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"I'm Ready for My Close-Up" Ethical Issues in Filming Patients and Staff

A trip to some exotic clime and a chance to win one million dollars may sound more appealing than admission to your local trauma unit or delivery suite, but in either scenario your image could appear in living rooms across America. The burgeoning of "reality TV" includes documentaries and weekly programs featuring interactions between patients and healthcare providers.

Responding to increasing concern about privacy and safety, in June 2001 the American Medical Association's Council on Ethical and Judicial Affairs issued Opinion E-5.045, "Filming Patients in Health Care Settings." These guidelines weigh legitimate educational objectives that filming and subsequent broadcast may achieve against the requirement of informed consent.

The guidelines recommend that dramatic reenactments be considered as an alternative to filming patients who lack decisional capacity. The Council maintains that surrogate consent is insufficient for permission to videotape, since filming provides no medical benefit to the patient and thus lies outside the scope of the surrogate's duty to make decisions that are "medically necessary." (Exceptions may be made in cases where patients are permanently incapacitated and a parent or guardian permits filming.) The AMA's preference for explicit consent from the patient alone may seem overly restrictive, but it highlights an important distinction

between privacy and confidentiality that is frequently overlooked—particularly since the terms are often used interchangeably.

Strictly speaking, confidentiality entails keeping information about patients within proper bounds. Privacy involves bodily integrity and protection of the patient's person and physical space. Protocols that allow filming before consent is obtained may protect confidentiality by permitting patients to prohibit use of the footage and require its destruction. But the breach of privacy has already occurred because the patient did not consent to be viewed for the purpose of filming. The unauthorized viewing may be forgiven, but the patient cannot be "unviewed." The fact that it was captured on film goes to the issue of compounding harm, not whether harm has occurred.

Without referring explicitly to the established notion of consent as a process and not merely an event, the guidelines follow that paradigm by providing that patients who initially consent to filming may later request that it be stopped and that the crew leave. The AMA recommends continuation of this right to revoke consent until "a reasonable time period" before public broadcast, presumably to provide time for reflection under less stressful and hurried conditions. Even when patients consent to being filmed, their safety comes first; thus providers directly involved in patient

care may require the film crew to leave the treatment area.

The AMA guidelines also include information that patients should be given prior to consent, discuss how consent is obtained, and consider potential conflicts of interest. They recommend, for example, that patients be told whether footage will be destroyed if consent is revoked, and told the extent to which they will be able to view and edit what is selected for broadcast. Permission to be filmed should not be combined with consent required for medical care. In fact, the AMA recommends that a third party unconnected with either the care team or the film crew obtain consent for filming in order to avoid possible conflicts of interest. It also recommends that, prior to filming, members of the crew demonstrate understanding of the confidential nature of health care and their willingness to respect it.

While the AMA policy addresses only the physician's role in filming patients, its guidelines raise important issues for the entire team and institution to consider. For example, in order to avoid conflicts of interest, care providers should not be directly compensated for their participation. Additionally, in order to ensure that potential benefits such as remuneration or good publicity do not overshadow the obligation to safeguard patients, requests to film should not depend on the judgment of a single

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individual, but should be institutionally reviewed and approved.

An important aspect of this issue that is not included in the AMA opinion concerns the willingness or reluctance of care providers to be filmed, and whether, having obtained institutional permission, the film crew should also obtain consent from each individual on the care team. If the latter is not required, may staff members nonetheless opt out? If they may, could resulting difficulties in staffing compromise care? Could institutional approval and/or departmental enthusiasm for filming have a chilling effect on those who would rather not participate but may be reluctant to say so? This possibility should be of particular concern at teaching institutions; consider, for example, the hapless intern or student nurse whose rotation begins on the day of filming.

Attending to our obligations to patients should not obscure legitimate concerns that some staff, particularly those with less power and authority, may feel reluctant to express a preference not to be filmed. There is also the possibility that some viewers will perceive an invasion of privacy even though responsible consent procedures were followed. They might wonder, "If I

were rushed to that hospital, would they film me?" Thus, review of requests to film should consider whether any subsequent broadcast would include a statement that permission was obtained.

Even when these concerns have been adequately addressed, questions may remain about participating in programming that presents human suffering for its entertainment value. News reports usually include information about illness or injury prevention, new medications and procedures, or important safety alerts. Documentaries about specific individuals or medical conditions typically follow a story arc that includes the particulars of individual cases. The new reality programs do neither. Instead, they feature serial presentation of illness and injuries week after week. Do those who consent to be filmed receive their 15 minutes of fame, or does the repetitive content of each episode ultimately undermine their dignity by making them objects of medical voyeurism? While it may be difficult to prove that such programming does lasting harm, perhaps consideration of institutional participation should require more—reasonable anticipation of a positive good for patients and the community.

e-Ethics provides discussion of important ethical issues in clinical care and organizational life. In specific cases, fuller ethical analysis may be required. The discussions in *e-Ethics* should not be construed as legal advice and do not necessarily represent official positions of Advocate Health Care.

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