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Speculation fit for a king? Medical announcements from the British royal family and the recurring ethical complexities of personal privacy and public commentary from physicians

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Abstract
This article explores the ethical complexities of openly-expressed medical commentary using recent cancer diagnoses within the British monarchy as illustrative cases. Specifically, it examines tensions between public interest, personal privacy, and professional standards, underlining the adverse implications of conjectural discourse, alongside the role of physicians in enhancing wider medical understanding.

Keywords Medical commentary, King Charles III, Princess of Wales, Goldwater Rule, American Medical Association, General Medical Council, Medical Board of Australia, Ethics, Public education

Introduction

In February 2024, the news from Buckingham Palace that the British monarch, King Charles III, had been diagnosed with an unspecified cancer, which was identified during a procedure for benign prostatic hyperplasia, commanded widespread attention [1]. Across media outlets in the United Kingdom, Australia, the United States, and elsewhere, numerous medical professionals were asked to provide their expertise about this evolving story (e.g [2–4]). Similar requests transpired after the disclosure in March 2024 from the Princess of Wales that she was receiving adjuvant cancer therapy, coming amidst intense rumour and debate following her withdrawal from public life months earlier (e.g [5, 6]).

These demands for specialist insights were somewhat expected given King Charles III's position and the global curiosity that surrounds the British royal family, though they simultaneously engendered tensions between health privacy, press interest, and societal notions of a "right to know". Notably, certain medical analysis about these two individuals occasionally bordered on the conjectural and the intrusive, prompting broader questions about ethical standards and the purpose of openly-expressed views on the health of prominent figures. Separately, other physicians avoided personal supposition, instead leveraging these events as educational opportunities to illustrate

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general aspects of oncological prevention, diagnosis, and care.

Accordingly, this article begins by describing ethical standards from various professional organisations in jurisdictions where physicians opined about the conditions of King Charles and Princess Catherine. Subsequently, it appraises medical confidentiality issues and the "right to know" in relation to political office and the British monarchy. Finally, the paper discusses the nature of medical commentary on the King and the Princess of Wales, highlighting the possible negative consequences from speculative discourse whilst also underlining the contribution of physicians in advancing public health literacy.

Ethical and professional positions on medical commentary and media interactions from prominent medical associations

As a well-trodden path in psychiatry and other healthcare domains, debates continue about the probity of openly-expressed medical commentary (or so-called "armchair diagnoses") [7, 8]. Following a 1964 *Fact* magazine article collating the views of over two thousand psychiatrists on the mental health of the-then presidential nominee in the United States, Senator Barry Goldwater, the American Psychiatric Association (APA) censured this practice. In its eponymous Goldwater Rule, the APA asserts: "it is unethical for a psychiatrist to offer a professional opinion unless he or she has conducted an examination and has been granted proper authorization for such a statement" [9]. This has been endorsed by the Royal College of Psychiatrists in the United Kingdom and several European psychiatric associations [8], and was reinforced by the APA following the 2016 US presidential election when Donald Trump's behaviours and statements attracted speculation [10].

Similar guidelines have been implemented for every discipline represented by the American Medical Association (AMA), aligned with the Health Insurance Portability and Accountability Act of 1996. The AMA *Code of Medical Ethics* advises that physicians should: "[r]efrain from making clinical diagnoses about individuals (e.g., public officials, celebrities, persons in the news) they have not had the opportunity to personally examine" [11]. Equally, akin to the APA's rubric, the AMA indicates that doctors should "[o]btain consent from the patient or the patient's authorized representative before releasing information", avoid prognostic assessments, and "distinguish the limits of their medical knowledge where appropriate" [11, 12].

Elsewhere, the United Kingdom's General Medical Council (GMC) does not explicitly stipulate the necessity of obtaining consent for public communications from specialists [13]. Nevertheless, in its *Good medical practice* guidance, the GMC advises that "any information you communicate as a medical professional" should not be "false or misleading" and physicians must "take reasonable steps to check the information is accurate" [13]. Additionally, all open statements from GMC doctors need to support the "duty to promote and protect the health of patients and the public" and opinions should not be framed as "established fact" [13]. The Medical Board of Australia (MBA), where King Charles is also sovereign and where physicians have commented on his diagnosis in the press, affirms that "doctors have a right to have and express their personal views and values" [14]. Though, the MBA do attest that physicians need to consider "the effect of public comments" and "how they reflect" on the role of "a doctor and on the reputation of the profession" [14].

These recommendations are designed to safeguard confidentiality and professional integrity [9–14]. That said, with culturally-contingent and cross-jurisdictional nuances, their applicability inevitably varies case-by-case; in short, there may be a degree of flexibility in the scope and enforcement of certain provisions. In this regard, the GMC concedes that *Good medical practice* "isn't a set of rules" and physicians must use their "judgement to apply the standards" to "day-to-day practice" [13]. This entails "working out which of the professional standards are relevant to the specific circumstances" and utilising "knowledge, skills and experience to follow them in that context" [13]. Moreover, the MBA places the ethical responsibility on individual doctors to appraise the implications of openly-expressed opinions, rather than through explicit organisational measures [14].

Analogously, even despite the seemingly prescriptive tenor of the Goldwater Rule and the APA's reaffirmation of its principles in 2017 [9, 10], its applicability continues to be contested in various scenarios. For example, this has included questions about its relevance for deceased historical figures and evolving media formats [8, 15]. Related to this, the frequent use of the term "should" in the AMA's *Code Medical Ethics* on public commentary, in favour of the didactic "must", appears to be not an insignificant choice [11, 12].

Medical privacy, the "right to know", and the British monarchy

These guidelines notwithstanding, there have been prominent instances across the English-speaking media where medical specialists have opined on the health of individuals in the public sphere whom they have not personally treated and where they lacked approval to do so. Prior situations have involved physicians hypothesising in the press about the pathology of violent offenders, and the physical and mental wellbeing of musicians, actors,

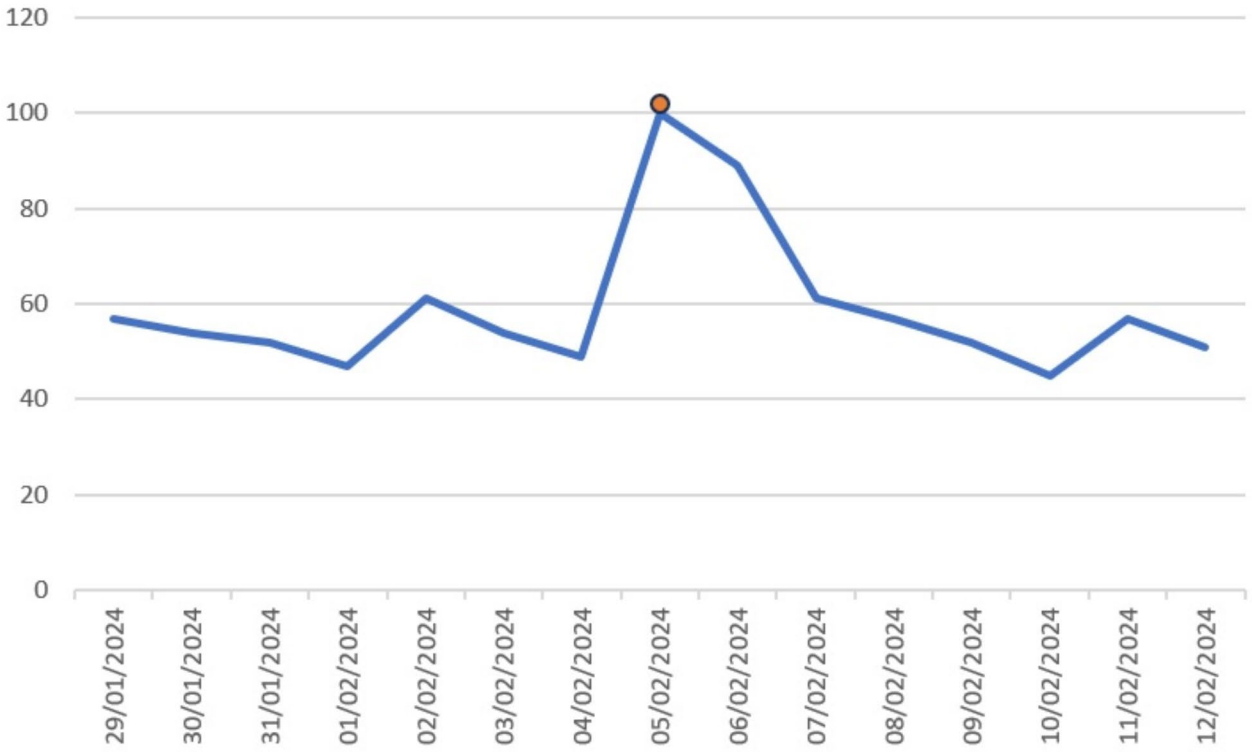

Fig. 1 Google search volumes for "Cancer symptoms" in the United Kingdom 29.01.2024–12.02.2024

athletes, politicians, and others who were not under their care and did not provide explicit consent (e.g [7, 8, 16]).

Specifically, in relation to democratically-elected politicians, the extent to which voters have the "right to know" about the health status of prospective or incumbent officeholders remains an unresolved and somewhat nebulous issue [17, 18], which has influenced recent medical commentary. This was apparent within the psychiatric discourse surrounding the former president, Donald Trump, and during the 2024 United States' election campaign that saw the-then president, Joe Biden, withdraw his candidacy, in part due to age-related health concerns [18, 19]. In a similar context, physicians who hypothesised about Mr. Trump defended their actions as part of a medical "duty to warn" about what they perceived to be the exhibition of socially dangerous behaviours [8].

Elsewhere, proponents of greater transparency on personal health affairs in political spheres accentuate this as a key tenet of accountability and robust democratic governance [17]. Separately, others have argued against politicians having to make medical records completely public for fear of perpetuating misinformation and disorder-based stigma [18]. To an extent, these debates have been shaped by sociocultural paradigms, with different national settings having different sociopolitical values and different norms about confidentiality and openness in public life [20].

In this regard, across British society and beyond, the royal family fulfil dual functions as private persons and emotive embodiments of historical, cultural, and national identity and tradition. Akin to democratically-elected officeholders, King Charles III's position as head of state in fifteen countries further complexified wider concerns about his condition and capacity to exercise the duties of his role, albeit largely ceremonial and constitutionally restricted [2, 4].

Indeed, there has long been an intricate relationship between the monarchy and the media, particularly in the United Kingdom, encompassing conflicting paradoxes of visibility and privacy [21], which inevitably drove the clamour for medical insights. The former is reflected in a colloquial and oft-used expression across British society to describe the relationship with the royal family, namely: "we pay, you pose". Moreover, popular dramas such as *The Crown* have undoubtedly served to heighten their international allure. Equally, the immediacy of modern communication, especially in its digital forms, likely intensified demands for expertise about the King's condition in 2024, as it did for the Princess of Wales, about whom numerous conspiracy theories abounded on social media [5, 6].

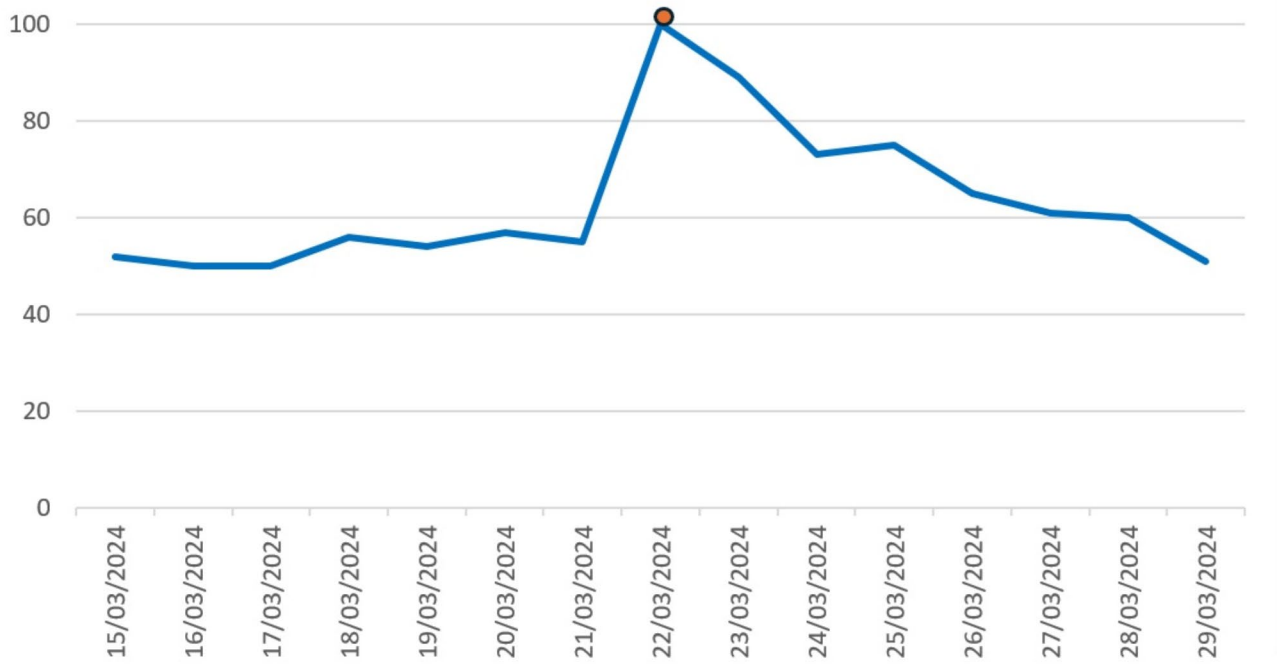

Fig. 2 Google search volumes for "Cancer symptoms" in the United Kingdom 15.03.2024–29.03.2024

Of course, we acknowledge the logic behind these arguments, which can be predicated on individual interpretations of public interest. Yet, in the authors' opinion, the assertion that they justify the necessity to comprehensively disseminate confidential health-related information, together with legitimising open medical conjecture when such disclosures are made, raises troubling questions. The latter becomes ever-more pertinent given that the official release from Buckingham Palace about Charles's diagnosis was motivated by a desire "to prevent *speculation*" (italics ours) [1]. Whilst ethics are often nuanced, there must be some borders between public interest and medical privacy, even for kings and princesses in the 21st Century.

For us, the inference that the British monarchy has a transactional social contract where they trade discretion for support and affection, though pragmatically plausible (and perhaps, to-date, sociopolitically effective), jeopardises morals of personal privacy based on status and privilege. Conceivably, *ad extremis*, this thesis could undermine such rights for all high-profile figures and celebrities. In the cases of Charles and Catherine, regardless of notions of privilege and royal complicity (again, "we pay, you pose"), we believe that allowing one's public role to dictate the boundaries of medical confidentiality is a precarious path to collectively tread. As a message from Kensington Palace affirmed: "The princess has a right to medical privacy, *as we all do*" (italics ours) [22]. This aligns with the guidelines from medical entities detailed in Sect. Ethical and professional positions on medical commentary and media interactions from prominent medical associations, which above all emphasise preserving patient confidentiality, accuracy, and prudence in physician communications [9–14].

Corresponding legal concerns may conceivably arise around Article 8 of the European Convention on Human Rights, of which the United Kingdom is party. This guarantees the right to "private and family life" except "in accordance with the law and is necessary in a democratic society in the interests of national security, public safety or the economic well-being of the country, for the prevention of disorder or crime, for the protection of health or morals, or for the protection of the rights and freedoms of others" [23]. Previously, the British monarchy has unsuccessfully attempted to enforce these clauses, and the European Court of Human Rights has ruled both for and against other royal families within past privacy proceedings [23, 24]. These concepts remain untested for health matters amongst royal figures and politicians and hence readers can draw their own conclusions about their aptness for the present discussion. Additionally, the European Court of Human Rights solely holds jurisdiction over members of the Council of Europe, meaning individuals in other states where there is widespread media coverage of the monarchy would not be affected.

Amidst this background, official releases from the royal family about the King's illness and that of the Princess Wales drew criticism from certain commentators, who contended that greater transparency may have mitigated conjectural concerns [25, 26]. However, both statements superseded the secrecy surrounding King George VI's death from lung cancer in 1952 [27], with Catherine's choice of a video announcement reflecting a step towards modernisation (albeit possibly informed by widespread rumours about her wellbeing) [28]. Nevertheless, Charles and Catherine did not reveal the type of cancer they had been diagnosed with, arguably leaving gaps for media agendas and medical speculation to fill.

That said, it should be noted that whatever the supposed shortcomings of these respective communications, oncology patients recurrently face difficulties in revealing their diagnosis to their families [29], let alone to a substantial and demanding public audience. Consequently, these individuals will have their own justifications as to why they did not wish to release the full details of their health status and we believe their right to medical privacy should transcend perceptions of the "right to know".

Medical commentary about King Charles and Princess Catherine

The bad, the ugly?

Owing to the scrutiny surrounding King Charles and the Princess of Wales, physicians were repeatedly requested to offer medical insights after their disclosures. Contingent on the jurisdiction, standards from professional bodies constitute critical frameworks for informing the ethical parameters of health-related discourse from physicians and their interactions with the media [9–14]. Yet, as has been previously demonstrated, these provisions may be subject to inconsistent interpretation and enforcement [7, 8].

Nonetheless, it is disputable as to whether all the relevant medical discourse about these members of the British royal family has adhered to professionally recognised best-practices [9–14]. Importantly, physicians were not privy to verifiable information about the nature of Charles's and Catherine's conditions beyond their press releases, and these individuals did not knowingly give consent for the resulting commentary. As detailed in Sect. Ethical and professional positions on medical commentary and media interactions from prominent medical associations, these are common aspects foregrounded in the guidelines from medical organisations about physician-public interactions [9–14]. Whilst physicians reportedly opined on King George VI's cancer treatment [27], contemporaneous media in the 1950s lacked the reach of modern platforms, thereby likely keeping these discussions localised and curtailing their impact on popular discourse.

For King Charles III, the purpose of publicly-voiced insights from physicians about his exact diagnosis, his cancer staging, his therapeutic options, and their ensuing media representations sometimes remained unclear (e.g [2, 3, 30–32]). Often, such commentary has not contributed meaningfully to enhancing wider education and did not appear to immediately provide benefits for patients who were receiving oncological treatment. Indeed, some medical statements may have arguably verged into intrusive and inappropriate territory, particularly those that appeared to hypothesise on the monarch's prognosis without first-hand knowledge or consent.

Similarly, as news broke about the Princess of Wales undergoing abdominal surgery in January 2024, conjecture circulated regarding her condition and absence from public life, especially on social media. In this case, medical perspectives about the duration of her inpatient care for abdominal surgery provoked contention about professional boundaries and respect for personal privacy, as underlined by the British press [24]. Speculation intensified after Catherine's announcement about her cancer diagnosis three months later, for which she was receiving adjuvant treatment [5, 6]. At this time, experts posited ideas about the type of cancer she had and her recovery time, with some appearing to query the scientific veracity of her announcement [5, 33, 34]. Much of this supposition occurred amidst a media climate of conspiracy and rumour about the Princess, again raising questions about prudence and medical intentions. Notably, this febrile atmosphere was exemplified by staff at the clinic where Catherine was being treated allegedly attempting to illegally access her health records [35].

As a whole, ethical judgements are seldom straightforward or uniform, as several professional entities across international medicine assert (e.g [13, 14]). Accordingly, one can argue about whether a specific statement from a physician about Charles or Catherine infringes apposite standards from the AMA, the GMC, and others. Nevertheless, what is clear is that certain medical discourse may have fed into or amplified sensationalistic reporting about these individuals, potentially detracting from public health messaging and stimulating further conjecture. Ultimately then, where do we draw a moral line? Irrespective of privileged status, we believe that confidentiality must be safeguarded and individual dignity must be preserved. These are fundamental components of medicine, underpinning the very basis of the social contract between physicians, their patients, and society.

In similar situations, we urge physicians to act with diligence since hypothetical supposition about an individual's diagnosis or treatment options could be counter-intuitive to advancing broader health outcomes [7]. Conceivably, based on views expressed in the media and their subsequent framing and dissemination, patients in

the general population could begin to doubt the efficacy and appropriateness of their own treatment regimens, which may undermine trust in medicine. To that end, prestigious professional associations can help advance this goal, providing education about their ethical expectations and how specialists can engage responsibly in press interactions [8].

The good

In cases involving high-profile figures where a medical matter arises, physicians can prioritise their responsibility to enhance collective wellbeing and health literacy, leveraging popular interest to disseminate expertise through the media. Again, the promotion of public health is recognised in documentation from the AMA, the GMC, and different medical organisations cited previously [11–14]. Such initiatives can enable physicians to channel larger curiosity and speculation into productive dialogues, ensuring that openly-voiced commentary serves to enhance societal understanding and dispel misconceptions without compromising personal integrity [7]. However, the nature of shareable knowledge will inevitably vary in its vagueness or specificity depending on the medical facts disclosed within individual cases.

Commendably, in this regard, many doctors have done this effectively following the King's statement (e.g [3]), which in itself was issued to "assist public understanding for all those around the world who are affected by cancer" [1]. These are valuable intentions as help-seeking barriers remain a persistent problem in cancer care, especially for men [36]. Likewise, when Catherine's announcement was broadcast, physicians used this event to discuss general concepts related to diagnostic advancements in oncology, adjuvant therapy, and health service waiting lists (e.g [37]). Akin to King Charles's stated aims, these activities can be beneficial for intended audiences in the Princess's video, which explicitly addresses "all those affected by cancer" [28].

Despite being an imperfect proxy, Google Trends data shows increased search volumes for "cancer symptoms" in the United Kingdom at the time of the King's disclosure (5th February, 2024) (Fig. 1) and Catherine's statement (22nd March, 2024) (Fig. 2). Alongside reiterating the influence of the royal family in British society, this underlines the potential reach of these communications.

Conclusion

In 2024, the cancer diagnoses of King Charles III and Catherine, Princess of Wales sparked extensive interest, reigniting contentious debates about individual privacy and the "right to know". Concomitantly, this created challenges for physicians who were tasked with balancing public demands for scientific insights alongside their duties to uphold accurate and sensitive discourse.

At times, the intense scrutiny towards the British royal family has tested these obligations, with diagnostic and prognostic speculation potentially transgressing established professional standards, often intensified by sensationalised media agendas. Yet, doctors have also used this coverage to enhance cancer awareness amongst the general population.

The complexities associated with these cases once again exemplify the importance of the medical imperative to safeguard individual privacy and promote healthier societies. This is underpinned by the universal principle that the health of every person warrants the same level of dignity and respect, regardless of privilege or status – king, princess, or otherwise.

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