

### ***3.1.3 Audio or Visual Recording Patients for Education in Health Care***

Audio or visual recording of patients can be a valuable tool for educating health care professionals, but physicians must balance educational goals with patient privacy and confidentiality. The intended audience is bound by professional standards of respect for patient autonomy, privacy, and confidentiality, but physicians also have an obligation to ensure that content is accurate and complete and that the process and product of recording uphold standards of professional conduct.

To safeguard patient interests in the context of recording for purposes of educating health care professionals, physicians should:

- (a) Ensure that all nonclinical personnel present during recording understand and agree to adhere to medical standards of privacy and confidentiality.
- (b) Restrict participation to patients who have decision-making capacity. Recording should not be permitted when the patient lacks decision-making capacity except in rare circumstances and with the consent of the parent, legal guardian, or authorized decision maker.
- (c) Inform the patient (or authorized decision maker, in the rare circumstances when recording is authorized for minors or patients who lack decision-making capacity):
  - (i) about the purpose of recording, the intended audience(s), and the expected distribution;
  - (ii) about the potential benefits and harms (such as breach of privacy or confidentiality) of participating;
  - (iii) that participation is voluntary and that a decision not to participate (or to withdraw) will not affect the patient's care;
  - (iv) that the patient may withdraw consent at any time and if so, what will be done with the recording;
  - (v) that use of the recording will be limited to those involved in health care education, unless the patient specifically permits use by others.
- (d) Ensure that the patient has had opportunity to discuss concerns before and after recording.
- (e) Obtain consent from a patient (or the authorized decision maker):
  - (i) prior to recording whenever possible;
  - (ii) before use for educational purposes when consent could not be obtained prior to recording.
- (f) Respect the decision of a patient to withdraw consent.
- (g) Seek assent from the patient for participation in addition to consent by the patient's parent or guardian when participation by a minor patient is unavoidable.
- (h) Be aware that the act of recording may affect patient behavior during a clinical encounter and thereby affect the film's educational content and value.

- (i) Be aware that the information contained in educational recordings should be held to the same protections as any other record of patient information. Recordings should be securely stored and properly destroyed, in keeping with ethics guidance for managing medical records.
- (j) Be aware that recording creates a permanent record of personal patient information and may be considered part of the medical record and subject to laws governing medical records.

***AMA Principles of Medical Ethics: I,IV,V,VIII***

*Background report(s):*

CEJA Report 3-A-16 Modernized *Code of Medical Ethics*

CEJA Report 2-I-05 Ethics of physician participation in reality television for entertainment

CEJA Report 12-A-03 Filming patients for educational purposes

CEJA Report 3-A-01 Filming patients in health care settings

### **3.1.3 Audio or Visual Recording Patients for Education in Health Care**

Audio or visual recording of patients can be a valuable tool for educating health care professionals, but physicians must balance educational goals with patient privacy and confidentiality. The intended audience is bound by professional standards of respect for patient autonomy, privacy, and confidentiality, *but physicians also have an obligation to ensure that content is accurate and complete and that the process and product of recording uphold standards of professional conduct. [new content sets out key ethical values and concerns explicitly]*

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- (c) Inform the patient (or authorized decision maker, in the rare circumstances when recording is authorized for minors or patients who lack decision-making capacity):
  - (i) about the purpose of recording, the intended audience(s), and the expected distribution;
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  - (iii) that participation is voluntary and that a decision not to participate (or to withdraw) will not affect the patient's care;
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- (f) Respect the decision of a patient to withdraw consent.
- (g) *Seek assent from the patient for participation in addition to consent by the patient's parent or guardian when participation by a minor patient is unavoidable. [new guidance consistent with 2.2.1]*

- (h) Be aware that the act of recording may affect patient behavior during a clinical encounter and thereby affect the film's educational content and value.
- (i) Be aware that the information contained in educational recordings should be held to the same protections as any other record of patient information. Recordings should be securely stored and properly destroyed, in keeping with ethics guidance for managing medical records.
- (j) Be aware that recording creates a permanent record of personal patient information and may be considered part of the medical record and subject to laws governing medical records.

*AMA Principles of Medical Ethics: I,IV,V,VIII*

- (c) advocate for the highest possible level of confidentiality of personal health information whenever clinical information is transmitted in the context of public health reporting;
  - (d) advocate for access to public health services to ensure timely detection of risks and prevent undue delays in the implementation of quarantine and isolation;
  - (e) help to educate patients and the public about quarantine and isolation through the development of educational materials and participation in educational programs;
  - (f) advocate for the availability of protective and preventive measures for physicians and others caring for patients with communicable diseases.
2. Individual physicians should participate in the implementation of appropriate quarantine and isolation measures as part of their obligation to provide medical care during epidemics (see Opinion E-9.067, "Physician Obligation in Disaster Preparedness and Response"). In doing so, advocacy for their individual patients' best interests remains paramount (see Opinion E-10.015, "The Patient-Physician Relationship"). Accordingly, physicians should:
- (a) encourage patients to adhere voluntarily to scientifically grounded quarantine and isolation measures by educating them about the nature of the threat to public health, the potential harm that it poses to the patient and others, and the personal and public benefits to be derived from quarantine or isolation. If the patient fails to comply voluntarily with such measures, the physician should support mandatory quarantine and isolation for the non-compliant patient;
  - (b) comply with mandatory reporting requirements and inform patients of such reports;
  - (c) minimize the risk of transmitting infectious diseases from physician to patient and ensure that they remain available to provide necessary medical services by using appropriate protective and preventive measures, seeking medical evaluation and treatment if they suspect themselves to be infected, and adhering to mandated public health measures.
3. Frontline physicians have an increased ethical obligation to avail themselves of safe and effective protective and preventive measures (for example, influenza vaccine).

(References pertaining to Report 1 of the Council on Ethical and Judicial Affairs are available from the Ethics Standards Group. The Council gratefully acknowledges the following individuals for their contributions to this Report: David Cundiff, MD, MPH, Secretary, American Association of Public Health Physicians; Kevin Sherin, MD, MPH, Vice President, American Association of Public Health Physicians; John Schneider, MD, Chair, AMA Council on Science and Public Health; Jonathan Weisbuch, MD, MPH, Director, Maricopa County (Arizona) Department of Public Health.)

## 2. ETHICS OF PHYSICIAN PARTICIPATION IN REALITY TELEVISION FOR ENTERTAINMENT (RESOLUTION 607, I-04)

### **HOUSE ACTION: RECOMMENDATIONS ADOPTED AS EDITORIALY CORRECTED BY CEJA IN LIEU OF RESOLUTION 607 (I-04) AND REMAINDER OF REPORT FILED**

At its 2004 Interim Meeting, the American Medical Association House of Delegates adopted Resolution 607, "Ethics of Physician Participation in Reality Television for Entertainment." The resolution called for the Council on Ethical and Judicial Affairs "to prepare an opinion on physician participation in television entertainment programs." Concurrently, at its December Open Forum, CEJA addressed concerns arising from television programs' influence on patient expectations regarding medical care and the need for standards to guide physicians' participation in such programs.

## BACKGROUND

Over the last decade, a growing number of reality and dramatized television shows have featured physicians--actual or portrayed--and depicted medical procedures. A surge in televised plastic surgery competitions has raised new questions regarding the appropriate role of physicians vis-à-vis contestants who wish to undergo procedures, such as "complete makeovers."

Among the considerations that participating physicians must consider are challenges to traditional norms of medical privacy and confidentiality due to cameras accompanying patients before, during and even after the surgical procedure. The voluntary nature of patients' medical decision-making may be brought into question by the prospect of extravagant rewards for which participants are vying. Prizes have the potential to become a determining factor in patients' medical determinations rather than anticipated risks and benefits. Moreover reality-based and other television shows may create false expectations among viewers, through creatively edited narratives. This concern is validated by findings, for example, that the portrayal of cardiopulmonary resuscitation on television fosters significant overestimation of survival rates.

## RELEVANT ETHICS POLICIES

The American Medical Association's *Code of Medical Ethics* already includes general standards on privacy, confidentiality, and informed consent that should guide physicians in their encounters with patients regardless of the context. Especially pertinent are notions that physicians must seek to protect patient privacy in all its forms and the confidentiality of information disclosed during the course of the patient-physicians relationship (Principle IV; Opinions E-5.059, "Privacy in the Context of Health Care" and E-5.05, "Confidentiality," AMA Policy Database).

Moreover, "the physician has an ethical obligation to help the patient make choices from among the therapeutic alternatives consistent with good medical practice" (Opinion E-8.08, "Informed Consent").

Other guidelines in the *Code* are useful in considering questions raised by medical entertainment on television. In relation to physicians' obligation to be honest in all professional interactions (Principle II), Opinion E-5.015, "Direct to Consumer Advertisements of Prescription Drugs," emphasizes the importance of upholding ethical standards of informed consent, especially when patients request treatment options that would not be suitable. It further states that "physicians must remain vigilant to assure that direct-to-consumer advertising does not promote false expectations." Similarly, Opinion E-5.02, "Advertising and Publicity," warns against deceptive practices in advertisement, stating that "aggressive, high pressure advertising and publicity should be avoided if they create unjustified medical expectations or are accompanied by deceptive claims."

These policies caution physicians to present information regarding their skills, as well as the possible outcomes of medical interventions, truthfully. They also encourage physicians to correct medically-related misperceptions that patients may develop from television programs.

Opinion E-5.045, "Filming Patients in Health Care Settings" pertains specifically to filming patients with the intent of broadcast for public viewing. These guidelines are intended to protect the rights of patients in this particular context, especially with regard to privacy and confidentiality. Moreover, the Opinion notes potential conflicts of interest and recommends that physicians "not allow financial or promotional benefit to the health care institution to influence their advice to patients regarding participation in filming."

## MANAGING PATIENTS' EXPECTATIONS

Physicians' participation in medical entertainment on commercial television--and reality-based programs in particular--also should respect Principle VIII: physicians should offer advice in accord with patients' best *medical* interest, and independent of any reward for which patients are competing. Medical advice also should not be influenced by the potential outcome of the contest, and its reflection on physicians' professional reputation. Therefore, physicians remain obligated to convey accurately treatments' risks, benefits, and alternatives to an audience of prospective patients. They also should refuse to participate in programs that foster misperceptions or are otherwise misleading, and generally should be prepared to correct false expectations that prospective patients may have formed from such television programs.

Beyond the responsibilities of individual physicians who choose to be featured in medical entertainment programs, the medical profession also has a role to play in preventing misleading information from reaching the public. Independent peer groups, such as specialty societies, can help prevent misleading information from reaching the public by making themselves available to assess the accuracy of content before it airs and by intervening as necessary in instances of misrepresentation.

## CONCLUSION

The Council believes that when acting in any capacity that relies on their medical training and practice, physicians should be guided by the profession's ethical obligations. To guide physicians' participation in reality television medical entertainment and physicians' response to the expectations patients may form from these programs, the Council proposes amendments to its Opinion on "Filming Patients in Health Care Settings."

## RECOMMENDATION

In lieu of Resolution 607 (I-04), the Council on Ethical and Judicial Affairs recommends that amendments to Opinion E-5.045, "Filming Patients in Health Care Settings," be filed at the 2006 Annual Meeting and the remainder of this report be filed.

## APPENDIX

### *Proposed Amendments to Opinion E-5.045 (Clean Version)*

#### *E-5.045, "Filming Patients for Public Broadcast"*

The use of any medium to film, videotape, or otherwise record (hereafter film) patient interactions with health care providers requires the utmost respect for the privacy and confidentiality of the patient. The following guidelines are offered to help ensure that the rights of patients are protected when filming occurs. These guidelines specifically address filming with the intent of broadcast for public viewing. As such, they consider physicians' role in striving to deliver information to the public that is both complete and accurate. They do not address other uses such as filming for medical education, forensic or diagnostic filming, or the use of security cameras.

1. Educating the public about the health care system should be encouraged, and filming of patients may be one way to accomplish this. This educational objective can be achieved ethically by filming only patients who can consent.
2. Filming patients without consent is a violation of the patient's privacy. Consent is therefore an ethical requirement for both initial filming and subsequent broadcast for public viewing. Because filming cannot benefit a patient medically and also may cause harm, filming should be done only if the patient being filmed can explicitly consent. When patients cannot consent, dramatic reenactments utilizing actors should be considered instead of violating patient privacy.

Consent by a surrogate medical decision-maker is not an ethically appropriate substitute for consent by the patient because the role of such surrogates is to make medically necessary decisions, and whether to film for public broadcast is not a medical decision. A possible exception exists when the person in question is permanently or indefinitely incapacitated (e.g., a patient in a persistent vegetative state) or is a minor child, in which case the consent of a parent or legal guardian (who has the authority to make non-medical decisions) should be sought.

- (a) Patients should have the right to have filming stopped upon request at any time and the film crew removed from the area. Also, persons involved in the direct medical care of the patient who feel that the filming may jeopardize patient care should request that the film crew be removed from the patient care area.
- (b) The initial granting of consent does not preclude the patient from withdrawing consent at a later time. After filming has occurred, patients who have been filmed should have the opportunity to rescind their consent up until a reasonable time period before broadcast for public viewing. The consent process should include a full disclosure of whether the tape will be destroyed if consent is rescinded, and the degree to which the patient is allowed to view and edit the final footage before broadcast for public viewing.

- (c) Due to the potential conflict of interest, informed consent should be obtained by a disinterested third party, and not a member of the film crew or production team.
3. Information obtained in the course of filming medical encounters between patients and physicians is confidential. Persons who are not members of the health care team, but who may be present for filming purposes, must demonstrate that they understand the confidential nature of the information and are committed to respecting it. If possible, it is desirable for stationary cameras or health care professionals to perform the filming.
  4. Physicians retain their responsibility to maintain professional standards whenever medical or surgical encounters are filmed for public broadcast. They should be mindful that the educational content of the finished product may become marginalized, potentially distorting the portrayal of the patient-physician encounter and of the medical procedures. Physicians should accurately convey the risks, benefits, and alternatives of treatments to an audience of prospective patients, and should refuse to participate in programs that foster misperceptions or are otherwise misleading.

Independent peer groups, such as medical specialty societies, also may help prevent misleading information from reaching the public by making themselves available to producers to assess the accuracy of program content. In the event of misinformation, they may help dispel misperception by providing educational resources and, if necessary, taking corrective or disciplinary action.

5. As advocates for their patients, physicians should not allow the care they provide or their advice to patients regarding participation in filming to be influenced by financial gain or promotional benefit to themselves, their patients or their health care institutions.
6. If a physician is compensated beyond services to the patient, the amount and conditions of compensation must be disclosed to the patient.
7. To protect the best interests of patients, physicians should participate in institutional review of requests to film.
8. Programs regarding various aspects of health care are commonly televised; therefore, physicians should recognize that their patients may have preformed expectations from public broadcasts that may need to be addressed. (I, IV, VII, VIII)

Issued December 2001 based on the report "Filming Patients in Health Care Settings," adopted June 2001; updated November 2005.

*Proposed Amendments to Opinion E-5.045 (Tracked Version)*

*E-5.045, "Filming Patients for Public Broadcast in Health Care Settings"*

The use of any medium to film, videotape, or otherwise record (hereafter film) patient interactions with their health care providers requires the utmost respect for the privacy and confidentiality of the patient. The following guidelines are offered to ~~assure~~help ensure that the rights of ~~the patients~~ are protected when filming occurs. These guidelines specifically address filming with the intent of broadcast for public viewing. As such, they consider physicians' role in striving to deliver information to the public that is both complete and accurate. They ~~and~~ do not address other uses such as ~~in~~filming for medical education, forensic or diagnostic filming, or the use of security cameras.

1. Educating the public about the health care system should be encouraged, and filming of patients may be one way to accomplish this. This educational objective can be achieved ethically ~~is not severely compromised by~~ filming only patients who can consent; ~~when patients cannot consent, dramatic reenactments utilizing actors should be considered instead of violating patient privacy.~~

2. Filming patients without consent is a violation of the patient's privacy. Consent is therefore an ethical requirement for both initial filming and subsequent broadcast for public viewing. Because filming cannot benefit a patient medically and also may cause harm, filming should be done only if, and moreover has the potential of causing harm to the patient, it is appropriate to limit filming to instances where the party-patient being filmed can explicitly consent. When patients cannot consent, dramatic reenactments utilizing actors should be considered instead of violating patient privacy.

Consent by a surrogate medical decision-maker is not an ethically appropriate substitute for consent by the patient because the role of such surrogates is to make medically necessary decisions, and whether to film for public broadcast is not a medical decision-in the best interest of the patient. A possible exception exists when the person in question is permanently or indefinitely incapacitated incompetent (e.g., a patient in a persistent vegetative state) or is a minor child), in which case the consent of ~~In such circumstances, if a parent or legal guardian (who has the authority to make non-medical decisions) should be sought provides consent, filming may occur.~~

- (a) Patients should have the right to have filming stopped upon request at any time and the film crew removed from the area. Also, persons involved in the direct medical care of the patient who feel that the filming may jeopardize patient care should request that the film crew be removed from the patient care area.
- (b) The initial granting of consent does not preclude the patient from withdrawing consent at a later time. After filming has occurred, patients who have been filmed should have the opportunity to rescind their consent up until a reasonable time period before broadcast for public viewing. The consent process should include a full disclosure of whether the tape will be destroyed if consent is rescinded, and the degree to which the patient is allowed to view and edit the final footage before broadcast for public viewing.
- (c) Due to the potential conflict of interest, informed consent should be obtained by a disinterested third party, and not a member of the film crew or production team.
3. Information obtained in the course of filming medical encounters between patients and physicians is confidential. Persons who are not members of the health care team, but who may be present for filming purposes, must demonstrate that they understand the confidential nature of the information and are committed to respecting it. ~~Where~~ If possible, it is desirable for stationary cameras or health care professionals to perform the filming.
4. Physicians retain their responsibility to maintain professional standards whenever medical or surgical encounters are filmed for public broadcast. They should be mindful that the educational content of the finished product may become marginalized, potentially distorting the portrayal of the patient-physician encounter and of the medical procedures. Physicians should accurately convey risks, benefits, and alternatives of treatments to an audience of prospective patients, and should refuse to participate in programs that foster misperceptions or are otherwise misleading.

Independent peer groups, such as medical specialty societies, also may help prevent misleading information from reaching the public by making themselves available to producers to assess the accuracy of program content. In the event of misinformation, they may help dispel misperception by providing educational resources and, if necessary, taking corrective or disciplinary action.

5. Physicians, as ~~As~~ advocates for their patients, physicians should not allow the care they provide or their advice to patients regarding participation in filming to be influenced by financial gain or promotional benefit to themselves, their patients or their health care institutions to influence their advice to patients regarding participation in filming.
6. If a physician is compensated beyond services to the patient, the amount and conditions of compensation must be disclosed to the patient. Because physician compensation for participation in filming may cause an undue influence to recruit patients, physicians should not be compensated directly.
7. To protect the best interests of patients, physicians should participate in institutional review of requests to film.

8. Programs regarding various aspects of health care are commonly televised; therefore, physicians should recognize that their patients may have preformed expectations from public broadcasts that may need to be addressed. (I, IV, VII, VIII)

Issued December 2001 based on the report "Filming Patients in Health Care Settings," adopted June 2001; updated November 2005.

(References pertaining to Report 2 of the Council on Ethical and Judicial Affairs are available from the Ethics Standards Group.)

### 3. PHYSICIAN PAY-FOR-PERFORMANCE PROGRAMS

#### HOUSE ACTION: RECOMMENDATIONS ADOPTED AND REMAINDER OF REPORT FILED

##### INTRODUCTION

Physician pay-for-performance (PFP) compensation arrangements attempt to provide an economic incentive to improve health care quality by linking remuneration to measures of individual, group or organizational performance. These programs typically offer bonus payments to physicians who either meet, or demonstrate improvement in meeting, pre-established standards of performance measures.

The American Medical Association has issued a set of principles and guidelines that advocate for acceptable parameters. The AMA states that PFP programs should strive to: ensure the quality of care; foster the patient/physician relationship; offer voluntary physician participation; use accurate and fair data reporting; and provide fair and equitable program incentives. Many of these principles are closely related to core concepts of medical ethics and professionalism, including patient autonomy, conflicts of interest and trust, as well as fairness and justice. Accordingly, this report examines the tensions that may arise from physicians' participation in PFP programs and offers guidance to physicians striving to practice ethically in the face of performance-based incentive arrangements.

##### BACKGROUND

The past decade has been marked by an emerging quality movement in medicine, prompted by the Institute of Medicine's health care quality initiative, "Crossing the Quality Chasm," which proposed a new quality construct based upon safety, effectiveness, patient-centeredness, timeliness, efficiency, and equity. To achieve these objectives, key health care leaders have emphasized the role of evidence-based guidelines.

In turn, this has led to the establishment of market-based quality improvement mechanisms that link compensation to measurements of patient safety and clinical outcomes. Among these, pay-for-performance programs provide participants with monetary bonuses to reward the achievement of predetermined quality or efficiency benchmarks.

To measure performance, PFP programs must collect data on health care process and outcomes, including patient safety indicators and patient satisfaction. These data are then incorporated into payment mechanisms for hospitals or physicians. Physicians or physician groups, upon meeting a given program's performance criteria, are rewarded with modest financial bonuses that may constitute up to 5% of the total revenue received from a given health plan.

##### ETHICAL RESPONSIBILITIES OF PHYSICIANS

Physicians are ethically obligated to provide competent, patient-centered care to each of their patients, as codified within Principles I and VIII of the *Code of Medical Ethics*. Physicians must also assume central roles in promoting patient safety by participating in the identification, reduction, and prevention of medical errors (see Opinion E-8.121, "Ethical Responsibility to Study and Prevent Error and Harm," AMA Policy Database). Stemming from these obligations, physicians and the medical profession assume a duty to improve the safety and effectiveness of the health care that patients receive.

## REPORT OF THE COUNCIL ON ETHICAL AND JUDICIAL AFFAIRS<sup>□</sup>

CEJA Report 12 - A-03

Subject:            Filming Patients for Educational Purposes

Presented by:     Leonard J. Morse, MD, Chair

Referred to:      Reference Committee on Amendments to Constitution  
                          and Bylaws  
                          (Donna A. Woodson, MD, Chair)

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1    Respect for the patient should be central in every interaction within the health care system.<sup>1</sup> This  
2    should extend to respect for patient privacy,<sup>2</sup> and to confidentiality. Indeed, whenever patient  
3    privacy or confidentiality is compromised, trust in the patient-physician relationship may be  
4    weakened.

5

6    Moreover, the *Principles of Medical Ethics* require physicians to be committed to providing  
7    competent medical care for the individual patient; to remain committed to medical education; and  
8    to participate in activities that will better public health.<sup>3</sup> Although filming for medical education  
9    can be used as a tool to facilitate these goals, it can create a conflict between the physician's  
10   ethical obligation to protect the privacy and confidentiality of patient,<sup>4</sup> and a professional  
11   obligation to further the education of current and future health care providers. This report  
12   examines the balance between patient autonomy and patient privacy, and the educational value of  
13   films. Similar ethical concerns exist when filming patients for commercial use. These concerns  
14   were examined in CEJA Report 3-A-01, "Filming Patients in Health Care Settings."

### 15

### 16   FILMING FOR MEDICAL EDUCATION

### 17

18   It is important to recognize that filming patients for educational purposes has direct implications  
19   in relation to privacy, which itself has become the object of detailed laws including recent federal  
20   regulations. Nevertheless, issues arising from filming require analysis from the perspective of the  
21   ethics of the patient-physician relationship.

22

23   Filming is an important tool both in teaching and evaluating medical students and physicians-in-  
24   training. For example, videotaped patient encounters can be used to demonstrate interviewing  
25   skills, physical exam skills, or other specific medical techniques. Films may also be used to  
26   review and evaluate the skills of medical trainees.

27

28   Filming offers unique advantages over other forms of observation. Films can be stopped at  
29   pertinent points for instruction, something that is not possible during real-time patient encounters;  
30   they can be shown to large groups; and they can illustrate rare cases that trainees otherwise may  
31   not be exposed to during their training.

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<sup>□</sup> Reports of the Council on Ethical and Judicial Affairs are assigned to the reference committee on Constitution and Bylaws. They may be adopted, not adopted, or referred. A report may not be amended, except to clarify the meaning of the report and only with the concurrence of the Council.

1 ETHICAL CONSIDERATIONS WHEN FILMING

2  
3 Ethical questions that were previously examined in the CEJA Report on commercial filming are  
4 re-examined here in light of the unique educational opportunities filming offers.

5  
6 *Privacy*

7  
8 Privacy limits the access others may have over a person. In law, it is linked to freedom from  
9 intrusion by the state or other persons. In the health care context, it generally designates a  
10 domain of personal decision about important matters related to bodily integrity. In its report  
11 devoted to privacy, the Council referred to four types of privacy relevant to patients: 1) physical,  
12 which focuses on individuals and their personal spaces; 2) informational, which addresses  
13 personal data; 3) decisional, which focuses on personal choices; and 4) associational, which refers  
14 to family or other intimate relations.<sup>2</sup> In the context of filming for educational purposes, several  
15 aspects of a patient's privacy may be affected, since the patient's image and related information  
16 will cease to be within the patient's absolute control.

17  
18 *Confidentiality*

19  
20 In relation to confidentiality, filming for educational purposes raises fewer concerns than when it  
21 is intended for commercial broadcast, since the intended viewers are ethically bound to respect  
22 confidentiality. Indeed, educational filming may be compared to sharing patient information  
23 with medical professionals directly involved in the care of a patient, a common and acceptable  
24 practice. For example, Opinion E-7.025, "Records of Physicians: Access by Non-Treating  
25 Medical Staff," permits disclosure of personal information without specific authorization when it  
26 is (1) relevant to patient care and (2) made to persons who are bound to uphold confidentiality.  
27 Arguably, these guidelines may be of limited value if the filming has limited direct impact on the  
28 care of the filmed patient. Alternatively, filming may resemble more closely informal case  
29 consultations, where all patient identifiers are removed, another generally accepted practice.

30  
31 *Patient Consent*

32  
33 When privacy or confidentiality may be compromised, it is important that patients be given an  
34 opportunity to assess the consequences. In the context of filming, this can be achieved by  
35 obtaining the patient's consent. The Joint Commission on Accreditation of Healthcare  
36 Organizations maintains that filming patients for medical education is appropriate as long as  
37 consent is obtained prior to filming or as soon as possible thereafter and the film is not used until  
38 consent is obtained.<sup>5</sup> The Society for Academic Emergency Medicine also states that educational  
39 filming is appropriate provided that informed consent is obtained and patient confidentiality is  
40 respected.<sup>6</sup>

41  
42 A recent study revealed that current methods of requesting consent from patients for video  
43 observation may fail to include the standard components of informed consent, namely: (1) that  
44 the patient understands that participation is voluntary, (2) that the procedure is described such that  
45 a "reasonable person" can understand, (3) that risks are clearly identified, (4) that a viable  
46 alternative is provided (such that the patient knows that his or her care will not be affected if  
47 consent is not given), and (5) that the patient is clear about implied benefit (e.g. educational  
48 benefits to health care professionals viewing the film).<sup>7</sup> Failure to inform the patient of these five  
49 criteria seriously undermines the patient's ability to make an informed decision.

1 A discussion regarding the potential benefits of filming for educational purposes requires careful  
2 attention, because patients may be unclear of the exact purpose of the film. Also, physicians  
3 should be mindful that patients may assess benefits very differently. To prevent  
4 misunderstanding, potential direct benefits (filming itself may be therapeutic or filming provides  
5 information that is subsequently pertinent to the patient's care), should be distinguished from  
6 indirect benefits (patients are helping future patients by helping to educate physicians).  
7

8 Using films for educational purposes is not intended and is unlikely to benefit a patient medically,  
9 so consent should be sought from the patient. Surrogate decision-makers may substitute for the  
10 patient only when the patient temporarily lacks capacity to consent to the filming. When the  
11 patient regains decision-making capacity, his or her consent should be obtained before the film is  
12 used. As in the case of commercial filming, it is permissible to obtain consent for filming from  
13 the parent or guardian of a minor child or the guardian of a permanently incompetent patient (see  
14 Opinion 5.045, "Filming Patients in Health Care Settings").  
15

### 16 When to Obtain Consent

17

18 Respecting patient autonomy and protecting patient privacy requires that every effort be made to  
19 obtain consent before filming for educational purposes. If it is not possible to obtain consent  
20 from the patient before filming, then consent must be obtained before using the film for  
21 educational purposes. If consent cannot be obtained from the patient or the surrogate, as  
22 discussed above, educational use of the film is not justifiable.  
23

24 The discussion about the possibility of filming should be afforded all the privacy of any other  
25 consent process. Patients should be encouraged to speak candidly about any apprehension they  
26 have toward filming. If a patient is inclined to refuse participation, the medical team may offer  
27 the patient an opportunity to make a final decision as to the use of the film after reviewing it.  
28

29 One study has shown that consenting patients had varied responses to the presence of a video  
30 camera.<sup>8</sup> Physicians should recognize that, at the end of a filmed encounter, patients may regret  
31 their decision to allow filming, particularly if they feel it has negatively impacted the clinical  
32 encounter. Therefore, a patient's expression of unwillingness for filming to continue, or for a  
33 film to be used for educational purposes, should be respected.  
34

### 35 *Filming and Medical Records*

36

37 Some uncertainty persists as to whether audiovisual records of patient-physician encounters are  
38 part of a patient's medical record. The American Health Information Management Association  
39 states that the recording should be treated as part of the patient's medical record.<sup>9</sup> It is worth  
40 noting that the Privacy Rule under the Health Insurance Portability and Accountability Act offers  
41 protections to the designated record set, which is composed of the official medical record and  
42 billing record, along with any other information related to the health of an individual or the  
43 provision of care and payment for it.<sup>10</sup>  
44

45 In determining whether to include a film as part of the medical record, it may be appropriate to  
46 distinguish between films that may contain relevant information, e.g., films made of a patient  
47 interview or made during surgery, and films with little information relevant to the individual  
48 patients, such as films used to improve trainees' communication skills.

1 *Error Prevention and Disclosure*

2  
3 Educational filming can serve as an important tool to prevent errors. By reviewing films, it may  
4 be possible to analyze and discuss complicating factors and help improve the overall competency  
5 of physicians. However, because films will allow physicians to scrutinize medical interventions,  
6 errors may be more readily detected. In such circumstances, physicians should act in accordance  
7 with existing policies on the reporting of errors and follow available ethical guidance on  
8 disclosure to patients.  
9

10 CONCLUSION

11  
12 Filming patient encounters and medical procedures offers an important means to enhance medical  
13 education, particularly as audiovisual technology becomes more widely accessible in health care  
14 institutions. Educational films can facilitate the demonstration of skills and can also permit  
15 detailed evaluation of medical trainees. Physicians should use these educational tools, but should  
16 be mindful that filming may compromise patient privacy and confidentiality. With proper  
17 safeguards in place, patients should be encouraged to participate in the education of medical  
18 students and other physicians in training, including through the use of films in which patients are  
19 featured. To ensure that the use of films for education purposes in which patients are featured  
20 respects their autonomy and privacy, patients generally should consent prior to the filming. If  
21 consent cannot be obtained at that time, nor before use of the film for educational purposes, the  
22 film should not be used.  
23

24 RECOMMENDATIONS

25  
26 The Council recommends that the following be adopted and the remainder of the report be filed:  
27

28 It is important to recognize that filming patients for educational purposes has direct  
29 implications in relation to privacy, which itself has become the object of recent detailed  
30 federal regulations. Therefore, filming for educational purposes in the health care setting  
31 should comply with relevant laws and regulations. In addition, filming for educational  
32 purposes should be analyzed from the perspective of the ethics of the patient-physician  
33 relationship. In this regard, an important distinction can be drawn between filming for  
34 commercial purposes (see Opinion 5.045, "Filming Patients in Health Care Settings") and  
35 filming for educational purposes, since the latter is performed and viewed by members of the  
36 health care team, who are bound by ethical responsibilities regarding patient autonomy,  
37 privacy, and confidentiality. Specifically:  
38

- 39 1) Informed consent should be obtained before filming whenever possible. If it is not  
40 possible to obtain consent from the patient before filming, then consent must be obtained  
41 before the film is used for educational purposes. A surrogate decision-maker may give  
42 consent for filming only if the patient temporarily lacks capacity to give consent before  
43 the filming. When the patient regains decision-making capacity, his or her consent  
44 should be obtained before the film is used. In the case of minor children or permanently  
45 incompetent adults, consent may be obtained from the patient's parent or guardian (see  
46 Opinion E-5.045, "Filming Patients in Health Care Settings").  
47
- 48 2) When obtaining consent, physicians should disclose information similar to that provided  
49 for other medical interventions, including an explanation of the educational purpose of  
50 film, potential benefits and harms (such as breaches of privacy and confidentiality), as  
51 well as a clear statement that participation in filming is voluntary and that the decision

1 will not affect the medical care the patient receives. Moreover, physicians should be  
2 aware that filming may affect patient behavior during a clinical encounter. The patient  
3 should be given ample opportunity to discuss concerns about the film, before and after  
4 filming, and a decision to withdraw consent must be respected.  
5

6 3) Information contained in educational films must be held to the same standards of  
7 confidentiality as other patient information. If filming requires the presence of non-  
8 clinical persons, these persons must agree to protect the patient's privacy and  
9 confidentiality. Viewing must be limited to health professionals, professionals-in-  
10 training, and students in the health professions, unless it has been disclosed to the patient  
11 that non-health professionals would view the film and the patient has consented to such  
12 viewing. If the film is to be distributed outside the institution in which it was produced,  
13 disclosure of the distribution must be made and explicit consent obtained.  
14

15 4) Films contain a record of personal patient information. Depending on its content, a film  
16 may or may not be considered part of the patient's medical record, and may be protected  
17 under privacy law. Irrespective of these legal standards, films should be securely stored  
18 and final disposal should ensure that they are properly destroyed.

References are available from the Ethics Standards Group.

## REFERENCES

The Council would like to acknowledge with appreciation Ms. Erin Talati for her assistance on this Report.

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<sup>2</sup> Council on Ethical and Judicial Affairs. "Report 2-I-01, Privacy in the Context of Health Care." American Medical Association: Chicago, IL (June 2001).

<sup>3</sup> Council on Ethical and Judicial Affairs. *AMA's Code of Medical Ethics: Current Opinions*. 2002-2003 ed. American Medical Association: Chicago, IL. See Principles I, V, VII.

<sup>4</sup> Council on Ethical and Judicial Affairs. "Principle IV." *AMA's Code of Medical Ethics: Current Opinions*. 2002-2003 ed. American Medical Association: Chicago, IL.

<sup>5</sup> Joint Commission on Accreditation of Health care Organizations. "Standards – Frequently Asked Questions". JCAHO: Chicago, IL. [http://www.jcaho.org/standard/faq/faq\\_frm.html](http://www.jcaho.org/standard/faq/faq_frm.html) (Accessed July 26, 2002).

<sup>6</sup> Society of Academic Emergency Medicine. "Filming of Patients in Academic Emergency Departments." Society for Academic Emergency Medicine Newsletter. May/June 2001.

<sup>7</sup> Butler, DJ. "Informed Consent and Patient Videotaping." *Academic Medicine*. (2002) 77(2): 181- 184.

<sup>8</sup> Shafir, MS et al. "Patient Consent to Observation." *Canadian Family Physician*. (August 1995) 41: 1367-1372.

<sup>9</sup> AHIMA. "Practice Brief: Managing Multimedia Medical Records: A Health Information Manager's Role." *Journal of AHIMA*. (February 1998).

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## RECOMMENDATIONS

The Council recommends that the following be adopted and the remainder of the report be filed:

Physicians, either in their role as investigators or as decision-makers involved in the deliberations related to the funding or the review of research, hold an ethical obligation to ensure the protection of research participants. When the research is to be conducted in countries with differing cultural traditions, health care systems, and ethical standards, and in particular in countries with developing economies and with limited health care resources, US physicians should respect the following guidelines:

1. First and foremost, physicians involved in clinical research that will be carried out internationally should be satisfied that a proposed research design has been developed according to a sound scientific design. Therefore, investigators must ascertain that there is genuine uncertainty within the clinical community about the comparative merits of the experimental treatment and the one to be offered as a control in the population among which the study is to be undertaken. In some instances, a three-pronged protocol, which offers the standard treatment in use in the US, a treatment that meets a level of care that is attainable and sustainable by the host country, and a placebo (see Opinion 2.075), may be the best method to evaluate the safety and efficacy of a treatment in a given population. When US investigators participate in international research they must obtain approval for such protocols from US Institutional Review Boards (IRBs).
2. IRBs, which are responsible for ensuring the protection of research participants, must determine that risks have been minimized and that the protocol's ratio of risks to benefits is favorable to participants. In evaluating the risks and benefits that a protocol presents to a population, IRBs should obtain relevant input from representatives from the host country and from the research population. It is also appropriate for IRBs to consider the harm that is likely to result from forgoing the research.
3. Also, IRBs are required to protect the welfare of individual participants. This can best be achieved by assuring that a suitable informed consent process is in place. Therefore, IRBs should ensure that individual potential participants will be informed of the nature of the research endeavor and that their voluntary consent will be sought. IRBs should recognize that, in some instances, information will be meaningful only if it is communicated in ways that are consistent with local customs.
4. Overall, to ensure that the research does not exploit the population from which participants are recruited, IRBs should ensure that the research corresponds to a medical need in the region where it is undertaken. Furthermore, they should foster research with the potential for lasting benefits, especially when it is undertaken among populations that are severely deficient in health care resources. This can be achieved by facilitating the development of a health care infrastructure that will be of use during and beyond the conduct of the research. Additionally, physicians conducting studies must encourage research sponsors to continue to provide beneficial study interventions to all study participants at the conclusion of the study.

(References pertaining to Report 2 of the Council on Ethical and Judicial Affairs are available from the Department of Ethical Standards.)

### 3. FILMING PATIENTS IN HEALTH CARE SETTINGS

#### **HOUSE ACTION: RECOMMENDATIONS ADOPTED AND REMAINDER OF REPORT FILED**

#### INTRODUCTION

Patient privacy and confidentiality of medical information are the bedrock of the patient-physician relationship. A patient's knowledge that he or she can reveal personal information to a physician, and that the physician must keep this information confidential, is what enables patients to candidly disclose to their physician information that they might not want generally known. Knowing this information is what allows physicians to provide care effectively. This fundamental element of the patient-physician relationship is potentially compromised when film crews are allowed to film, videotape, or otherwise record, (hereafter film) patients in the clinical setting. Such filming has recently proliferated with the advent of reality-based television shows featuring health professionals.

The laudable objective behind publicly broadcasting such films of patients is to inform and educate the public about the health care system and medical care. It is possible that this can even reduce injury and disease prevalence through education about risk factors. However this educational objective must be balanced against the competing and arguably more fundamental right to privacy and confidentiality held by patients.

A potential compromise between public education and privacy may exist when patients consent to being filmed for the purpose of public viewing. However, when it is not possible for patients to consent to being filmed, for example when a patient arrives at an emergency department (ED) unconscious, there is no clear ethical consensus as to whether privacy can be compromised. Current practice appears to allow the filming to precede consent, and for consent to be obtained subsequently, but prior to the broadcast. Indeed, there appears to be a general consensus that it would be unethical to air any footage acquired without obtaining consent from the patient or the patient's surrogate decision-maker. However, it is unresolved to what extent the initial filming represents a breach of the patient's privacy and confidentiality.

In this report the Council provides guidance regarding ethical filming of patients by discussing the scope of patient privacy and confidentiality; the responsibility to obtain informed consent; and the importance of ensuring the objectives in filming are first and foremost educational.

#### PATIENT PRIVACY AND CONFIDENTIALITY

The areas of both privacy and confidentiality are important when contemplating the issue of filming and broadcasting patient encounters. In the realm of privacy, patients are ethically, and to a great extent legally, entitled to have only those individuals who are involved in their medical care examine them, or observe their examination. Opinion 5.04, "Communications Media: Standards of Professional Responsibility," states that "Physicians are ethically and legally required to protect the personal privacy and other legal rights of patients." Thus the presence of the film crew may be an infringement of the patient's privacy.

Protecting confidentiality arises from the need of patients to share personal information with their physicians in order for them to provide medical care. This privileged communication is a voluntary surrender of privacy with the expectation that some control over the information is retained, namely that the information will not be disclosed beyond the person with whom it was entrusted, or to others directly involved in the patient's care. According to Opinion 5.05, "Confidentiality," information that is shared with a physician should not be further disclosed unless disclosure can be "ethically and legally justified because of overriding social considerations," or the patient gives consent to the release of the information. Exceptions that are contemplated by the Opinion include physical threats and other circumstances related to the potential harm of self or others, such as physical violence, and communicable disease. Also, according to Opinion 7.025, "Records of Physicians: Access by Non-Treating Medical Staff," patients are entitled to have their medical information accessed only by individuals directly involved in their medical care.

In considering the issue of filming, it is important to consider the general expectation of privacy in the health care setting and how this might be compromised by filming, particularly when individuals not necessary for the medical care of the patient are present.

##### *Expectation of Privacy in Health Care Settings*

First, it is important to note that the nature of the professional interaction between a patient and his or her physician renders this interaction private, and therefore there likely is an expectation that the setting in which the patient-physician interaction occurs, be it a hospital room or a private office, is a private rather than a public space. *Black's Law Dictionary* defines a public space as:

A place to which the general public has a right to resort; not necessarily a place devoted solely to the uses of the public, but a place which is in point of fact public rather than private, a place visited by many persons and usually accessible to the neighboring public (e.g., a park or public beach). Also, a place which the public has an interest as affecting the safety, health, morals, and welfare of the community. A place exposed to the public, and where the public gather together or pass to and fro.

Certain parts of a hospital might fit within this public space definition, but the immediate moment that a space is used for interaction between a patient and his or her physician renders that space private.

This is important because courts have held that surveillance or recording without consent or court order is impermissible in areas where there is a reasonable expectation of privacy. In cases when the media have broadcast footage or published photographs of patients without their consent, courts have ruled that such broadcast or publication was an unlawful violation of privacy. It does not appear that courts have yet ruled on whether the act of filming alone (without the subsequent broadcast) likewise constitutes an unlawful invasion of privacy. However, even if it is determined that similar legal protection is not necessary (because for instance, the potential harm in being seen by millions of people via broadcast is not the same as the harm in being seen by a film crew), this does not preclude the establishment of ethical standards to offer greater protection of patient privacy, and to also protect the patient-physician relationship from being hindered by third parties for purposes of questionable benefit.

#### *Presence of Non-Health Care Professionals*

Another privacy and confidentiality concern involves the presence of film crews composed of non-health care professionals in the clinical encounter. Unless a stationary camera is used, or a health professional performs the filming, someone is present to film who is not essential to the medical care of the patient. If the patient subsequently does not provide consent, this invasion of privacy cannot be undone. Furthermore, film crews, unlike health care professionals, are not bound by professional duties to keep medical information confidential. Thus, even if consent to broadcast was denied, and the tape destroyed, there is no guarantee that the film crew will maintain the confidentiality of the information they obtained as observers.

Some physicians who have participated in filming of reality-based television shows contend that the crews blend in, and feel like "...an ancillary member of the team." In fact, it may be very difficult for patients to distinguish members of the film crew from members of the health care team because the film crews may dress like the medical staff, a source of concern for some.

#### *Justifiable Breaches of Privacy and Confidentiality*

In certain circumstances, the "overriding social considerations" set out in Opinion 5.05 may warrant not only breaches of confidentiality but also an invasion of patient privacy. For instance, when a person is suspected of physically abusing someone under his or her care (often a child, but possibly the elderly or physically or mentally impaired), Factitious Disorder by Proxy (also known as Munchausen syndrome by proxy) must be considered, and it may be appropriate to implement covert video surveillance (CVS) to monitor for the occurrence of such abuse. Also, it may be beneficial for medical education purposes to film patient encounters or procedures with the understanding that such footage will not be publicly released. In the conduct of forensic medical examinations or interviews, particularly for psychiatric consultation, filming may be requested by the court. The conduct of telemedicine also often may result in a filmed record. Finally as a standard security measure, medical facilities often employ security cameras in corridors and other public areas.

In the above scenarios, it is always desirable to obtain the patient's consent prior to filming, or at a minimum, disclose to the patient that filming will occur (although it is understood that if CVS is being performed, disclosure or consent would undermine the purpose of the filming). Additionally, impartial review by an entity such as an institutional review board or hospital ethics committee is an appropriate mechanism for ensuring that patients' rights are protected. After any patient footage has served its purpose, additional protection against unauthorized use is to destroy the tape.

Additionally, in all the above scenarios the film is not made available for public viewing, but rather is narrowly used for purposes which have clear benefits to patients, the health care system, and society as a whole. When the use is for the education of medical professionals, the presumption of confidentiality (non-public viewing only), the ability to remove or obscure the patient's identity, the use of health professional or stationary cameras in performing the filming, and the ability to control possession of the footage, create circumstances that are significantly different from filming with the intent of broadcast for public viewing. The American College of Emergency Physicians (ACEP) Ethics Committee states:

Recorded images that are used for education and training are in a different category. Here the audience is clearly not just the people who needed the information to further the patient's interests. One can argue, however, that the public good is served by educating physicians and others with the most accurate materials available. If the patient gives consent for this use prior to obtaining the images, and the audience is limited to persons within the bounds of this consent, then privacy and confidentiality expectations are met.

Use of recorded images for training, if done automatically, or at least by someone who is part of the caregiver facility, may be appropriate. The process must be carefully controlled, and consent must be obtained before any use of the images. With these careful limits, it can be argued that the public good outweighs the problem of obtaining consent after the fact, and in any case the tapes are not released without the patient's permission.

## INFORMED CONSENT

The discussion above illustrates patients' rights to both privacy and confidentiality and the physician's duty to protect these rights. Unless the patient provides informed consent, breach of privacy or confidentiality can only occur because of "overriding social considerations." In Opinion 8.08, "Informed Consent," the Council discusses a framework within which a patient actively participates in choosing among "therapeutic alternatives." The Opinion also recognizes that sometimes patients may refuse treatment all together. Exceptions to obtaining consent are provided in relation to individuals who are "unconscious or otherwise incapable of consenting." Under such circumstances, treatment is undertaken based on the implied consent doctrine that a reasonable person capable of consenting would want to receive medical care that is in his or her best interests. However, since filming a patient confers no therapeutic benefit, this standard should not be applied to unconscious or incapable patients when the issue in question is filming.

The process of obtaining informed consent is intended to allow the patient to make an informed decision based upon the likely risks and benefits of a course of action. Ideally, this assumes that there is sufficient time to explain precisely what the patient is consenting to, time to resolve any questions or concerns the patient may have, and time for the patient to reflect on the implications of what he or she is consenting to. When the filming is being performed with emergent patients it is ethically questionable whether it is wise to spend time obtaining consent for anything that is not of therapeutic benefit to the patient.

Additionally, even if a patient is conscious, it is important to evaluate whether he or she is competent to consent to something that is not of medical benefit and poses a potential violation of privacy. The ACEP Ethics Committee notes that "An alert patient can presumably give...consent, but the very nature of emergency medicine suggests that the patient is under some duress, which may cloud their thinking."

Since the objective of informed consent is to ensure that the patient is informed of all elements that they are consenting to, it is important to have more than one mechanism in which the information is disclosed. Thus, signs should be posted in and around the area where filming is to occur, indicating that filming is in progress. These signs are of benefit not only to patients but also to the medical staff, who should likewise have an opportunity to consent or object to being filmed.

### *When Consent is Denied or Withdrawn*

Consent is a dynamic process, not a static one, and once a patient consents to filming, he or she reserves the right to rescind consent, right up until the time the footage is to be broadcast. This was established when the Federal District Court for the 9th Circuit ruled in *Virgil v. Time, Inc.* that "...if consent is withdrawn prior to the act of publicizing, the consequent publicity is without consent." One way to ensure that patients do not have reservations about giving consent is to provide them with an opportunity to view the final edit of the material prior to it being broadcast.

If a patient initially consents to filming and subsequently withdraws that consent, the highest ethical standard would be to destroy the filmed record. This would also apply in the less desirable scenario of initial filming occurring without the patient's consent, and subsequently the patient refuses to consent to broadcast. Another possibility that would protect patient confidentiality, although not privacy, would be to edit the patient out of the filmed record, or obscure visual and voice recognition of that patient.

### *Consent by Surrogate Decision-Makers*

The utilization of surrogate decision-makers to provide consent for a party who does not have the capacity to consent typically involves two assumptions: (1) that it is necessary for a decision to be made one way or another (between two courses of action or therapies for instance); and (2) that absent any advance directive, the person in question would want medical care in his or her best interests which provides the greatest probability for a successful

outcome. When the issue in question involves filming patients for public viewing, neither of the above assumptions can be affirmed--it is not necessary for the decision to be made for the person's medical care, and the filming itself will not provide medical benefit. Furthermore, the domain of surrogate decision makers in the health-care setting is appropriately limited to making health-care decisions. For instance, because a surrogate is empowered to decide between therapeutic alternatives when the patient cannot decide, he or she would not automatically be empowered to sell the patient's house. Thus it is not permissible to allow a surrogate to provide consent for the party being filmed. Consent must be obtained from competent patients themselves.

A possible exception exists when the patient is permanently or indefinitely incompetent and a parent or legal guardian is legally empowered with the ability to make all decisions for that person using a best interests standard. Examples of such exceptions might include minor children, mentally retarded individuals, or persons in a permanent vegetative state. In these instances, if the parent or legal guardian provides consent, filming may occur.

#### *Is the Film Part of the Medical Record?*

One legal question that deserves some attention is whether once a filmed record is made, does it constitute part of the medical record? If it is considered part of the medical record, it would potentially be unlawful to destroy it. The federal Interagency Committee on Medical Records (ICMR) does not consider videotapes part of the medical record, although its policy is advisory and does not specifically mention footage taped for broadcast purposes. Notably, the Joint Commission on Accreditation of Healthcare Organizations states in its policy clarification that absent consent, the filmed record should be destroyed. Physicians should comply with local regulations pertaining to whether the film is part of a medical record, and should not destroy the tape if contrary to local law.

#### *Consent of Medical Staff*

While the medical staff are not in the vulnerable position that patients are in, filming can represent an invasion of their privacy. Furthermore, filming may be an especially sensitive area for those in undergraduate or graduate medical education and still developing their clinical skills. In these circumstances, filming may create a source of anxiety that could induce medical errors, although some physicians have commented that they slow down and are more careful when they are being filmed because they fear that a mistake may be recorded. Other physicians have expressed concern about being filmed during emotional moments, such as the death of a patient. For these reasons, every effort should be made to obtain consent not only from patients, but also to obtain consent from the medical staff.

#### EDUCATIONAL VERSUS COMMERCIAL PURPOSE

Some have argued that medical reality shows are educational and benefit the public. This issue has been discussed in light of fictional medical dramas, which sometimes give false impressions of medical care in general and "injury management and survivability" in particular. Recent research has verified that these dramas can convey health information, but that sometimes this information is inaccurate. This raises concern about the educational purpose of these shows, and their responsibility to be accurate.

Additionally, the increased exposure that is provided for the medical center and the medical staff cannot be ignored. Referring to one of the recent programs, Jerome Kassirer, editor-in-chief emeritus of the *New England Journal of Medicine*, noted that "The program glorified the [medical center's] staff...[and] seemed intended more for public relations than for public service."

Furthermore, many outrightly question whether the viewers of these shows have any "academic or clinical interest in emergency medicine," but rather assert that "They watch the shows for the same reasons people gawk at accidents--out of morbid curiosity and prurient interest." In fact, the time slot during which one network features its shows is called "The Adrenaline Rush Hour" and its web site encourages people to "experience the rush of life-and-death situations and intense conflict in and out of the emergency room." This may suggest that the audience for these shows are more likely be thrill seekers than those curious about medical care or the health care system.

### *Financial Compensation*

The majority of recent television shows featuring patients have been on commercial networks, indicating that profit making is an important motive behind the production of these shows. This raises the potential question of whether patients or the medical staff (who essentially star in these shows) should receive financial compensation for their appearance in the broadcast but raises additional questions as to whether compensation would constitute a coercive pressure for either patients or physicians to participate in filming. Factors that might be important include whether the broadcast was on a commercial or public broadcast station, the potential for revenue from the broadcast of the show, and who might receive that revenue. To ensure that such coercive pressure is not present, any remuneration or other form of compensation, such as reimbursement for the care that was received at the time of the filming, probably should be donated directly to the health care institution.

### CONCLUSION

Filming in health care facilities affords the opportunity to inform the public about the health care system, and even the possibility of reducing injury and disease through education about risk factors. While these are worthwhile endeavors, they are not of sufficient benefit to warrant undermining patient privacy and confidentiality. For this reason, filming should only proceed when the patient (or the patients' surrogate decision-maker) and all medical staff treating the patient, explicitly consent to the filming.

### RECOMMENDATIONS

The Council recommends that the following be adopted and the remainder of the report be filed:

The use of any medium to record (hereafter film) patient interactions with their health care providers requires the utmost respect for the privacy and confidentiality of the patient. The following guidelines are offered to assure that the rights of the patient are protected. These guidelines specifically address filming with the intent of broadcast for public viewing, and do not address other uses such as in medical education, forensic or diagnostic filming, or the use of security cameras.

1. Educating the public about the health care system should be encouraged, and filming of patients may be one way to accomplish this. This educational objective is not severely compromised by filming only patients who can consent, and when patients cannot consent, dramatic reenactments utilizing actors should be considered instead of violating patient privacy.
2. Filming patients without consent is a violation of the patient's privacy. Consent is therefore an ethical requirement for both initial filming and subsequent broadcast for public viewing. Because filming cannot benefit a patient medically, and moreover has the potential of causing harm to the patient, it is appropriate to limit filming to instances where the party being filmed can explicitly consent. Consent by a surrogate decision-maker is not an ethically appropriate substitute for consent by the patient because the role of surrogates is to make medically necessary decisions in the best interest of the patient. A possible exception exists when the person in question is permanently or indefinitely incompetent (e.g., permanent vegetative state or minor child). In such circumstances, if a parent or legal guardian provides consent, filming may occur.
  - (a) Patients should have the right to have filming stopped upon request at any time and the film crew removed from the area. Persons involved in the direct medical care of the patient who feel that the filming may jeopardize patient care should also request that the film crew be removed from the patient care area.
  - (b) The initial granting of consent does not preclude the patient from withdrawing consent at a later time. After filming has occurred, patients who have been filmed should have the opportunity to rescind their consent up until a reasonable time period before broadcast for public viewing. The consent process should include a full disclosure of whether the tape will be destroyed if consent is rescinded, and the degree to which the patient is allowed to view and edit the final footage before broadcast for public viewing.
  - (c) Due to the potential conflict of interest, informed consent should be obtained by a disinterested third party, and not a member of the film crew or production team.

3. Information obtained in the course of filming medical encounters between patients and physicians is confidential. Persons who are not members of the healthcare team, but who may be present for filming purposes, must demonstrate that they understand the confidential nature of the information and are committed to respecting it. Where possible, it is desirable for stationary cameras or health care professionals to perform the filming.
4. Physicians, as advocates for their patients, should not allow financial or promotional benefit to the health care institution to influence their advice to patients regarding participation in filming. Because physician compensation for participation in filming may cause an undue influence to recruit patients, physicians should not be compensated directly. To protect the best interests of patients, physicians should participate in institutional review of requests to film.

(References pertaining to Report 3 of the Council on Ethical and Judicial Affairs are available from the Department of Ethical Standards.)

#### 4. SURROGATE DECISION MAKING

##### **HOUSE ACTION: RECOMMENDATION ADOPTED AND REMAINDER OF REPORT FILED**

##### INTRODUCTION

At the 1991 Annual Meeting, the American Medical Association adopted the report of the Council on Ethical and Judicial Affairs, "Decisions to Forgo Life-Sustaining Treatment for Incompetent Patients." The recommendations of the report were the basis for amendments to Opinion 2.20, "Withholding or Withdrawing Life-Sustaining Medical Treatment." The report itself provides guidelines for physicians who may have to identify a surrogate decision maker, assist a surrogate or proxy in making decisions for incompetent patients, and resolve conflicts that may arise between decision makers, or between the decision maker's choice and medically appropriate options. Since the incorporation of these guidelines into the AMA's *Code of Medical Ethics*, the Council has deferred to Opinion 2.20 to address inquiries involving surrogate decision making, even though the guidelines presented in this Opinion refer only to decisions made near the end of life.

With continued discussion concerning health care preferences for all patients, including those who are incompetent, and greater options available to secure health care directives, the involvement of third parties in a patient's health becomes more likely in decisions that may occur in instances other than the end of life.

In addition, the Council recognizes that there is a spectrum of decision-making capacity ranging from immaturity, to mental illness, to serious brain damage, and that health care decisions often must be made for individuals with diminished decisional faculties over extended periods of time. The Council offers the following report to expand on its previous guidelines and to identify features related to a meaningful and effective physician-proxy relationship.

The report begins by defining a number of terms related to health care directives before presenting theoretical frameworks used in making decisions for incompetent patients. It then provides a protocol for identifying a surrogate decision maker as well as guidance for physicians who may run into conflict either assisting the surrogate in coming to a decision or with the decision itself. Finally, the report offers guidelines for nurturing an effective physician-proxy relationship.

##### *Defining Key Terms*

An advance directive is a document that enables competent persons to exercise their rights to direct medical treatments in the event that they lose their decision-making capacity. Previously, the Council on Ethical and Judicial Affairs considered two general categories of advance directives: 1) a living will, which indicates the types of treatment an individual wishes to receive or forgo under specified circumstances, and 2) a durable power of attorney for health care (or a health care proxy appointment), which designates another person to make health care decisions on behalf of the patient.