

## Boundary crossing: the physician and the photographer

Anne Marie Todkill

A photograph that brings news of some unexpected zone of misery cannot make a dent in public opinion unless there is an appropriate context of feeling and attitude. The photographs Mathew Brady and his colleagues took of the horrors of the battlefields did not make people any less keen to go on with the Civil War. ... Photographs cannot create a moral position, but they can reinforce one — and help build a nascent one.<sup>1</sup>

Photographs have a peculiar bivalence, which is their ability to exchange atoms with both the real and the imaginary. On the one hand, they testify that their creator was present in a certain place, at a certain time: photographs deal in facts. On the other hand, they necessarily interpret what they appear merely to replicate. Some photographs are manipulated. All of them are biased. It is possible to doubt the veracity of any photograph.

But in most ordinary contexts we don't. In the context of medical applications, for example, photography is viewed as a technical instrument in the service of science. It is meant to be evidential, not interpretative. One takes photographs of a case (as distinct from a person) to act as teaching aids, as demonstration of a diagnosis, as a record of the progress of treatment or the process of disease, as legal record, as forensic evidence. The clinical photograph is perhaps the furthest that photography can get from art. So close is it, apparently, to the physical reality of a patient that it is ethically intolerable to create or use a patient photograph without the patient's express and informed consent. Certainly, we cannot publish without permission a clinical photograph in which the identity (that is, the personhood) of a case is evident.

Or even when it isn't. Recently, privacy issues have become tangled up with discussions of ownership, which in turn have stemmed from the realization that researchers may stand to profit from "patient information" — DNA samples, most notably — provided altruistically or even unknowingly. Those involved in formulating policy in this area are attempting to ensure the patient's continuing ownership of his or her own "health information" — whether this takes the form of DNA, tissue samples, data or medical images. To take the emerging logic to an extreme end, a diagnostic radiograph of even the most generic of dislocated shoulders could not subsequently be used for teaching purposes without the specific consent of the particular patient whose damaged shoulder this was, even if all identifying information were removed.

To be fair, however, these concerns go rather deeper

than proprietary interest, and even deeper than concerns about privacy. The extreme caution now shown by medical journals in the use of patient photographs rests on that sacred contract we describe as physician–patient confidentiality, on which all trust, the soul of medicine, rests. The clinical photograph displays information disclosed within the privilege of the therapeutic relationship, a relationship that is singular and private.

But there are occasions when physicians become acutely aware that potential modes of intervention and healing go beyond the one-on-one. Health and disease arise in a setting that is always socioeconomic, political and environmental. When these determinants of health status are particularly evident, and particularly distressing, physicians may find themselves caught by an urge to look at the broader picture, to investigate, to record and to send reports from the front that do not fit the mould of conventional scientific medical reporting.

When David L. Parker, an occupational health physician in Minnesota, encountered workplace injuries in adolescent patients, such an urge possessed him.<sup>2</sup> He began to wonder about the working conditions of the estimated 500 million child members of the world's labour force. For Parker, the role of healer demanded that he learn, and inform others, about children who work at carnivals in the American Midwest, mine tin in Bolivia, pick garbage in landfill sites in Mexico or weave carpets in Nepal. He became a photojournalist. If one needs a demonstration that the physician's and the journalist's role are not incompatible, Parker's work should be enough. Reportage can be a natural extension of the healer's role, even though the journalistic imperative to disclose runs counter to the physician's mandate to preserve confidentiality, and even though the journalist's mandate to observe contradicts the physician's imperative to act.

Susan Sontag has described the act of taking a photograph as

essentially an act of non-intervention. Part of the horror of such memorable coups of contemporary photojournalism as the pictures of a Vietnamese bonze reaching for the gasoline can, [or] a Bengali guerrilla in the act of bayoneting a trussed-up collaborator, comes from the awareness of how plausible it has become, in situations where the photographer has the choice between a photograph and a life, to choose the photograph. The person who intervenes cannot record; the person who is recording cannot intervene.<sup>1</sup>

But the physician who takes on an ancillary role as journalist may do both. The medical intervention is not abandoned; the photographic intervention merely widens it into a public and even political sphere, which is where medicine, considered as a global enterprise, actually belongs.

In this issue, Florian Pilsczek<sup>3</sup> describes the tragically constrained sphere of healing in a government hospital in Phnom Penh, Cambodia, where he worked for a year in 1998. He describes the political and economic upheaval that reduced Cambodia to one of the poorest countries in the world, and the implications of that poverty for the estimated 120 000 Cambodians who are infected with HIV. The conditions he describes, although rooted in a historical trajectory that is uniquely Cambodia's, are not unlike those in many other impoverished countries. The author did what many contributors do when they submit accounts of their experiences in far-flung places: he sent snapshots. But these pictures were so far removed from the usual run of hospitable villagers posing with foreign aid workers beside the newly installed water pump (not that such things are not essential) that they stopped us in our tracks. We pondered the propriety of publishing photographs taken by a physician *qua* physician, not *qua* photographer or journalist. We questioned the author about his means of obtaining consent and discovered that it was verbal, informal and undocumented. We considered an earlier time when we were, apparently, so distracted by the remoteness of the setting and the humanitarian theme that we published a patient photograph, with a caption disclosing the diagnosis, without consent.<sup>4</sup> On that occasion we restated our commitment to patient-physician confidentiality regardless of context.<sup>5</sup> But, faced with Florian Pilsczek's experience, we thought it out again, from the opposite direction. What would it mean *not* to include the photographs with his article? It struck us as perverse that while we have felt at liberty to publish photographs of prisoners at Tuol Sleng prison,<sup>6</sup> photographs taken abusively, with the most evil of motives, by the Khmer Rouge, we hesitated to publish photographs

that give a glimpse into a new generation of suffering in Cambodia, taken by a doctor motivated by humanitarian concern. This time, in publishing patient photographs, diagnoses and case details, we are not distracted by the thematics of Third World relief. We are committed to it.

Any form of activism in medicine will lead physicians into grey areas, which returns us to one of the essential characteristics of photography: its potential to be artful and interpretive. Medicine has a similar potential. Physicians, in being told their patient's stories, have no choice but to try to interpret them. Diagnosis is one interpretative mode. Educating oneself about political and social forces is another. There is always the risk in any interpretative activity of getting it wrong. But the risks of silence are greater. We should not suppose that our comfortable notions of privacy, confidentiality and consent are definitive. *CMAJ* has been justly chastised in the past for not applying those standards equally to everyone.<sup>7</sup> But those standards have been enabled by social conditions that derive from peace and affluence. We should not assume that our notions of propriety are necessarily weighty enough to supersede the need to draw attention to the plight of people who are losing not only their dignity but also their lives.

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