The Physician and the Media: Flippant Professionalism?

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סייג לחכמה שתיקה (פרקי אבות ג:יז)
A hedge to one's wisdom is one's silence
(*Ethics of our Fathers** 3:17)

From the beginning of recorded history, people have turned to the medical healer for advice, consolation, comfort, alleviation of pain, and even cure. It is for that reason that the medical healer or physician, as he or she is termed today, generates tremendous trust and respect. However, this role, assigned by the community, carries a heavy responsibility. It is a role that bears a special identity and there is no escape. It is a central element of who the physician is, and over time this identity perhaps becomes the most important part of who the individual is. However, along with this respect, admiration and esteem comes enormous responsibility. The physician cannot hold this role without basic ethical conduct. This forms the foundation of the social contract that the community has with the physician. Our mandated "social contract" with the community is to describe, understand, predict, and manage illness. As such, physicians have privileged access to information and knowledge about illness and behavior. This privilege is vested with responsibilities and the primary duty to care for the health of our patients. This is the bedrock of the profession. To act otherwise would constitute abdication of professional responsibility [1].

THE CHALLENGE OF OUR GENERATION

With the proliferation of the media in all forms today – from radio and television, from the internet to facebook, twitter and podcasts – the public is fascinated with medicine and is often preoccupied with medical issues. Too often this is not limited to issues of pure health, but how issues of health influence society, political behavior and process, individuals in power, criminality and, most importantly, individual well-being. In order to satisfy this unquenchable thirst for medical information, which in itself is not a bad thing, most often it is the doctor who is called upon to provide information, advice, prediction, direction, and answers. Herein lies the minefield. There are important ethical principles that need to be maintained when engaging in any contact with the media under all circumstances. Too often physicians forget these important criteria and become oblivious of the critical principles that are intended to guide our interaction with the community. Medical ethics applies not only to the so-called big issues of abortion, end of life, and genetic engineering, but also factors of professionalism, boundary violations, and confidentiality. We live in an information age where subtlety and discretion are not foremost on the community's priority list. Rather, due to the internet and reality shows, total openness has become the name of the game, with many individuals comfortable to share their and others' most intimate secrets with the world. While this may be true and permissible for individuals, it cannot become the rule for physicians in their professional dealing and interaction with the media, internet-based or radio/television, no matter how appealing it might be [2].

It should be made clear in any physician consultation outside of the traditional patient visit to the doctor, and in the absence of any preexisting patient-physician relationship such as via the media (radio, television, internet, etc.), that there are limits to such a professional interaction. The public in general and patients in particular need to understand that it would be unethical to diagnose and treat in such a context [3]. This is particularly relevant for any "ask the expert" service that may be offered by the media (newspaper, radio, television, online, etc.) for public medical education or for any commercial media purpose. These interactions are prone to misunderstanding and may affect delicate balances that exist in optimal medical care and worsen social disparities in health outcomes [4]. In addition, there is no means of appropriate follow-up, which is central to optimal medical care and standard operating procedure in medicine. In addition, some have condemned indirect medical practice since it bypasses existing patient-physician relationships and limits optimal communication [5]. This is also influenced by the absence of any official contractual relationship between patient and physician in such a context [3]. Nevertheless, the physician involved may not be exempt from liability and responsibility to maintain acceptable standard of care.

WHY DO WE FALL?

Physicians cooperating and engaging with the media when contacted for information in many cases disregard vital ethi-

*_Pirkei Avot_, in Hebrew, is the compilation of ethical and moral principles in the Talmud

cal principles. There are several reasons for this. These include 'heat of the moment' circumstances; in emergency situations medical ethical principles, including confidentiality and patient dignity, also demand respect and adherence [6]. In addition, a physician (often a psychiatrist) may be called upon to provide a medical/psychological assessment or opinion of a national or international political leader. Without having received permission from the individual and actually performing an examination, it would be grossly unethical to provide the media with any professional analysis of the individual's personality, ability, competence or functionability. Even though the leader may not be a patient of the physician, medical ethical principles would apply and would be no different had he or she been the physician's patient. There is a major difference, however, between providing general information about a condition as it may apply to a particular individual, and rendering a professional opinion about a well-known individual or celebrity regarding a specific diagnosis, condition or prognosis [7]. Similar scrutiny by a political analyst or social scientist may not be forbidden as it would be for a physician who is held to a higher standard with a strict code of professional ethics. Further reasons for errors in contact with the media along these lines include failure to maintain important boundaries. An example of this may be similar to the above case but would include the physician believing that he or she could influence political process or community policy in a manner that would be inappropriate. For example, it would be inappropriate for a physician to nurture contact with the media and only on the basis of being a physician expect that his or her opinion be accepted and established.

Perhaps the most worrisome factor accounting for the explosion of involvement of physicians in the media is that of intoxicating hubris. This is often due to a symbiotic relationship between the physician and the media where a charismatic physician who also has strong features of a 'show personality' and perhaps unfulfilled dreams of stage acting or media performance becomes known by the media as a focus of medical information. This may take the form of a private and exclusive media show on television or the radio. This is most prevalent in the United States, but there are signs that this showmanship is coming to Israel as well. While the concept is not intrinsically unethical, the dangers in such performance are inherent. For example, when a telephone call for advice is made, a doctor should only give general information about the subject. To be specific, recommending a medication that should be prescribed for the condition that the caller is describing without examining the patient is not only bad medical practice but grossly unethical. This may extend to another problem so evident under such conditions. When names of medications are mentioned for the management of various medical conditions, the generic name should always be stated, never the trade name. While this may seem obvious to even a first-year medical student armed with basic medical ethical concepts, this is often not the case with many seasoned physicians who are frequently consulted by the media. The reasons for this are clear. The medical profession today is plagued by issues of conflict of interest [8]. Often the influence of pharmaceutical company involvement in our profession borders on the subconscious, even without considering the frequent industry contacts that senior so-called key opinion leaders have and the attendant financial benefits. It is precisely these "key opinion leaders" [9] who are consulted by the media for information when a particular issue becomes newsworthy and who consciously or subconsciously mention in passing the medication for which they are being paid significant sums to represent in various forums. Stating trade names of medications for specific disorders when requested to provide advice on specific conditions breaks all ethical boundaries and must be avoided. A study examining news articles on medications noted that 67% of physicians referred to medications used in a study by their trade names rather than their generic names [10]. While this behavior by physicians contacted by the media could be considered a lapse and a consequence of ignorance and naiveté, unfortunately this is usually not the case and the dignity of the profession is sorely compromised.

Arguably, the most important reason for desisting from contact with the media on specific cases, and which may lead to the most profound damage to both the patient and the reputation of the profession, is to maintain confidentiality and respect for the ill. Examples of this would include emergency room physicians giving precise details on individuals injured in accidents and terrorist attacks without receiving permission from the patient. Another common example involves senior physicians providing medical information to the media about well-known personalities in their care (celebrities, political leaders), including reports on the outcome of treatment. Although this may appear innocuous, providing information that a political personality has recovered from a serious condition may have political consequences and is a gross boundary violation especially without the express permission of the ill individual, which is usually the case. While it is often assumed that such information should be shared since the individual is in the public domain and the medical information has relevance from a public benefit perspective, it *is* forbidden. This would include information such as the severity of injuries in victims of a terrorism incident. This information should be extremely general with no specific details, even if the victim is anonymous, since it may in some manner even at the conceptual level affect the ill individual at a later stage. Although it may be claimed that based on Thomas Aquinas's principle of the "doctrine of double effect" [11] the intention is not to break confidentiality and only good is intended, this breach is inevitable and therefore would not stand the test of proper medical ethical conduct. This is basic ethical practice with protection of confidentially and dignity of the sick individual.

INTERNATIONAL ETHICAL GUIDELINES

Eysenbach [3] reviewed several codes of medical ethics from several countries on this issue. For example, the Standing Committee of European Doctors states that direct telemedicine consultation should only take place when there is already an existing relationship between the doctor and the patient, or when the physician has an adequate knowledge of the clinical situation. Any physician would be hard pressed to prove that any radio or internet contact on its own would suffice for adequate information given the requirements of an acceptable and complete examination. In addition, the German medical professional code states that physicians "may not give individual medical treatment including medical advice, neither exclusively by mail, nor exclusively over communication media or computer communication networks." Similar guidelines exist in other countries such as Switzerland and the USA [3]. Both physicians and the media share an ethical responsibility to ensure that medical information is distributed to the public but without sensationalism, bias or conflicts of interest, including full disclosure, when indicated, of commercial support and affiliations [12,13].

The public does have a right to know. However, this has to be communicated in an ethical fashion with preservation of patient dignity, confidentiality, preciseness, and professionalism of relationship with the media by means of the preservation of appropriate boundaries [6,14,15]. Medical ethicists when called for input must beware of being exploited for their opinion on sensational medical cases; they must maintain a professional distance from the display of medical 'human curiosities,' and should focus on issues rather than a particularity. This is especially important when the information might have been obtained without optimal patient consent prior to media dissemination [16,17].

WHAT CAN WE DO?

While the interaction with the media may be complex, there should be certain ground rules:

1. No personal or identifying medical information should be provided by the physician to the media, especially without the specific and express permission of the individual even if he or she is not the physician's patient. This would apply even following a terror event and even if of significant public interest.
2. Names of medications when quoted should always be in generic terminology.
3. When a physician is asked in a media interview to comment on a procedure, medication, etc., and there is some level of conflict of interest for any variety of reasons, this should be stated.
4. Physicians when encouraged to reveal important information about patients even in the interests of national curiosity such as after a terror attack should not feel compelled to do so. Imagine the good that it would do for the name of our profession if a physician would state that while he or she would like to share such important medical information with the public, it is forbidden to do so according to fundamental medical ethical principles.
5. A physician should never recommend specifics of medication prescription (name and dose) to a patient when appearing on a media broadcast without examining the patient. While there may be legal loopholes covering the physician, the practice is unethical and should not be engaged.
6. In any form of telecommunication consultation or advisory service, the physician should never state a clinical diagnosis since this is not an acceptable medical examination. In addition, no judgment of appropriateness or therapeutic interventions of other physicians should be made. Physicians may, however, provide, and may even have an ethical obligation to impart, general information regarding illness, nutrition, lifestyle guidance, disease prevention, and medication side effects [3].
7. With the exponential use of social media, physicians should take care to maintain boundaries of personal and professional identities. This is especially important in the interests of professionalism and in order to preserve confidentiality, integrity and trust in the medical profession [18].

Too often physicians pay lip service to the Georgetown mantra of autonomy, beneficence, non-malfeasance and justice. Health communication between medical professionals and the media also requires commitment to ethical principles [19]. It is here in the domain of media contact that the challenge, while complex, becomes real. We cannot fall. While the vast majority of ethical breeches in this regard are made with good intention, this fact does not negate the responsibility to improve in this domain and to strive for a higher standard. The power of public media is considerable and, as in other areas of medicine, physicians must invest wisdom into their relationship with the media [20]. Physicians need to be left alone to care for their sick and not be hounded by the media to solve their problems and those of the public whose insatiable need for medical information places physicians at ethical crossroads. We need to uphold our lofty standards of medical care and management tempered by humility without being distracted by factors of national influence, fame, recognition, financial consideration and power. Anyone acting otherwise is abdicating their profound responsibility and commitment to the profession and must be held accountable. There is too much at stake.

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Capsule

Vaccine protection against acquisition of neutralization-resistant SIV challenges in rhesus monkeys

Preclinical studies of human immunodeficiency virus type 1 (HIV-1) vaccine candidates have typically shown post-infection virological control, but protection against acquisition of infection has previously only been reported against neutralization-sensitive virus challenges. Barouch et al. demonstrate vaccine protection against acquisition of fully heterologous, neutralization-resistant simian immunodeficiency virus (SIV) challenges in rhesus monkeys. Adenovirus/poxvirus and adenovirus/adenovirus-vector-based vaccines expressing SIV_{SME543} Gag, Pol and Env antigens resulted in an 80% or greater reduction in the per-exposure probability of infection against repetitive, intrarectal SIV_{MAC251} challenges in rhesus monkeys. Protection against acquisition of infection showed distinct immunological correlates compared with post-infection virological control and required the inclusion of Env in the vaccine regimen. These data demonstrate the proof-of-concept that optimized HIV-1 vaccine candidates can block acquisition of stringent, heterologous, neutralization-resistant virus challenges in rhesus monkeys.

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Capsule

Melanopsin signalling in mammalian iris and retina

Non-mammalian vertebrates have an intrinsically photosensitive iris and thus a local pupillary light reflex (PLR). In contrast, it is thought that the PLR in mammals generally requires neuronal circuitry connecting the eye and the brain. Xue and collaborators report that an intrinsic component of the PLR is in fact widespread in nocturnal and crepuscular mammals. In mouse, this intrinsic PLR requires the visual pigment melanopsin; it also requires PLCβ4, a vertebrate homologue of the Drosophila NorpA phospholipase C which mediates rhabdomeric phototransduction. The *Plcb*4$^{-/-}$ genotype, in addition to removing the intrinsic PLR, also essentially eliminates the intrinsic light response of the M1 subtype of melanopsin-expressing, intrinsically photosensitive retinal ganglion cells (M1-ipRGCs), which are by far the most photosensitive ipRGC subtype and also have the largest response to light. Ablating in mouse the expression of both TRPC6 and TRPC7, members of the TRP channel superfamily, also essentially eliminated the M1-ipRGC light response but the intrinsic PLR was not affected. Thus, melanopsin signaling exists in both iris and retina, involving a PLCβ4-mediated pathway that nonetheless diverges in the two locations.

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