Consensus in Medicine

Medicine and the media

SUMMARY OF A CONSENSUS CONFERENCE

For many doctors, relations with the communications media reached their lowest ebb for years as a result of the *Panorama* programme on brain death on 13 October 1980. So, taking as its model the consensus workshops organised by the US National Institutes of Health, the *BMJ* recently brought together at Trinity Hall, Cambridge, a small group of doctors, journalists, and broadcasters* to discuss the potential sources of conflict between the medical profession and the communications media and to look for possible solutions. Seven questions were examined.

(1) Are there matters too sensitive, problematical, or harmful for television to cover?

In so far as these judgments are made by the journalists they generally do not accept that any matter can be too sensitive; indeed, the more sensitive a topic is—in the sense that its discussion may arouse strong emotions—the more important it may appear as an assignment. The same is true of intellectually complex topics that may prove difficult to explain to viewers or readers—again, journalists view such a prospect as demanding and challenging. Journalists believe that the medical establishment is less accustomed to questioning than more clearly accountable bodies such as Parliament, the TUC, and the CBI. They argue that doctors should recognise that the challenging of assumptions, policies, and practices forms an essential part of journalism in a free society and should not react to criticism with such hostility that further communication becomes impossible.

The one restraint journalists do recognise is harm (matter leading to actual direct emotional or material damage to individuals). Even so, the judgment is a subjective one and in practice has to be left to the individuals making the programme (and those supervising them). In the United States lawyers in past eras have constructed the notion of "clear and present danger" as a formula for judging when freedom of expression might be curtailed. Here in Britain a more acceptable condition for special caution might lie in reasonably predictable or foreseeable harm either to individuals or to society at large.

Nevertheless, journalists insist that they must retain the right to publish or broadcast material that may be expected to cause harm—if that harm is outweighed by some clear public benefit or by the need simply to pursue the truth. Investigative journalism almost always damages someone. For the foreseeable future the assessment of the risk:benefit ratio seems likely to rest with the programme makers and journalists themselves.

(2) Should minority/lunatic views on medicine be aired on television?

Predictably enough, the medical establishment is at its most indignant when publicity is given to unorthodox views on the treatment or causation of disease, but journalists are convinced that one of their more important functions is giving dissidents a chance to voice their dissent—on the sound argument that today's heresy may be tomorrow's orthodoxy. The hazard is, however, that cranks and charlatans may appear totally convincing on television or in print. Some sort of comment on a speaker's orthodoxy or unorthodoxy is surely needed. Much of the criticism from doctors would be avoided if journalists were more careful to explain that the views expressed by a dissenter from orthodox medical beliefs represented a minority opinion rather than giving the impression that two equally plausible theories were on offer.

(3) Is it possible to have any advisory body or panel which would satisfy the medical profession, those working in the media, and the public?

Much if not most medical journalism and broadcasting is of a standard which suggests that many journalists have no need of any additional source of medical advice; yet the most cogent and frequent criticism of the bad programme or bad article is that the medical facts were wrong. One suggestion for reducing the chances of such accidents is that the Royal Colleges should set up panels of advisers who would be available to help or advise any journalist with questions to be answered. One BBC department already has a medical adviser, who was appointed as a service to producers to provide expert information at an early stage in projects. The system works well much of the time in that department, but reference to the adviser is not required by other departments.

A widely held view is that science and medicine journalists rarely have any difficulty in finding any expert advice they may need and that the problems arise only or almost only when news and current affairs journalists stray into medicine for a "one-off" story. News editors and current affairs producers do not accept this judgment.

Medical criticism of specific programmes should take account of the fragmented nature of British broadcasting and newspapers. Sweeping judgments should not be based on particular programmes or articles. Nevertheless, most of the confrontations between medicine and the media might have been avoided had the journalists concerned had access to expert opinion acceptable as objective and reliable. Further efforts are needed to make mainstream medical opinion more readily available for consul-

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tation by journalists at an early stage of their work. One way in which this occurs most easily is when individual journalists and doctors maintain informal contacts leading to mutual trust.

(4) Should programmes be balanced, and if so, how?

Current policy on BBC television is that conflicting views should be balanced but over a period of time rather than in each programme. Certainly a well-argued case for one view is much more attractive to the listener or viewer than a fence-sitting "on the one hand, on the other hand" type of production. Insistence on immediate balance is likely often to be a recipe for dullness and loss of audience. Programmes need to be interesting and often to be barbed, but controversial topics need fair treatment over a short period.

(5) Should there be a correction-apology mechanism and, if so, how can an impact equivalent to the original be achieved?

The statutory media council that is shortly to come into operation will provide a mechanism through which aggrieved parties can obtain a formal apology or correction. The problem lies in securing as much publicity for the correction as was given to the original allegation. Here some newspapers and journals have an effective mechanism through the prominence they give to readers' letters—often one of the most read sections of the publication—but they do not guarantee space in the correspondence columns to persons who believe themselves wronged. Neither radio nor television gives equivalent prominence to the views of its audience; broadcast contributions from viewers are rarely seriously critical. Comment that appears in the *Listener* does not necessarily reach the same audience as the original programme. If the BBC and commercial television were to give critics more opportunity to air their views the process could be used to augment the existing apology-correction mechanism. In particular, the "open door" policy, which allows minority groups to put their views in a programme labelled as such, offers a socially valuable safety valve, though such programmes often have very small audiences. It should not be beyond the talents of broadcasting journalists to devise a more popular programme format that gives opportunities for both correcting inaccuracies and presenting alternative viewpoints.

(6) Are there differences between various channels and various timings?

The credibility of any specific programme depends on the overall credibility of that particular series or channel, so to that extent a misleading programme or deliberate propaganda is likely to be more convincing if it appears at a time and on a channel associated in viewers' minds with reliable, trustworthy information. Conversely, programmes which discover a new scandal each week inevitably lose credibility.

(7) Should there be a code of practice, and is it enforceable?

A code of good practice—such as that put forward by Stephen Lock after the *Panorama* programme on brain death and reproduced in the box—can serve only to define ideal relationships between doctors and television journalists. Most of the requirements are already part of good practice; many are essentially matters of courtesy, and some are likely to prove impracticable when a programme has to be produced hurriedly.

Possibly, however, journalists in television (and on newspapers) might ask themselves why so many features that take months to prepare are edited and given their final shape only hours before transmission, so making many of the suggestions in the code impossible. Is all this urgency genuine?

In practice, no code would be acceptable on any basis other than advisory. But an advisory code could be valuable as an indication to newcomers to television journalism of the expectations of the medical profession (and other scientists) and as a reminder to established journalists of the optimum relationship between themselves and doctors.

Towards a code of practice

- When approaching a doctor to discuss participation in a medical television programme, a producer or his representative should give a full account of his intentions, including details of other people who have been approached and the reasons for wanting to deal with the topic.
- If, in the course of his research, the producer decides to change his initial approach to the topic he should inform the participants in time for them to withdraw their help should they wish to do so.
- When asked to take part in a filmed sequence or a studio recording the participant should be given some idea of (i) the duration of the initial filming or recording; and (ii) how much of it is likely to appear in the final programme.
- Whenever possible—for example, with a documentary programme that takes several weeks to edit—a participant should be supplied before transmission with a transcript of his words as edited for final use in the programme.
- Whenever possible, participants who have made an important contribution should be invited to see a version of the edited programme before transmission. This would not be taken as an invitation to approve the final product, but if issued before completion of the programme it would enable the producer to avoid major inadvertent errors of fact or emphasis.
- If a contributor is filmed or recorded and then removed from the programme for whatever reason, he should be told of his removal before the transmission date.

A teenage girl is severely allergic to penicillin, cephalexin (Keflex), and sulphamethoxazole/trimethoprim (Septrin). When she needs antibiotics she takes oxytetracycline. Is there a better antibiotic that she could be given for her occasional otitis media and sore throat? What could she use if she became pregnant?

The three common pathogens causing acute otitis media are *Streptococcus pyogenes*, *Str pneumococci*, and *Haemophilus influenzae*. Sore throats requiring antibacterial treatment are usually due to *Str pyogenes*. The most suitable alternative to penicillin for these organisms is erythromycin, and this can also be used during pregnancy.