual identifiers and verify the anatomical site, side and purpose.
2. Remove unrelated people, documents, screens and distinctive background objects from the frame.
3. Capture the least identifying field that still answers the clinical question; include wider orientation and close-up views only when both add value. Figure 1 illustrates unnecessary inclusion of the patient's face when the foot is the intended subject.
4. Use consistent patient position, camera angle, focal distance, lighting and background for serial comparison.
5. Where dimensions matter, use an approved measurement scale in the same plane as the lesion or wound; follow infection-prevention requirements.
6. Avoid filters, portrait modes and automatic enhancements that could change colour, texture or margins. This is a technical recommendation of the present review. If cropping or annotation is necessary, preserve the original.
7. Check focus, exposure, colour fidelity and completeness before ending the encounter, while minimising unnecessary repeat images.
8. Transfer promptly to the approved record, confirm successful association with the correct patient and encounter, and remove any residual local copy through the approved process.



Figure 1. Over-inclusive framing during clinical photography. The patient's face and surrounding room are captured even though the foot is the intended clinical subject. The field should be restricted to the minimum area required for the clinical purpose (note – this is an AI-generated image and does not show an actual patient).

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The Minimum Image Record

Table 2 proposes a minimum dataset for local adoption, informed by professional and records guidance; it is not an externally validated standard [12,14,16].

Record element	Recommended content	Governance purpose
Patient linkage	Approved unique patient identifier in the record system, not necessarily visible within the image	Preserves provenance and reduces misfiling risk
Date and time	Capture date and time, generated reliably by the approved system	Supports chronology and audit
Author	Name or unique identifier of photographer and responsible clinician where different	Establishes accountability for capture and interpretation
Clinical context	Purpose, anatomical site, laterality, orientation and relevant episode	Makes the image clinically intelligible
Permission record	What was explained, agreed purpose and any limitations or withdrawal discussion	Shows the scope of agreement and any restrictions
Technical context	Scale or calibration method where measurements or colour comparison are material	Supports valid serial comparison and measurement
Alteration	Any crop, annotation or processing; retain the source image under local policy	Protects evidential integrity and distinguishes derivatives
Disclosure	Recipient, purpose, method and date for transfers outside the usual care record	Provides an audit trail for onward sharing

De-Identification Metadata and Emerging Technologies

A photograph without a face or name may still be recognisable. A tattoo, scar, rare presentation or accompanying clinical story can be enough [3-5,7]. Figure 2 illustrates this problem. Metadata may also contain the capture time, location or device details [3,4]. Approved systems should control that information while preserving what is needed to establish the image's origin. Anonymisation depends on context and on the means reasonably likely to identify the person. Record the assessment and revisit it when the data or technology change. Pseudonymised images remain personal data [9-11,25]. Removing names or replacing identifiers with a code does not necessarily anonymise an image. If the patient remains identifiable through a retained linkage, distinctive features or accompanying information, it must continue to be handled as personal data [9-11,25].

Do not upload patient images to public or unapproved AI services. Using AI to analyse, enhance or classify an image may send it to a supplier, retain it outside the usual record, transfer it internationally or use it to improve a product. Before deployment, the organisation should examine the service's terms, configuration and data flows, then complete the necessary clinical-safety, procurement, security and data-protection review [9-11,26]. It should record the purpose, lawful basis, access, retention, contracts and transfer arrangements, and complete a data protection impact assessment where required. Clinical decisions remain subject to appropriate human oversight.

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Figure 2. Residual identifiability without a face. A distinctive tattoo may allow a patient to be recognised even when the photograph is limited to the foot and ankle (note – this is an AI-generated image and does not show an actual patient).

Publication Teaching and Social Media

Before reusing a care image, consider the new audience and purpose. Teaching, research and publication have different requirements; removing identifying details does not automatically resolve them [14,15,20,25]. GMC guidance distinguishes photographs made specifically for public media from existing care images. For a new recording intended for widely accessible public media, consent should usually be obtained in writing whether or not the patient is considered identifiable, subject to the exceptions in paragraph 10. For an existing care recording, consent is required if the patient is, or may be, identifiable. If it is genuinely anonymised, seeking consent before publication is good practice; paragraph 38 permits publication without consent where seeking it is impracticable, while warning that complete anonymisation can be difficult [14, paragraphs 37-38]. Publisher requirements and organisational policy must also be followed [20]. Where permission is sought, show the patient the proposed images and accompanying information, explain where they will appear and discuss worldwide, lasting access. Keep the original clinical image separate from the publication copy.

HCPC social-media guidance applies to personal and professional accounts. Identifiable information about a service user must not be posted without permission, and privacy settings cannot prevent wider circulation [27]. Both patient permission and an approved organisational process are needed where applicable. Neither compensates for the absence of the other. Requests to use images for promotion deserve particular care: a patient asked by their treating clinician may feel obliged to agree. Make clear that refusal will not affect their care.

Clinical Photography in Podiatry and Wound Care

Photographs of the foot and lower limb may seem less identifying than facial images, yet tattoos, deformity, amputation, rare disease, the home environment or handwritten labels can reveal identity [3-7]. Their clinical value depends on consistency. Services should agree standard views for common conditions, with clear laterality, foot position, camera distance, background, lighting and use of a scale. In bilateral disease, careful labelling helps prevent

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laterality errors. For wound measurement, the camera should be positioned as close as practicable to perpendicular to the wound plane, with calibration markers in the same plane; oblique views, curved surfaces and inconsistent calibration can introduce material error [1,2]. Measurement scales must be used without contaminating the wound field. Images sent for specialist advice should use an approved referral or telemedicine route and include the relevant history and examination findings [14,16,17,24]. A photograph cannot establish temperature, sensation, odour, pain, systemic illness, vascular status or probe-to-bone findings. Patient-supplied images also need reliable identification and secure transfer; differences in angle, lighting, focus and scale can make comparisons misleading. A clear image is useful, but it cannot replace clinical context or justify delaying urgent assessment or referral.

Proposed Organisational Policy Requirements

The following policy framework is based on the sources reviewed and should be adapted to the organisation's setting and risk profile [8-17,19,24,26].

- Define the scope, including employees, contractors, students, images supplied by patients and every permitted capture device.
- Distinguish the requirements for care, audit, teaching, research, publication and promotion.
- Specify approved equipment, applications, transfer routes, repositories and arrangements for downtime.
- Set out consent and capacity procedures for adults and children, including intimate images and requests to withdraw permission.
- State the required standards for patient identification, image quality, clinical metadata, editing and version control.
- Apply role-based access, audit logs, retention periods and secure disposal in line with the records policy.
- Explain how disclosure, remote consultation, transfers between organisations and subject-access requests will be handled.
- Prohibit unapproved personal storage, cloud synchronisation, messaging and social-media use.
- Provide training, assess competence, report incidents and audit practice regularly.
- Govern the use of AI, automated analysis, external vendors and reuse of image datasets.

Audit Standards

Table 3 offers starting points for local audit, rather than validated performance thresholds. Services should adapt them to their risks, systems and baseline performance. A target of 100% means that each exception needs review and corrective action; it does not imply that every control can always be verified technically.

Indicator	Illustrative local target	Audit data source
Defined clinical purpose recorded	≥95%	Clinical record review
Patient agreement or lawful exception documented	≥95%	Clinical record and consent record
Correct patient, site and laterality linkage	100%; review every exception	Image repository and record
Capture and transfer through an approved workflow	100%; review every exception	System logs and device audit
No residual image on unapproved device after verified transfer	100%; review every exception	Device/process audit
Secondary use supported by documented purpose-specific permission or other valid authority, with applicable governance approval	100%; review every exception	Publication/education register

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Indicator	Illustrative local target	Audit data source
Staff training current	≥95%	Training records
Incidents reviewed and actions completed	100%; review every exception	Information-governance incident log

Discussion

In practice, it is easy to give the consent form more weight than it can bear. A patient may understand and agree to a photograph, yet the image may still end up in an unsuitable cloud account or be reused for a purpose never discussed [8-17,24]. The reverse problem is also possible: an organisation may have a lawful basis to hold a care image, but the clinician may have failed to explain the photography or protect the patient's dignity [12-15]. Both the conversation and the handling of the image matter.

Asking why the photograph is needed makes these decisions easier. A care image should be managed within the clinical-record system [14-17]. Using it later in a lecture, research dataset, journal or promotional post requires a fresh assessment and, where required, specific permission [14,15,19,20]. Appendix 1 provides a short form to record agreed uses. It keeps optional uses separate from care and leaves space to identify the actual images, audience and publication channels.

The available evidence is uneven. Much of the published work comes from dermatology, plastic surgery, emergency medicine or non-UK settings, so it provides context rather than authority for UK legal obligations [3-7]. Within the literature selected for this review, the most directly relevant podiatric evidence concerned diabetic-foot ulcer assessment and wound-area measurement. These studies support serial assessment but show that camera angle, calibration, surface curvature and acquisition technique affect validity [1,2]. This narrative selection does not establish the relative strength of evidence across all podiatric applications. Technical practice also changes faster than conventional publication. UK guidance is spread across regulators and health systems, with some variation between the four nations. Further study is needed on patient preferences in different specialities, managed smartphone systems, reproducible podiatric photography standards and the governance of AI-assisted image analysis.

Conclusions

Clinical photography is most useful when the purpose is clear, the patient understands the proposal, and the images are technically consistent. The responsibility continues after the shutter is pressed: the photograph needs a secure route into the correct record and controls on access, retention and later use [8-17,19,24,26]. Services should make those steps straightforward for staff. In podiatry, a reliable series of comparable images can support clinical judgement; a collection of poorly framed or inconsistently taken photographs may add little.

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Appendix A. Consent for Digital Clinical Photographs

Complete with the patient. Mark Yes or No for each use; an unmarked use is not authorised by this form.

Patient and photographs	
Patient name and DOB	
Record number and photo date	
Body site and side / image IDs	
Practice and clinician	
Uses I agree to	
Photography for assessment and my confidential health record	☐ Yes ☐ No
Secure sharing with professionals involved in my care	☐ Yes ☐ No
Closed teaching or training session	☐ Yes ☐ No
Conference presentation	☐ Yes ☐ No
Public online or recorded presentation	☐ Yes ☐ No
Journal, book or other publication	☐ Yes ☐ No
Practice website, social media or marketing	☐ Yes ☐ No
Optional uses and limits	
Audience, event, publication or platform; public / recorded access	
Agreed caption and limits; features that may identify me	
I have seen images and wording for public use	☐ Yes ☐ N/A
What I understand	
The purpose and storage have been explained and I can ask questions. I may decline photography; the clinician will explain any implications for assessment or treatment and available alternatives. Refusing optional teaching, publication or promotional use will not affect my care.	
Images are held securely under the records policy. Care images may need to be retained after withdrawal. Public images may be seen worldwide and copied; removing details cannot guarantee anonymity. I can withdraw permission for future optional use, but published copies may not be recoverable. The practice will stop further authorised use and remove material it controls where possible.	
Privacy and withdrawal contact	Ian Reilly: info@podsurgeon.co.uk
Agreement: I agree to the marked uses within the limits above	
Patient signature / date	
Clinician signature / date	
Copy offered ☐	Review / expiry if agreed:

Staff: retain with the record. Record objections to care sharing and assess confidentiality and local policy. This form does not replace the lawful-basis assessment or govern legally required or otherwise authorised disclosures. Research requires a separate governance pathway, with consent where required or an approved alternative; this form does not authorise research. For children or adults lacking capacity, record competence, assent and legal authority separately. Publisher forms may also be needed.

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