Filming in Medical Emergencies

This Guidance Note derives from consent protocols drawn up by BBC teams who worked, with advice from Editorial Policy, on series such as Trauma. It should be read in conjunction with the BBC Editorial Guidelines on Privacy and Consent. (www.bbc.co.uk/editorialguidelines).

In cases of doubt, further assistance can be sought from the duty Editorial Policy Adviser by telephoning 0870 333 4550 or BBC extension (02) 81819.

All Guidance Notes can be found at edpol.gateway.bbc.co.uk/guidance_notes.shtml (BBC internal link) or www.bbc.co.uk/guidelines/editorialguidelines/advice/.

Introduction

This guidance applies to observational filming of medical and other emergencies for inclusion in programmes following the work of hospitals or the emergency services. In this context, the people we would like to film are not, in the first instance, considered capable of giving informed consent, by reason of their medical incapacity, traumatic shock or distress. For ease of reference, we call these people “patients”. This guidance is not intended to cover all conceivable scenarios; further advice may be sought from Editorial Policy.

Principles

The right of patients to privacy and confidentiality is usually paramount. To enable us to film in highly sensitive medical environments, or on location with the emergency services, we distinguish between consent to film (often verbal) and consent to broadcast (always in a form that is provable, often in writing). We would not normally broadcast any footage without clear, informed consent from patients and key medical or emergency staff featured.

Key to filming in these circumstances is the principle that we consult with the medical or emergency personnel whose work we are following before making the initial decision to film a patient.
Filming patients

When key medical or emergency personnel agree it is appropriate to film, we would expect them to approach the patient to ask whether we may film their treatment. In so doing, they should briefly explain the editorial purpose and nature of the film.

Where a patient does not object to being filmed, programme-makers should, if possible, seek confirmation from the patient that consent has been given before proceeding to film. If relatives are present, it is advisable to talk through the purpose of filming with them as soon as it is appropriate to do so; this is not to seek consent but to ensure that the family are fully informed at the earliest opportunity.

With initial verbal consent, we may film the patient’s treatment, relevant interactions with medical or emergency staff and, if the patient is well enough to be interviewed, a short interview about his/her condition. **We should not interview anyone who is distressed or in pain and we should only attempt to interview the patient after taking advice from the clinical team.**

**Where a patient is unconscious**, but is accompanied by their next-of-kin, their relative should be approached by the clinical staff member responsible for the patient’s treatment to discuss consent to film on the patient’s behalf. It should be explained that consent to broadcast will normally only be given by the patient, and that this will be requested at a later stage. A friend who accompanies the patient may not give consent to film on the patient’s behalf but should nevertheless be informed and consulted.

Where an unconscious patient is unaccompanied, and it is agreed that there is clear public interest in following the case, and the clinical staff member deems it appropriate to film, we may begin filming until the next-of-kin arrives. Care should be taken to film respectfully and in a way which minimises intrusion, for instance, by concentrating where possible (practically and editorially) on the actions of medical staff rather than on the patient and their injuries. When a family member arrives, they should be approached by the clinical staff member (as above). If the relative tells the medical team that they want filming to stop, we should stop immediately and log the exchange for future reference.

When an unconscious patient leaves A&E, if appropriate and with the consent of their next-of-kin, if available, and permission of medical staff, we may film them at crucial points in their treatment process. If the patient becomes conscious during this time and is able to engage in discussion, after consulting with the family the clinical staff member responsible may approach the patient to discuss the nature of the series. We may discuss consent to broadcast at this stage or at a future date, depending on the robustness and lucidity of the patient.

If a patient is unhappy about being filmed while unconscious, we may, as a way of reassuring them, offer to destroy the filmed material and any copies made of it; however, it is worth considering that they may change their minds at a later stage.
If a patient dies before regaining consciousness, we will need to take a view on whether the story is significant or important enough to justify approaching the next-of-kin again to discuss its broadcast in the public interest. This requires weighing up the public interest in the story with any distress an approach may cause the family. We would normally only broadcast the story with the family’s clear provable consent. If they do not give consent it may be appropriate to offer to destroy the footage.

Where a patient has passed away, we never normally contact the family directly without taking advice from the relevant press office. Choosing the appropriate time to tell a family that their relative has been filmed requires great sensitivity and awareness of the grieving process. Experience suggests that it is often better to do this as close to the time of filming as possible; people tend to get more distressed about not being told about filming than when informed of it at the earliest possible opportunity. However, this issue should be dealt with on a case-by-case basis. We should be confident that our protocols are clear and robust enough for a family to understand why and how we have filmed their relative. It may be appropriate to offer to destroy the footage if they so wish.

It is very important to stay in touch with the family and the patient throughout their treatment and recuperation. In the context of a long form documentary or series, it may be advisable to consider having a dedicated permissions team whose task it is to build a relationship with the family while the patient is receiving treatment, and with the patient when they become conscious or well enough to talk to us.

All calls and visits to patients and their relatives should be logged and a brief record kept of any conversations we have with them. In this way, the status of a case may be checked at any time and a complete record of the consents process will exist in case of complaint or investigation at a later date. In the context of a large and complex production, it may be advisable to keep a master database of all cases that we film so that we can keep track of individual stories, as well as have a clear idea of their consent status and which key member of staff is treating the patient. This database should be updated regularly.

Before editing, when the decision has been made about which stories are suitable for broadcast, patients and next-of-kin should be contacted to let them know that we would like to include their stories in the programme. If they have already signed a consent form, we should remind them that they have given consent for us to broadcast their story. If they have not yet signed a consent form we should ask whether they are happy to do so.

Exceptionally, we may consider offering some patients a viewing of their cut story, where practical and where we consider it necessary to secure their properly informed consent (for instance, where the patient was unconscious at the time of admission and during a significant part of their treatment). We should give due consideration to any personal sensitivities or concerns they raise with us.
If we cannot locate a patient or their relatives after filming in order to confirm their consent to broadcast, the material should not normally be used; further advice may be sought from Editorial Policy.

**Filming people in hospital waiting rooms**

With the permission of the hospital we should normally put up notices around the department to let people know that filming is taking place. If we want GVs of people in the waiting room, the production team should ensure that those people waiting are aware that they are being filmed. We should explain what the programme is about and how the shots will be used. Anyone who expresses the wish not to be filmed should be kept out of shot or asked to move out of frame. We do not normally ask for written permission for these general views.

If we interview anyone in the waiting room, we should gain informed consent to broadcast.

**Negotiating access with hospitals and emergency services**

For the purposes of documentary film-making, we would expect to have a written contract with the hospital or emergency services whose work we are following. Before entering this you should read the Guidance on Access Agreements ([www.bbc.co.uk/editorialguidelines/advice/accessagreements/index.shtml](http://www.bbc.co.uk/editorialguidelines/advice/accessagreements/index.shtml)) and Editorial Guidelines on Access Agreements and Consent ([www.bbc.co.uk/editorialguidelines/edguide/fairness/accessagreement.shtml](http://www.bbc.co.uk/editorialguidelines/edguide/fairness/accessagreement.shtml)).

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