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Not a "Reality" Show

Terence Wrong and Erica Baumgart

ABSTRACT

The authors of the preceding articles[1] raise legitimate questions about patient and staff rights and the unintended consequences of allowing ABC News to film inside teaching hospitals. We explain why we regard their fears as baseless and not supported by what we heard from individuals portrayed in the filming, our decade-long experience making medical documentaries, and the full un-aired context of the scenes shown in the broadcast. The authors don't and can't know what conversations we had, what documents we reviewed, and what protections we put in place in each televised scene. Finally, we hope to correct several misleading examples cited by the authors as well as their offhand mischaracterization of our program as a "reality" show.

At ABC News we are bound to uphold the division's "standards and practices" policies, which contain a strong ethical component. These policies, basic journalistic ethics, and common sense governed our actions throughout the production of *Boston Med.* Although ethical journalism and ethical medicine don't always overlap, they share common values. In particular, we would never want something to happen or not happen just because we were there. We would never want the quality of care impacted. Still, ethicists and journalists start from a fundamentally different place. Journalists hope patients will consent to waive their privacy, while ethicists are geared to protect it.

Prior to filming at a hospital, we meet with hospital administrators and clinicians in an effort to arrive at ground rules that will allow both missions (ours and theirs) to go forward with a good chance of success and minimal conflict. Krakower, Montello, Mitchell, and Truog raise some valid concerns. I'd like to use this opportunity to correct some inaccuracies and give behind-the-scenes context to the patient and doctor vignettes that were broadcast. In the end, the authors of the preceding articles can't know what was excluded from the final broadcast or the rigorous background work that went into what was finally included. In other words, they lack the context for each case they cite. Even with more information, it would be challenging to deconstruct the elaborate unseen infrastructure of meetings, documents, and other arrangements that allowed the several dozen scenes that were ultimately broadcasted.

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The first point to correct is the label in Krakower, Montello, Mitchell, and Truog's title, "The Ethics of Reality Medical Television." Until now, no one has referred to our ongoing hospital documentary series as a "reality" program, not ABC News, not the hospitals themselves, nor the journalists who write about television in newspapers and magazines. "Reality" is a fairly loaded label, and to many it carries with it more than a whiff of exploitation and the sensational. Television professionals know that reality shows usually involve a paid cast of characters, signed up under highly restrictive contracts, and brought to a set or controlled location where they will act out scripted scenarios. The dialogue may be improvised, but often little else is.

Now let's consider *Boston Med*. It is produced by a veteran broadcast journalist with 29 years working in television news and documentary. Half of my career was spent reporting from overseas in war and crisis zones. For example, I was ABC's lead producer at the Berlin Wall the night it fell. I have no background in "reality" television. As previously mentioned, we are obliged to follow news division guidelines. About the environment or "location" where we produce this series: it is a hospital, and we do not control a single room or thing that happens there. We don't create scenarios and our "cast" are caregivers and patients who we observe as they go about the normal business of delivering and receiving care. We follow minimally intrusive methods of filming, consistent with traditional cinéma verité documentary making. Mostly, this comes down to a lone videographer in scrubs (with a hospital ID that says "Press") working in a unit, shouldering a small camera with no lights or cables. Our original hospital series, *Hopkins 24/7*, won a duPont-Columbia University Award for journalistic excellence. The next edition, simply called *Hopkins*, won a Peabody. *Boston Med* won a CINE "Special Jury" Award for being one of three top *documentary* series that year.

The authors state that "patients stand to gain nothing" by consenting to be filmed. How do they explain the hundreds of letters we have received from patients thanking us for showing their surgery or treatment in the series? They often keep the program as a keepsake and a way to explain their medical ordeal and struggles to others. In the case of minors, we have been doing this long enough to see them grow up and express gratitude that there is a visual record of what was often a turning point in their lives. Sometimes, it helps patients understand what their parents endured emotionally. Often, families ask us for the footage. We have even received those requests from the families of physicians who have passed.

Krakower and colleagues state that once patients gave us consent to be filmed, they couldn't later rescind their permission. In fact, this has never been the case. Patients may revoke their consent at any time up until the actual broadcast, a full year after they were filmed. Moreover, patients are often contacted multiple times by our staff during the intervening period until the broadcast. Besides getting an update on their progress, we usually seek additional information related to their treatment or condition. During these conversations, we always ascertain that they are still comfortable being portrayed. To date, we've maintained long-standing relationships with many patients and families. Sadly, sometimes families request footage as a keepsake to memorialize patients who have passed away. This can be incredibly meaningful to the family. Caregivers may also decline to be filmed or drop out of the documentary at any time. We maintain a file during production on who specifically has "opted out."

Krakower, Montello, Mitchell, and Truog state that the patients and staff "were told that once they agreed to be filmed, they would not be able to see what was filmed, or rescind consent." ABC News—and all other reputable news organizations, large and small—adhere to the principle that subjects of a work or of reporting must not read, view, or be able to influence the work being done about them before broadcast or publication. This is basic to balanced and objective reporting, whether for a documentary or a news report.

Another concern raised is related to the question of patients' "competence" to give informed consent to being on television. Frankly,

over the course of making each edition of this series, we have always been struck by how well patients understand the essence of the program we are making. Many of the patients who consent to be filmed articulate the hope that portraying their care will inform the public about a particular disease process or perhaps give heart to other patients fighting the same disease. We believe this is exactly what sharing their individual stories accomplishes. Anecdotally, we have been approached many times by patients who tell us that they found the courage to undergo a particular procedure because they had seen it performed on a patient in one of our earlier series. Talk about things coming full circle. In one case, we were actually filming a pre-surgical consult when the patient cut the doctor off and said, "I know all about what's going to happen, I saw that lady have the operation done in *Hopkins*."

Unfortunately, Krakower and colleagues are forced to make judgments based on the few minutes of each case that were included in the *Boston Med*. It's not their fault that they couldn't be there with us during filming or editing, but it does mean they were sometimes deprived of the larger context and facts that actually contradict or mitigate their point. Here's one example they cite:

> A 49-year-old man with a history of heroin and alcohol abuse is seen in the emergency department while inebriated. The doctors and staff in the ED are pictured chuckling at his offbeat behavior, and a resident is quoted as saying, "This guy's pretty entertaining." The camera focuses on the man's "born to lose" tattoo while he dances and sings inappropriately on his gurney. He is later filmed kissing his lunch.

Actually, the man had a bipolar diagnosis and was off his meds. The young resident in question had spent close to an hour with the man, displaying great compassion and eventually giving into his playfulness and joking, hence his comment, "This guy's pretty entertaining." When we visited the patient at home a year later to make sure he was still comfortable being portrayed, he was on his meds. We reminded him in detail of exactly what his conversation with doctors had been and how he appeared. He said he thought the caregivers did an amazing job caring for people like him, that he was a "frequent flier" in that particular emergency room, and that he was comfortable with the public seeing how patients with mood disorders like his are treated humanely.

Krakower, Montello, Mitchell and Truog also mention the case of another patient with altered mental status. This one, however, is belligerent and abusive to staff. The authors claim that his dignity may have been violated by exposing his surly behavior. However, it was precisely to protect him from these retrospective feelings that we blurred his face and altered his voice. These authors incorrectly state that his voice was "unaltered," and might give his identity away. They are wrong about this. Perhaps they may not know that the latest audio software can now disguise voices without making them sound robotic. Finally, the authors should know that we were thanked by ER staff for showing that scene because they believed it captured the difficulty and unpleasantness that they sometimes confront when trying to deliver care to unreceptive patients.

Several times Krakower and colleagues raise disturbing questions, but are unable to support or answer those questions with examples from the program. In the same vein of misunderstanding that led the authors to call us a reality show, they ask at one point if the producers of *Boston Med* engaged in a *quid pro quo*, perhaps unspoken, with patients to get their consent by promising or implying that they might receive better care if they agree to be filmed: "perhaps those in more desperate clinical situations were more vulnerable to implicit coercion or manipulation, or the unspoken possibility that participation would improve their odds."

In fact, both in our conversations with patients and on the consent form they signed, it was stated clearly that participating in the series would not help or harm their care in any way. Caregivers and producers were always at pains to repeat and emphasize this principle at the outset of any filming. Perhaps this is a good place to mention that most of the producers and

not a few of the videographers are themselves from medical families. I am happy to say that those who produce medical series have not just a passion bordering on reverence for the medical profession, but they consider medical documentary work a calling.

Another worry for Krakower and colleagues is whether caregivers may have been distracted from delivering their most focused care because they were too conscious of—or too complicit with—the camera. I would answer by saying that it is unfortunate that the authors were unable to watch the hundreds of hours—weeks and months worth of footage—filmed with each caregiver that was not broadcast. In practice, after a day or two, caregivers who don't relax and just go about their business, who don't lose the "butterflies in the stomach" feeling, either "opt out" of being filmed or we decided to stop observing them. It is also my conviction that no one remains camera-conscious over such a sustained period of observation. To support the notion that we might have affected care negatively, the authors cite the example of a young ED resident who struggles to do an intubation during a code. After describing the scene, they make the following comment: "The effect of the camera in the room may be difficult to identify or measure, but it is possible the presence of a camera and crew changed or hampered resuscitation. Several times in the series, staff spoke directly to the camera while performing work duties, suggesting it was not always an inert factor in the room. . . ."

Fair enough, but during the incident they cite, at no time did the resident in question address anyone other than her coworkers. She never addressed the camera or said anything that one would imagine her saying if the camera weren't present. She is surrounded by half a dozen colleagues supporting her efforts, and they are all working frantically. Krakower and colleagues do not mention a single case in which care appears to have been affected negatively. This seems like a good place to point out that, in our agreement with the hospital, and in introductory meetings with the full clinical staffs of each unit—especially nursing—it was stressed that anyone on the care team can ask us to leave a room or an area at any time with no explanation required. During filming, this does happen, and in each situation we comply immediately and withdraw.

One more point about residents in training who are depicted being "pimped" or constructively criticized by demanding attendings. Far from being humiliated, they are mostly grateful that their own families and friends can now see and understand the rite of passage that their training entails. As with the patients who undergo major surgeries, we tend to remain in contact with the residents who appeared in our past series. They too, for the most part, regard the program as a keepsake and remain happy with their decision to participate.

Another matter that troubles the authors concerns "surrogate decision makers for consent." In such cases, patients may die or be incapacitated in such a way that they cannot give consent to be filmed. In these instances, sometimes consent is obtained from a family member, legal guardian, or healthcare proxy. One can almost see the hand wringing as the authors ask: "Should parents be allowed to consent for their child?" It is strange that the authors believe a family member can be trusted to give consent for a surgery that may be life-altering or even life-ending, but can't be trusted to permit a loved one to be filmed. I'd like to emphasize that even with family consent, if patients recovered enough and regained their power to grant consent, we always sought to obtain it, and, if refused, we refrained from broadcasting the case. In the case of minors, sometimes even when parents consented, upon review, we decided to exclude the case, and decided that broadcasting it would be inappropriate. We have to exercise good judgment and sensitivity. We never forget that this is delicate work and, as Krakower and colleagues state, dealing with grief-stricken families is an area where it is wise to move slowly and leave everyone adequate time to reflect on decisions or choices.

Krakower and colleagues also cite the case of physician error shown in the series during a heart surgery. They posit that exposing this incident could damage the reputation of the physician. In fact by the time we aired this segment,

the physician in question was no longer on the Massachusetts General Hospital faculty with privileges. In addition, the pediatric heart surgery program at the hospital had been largely suspended and was under review. The particular case in question had been covered in detail in the local newspapers. Our segment, however, mentioned none of this fallout. In fact, the surgeon is depicted as ethical, humane, and candid in how he dealt with the error. The family in question refused to have another surgeon do the subsequent corrective surgery and remained confident that the original "honest" surgeon should do the correction, which is precisely what happened.

The authors are concerned that the confidence of young doctors in training could be adversely effected by having their mistakes portrayed, or by showing "pimping"—the process of interrogation and criticism at the hands of established attendings. During a cardiac surgery, an attending tells a resident, "your technique sucks." This resident went on to become an attending surgeon at a major hospital and at no time did he ask us not to use that scene. Residents, like other hospital staff, can "opt out" and choose to cease participation at any time. Incidentally, the fourth-year emergency medicine resident who struggled to intubate her patient also went on to a successful career as an attending, and graduated Harvard Medicine with high honors. Those who participated in the filming were supportive of the notion that showing the good, the bad, and even the ugly, educates viewers about the mission of a teaching hospital and the process of making a doctor. They put their faith in us to show that missteps occur when learning is going on.

Krakower and colleagues also worry about patients' reactions to portraying the teaching or pimping that goes on. They write, "Although the patient had a positive outcome in this case, it is possible that seeing this surgery might cause her retrospective distress." They fail to consider the equally probable possibility that the patient may have watched the scene when it was broadcast and said, "Boy, my surgeon was a tough taskmaster, he sure was on top of that resident. I bet I got top-level work done on me."

Staff demeanor is another area that gives the authors qualms. In particular, they seem bothered by what they regard as inappropriate humor. The authors lament moments that were broadcast, in which a caregiver may have made a sarcastic remark about a particularly troublesome or unruly patient. They characterize this as the patient being "mocked." First, it should go without saying that we never put words in anybody's mouth or prompt them to say anything. Second, doctors and nurses are not saints, and ERs are not full of well-behaved, courteous patients. Not infrequently, staff have to deal with verbal and even physical assault. They are exposed to highly infectious patients who spew bodily fluids, make unwanted advances, act belligerently and sometimes violently. Some of the patients are intoxicated with drugs or alcohol and others are psychotic. It is understandable that these type of encounters may engender black humor on the part of caregivers: it is a coping mechanism. Choosing to broadcast moments like these, rather than air brush them onto the edit room floor, gives a realistic portrait to viewers of what staff must contend with, and, paradoxically, deepens their humanity. That said, in the great majority of cases we cover, caregivers behave with compassion, sensitivity, and a practically superhuman degree of self-control.

The authors express their disapproval that we seek to include windows into the personal lives of the caregivers we profile. In particular, they quote pediatric cardiologist Elizabeth Blume saying, "It was hard to maintain boundaries" in her explanation of why she chose not to invite the camera into her home. However, the quote by Blume has been used out of context. She made her remarks at a symposium about *Boston Med* that was held at the Harvard Medical School and organized by one of the authors. I was present when she spoke. A fuller rendition of Blume's comments would have included her conclusion that after watching how other physicians were portrayed at home with their families, she regretted not letting the ABC team portray her in a more fully rounded way, and see her discussing homework with her daughter at the kitchen table.

Patients' privacy is of course the main bugaboo. The authors wonder about emergent cases where patients are clearly not in a position to give consent to be filmed, and they ask, "To what extent should patients' privacy have been honored?" The correct answer is: patients' right to keep their medical information confidential from the public should be absolute. To us, this means that no patients should ever be identified in a broadcast without having consented to being identified and having the details of their medical treatment exposed. In some instances we will conceal patients' identity altogether. We do this by making sure that neither face, nor voice, nor tattoos, nor any other identifying aspect of the individual—specific facts such as age, gender, or the circumstances of injury—will compromise patients' medical privacy. Even if we don't report it, should we even be in a position to learn of patients' medical condition without their consent? After all, "ER tourists" such as third-year medical students, instrument salesmen, and hospital administrators are not part of patients' immediate care circle. In our case, hospitals decided there is a benefit to educating the public and allowed us to observe. Taken into consideration is our status as a deeply experienced medical documentary unit that has worked for over a decade in some of our nation's most august medical institutions. We are trained in Health Insurance Portability and Accountability Act (HIPAA) and hygiene protocols. We undergo background and health checks, and our vaccinations are up to date.

Krakower and colleagues sum up with an anonymous quote attributed to a physician: "The series was a bad idea catering to the worst aspects of voyeurism for the public."

Professional journalists and documentarians tend to hold anonymous quotes in low regard. In fact, as for what physicians thought of the series, faculty from Massachusetts General Hospital and Brigham Women's Hospital were in attendance at the Harvard Medical School symposium arranged to consider *Boston Med*. Also in the audience were family members related to patients who were portrayed in the series. Not a single speaker regretted their participation in the broadcast or offered a negative assessment. On the contrary, the prevailing sentiment was overwhelming: the series had been a comfort to them personally—sometimes documenting the last days of a loved one—and had served the public interest by providing an inside look at how top medical centers confront their work.

Since we were first asked to respond to Krakower and colleagues, we have broadcast another edition of our medical series, this time examining institutions in New York. We continue to be invited into top medical centers across the country. Presumably, ethicists at those hospitals will be concerned about protecting patients and staff from programming that they may perceive as exploitative. We share their concern and do our utmost to maintain rigorous standards and self-scrutiny. However, what is not debatable are the empirical benefits of the series, including: spikes in the recruitment of emergency medical technicians and nurses, applications to medical school, thousands of viewers signing organ donor cards, and the many anecdotal stories we hear from patients who tell us that the series gave them courage to get through difficult times. Above all, we continue to believe that the greatest service performed by this type of programming is to give our viewers—all of them potential patients—a more realistic portrait of both the achievements and limitations of modern medicine.

NOTES

1. Krakower, M. Montello, C. Mitchell, and R.D. Truog, "The Ethics of Reality Medical Television," in this issue of *JCE*.