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

must be asked to sign consent for actual broadcast later. The problem with this approach is that by the time the patients are asked for their "consent", their privacy (as opposed to their confidentiality) has already been violated by the film crew and others who watched as their cloths were cut off, their bodily orifices were filled with plastic and latex tubes, and their loved ones anguished over them.

Ethical Issues

Ethical issues are usually examined through the prism of the principles articulated by Beauchamp and Childress; namely, autonomy, nonmaleficence, beneficence, justice, and fulfillment of professional obligations—including the duties to uphold privacy and confidentiality.

In this circumstance, autonomy can only be fulfilled if the patient is asked in advance whether or not they would like to participate. Under current practices, this does not routinely occur. When patients are routinely filmed before consent occurs, this violates what a good portion of them would have wanted for themselves if asked. Another concern with regard to consent is that many patients who come to the ED lack, to a varying degree, sufficient capacity to give consent. These include patients who are severely ill or injured (e.g. with sepsis, myocardial infarction, or hypotension); intoxicated; psychiatrically disturbed; or experiencing severe pain, anguish, or grief. Other problems with consent are possible language or cultural barriers, status asymmetry (between caregiver and patient) and the inability to foresee the full consequences of an action that must necessarily be made in haste in a situation where there is no possible medical benefit.

Nonmaleficence in this instance involves ensuring that harm does not come to patients. This includes ensuring that patient (and family) stress and grief are not exacerbated, that patients are not exploited, and that they are making a choice that they can fully comprehend and that they will not regret at a later date. Additionally, it must be assured (and there is no way to guarantee it) that the very presence of cameras will not deter some patients from seeking necessary ED care. Beneficence lies in assuring that the patients who are being filmed—as well as those who run the risk of being ignored while staff are distracted with the filming activities—receive the best possible care. Finally, justice may not prevail, since filming is more likely to occur at large public hospitals that treat a disproportionate number of poor and minority patients.

Participating in exploitative television shows may also result in harm to the profession in general, and to emergency medicine, in particular. Such exploitation will, sooner or later, be obvious to the public. In addition, the commonly held image of the zoo-like atmosphere that some members of the public have about EDs, risks being amplified by the broadcasting of these shows, which are produced for maximum dramatic and entertainment effect.

Legal and Regulatory Considerations

These have been reviewed elsewhere and space limitations preclude a full discussion of these issues here. In short, violating patient privacy runs the risk of litigation for "intrusion" claims, as well as the violation of state and federal statutes (including, in the near future, HIPAA).

Opinions of Professional Organizations and Authoritative Journals

The Council on Ethical and Judicial Affairs of the American Medical Association has approved a set of guidelines governing commercial filming of patient care activities. Included among these guidelines is a requirement for advanced consent for filming. I recently published a more exhaustive list of guidelines in *JAMA*. In this guideline I noted that "these recommendations would preclude filming in emergency departments of most urgent patient-physician interactions (eg, trauma, cardiopulmonary resuscitation) and of children and others deemed vulnerable."

In 2002, the American College of Emergency Physicians (ACEP) approved a policy stating that it "discourages the filming of television programs in EDs except when patients and staff members can give fully informed consent prior to their participation." The Society of Academic Emergency Medicine (SAEM)

published a policy statement in March of the same year, stating: "Image recording by commercial entities does not provide benefit to the patient and *should not* occur in... the emergency department setting." To date, the American Academy of Emergency Medicine has yet to weigh in on this subject.

Summary

There are few patient-centered arguments to support the current practice of EDs (and EPs) participating in the filming of reality television programs. The potential ethical violations of patients' rights cannot be justified and therefore this activity should be halted. This can and will occur when emergency physicians refuse to participate.

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2) Iserson KV. Film: exposing the emergency department (editorial).*Ann Emerg Med.* 2001; 37:220-221.
3) Foubister V. "Acting in the ER", *American Medical News.* 2000; 43:8.
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6) Patient rights and informed consent when videotaping or filming. Joint Commission on Accreditation of Healthcare Organizations. Standardsclarification. September 26,2000. Available at: http://www.jacho.org/standard/clarif/ri/rights.html <http://www.jacho.org/standard/clarif/ri/rights.html>. Accessed 8/8/2000.
7) CEJA Report 3-A-01- Filming patients in healthcare settings.
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REBUTTAL TO "SAYING NO..."

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I am sure that the positions espoused in my editorial for the pro side of the debate regarding the presence of commercial filming in the ED will be controversial. Despite strongly held opinions on both sides, it is my hope that discussion on this topic can avoid vitriol. While some emergency physicians (EPs) will disagree with my arguments, others will recognize their merit.

The old adage about medicine being "hours of boredom punctuated by seconds of terror" is true. This is the physician's perspective. Most of the public knows that they are likely to be emergency patients someday, but unfortunately they know nearly nothing about what to expect in the ED. It is my opinion that this is the real reason for the popularity of emergency medicine "reality TV". There is nothing like being in a real ED. Ours is the business of life, death, near-death, and resuscitation. Rather then completely banning broadcast filming in the ED, the goal should be to manage the process of educating the public about what real ED practice is. Emergency medicine (EM) needs a seat at the editorial board to protect our patients and our practices. This is realistic and doable.

Against this backdrop, arguments that summarily dismiss potential educational value to the public of broadcast filming in the ED seem misguided. Organized EM should include the general population in the target audience for accurate teaching. Similarly, arguing that retrospective consent violates privacy seem unfair since the "first SAEM Ethics Consultation request" entitled "Filming of Patients in Academic Emergency Departments[1]" states that retrospective consent is allowable for educational filming if the audience is composed of medical professionals (but not for the lay public). Filming of resuscitative efforts for patients who have suffered acute medical illness or traumatic injury is common for education, peer review, and quality assurance. Consent for this type of filming is usually covered by the ED 'consent to treatment', which many have seen and few have read. Patient filming in this setting results in video that is unedited and fully exposes the patient's anatomy, traumatic emotions, and clinical course. Yet, such filming is allowable under our current guidelines. In the interest of fairness, it would be interesting to know what percentage of hospitals currently practicing such filming allow patients to review their videos or opt out of having it seen by medical staff.