CAJEM PRO/CON
COMMERCIAL FILMING IN THE ED

"Who shall decide when doctors disagree?"
-Alexander Pope 1732

The following is our first installment of CAJEM Pro/Con, a forum for the discussion of controversial topics in emergency medicine. In this issue, Dr. Carter Clements from the Alameda County Medical Center in Oakland and Dr. Joel Geiderman from Cedars-Sinai Medical Center in Los Angeles discuss the merits of commercial filming in the emergency department.

PRO POSITION FOR FILMING IN THE ED

R. Carter Clements, MD, FACEP

Homo sapiens are a curious species. We love to see, to learn about and to be exposed to new things. This desire is clearly the underlying motivation for the proliferation of shows offering "Reality TV". Medicine has not escaped the unblinking gaze of television. The success of "*ER*" and reality based shows such as The Learning Channel's (TLC's) *Trauma: Life in the ER* illustrates this point. By their very nature, emergency departments and trauma centers provide a dramatic stage upon which the human experience of medicine is writ large. Whether or not the eye of television should witness the physician-patient interaction is currently a matter of vigorous debate. In the interest of full disclosure, I should state that I have been videotaped, by the producers of the TLC series noted above, while working in the emergency department. I will argue that video documentation of the physician-patient interaction is unavoidable and that broadcast, not only does not harm, but actually has the potential to improve our patients' experience of emergency medical care.

Motion pictures and video entered the clinical environment as educational, teaching and evaluation tools for medical student and post-graduate medical education. Few would argue that this was a negative development. The problems that recording of patients posed then are the same ones that recording for broadcast pose today. First, the presence of video equipment and personnel is often felt to be intrusive to the patient care environment. Secondly, it is feared that patient privacy is lost. Finally, the act of recording the physician-patient encounter alters its basic nature due to an observation effect. Despite these concerns, the question at issue now appears to be the target audience and not the filming itself. Educational video is a firmly established teaching tool.

Let us address these issues. Claim number one is that recording is intrusive. My experience of being an unpaid video subject is that initially it felt extremely intrusive, but that I quickly habituated to the camera and personnel. After about a week, I was no longer aware of the recording staff being out of the ordinary. Any new technology used in clinical practice will be intrusive until staff and patients come to see it as the status quo. Ultrasound is a good current example of this. During filming in my department, patients who declined had their requests honored promptly. This practice addressed the second major concern. Patients were variable in their response to the camera but most did not seem to object to filming. They seemed to take their cues from the staff. The final concern about extraneous observers altering the physician-patient interaction is a value judgment. Is there a greater good that results from exposing a large audience to the everyday practice of emergency medicine and does that good offset the potential for damage to an individual patient encounter? I believe the answer is affirmative.

A basic set of ethical ground rules should be adopted by those involved in the recording of clinical patient encounters. Any patient who declines to be recorded must be completely expunged from the project footage and final broadcast. Patient participation must be completely voluntary and as fully informed as possible. Physicians and other patient care providers should not have financial incentive to participate in or to recruit patients to participate in the recording. Videographers must remain observers only. They cannot direct the patient interaction. They must accept that what you see is what you get. Finally, the

primary goal of recording clinical encounters should be the dissemination of accurate information about medical care and care providers for the educational benefit of the viewer.

Ours is a society where information is king. Guttenberg began the explosion of mass media. Marconi and Farnsworth multiplied it by inventing radio and television. The information age of the World Wide Web has created an environment in which consumers want and expect nearly instant access to essentially all types of knowledge via digital means. Video will become integral part of the medical record as electronic patient charting spreads. Against this backdrop, it should come as no surprise that our patients are information consumers. They want to know more about what we do in the practice of medicine than we have historically been willing to divulge. They want to know about us, the practitioners of medicine. Their desire for information, as evidenced by popularity and ratings, includes broadcast video of procedures and patient care encounters. Video recording has already entered the clinical environment and is unlikely to be evicted. Our business is education and patient care. Poorly educated patients and families make bad decisions in times of illness and crisis. Broadcasts of emergency medical care educate viewers about the reality of being a patient in the emergency department. This should diffuse some of their anxiety over facing the unknown.

Medicine has traditionally wrapped itself in a cloak of secrecy by invoking the inviolable status of the physician-patient interaction. While none should question the basic patient right to privacy, in this debate we should not be so naïve as to believe that the only source of assault on patient confidentiality is from the video media. There is a long queue of interested parties who would love to know more about our patients; governments, insurance companies, corporations, and law enforcement agencies to name a few. Many laws exist that require involuntary or mandatory reporting of privileged patient information for the public good. Should we now disallow voluntary sharing of personal patient experiences by informed willing individuals to provide education for the same public good? It is not clear that such a prohibition would survive a First Amendment challenge. We should remember that video is simply a tool. It may be used for good or ill. It is incumbent upon the emergency medicine community to see that all potentially privileged patient information, not just video, will be used in a positive manner.

SAYING NO TO CAMERAS IN THE EMERGENCY DEPARTMENT

Joel Geiderman, MD

The issue of the commercial filming of patients in hospitals has recently come to the fore as a result of the proliferation of reality television shows that are dedicated to this subject. Emergency medicine and its practitioners have been in the vanguard with regard to participation in these programs, as well as efforts to regulate and control them. This article examines the thorny ethical issues that arise during such filming and argues against emergency department /emergency physician participation in such activities.

The Producers' Perspective

Producers of reality programming find an ideal opportunity when it comes to filming in hospitals—especially emergency departments. The public has long had a healthy appetite for fictionalized medical dramas, the latest example of which is the long running, number one rated "E/R." Add to this the current rage for "reality TV"—where real people can be seen in moments of danger, crisis, pain, or grief—and filming that occurs in the ED results in a highly marketable commodity. Whereas an hour programming of "E/R" may cost producers 20-30 million dollars, producing a reality program is cheap. After all, there are no writers or actors to pay! Of course, producers and journalists lay claim to some educational value derived from these activities as well as the public's "right to know", but to me these claims ring hollow.

Producers have taken the position that in order to be able to capture as much drama (and blood and guts) as possible, filming must take place first, and patients