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The Ethics of Reality Medical Television

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ABSTRACT

Reality medical television, an increasingly popular genre, depicts private medical moments between patients and healthcare providers. Journalists aim to educate and inform the public, while the participants in their documentaries—providers and patients—seek to heal and be healed. When journalists and healthcare providers work together at the bedside, moral problems precipitate. During the summer of 2010, ABC aired a documentary, *Boston Med,* featuring several Boston hospitals. We examine the ethical issues that arise when journalism and medicine intersect. We provide a framework for evaluating the potential benefits and harms of reality medical television, highlighting critical issues such as informed consent, confidentiality, and privacy.

Television viewers have been fascinated by the human drama of fictional illness and injury, beginning with *Dr. Kildare* in the 1960s and continuing with *M.A.S.H.* in the 1970s and 1980s. More recently, reality television has combined with this long-standing interest in medical drama, and camera crews have begun to film patients at the bedside, surgeons in the operating room, and birthing mothers in labor. The ABC documentary *Boston Med,* which aired in the summer of 2010, was widely admired and critically acclaimed, and presses home the need for exploring the ethical issues involved in this kind of filming. The eight-part series, available at *www.http://abc.go.com/watch/bostonmed/SH5570013,* focuses on three prestigious Boston hospitals, following physicians, nurses, and patients through events that are satisfying and harrowing without flashy editing or obvious manipulation. Following the genre of "reality television," the show features purportedly unscripted interaction, documenting actual events and filming ordinary people. While engaging and technically adroit, reality television in the medical arena raises ethical questions that should be carefully considered by physicians, hospital administrators, medical staff, journalists, producers, and the viewing public.

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Several months after the series aired, we identified and explored the ethical issues facing *Boston Med* and the genre of reality medical television through a public forum sponsored by the Division of Medical Ethics at Harvard Medical School.[1] In addition to watching segments from several episodes, we convened a panel discussion that included the producer from ABC News, the wife of one of the featured patients, the chief medical officer of one of the participating hospitals, the associate chief nurse of another, and several other participating administrators and healthcare providers. We also solicited comments from the local medical community to gain insight into the motives and experiences of the patients, clinicians, and families who participated in the televised series.

COMPETING CODES OF ETHICS

When a hospital opens its doors to a camera crew, and journalists join patients in times of crisis to record physicians and nurses at work and at home, which code of ethics should be followed, and by whom? When journalism and medicine intersect, which ethical principles apply? While being filmed in their interactions with patients, should physicians be held to the usual rules of confidentiality, consent, privacy, honesty, and autonomy on behalf of patients? Should journalists be accountable to those same rules and principles as they cross into and become active agents in the medical sphere, or are they held only to their own code of journalistic ethics?

Journalists and health providers abide by their respective professional codes of ethics, with influence from individual moral intuition. While physicians and nurses are primarily responsible for protecting and serving patients, journalists must balance a duty to inform the public with a duty to not harm private persons. Which responsibility should take precedence? When documentary filmmakers were interviewed in a study conducted by the Center for Social Media at American University, many said that, in the absence of any firm or widely accepted standard, ethical dilemmas are resolved on an *ad hoc*, individual basis. In general, they expressed a primary commitment to "do no harm" and "protect the vulnerable," although how individual journalists prioritize those goals while providimg information to the public may be highly variable.[2] Such situational ethics may be particularly vulnerable to subjectivity, individual self-interest, and *ad hoc* values.

INFORMED CONSENT, PRIVACY, AND CONFIDENTIALITY

Clinicians may react with caution or even criticism when viewing *Boston Med* because physicians and other healthcare workers are accustomed to explicit rules and standards of privacy, confidentiality, truth-telling, and informed consent that are not defined as rigidly or precisely in the ethics of journalism. The Society of Professional Journalists (SPJ) *Code of Ethics* does not specifically address informed consent, but adheres to several important principles that show a similar impulse:

- Show compassion for those who may be affected adversely by news coverage.
- Be sensitive when seeking or using interviews or photographs of those affected by tragedy or grief.
- Recognize that private people have a greater right to control information about themselves than do public officials and others who seek power, influence or attention.
- Show good taste. Avoid pandering to lurid curiosity.[3]

Hinged on compassion and sensitivity, the SPJ *Code of Ethics* cautions journalists to use common sense and widely accepted values. The emphasis is on the moral behavior of the individual journalists. Prescriptive guidelines are absent from this code.

The imperative of informed consent in clinical and research ethics is considered by the medical community to be central to sound practice. It specifies that patients who are competent to make decisions must receive adequate disclosure of the risks, benefits, and alternatives of certain choices; show evidence of understanding the information; and make decisions that are voluntary.[4] Medical ethics acknowledges the dynamic nature of patients' wishes and stipulates that consent may be withdrawn

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in both the research and clinical spheres until a "point of no return" has been reached. While both journalists' ethics and medical ethics attend to the interests of persons/patients, they are generally applied differently; only the medical code of ethics articulates inviolable moral boundaries for protecting and empowering the potentially vulnerable person.

For *Boston Med*, the process of gaining initial contact with patients varied. During the public forum, producer Terence Wrong said,

> Sometimes we go to clinics and the administrative assistant . . . or the nurse practitioner or the physician's assistant will say, "There is an ABC documentary being made about the medical care here. Would you be willing to talk to the producers about it?" And usually always adds, "In no way will your care be affected one way or another." The hospital put cards in waiting rooms and posters and things that specifically made that point. You don't have to do this. It's not going to affect your care one way or another.

Jeannette Pollet, whose husband was a featured patient on *Boston Med*, said one of his treating doctors asked them to consider participation, and that they were provided with a simple consent form (not publicly available). She said,

> We weren't told good reasons, bad reasons. It was one simple form, and we were told we would not be able to see the film ahead of time. In other words, when it aired, I had no idea what was going to show. And we were filmed in the patient's room, in the hallways, many different environments with and without the doctors. But, no, it's really "would you be interested?" and no stipulation, no payment; so no other motivating factors that would have coerced us, so to speak.

Producer Wrong reported that most of those approached consented to being filmed, although the rate of consent varied widely among patients according to their medical problem. For example, he said that about 99 percent of potential transplant patients approached gave consent, but only about half of teenagers or those considering plastic surgery consented. In the emergency department, about 80 to 90 percent of those approached consented.

Patients were reportedly given the right to refuse filming, and cameras were quickly turned off without further question. In curious contrast, other participants (patients, physicians, and the hospitals) were told that once they agreed to be filmed, they would not be able to see what was filmed, or rescind consent. Wrong said this was necessary to maintain the integrity of the documentary, to protect it from censorship.

Wrong said that he felt physicians' commitment to medical ethics caused them to respect journalistic ethics:

> As a news organization, our standards and practices are that we can't show you the report before it airs and you don't have the right to essentially censor any part of it. And this is applied to all of our reports across the board, and as a precedent, it would be terrible if we gave in anywhere on that. You can think of an interview with a politician, you can think of any context you want. And I particularly bristle at that, kind of reflexively, because I spent 15 years as a foreign news producer going to countries where we had to turn in our tapes to the ministry of information for review before being allowed to leave the country. So, of course, the hospitals never insisted on that. One of the great joys of working with teaching hospitals and doctors is they do have a very highly developed ethical set of precepts that they operate under. So they treated our precepts with the utmost respect the entire time.

Wrong described his filmmaking style as cinéma verité, in which the camera renders an unmediated view of reality—as if there were no camera. The technique seeks to make the camera invisible as it captures individuals at deeply personal and unguarded moments. Given this, *Boston Med* challenged three fundamental requirements of informed consent: competence, voluntariness, and disclosure.

Competence

A competent patient must be able to understand a medical decision, express the rationale

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for the decision, and understand the risks and benefits associated with the decision. Most patients and providers featured in *Boston Med* were competent by these standards to make decisions regarding their participation. Ethical safeguards are typically developed to protect more-vulnerable patients and subjects.

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.

In the moment, a patient like this would be considered incompetent to make almost all medical decisions. During the panel discussion, Wrong said producers contacted patients later, to confirm their consent. In the case of a patient with a dynamic level of competence, should the crew have filmed the patient—as they did in this case—with the hope of obtaining valid consent later? If so, what is the likelihood that a patient would later be able to adequately remember the details of an inebriated moment, without seeing the film, and to be able to understand the implications of his consent?

Voluntariness

Morally sound autonomous consent may be threatened by manipulation, coercion, and persuasion. The producers of *Boston Med* explained to participants that their care would not be affected, nor would they be paid. As noted above, there were noteworthy differences in consent rates for transplant patients (99 percent) and plastic surgery patients (approximately 50 percent). Such disparity may provide a valuable window into the psychology and motivations of those consenting. Although it is impossible to know the driving forces behind these differences, 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 2004, the American Medical Association Council on Ethical and Judicial Affairs addressed this area of consent with the "Ethics of Physician Participation in Reality Television for Entertainment," in which it recommends consent be obtained by a third party, not a member of the production team, to minimize coercion or conflicts of interest.[5] In the case of *Boston Med*, although the idea was often introduced to patients by their medical providers, producers obtained patients' consent.

Disclosure

In the clinical context, informed consent requires that physicians disclose the risks and benefits of a proposed procedure. With regard to risks associated with participation in *Boston Med*, the producers provided assurance that care would not be affected by participation or refusal to participate—a promise worth examining. Although in cinéma verité awareness of the camera is minimized, how can one promise that it will have no effect on what happens?

In the opening episode of the series a patient in dialysis arrests and a "code blue" is called. In the ensuing chaos, the code leader attempts to intubate the patient. Although she is ultimately successful, there is a delay in establishing an airway. 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, and at least part of their attention was directed to being filmed. Cinéma verité records moments of life and death; it is reasonable to ask whether it affects the outcome of care, positively or negatively.

Surrogate Decision Makers for Consent

Several patients died during the series. The deaths and resuscitation attempts were filmed.

An 18-year-old, asthmatic young man is brought to the emergency department in cardiac arrest. The scene segues to his resident physician's reflection on her need to be more aggressive and self-assured. The patient's face is shown without obstruction, intubated, while his chest is compressed by a machine and he undergoes last-ditch procedures such as needle thoracostamies. The camera pans to his sneakers while the team combs for different avenues of resuscitation and discusses his recent acceptance to college. His family is brought to his bedside, and their raw grief is captured on film, again without concealing their identities.

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Can consent to be filmed be provided postmortem? Should parents be allowed to consent for their child? In the medical realm, the AMA advises, "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."[6] The SPJ *Code of Ethics* advises journalists to "be sensitive when seeking or using interviews or photographs of those affected by tragedy or grief."

Those Who Did Not Consent

Participants were involved to varying degrees. Some physicians, nurses, and patients were featured and followed in the series; others were more peripherally involved; some faces were shown in the background. Faces of patients in the background were blurred for anonymity, but doctors' and nurses' faces were not.

A team of residents and nurses are shown being scolded by a consulting physician for administering a drug that he believed was unnecessary and may have caused the patient harm.

Should the producers—or hospital administration—have required that every member of the team consent to participation? Many patients who did not consent were included in the series with blurred faces.

An intoxicated man who presents to the emergency department is mocked by several staff members and then reprimanded by his nurse for his dangerous behavior. He is shown with his face blurred, but his voice unaltered. At the end of this interaction, his nurse is filmed saying, "I liked it much better when he was unconscious."

Although that patient's face was not identifiable, his voice may have been. Should this particularly vulnerable and potentially humiliating moment have been filmed without his consent simply because his face was not visible?

Privacy

Patients' right to privacy is a fundamental ethical and legal principle. Patients serve as their own gatekeepers—allowing or denying access to their personal information and their bodies. In contrast, the *Boston Med* crew often filmed scenes (moments in private persons' lives) first, particularly in emergency settings, and then requested consent later. To what extent should patients' privacy have been honored? Should hospitals be allowed to offer access to patients' personal and intimate moments, including death?

BENEFITS AND HARMS

In addition to these traditionally deontological concerns about informed consent, privacy, and confidentiality, it is useful to weigh potential benefits versus harms for the primary stakeholders: patients, staff, hospitals, the public.

Patients

While the stated goal of the production crew was to have no effect on the care provided, this depends on the possibility that providers are not influenced by the presence of cameras and crew, or by the possibility they will appear on national television—as a hero or as an embarrassment. Many times caregivers address the camera while working, including a nurse dispensing medication and a surgeon operating, both moments that are vulnerable to error.

At the public forum Theresa Gallivan spoke from a nursing and clinical operations perspective: "Were there operational challenges? Yes. The presence of cameras and crew, of course, caused a degree of disruption to . . . normal clinical operating procedures, particularly in an extraordinarily busy environment." Although she reported these disruptions were "manageable," how much disruption in a life-and-death circumstance is morally tolerable? At the same time, it is conceivable that caregivers were on their "best behavior" on film, or provided extra attention to patients on camera.

Potential benefits of participation. Some patients may have benefited from personal altruism. Jeanette Pollet reflected on her late husband's decision: "My husband felt like if he could just help one person, it would be well worth it." In retrospect, she said, they helped others by raising awareness of her husband's rare illness and the need for organ donors.

Potential harms of participation. At times careproviders mocked patients from behind a curtain, in full view of the television audience.

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Patients and families had no way of knowing, when they gave their consent, that such moments would be aired. When patients stand to gain nothing, and it is clear that they unknowingly risk public humiliation, should we act upon their consent? Consent is a necessary but not sufficient requirement for intervening in a patient's care. If a patient consents to a procedure that would be more likely to cause harm than to benefit, it is a physician's duty to protect that patient and withhold the procedure. Should journalists show "compassion for those who may be affected adversely by news coverage" and preserve the confidentiality and dignity of the patients, in spite of their consent? Witnessing their own experiences in retrospect—and on national television—may be painful or challenging in ways that patients may not be able to anticipate.

A chief cardiothoracic resident "consents" a young mother prior to aortic valve replacement and aortic aneurysm repair. He quotes to her a 1 to 2 percent chance of "something bad happening," but reassures her, "Dr. Cohn is the guy you want, he's been doing this for 40 years." We watch the surgery and see Dr. Cohn walk in after the resident has started the surgery and scold his resident for "screwing this all up . . . your technique sucks."

Although the patient had a positive outcome in this case, it is possible that seeing this surgery might cause her retrospective distress. Do filmmakers and hospital administrators have an obligation to warn a patient about potentially embarrassing material that will be aired? Do they have a responsibility to follow up with a patient who was filmed, to answer questions or offer psychological support if necessary?

Staff

Potential benefits of participation. Some providers may find that participation in a series like *Boston Med* is gratifying for the ways it may help current or future patients. Several physicians who participated in the series reflected on the benefits of their experience at the public forum. They cited positive feedback from patients and advocacy groups for raising awareness. Another physician reflected that she found her participation gratifying because she was able to publicly share the wisdom that she learns from her patients.

Potential harms of participation.

At 22 hours of life, baby Michael is transferred to his third hospital, where he will receive expert care for his life-threatening, congenital heart defect. His new parents anxiously await his reparative surgery that was originally scheduled for his fourth week of life, but it is emergently scheduled for the next day after he starts showing early signs of congestive heart failure. They place all their faith in his surgeon, who makes a critical, human error during the surgery, further complicating the baby's course. After weeks of the baby's struggle in the intensive care unit,, the surgical error is ultimately discovered. His surgeon swiftly and openly explains and apologizes for his error, which Michael's parents graciously forgive.

Although such vignettes may benefit the public by making them aware of the reality of medical error and how it is handled, it may come at considerable cost for clinicians whose lapses in skill and judgment are put on public display. Filming such events could significantly impact and even profoundly damage a clinician's reputation and future livelihood.

Another clinician commented on the erosion of barriers she set up to prevent access to her personal life. Elizabeth Blume, MD, said:

> The ABC videographers hung out with us for three or four months. They were part of our team. We knew about their families. We developed relationships with them. And, for me, as a relatively senior clinician who went in with very strict boundaries that I wanted to maintain–and I will admit that those were supported actually by a husband who wanted nothing to do with this and kids who actually were not that interested either—even with all of that, it was hard to maintain those boundaries. The crew wanted the story. They wanted me on the sideline cheering the soccer team. They wanted me doing homework at night. The boundaries were hard, even coming from where I was coming from. It was hard to maintain those boundaries.

Over time, the relationships between the journalists and their subjects were dynamic, given the intimacy of their shared space. Boundaries blurred as cameras wove together professional and personal worlds. Consent may have been given before participants could predict

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how they would respond being filmed, but once the event was aired, consent couldn't be "taken back." Some participants said they regretted that participation exposed their personal lives.

The Public

Potential benefit. A series like *Boston Med* may raise awareness of rare illnesses, increase organ donation, and empower patients. Terence Wrong explained his mission, through projects like *Boston Med,* is to help align the public's expectations with medical reality—a valuable goal, given that many well-known medical shows like *ER, Chicago Hope,* and *Rescue 911* typically portray wildly unrealistic outcomes from common interventions.[7] It is possible that, by witnessing real medical encounters, the public will be better prepared to interact with the medical system as more informed consumers of healthcare, with a more complex understanding of their careproviders, including the deep emotional investment that many physicians and nurses make in their patients.

Potential harms. But, in addition to seeing the compassionate care provided by many providers, the public also witnessed offensive and unprofessional care.

After a man presents to the emergency department with a stab wound inflicted by his wife, a resident physician looks to the camera and flippantly jokes, "All I'm sayin', is you better not mess with your woman."

In another scene, one obstetrics resident sends another obstetrics resident this prank page: "47 yo morbidly-obese woman, quadriplegic, with Tourette's syndrome needs a pelvic exam."

Although Wrong argues that it is important and honest to share the humor that physicians use to cope with stress, scenes like these may diminish the public's trust in physicians and hospitals. Patients and families may lose faith in their healthcare providers after seeing unprofessional and disrespectful behavior by physicians and nurses in these elite hospitals.

The primary goals of *Boston Med* are to educate the public and to realign its expectations with reality. But which reality is captured by this documentary—that of the patients, doctors, nurses, hospitals, or filmmakers? The process of whittling down 400 hours of videotape for each hour that was aired unavoidably introduces the risk of distorting reality and so misaligning expectations. John Grierson, a leader in documentary filmmaking, referred to the genre as "creative treatment of actuality."[8] Should documentary filmmakers maximize the transparency of values, conflicts of interests, and biases that frame their narrative choices?

The AMA implores physicians involved in reality television to prevent misleading information from reaching the public. In the case of *Boston Med*, patients and their providers were filmed in real crises, in actual medical settings, without scripts. But to attract and keep viewers, certain narratives were featured. In particular, as Wrong explained, "There's a host of criteria [for what you show], how relatable is the story. At the most basic level, it's a narrative and people like to have the beginning, they like to have the middle, and then they like to have the resolution. We do skew slightly towards positive outcomes because if every show was all about negative outcomes, nobody would watch it at all." From his perspective, producing a program that is well received by viewers must be balanced with the goal of accurately representing the provision of medical care.

The Hospitals

Potential benefits of participation. From the perspective of the hospitals, one hoped-for benefit of participation was to increase trust. Anthony Whittemore, MD, Chief Medical Officer of Brigham and Women's Hospital, explained his motives for supporting his hospital's decision to participate in *Boston Med:* "We welcomed the opportunity to open our doors and show the public a complex organization. I think the documentary [is] an opportunity to educate the public about our shortcomings, about our efforts to deal with them, and I think it's a major contribution in our effort to be much more transparent about our business."

Another potential benefit could be self-reflection. Seeing both inspiring and downright unprofessional behavior by staff may provide leaders of these hospitals and the staffs a glimpse into areas that call for change, growth, and development.

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Potential harms of participation. At the same time, by revealing themselves to the camera, the hospitals risk damaging publicity when errors and unprofessional behavior are aired alongside moments of excellent care. They risk losing the trust of patients and employees, as well as the respect of the public. At the panel, one physician participating in *Boston Med* opined:

> The series was a bad idea. Catering to the worst aspects of voyeurism for the public. It seemed that the focus was all too often on the personal lives of the staff. I was asked if I could have a camera crew come to my house and film my family, something that struck me as totally nuts and which I refused. While the team was generally very nice and respectful, I would have to say that this series seemed to be something with a preset agenda, looking to stir up drama and theatric events. Ultimately, it seems that the hospital catered to the lowest common denominator here, selling out the Harvard name and the plight of the patients for what seemed to be free advertising on a national stage.

CONCLUSIONS

Boston Med brought cameras to the bedside, filming beyond the curtains of patients' rooms, revealing their most intimate experiences, both traumatic and triumphant. The journalists' expressed goal was pure observational documentary, honoring the narratives they captured by not scripting, editing, or censoring them. The SPJ *Code of Ethics* recognizes the need for sensitivity, compassion, and respect for the relative privacy of private persons. Wrong suggests that physicians, already committed to a highly developed ethical framework, are apt partners with journalists, as they respect another profession's canon of ethics.

The field of medical ethics rests on a deep commitment to the sanctity of caring for the vulnerable. It has continually evolved, throughout history, around an understanding of patients' best interests. Our medical culture now accepts that patients own their bodies and their stories and may choose to withhold and share their bodies and personal information as they wish. They can refuse care–even when it is life-saving—even after having previously consented. Exams and procedures performed without consent are forms of assault. In contrast, documentary filmmakers juggle responsibilities to private persons, viewers, and their own art, often relying on "situational ethics" to navigate ethical conflicts.

Journalists and filmmakers work to inform. Physicians and nurses work to heal. When their work intersects at a patient's bedside, we need to be clear about which ethical framework should be followed. When the professions follow parallel ethical tracks, a gap is created where morally questionable situations can arise. The two professions collaborate best when they achieve an understanding and integration of their differing ethical obligations.

NOTES

1. "The Ethics of Boston Med," 10 March 2011, Division of Medical Ethics, Harvard Medical School, Boston, *medethics.med.harvard.edu/public_ programs/forums/03-10-11/,* accessed 15 February 2013.

2. P. Aufderheide, P. Jaszi, and M. Chandra, "Honest Truths: Documentary Filmmakers on Ethical Challenges in their Work," September 2009, *www.centerfor socialmedia.org/sites/default/files/Honest_Truths_Documentary_Filmmakers_on_Ethical_Challenges_in_Their Work.pdf,* accessed 15 February 2013.

3. Society of Professional Journalists, *Code of Ethics*, 1996, *www.spj.org/ethicscode.asp,* accessed 15 February 2013.

4. T.L. Beauchamp and J.F. Childress, *Principles of Biomedical Ethics*, 5th ed. (Oxford, U.K.: Oxford University Press, 2008.

5. "Report of the Council on Ethical and Judicial Affairs, CEJA Report 2-I-05: Ethics of Physician Participation in Reality Television for Entertainment," *www.ama-assn.org/resources/doc/code-medical-ethics/5045b.pdf,* accessed 15 February 2013.

6. Ibid.

7. S.J. Diem, J.D. Lantos, and J.A. Tulsky, "Cardiopulmonary Resuscitation on Television—Miracles and Misinformation," *New England Journal of Medicine*, 334 (1996): 1578-82.

8. See note 1 above.