

.REPORT OF THE COUNCIL ON ETHICAL AND JUDICIAL AFFAIRS*

CEJA Report 2-I-17

Subject: Ethical Physician Conduct in the Media

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Referred to: Reference Committee on Amendments to Constitution and Bylaws
(Edmund R. Donoghue, Jr, MD, Chair)

1 Directive D-140.957 (1), “Ethical Physician Conduct in the Media,” adopted at the 2015 HOD
2 Annual Meeting, calls for a report on the professional ethical obligations of physicians in the
3 media. The following analysis by the Council on Ethical and Judicial Affairs (CEJA) addresses
4 ethics concerns in this area and offers guidance for physicians who participate in the media.
5

6 PHYSICIANS IN THE PUBLIC SPHERE

7
8 Physicians’ knowledge is not confined to the clinical setting. Physicians have well-recognized
9 responsibilities to use their knowledge and skills for the benefit of the community as a whole,
10 whether it is by assisting a state health agency in identifying and tracing infectious disease during
11 an epidemic, advocating for improved health care resources to lessen health disparities, or
12 promoting behaviors that improve the health of communities [1]. Stepping into the media
13 environment can serve as an extension of this public function.
14

15 However, the expectations held of physicians as members of the medical profession and of persons
16 in the media are not always compatible. Participation in the media can have unintended
17 consequences for the physician and the medical profession. Information in the public sphere can be
18 sensationalized, misrepresented, or patently falsified, which can have potentially serious
19 consequences if the benefits and drawbacks of medical advice are not appropriately conveyed [2].
20 Furthermore, physician recommendations may not always reflect the standard of care [3, 4].
21

22 A CONTINUUM OF ROLES

23
24 Physicians can engage the media in a number of roles. For example, they can serve as conveyors of
25 information or advocates on behalf of public agencies or institutions; as expert consultants on
26 medical science and practice; as commentators on health-related issues of interest to the public; or
27 as journalists covering medicine-related stories. Imagine the following:
28

29 *Dr. A is head of a health care agency in the federal government. A physician with two decades*
30 *of public service experience, she is directly responsible for guiding the legislative goals of the*
31 *agency and is supported by a staff of thousands of federal employees. Dr. A often gives*
32 *statements to the press about matters under the agency’s jurisdiction, and has, from time to*

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1 *time, participated in press conferences to speak on urgent matters of public health or to make*
2 *statements intended to garner greater legislative attention and support.*

3
4 *Dr. B works at an academic medical center. He is frequently approached by media outlets to*
5 *comment on recent breakthroughs in medicine or topical issues in medicine and public health*
6 *that are making their way through the news cycle. Dr. B also regularly contributes opinion*
7 *pieces about medicine and health care policy to news outlets.*

8
9 *Dr. C is a physician whose work has been lauded by practitioners, academics, and celebrities*
10 *alike. Recently, she has launched a daytime television program in which she discusses popular*
11 *subjects related to medicine, public health, and a general assortment of topics regarding*
12 *health and well-being. Dr. C maintains a practice where she sees patients, but the majority of*
13 *her time is now spent producing and appearing on her television show.*

14
15 As a public official, Dr. A uses the media to further a political agenda regarding the health and
16 well-being of the American public, an agenda she has been tasked with upholding and protecting.
17 For her, the media is a vehicle to address the needs and concerns of the public, and to keep the
18 policy goals of her agency at the forefront of awareness among government and private actors
19 integral to the provision of medical care.

20
21 Dr. B is first and foremost an academic physician whose interactions with the media serve a more
22 consultative function. He generally offers his insight only when approached by the media, although
23 he may occasionally use his training and experience proactively to shed light on topics when he
24 feels the public may derive some educational benefit.

25
26 In contrast, Dr. C holds herself out to a national audience as a commentator on any number of
27 subjects falling under the general categories of medicine, health, and wellness—topics that are at
28 least in part developed by producers and pitched for their ability to boost ratings and increase
29 viewership. Her audience may or may not know the specifics of her training and experience,
30 although she uses her medical degree as a symbol of authority and credibility. Moreover, as a
31 media celebrity, the recommendations she makes on air may be especially persuasive [4].

32
33 Whatever role physicians adopt when they participate in the media is very different from that of a
34 clinical practitioner interacting with individual patients. Whether the medium is print, digital, or
35 social, physicians who take part in the media marketplace engage in what is fundamentally a
36 unidirectional relationship with the members of a vast audience who may regard themselves as
37 patients, but whom the physician will never encounter in person. When a video clip ends or a
38 reporter stops asking questions, the contact media physicians have with the audience ends. The
39 hundreds, if not millions, of individuals who have watched, listened, or read have no opportunity to
40 provide details about their unique medical histories, probe for more guidance about a treatment that
41 was discussed, or report back to the physician about what effect, if any, the physician's advice has
42 had.

43 44 FIDELITY, TRUST, AND DIVIDED LOYALTIES

45
46 For physicians in the media, then, navigating successfully among the potentially overlapping roles
47 of clinician, expert consultant, journalist, or (for some) media personality poses challenges. Being
48 clear about what role(s) they are playing at any given time is crucial [3]. So is being aware of how
49 media content they create or the media presence they have blurs the lines of medicine, journalism,
50 and entertainment [3, 5].

1 For a physician who pursues a distinct career as a singer, a dancer, or a cook on the line in a
2 restaurant kitchen, the new role is entirely different than that of a physician [6]. But when a media
3 career involves depending on the inherent authority of their MD or DO degree rather than their
4 training and skills, physicians in the media are taking advantage of the credibility and prestige
5 bestowed by the public and the media on members of the medical profession [6, 7]. It may never
6 occur to a cancer patient watching a physician on television that “someone highly credentialed
7 might mix critical medical advice with a touch of ‘shock and awe’” even when such behavior
8 might be condemned by other physicians and the medical profession as a whole [7].
9

10 Media entities themselves can have diverging interests and goals—winning a Pulitzer or an Emmy
11 for excellence may compete with attracting advertising dollars, viewership, and ratings. Where the
12 latter are the hallmarks of success, the qualifications of physicians who are media personalities, and
13 the quality of the information they are disseminating, can be secondary for producers and audiences
14 [6]. When there is temptation, or pressure, to attract an audience, it can be challenging for
15 physicians to navigate the overlapping roles of health care professional and media personality, and
16 to hold steady to the norms and values of medicine [7].
17

18 *Trustworthiness and Authoritativeness*

19

20 By using their medical expertise to reach out to an audience that is local, national, or even global in
21 scale, physicians in the media carry with them heightened expectations as trusted resources,
22 advisors, and representatives of the medical profession. Thus, like physicians in other roles that do
23 not involve directly providing care for patients in clinical settings, physicians in the media should
24 be expected to uphold the values and norms of medicine as a priority [8].
25

26 With respect to the recommendations or clinical perspectives a physician contributes to a media
27 forum, such information must be acquired through practical clinical experience or supported by
28 rigorous scientific research that has been carefully vetted within the peer-reviewed literature and
29 presented accurately in the appropriate context [9, 10]. Physicians should likewise be transparent
30 about the limitations of their knowledge or experience in a given area.
31

32 A message that is inaccurate, questionable, or false, may still be perceived as authoritative because
33 it comes from a physician [2, 7]. Efforts to correct or recant misinformation from the public forum
34 may prove futile. One contemporary example of this is the still pervasive but false public
35 perception that childhood vaccines are linked to autism, despite the fact that this perception rests on
36 a long-since discredited physician’s publication and there is overwhelming scientific consensus that
37 no such relationship exists [11]. Material that is of poor quality and that does not meet expected
38 standards of scientific rigor can mislead individuals who do not question the content of the
39 message, while the promotion of such subpar work can erode the public’s trust in the larger
40 medical community [7, 12].
41

42 *Maintaining Privacy in the Public Eye*

43

44 Physicians working in the media must be cognizant of their work’s impact on patient anonymity,
45 the process of patient consent (concerns of inadvertent coercion), and the potential to exploit
46 patients. They must also make decisions about whether they will present the outcome of a patient
47 case as a fictional representation or as a story of true events [2, 13]. While journalism requires strict
48 adherence to the facts and details of a story, physicians asked to recount a procedure or speak to
49 media about a particular case have a responsibility to obscure or alter details that would reveal a
50 patient’s identity unless the patient freely gave informed consent [13]. Physicians must also remain
51 sensitive to how a story will affect patients under their care, and avoid situations where breaches of

1 privacy and confidentiality may occur [13, 14, 15]. In the media, physicians may at times need to
2 emulate storytellers rather than journalists [13].

3
4 Physicians must exercise caution when they are asked to publicly diagnose celebrities, politicians,
5 or private individuals currently caught in the media's gaze. Physicians in the media must draw a
6 careful line between using the media to educate the public versus providing a professional opinion
7 when asked to comment on the physical or mental status of a public figure or someone else the
8 physician has not had the opportunity to personally examine [3]. While a sound professional
9 medical opinion reflects a thorough examination of a patient, the clinical history, and all relevant
10 information under the protection of confidentiality, none of this occurs when physicians make
11 casual observations about people [3]. There is a "critical distinction . . . between offering general
12 information about a condition as it pertains to a public figure and rendering a professional opinion
13 about an individual, involving a specific diagnosis, prognosis, or both" [3].

14
15 Moreover, physicians may be enticed into offering professional opinion that is outside their
16 individual area of expertise. Physicians who offer expert testimony in court are expected to testify
17 "only in areas in which they have appropriate training and recent, substantive experience and
18 knowledge" [16]. The same expectations should apply to physicians who offer public commentary
19 on health-related matters.

20 21 CONFLICTS AND DISCLOSURES

22
23 Competing interests are a fact of life for everyone, not only physicians in the media [17]. But as
24 individuals in positions of public trust, media physicians should be especially sensitive to possible
25 conflicts of interest. Even when there is no actual conflict, the appearance of influence or bias can
26 compromise trust in the physician and the broader profession, with downstream consequences for
27 patients and the public.

28
29 Taking steps to ensure transparency, independence, and accountability allows media consumers to
30 make informed judgments about the comments or recommendations offered by physicians who are
31 active in the media. Disclosing conflicts of interest is an essential first step [18, 19, 20]. Direct,
32 substantial financial relationships that may influence a physician's judgment, such as research
33 funding, remuneration for advisory services or speaking engagements, or equity interests in
34 featured products or services, should always be disclosed.

35
36 Nonfinancial relationships can also affect judgment and should be disclosed; for example, when a
37 media physician has fiduciary responsibilities to a commercial entity that has an interest in the
38 subject matter. Personal, political, ideological, or intellectual interests can also influence
39 professional judgment in particular situations and media physicians should be prepared to disclose
40 such interests [17, 21, 22].

41
42 Disclosure alone is not sufficient, however, and may have the perverse effect of inspiring false
43 confidence on the part of media consumers and even discourage the media physician from
44 rigorously ensuring that he or she is offering objective, unbiased information [23]. In some
45 circumstances, the threat of actual or perceived conflicts of interest may be so great that the only
46 way forward is for the physician to avoid the potential situation altogether.

47
48 Instituting measures to promote independent content is a further important step. For example,
49 editorial review of proposed content and presentation can help identify possible bias or the
50 appearance of bias or catch elements that media consumers might be expected to misinterpret.
51 Prohibiting physicians who have clear, unresolved competing interests from being media

1 spokespersons on issues that involve those interests can likewise help ensure independence [24].
2 Making explicit to viewers the measures taken to address and mitigate the influence of conflicts of
3 interest will hold media physicians accountable to their peers and the public for exercising sound
4 professional judgment.

5
6 CONCLUSION

7
8 As trusted members of the community who regularly communicate with the public about health
9 and wellness, physicians have a responsibility to consider their ethical obligations to their patients,
10 the public, and the medical profession. In an increasingly technologically adept media marketplace
11 where the context and delivery of messages are shaped by any number of social and financial
12 forces, physicians must carefully delineate who they are and how they want to be perceived.
13 Equally important, physicians should give thought to how they want to frame and support their
14 messages, and how those messages should be consumed and utilized.

15
16 RECOMMENDATION

17
18 In light of the foregoing analysis, the Council on Ethical and Judicial Affairs recommends that the
19 following be adopted in lieu of D-140.957(1) and the remainder of this report be filed:

20
21 Physicians who participate in the media can offer effective and accessible medical perspectives
22 leading to a healthier and better informed society. However, ethical challenges present
23 themselves when the worlds of medicine, journalism, and entertainment intersect. In the
24 context of the media marketplace, understanding the role as a physician being distinct from a
25 journalist, commentator, or media personality is imperative.

26
27 Physicians involved in the media environment should be aware of their ethical obligations to
28 patients, the public, and the medical profession; and that their conduct can affect their medical
29 colleagues, other health care professionals, as well as institutions with which they are affiliated.
30 They should also recognize that members of the audience might not understand the
31 unidirectional nature of the relationship and might think of themselves as patients. Physicians
32 should:

- 33
34 (a) Always remember that they are physicians first and foremost, and must uphold the
35 values, norms, and integrity of the medical profession.
36
37 (b) Encourage audience members to seek out qualified physicians to address the unique
38 questions and concerns they have about their respective care when providing general
39 medical advice.
40
41 (c) Be aware of how their medical training, qualifications, experience, and advice are
42 being used by media forums and how this information is being communicated to the
43 viewing public.
44
45 (d) Understand that as physicians, they will be taken as authorities when they engage with
46 the media and therefore should ensure that the medical information they provide is:
47
48 (i) accurate
49
50 (ii) inclusive of known risks and benefits

- 1 (iii) commensurate with their medical expertise
- 2
- 3 (iv) based on valid scientific evidence and insight gained from professional experience
- 4
- 5 (e) Confine their medical advice to their area(s) of expertise, and-should clearly
- 6 distinguish the limits of their medical knowledge where appropriate.
- 7
- 8 (f) Refrain from making clinical diagnoses about individuals (e.g., public officials,
- 9 celebrities, persons in the news) they have not had the opportunity to personally
- 10 examine.
- 11
- 12 (g) Protect patient privacy and confidentiality by refraining from the discussion of
- 13 identifiable information, unless given specific permission by the patient to do so.
- 14
- 15 (h) Fully disclose any conflicts of interest and avoid situations that may lead to potential
- 16 conflicts.
- 17
- 18 (New HOD/CEJA Policy)

Fiscal Note: Less than \$500

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