

Ethical Considerations of Unsolicited Medical Opinion in Movement Disorders

Rui Araújo, MD, PhD,^{1,2}  Jos J. Kole, PhD,³ Joaquim J. Ferreira, MD, PhD,^{4,5,6}  and Bastiaan R. Bloem, MD, PhD^{7,*}

The story of Nadia Popovici, a medical student who spotted a suspicious-looking mole on the neck of a hockey team manager in Canada, made headlines worldwide.¹ The unsuspecting manager was unaware of this lesion, which turned out to be a melanoma. Ms. Popovici shared her unsolicited suspicions with this manager, urging him to seek medical attention. After that, she reconsidered her actions, questioning whether it was appropriate for her to bring this up. After the lesion was removed, the manager and the team posted a tweet online looking for the person who alerted the manager. After finding Nadia, the team conveyed their gratitude. This captivating story went viral and was picked up by major news organizations. Ms. Popovici's actions received overwhelmingly positive feedback from the public.¹

This illustrates a recurrent medical-ethical issue called “unsolicited medical opinion” (UMO). The paradigmatic examples are from dermatology.^{2,3} A timely diagnosis of melanoma may have direct implications for a person's life. The issue of a UMO also arises in movement disorders. Consider a neurologist encountering an unknown person outside the examination room and incidentally noticing an asymmetrically reduced arm swing and a subtle resting tremor. Should he/she say something? How would this information be received? Would that benefit the person's health and well-being? Could the decision have medicolegal repercussions? And what would be the right way to approach the unsuspecting person?

The question of whether to provide UMO to unknown passersby (ie, people with no degree of familiarity with the observer) often presents to experts in movement disorders. This raises ethical (and legal) questions. In standard medical ethics, questions involving moral duties, rights, virtues, and values are framed in the “patient-physician” relationship. In the context of a UMO,

until the advice is given, such a relationship does not yet exist. Neurologists and other professionals will not always have the chance to do this at the very moment of the incidental observation, but it is important to justify their ethical decision afterward. Our position is that a justification based on intuition is not enough. In this article, we aim to explore the ethical considerations that should be weighed to justify one's decision concerning UMO in the field of movement disorders.

Neurological Observations Outside the Clinic

The issue of UMO in neurology may arise for several reasons. First, the art of neurological observation is sharpened through years of training and cannot be “turned off” outside the office. Secondly, the public usually expects physicians to have a moral responsibility to assist others, including people with whom they do not have an established professional relationship, for example, a medical emergency taking place on a plane. A physician's refusal to assist in such situations may even have legal repercussions, depending on the circumstances.⁴

The issue of incidental observations outside the clinic is particularly relevant for movement disorders where observation is paramount for diagnostics. A suspicion that a movement disorder might be present may be inferred by how people talk, walk, sit, and even by their handshake.⁵ This can occur in many different settings, for example, walking in the street or in a restaurant. One historical example illustrates this, as James Parkinson himself

¹Department of Neurology, Centro Hospitalar Universitário São João, E.P.E., Porto, Portugal; ²Department of Clinical Neurosciences and Mental Health, Faculty of Medicine of Porto, University of Porto, Porto, Portugal; ³Department of Ethics of Healthcare, Scientific Center of the Quality of Healthcare, Radboud University Medical Center, Nijmegen, the Netherlands; ⁴Laboratory of Clinical Pharmacology and Therapeutics, Faculdade de Medicina, Universidade de Lisboa, Lisbon, Portugal; ⁵Instituto de Medicina Molecular João Lobo Antunes, Faculdade de Medicina, Universidade de Lisboa, Lisbon, Portugal; ⁶CNS-Campus Neurológico, Torres Vedras, Portugal; ⁷Donders Institute for Brain, Cognition and Behaviour, Department of Neurology, Radboud University Medical Center, Nijmegen, the Netherlands

*Correspondence to: Prof. Bastiaan R. Bloem, Donders Institute for Brain, Cognition and Behaviour, Department of Neurology, Radboud University Medical Centre, Nijmegen, the Netherlands; E-mail: bas.bloem@radboudumc.nl

Keywords: ethics, movement disorders, neurology, observation, Parkinson's disease, unsolicited medical opinion.

Rui Araújo and Jos J. Kole are equal contributions.

Potential conflict of interest: No specific funding was obtained. BRB has received research support from the Netherlands Organization for Health Research and Development, the Michael J. Fox Foundation, UCB, the Stichting Parkinson Fonds, Hersenstichting Nederland, de Stichting Woelse Waard, Stichting Alkemade-Keuls, de Maag Lever Darm Stichting, Parkinson NL, Davis Phinney Foundation, the Parkinson's Foundation, Verily Life Sciences, Horizon 2020, the Topsector Life Sciences and Health, Nothing Impossible and the Parkinson Vereniging, outside the submitted work.

This is an open access article under the terms of the [Creative Commons Attribution-NonCommercial-NoDerivs](https://creativecommons.org/licenses/by-nc-nd/4.0/) License, which permits use and distribution in any medium, provided the original work is properly cited, the use is non-commercial and no modifications or adaptations are made.

Received 21 February 2023; revised 8 July 2023; accepted 12 August 2023.

Published online 4 September 2023 in Wiley Online Library ([wileyonlinelibrary.com](https://www.wileyonlinelibrary.com)). DOI: 10.1002/mdc3.13870

TABLE 1 General arguments in favor and against providing unsolicited medical opinion and the four principles approach (by Beauchamp and Childress)⁹ they can be referred to

Arguments in favor of providing UMO^a	Moral principle at work^b
<p>1. The autonomy-enabling argument People have a right to information about their health status, enabling them to make autonomous choices about their own life. A passerby may benefit from UMO if they are unaware of their condition, allowing them to make autonomous and informed choices, providing respect for autonomy.</p> <p>2. More-time argument A UMO may provide an earlier diagnosis, giving people additional time to deal with the condition and managing their lives according to their wishes, thereby respecting a person’s autonomy.</p> <p>3. Risk-disclosure argument Information provided through UMO may disclose early risks to a passerby. Such disclosed information about early risks may enable people to make informed choices about their health.¹²</p> <p>4. General-public-preference argument One study suggests that lay people may welcome UMO.¹³ Taking into account the preference of the person respects their autonomy.</p>	<p>Respect for autonomy</p>
<p>5. The prevent-unnecessary-examination argument People may have an undiagnosed condition and may be undergoing unnecessary examinations and consultations (eg, early-onset genetic parkinsonism).¹⁴ An early expert advice may save time, money and may prevent unnecessary and sometimes invasive examinations.</p>	<p>Non-maleficence</p>
<p>6. The symptom-improvement argument An earlier diagnosis may lead to earlier initiation of treatment, and also provide some comfort by providing an explanation for the person’s signs and symptoms. A UMO may thus ameliorate physical and emotional distress, proving beneficent to passerby.</p>	<p>Beneficence</p>
<p>7. The change-in-lifestyle argument Following the provision of a UMO, people may consider changes in their lifestyle leading to secondary prevention (eg, avoiding heights due to risk of falls, avoid unsupervised swimming to reduce the risk of drowning, etc.).</p>	
<p>8. The equal-access argument Passersby may not have easy or equal access to specialist care. Receiving a UMO may be a unique opportunity for a timely diagnosis that would otherwise not occur for this person (while it would for others). In this way, people could have a more equal chance to access to specialist care.</p>	<p>Justice</p>
Arguments against providing UMO	
<p>9. The privacy-breach argument Receiving a UMO may be experienced as a breach of privacy. UMO may be experienced as an unwelcome intrusion into people’s lives, and thus be considered a lack of respect for someone’s autonomy.</p> <p>10. The right-not-to-know argument People have the right not to know information relevant to their own health. This right leads to the complementary duty of physicians to respect it. Giving a UMO to a passerby would breach this right and complementary duty. Leaving it up to persons whether they want to receive information about their health is a way of respecting their autonomy.</p> <p>11. The paternalistic argument A modern view of participatory healthcare places the patient “in the center” of medical decisions. This is a way to respect the autonomy of patients and persons in general. Providing a UMO can be considered as a proactive attitude from the physician that runs the risk of disrespecting this autonomy. A disrespect of such autonomy may be considered as a kind of paternalism that should be avoided.¹⁵</p>	<p>Respect for autonomy</p>
<p>12. The redundancy argument The passerby who receives the UMO could already know the diagnosis and be already under the care of another medical professional. This would make the unrequested advice redundant and a possible harmful reminder of the burdensome diagnosis. Providing a UMO could do more harm than good in such cases.</p> <p>13. The distress argument Receiving a UMO about a neurological disease may be considered as receiving bad news that may cause distress. Furthermore, the passerby receiving the UMO might be in circumstances in which their own health is not a priority. In such circumstances giving a UMO might do more harm than good.</p>	<p>Non-maleficence</p>

(Continues)

TABLE 1 Continued

Arguments against providing UMO	
14. The stigma argument The UMO may concern a condition that is heavily stigmatized within a particular society or culture (eg, dementia or epilepsy). Providing a passerby a UMO may make him vulnerable to harmful stigma that should be prevented.	
15. The feeling-exposed argument People receiving a UMO may feel exposed because they were made aware they have visible signs of an illness. This feeling may be harmful, and one should prevent people from experiencing it.	
16. The wrong-diagnosis argument By providing a UMO to passersby, neurologists offer a preliminary diagnosis of a neurological disease. The circumstances in which UMO are given are often not ideal for optimal diagnosis. Their diagnosis may be wrong, which may cause harm.	
17. The lack-of-resources argument Receiving a UMO may inform people of the need for further medical assistance. Some people may lack resources to follow-up on the information given (ie, may not have easy access to healthcare). This may give them an experience of vulnerability and powerlessness that may be potentially harmful.	
18. The lack-of-a-cure argument Unlike the case of a melanoma, many neurological conditions and movement disorders do not have disease-modifying treatments. For the latter conditions symptoms may be partially relieved, but it is typically not possible to cure or remove the cause of the disease. The conscious experience of having an incurable or untreatable disease may, for some individuals, be worse than having the disease without knowing it. In this case, not knowing may be more beneficial to the passerby, and providing UMO could cause harm.	Beneficence

^aThis listing is not meant to be definitive; it details the main arguments that the authors identified as relevant to the issue of UMO in movement disorders. Please note that these arguments may have relative weight in different scenarios and they are not universally applicable in all situations.

^bMoral principles: (a) respect for autonomy: respecting the freedom and ability of patients to make their own informed choices; (b) non-maleficence (ie, “first do no harm”) not causing and prevent harm to others; (c) beneficence: “do good,” acting on the benefit of the patient; (d) justice: distribute benefits and resources equitably, treating all persons in equal terms, with fairness and without discrimination.

casually identified three out of the six patients described in his landmark “Essay on the shaking palsy” in the street.⁶ He went on to interview two of these individuals directly.⁷ Since it is not specified that they were seeking medical advice themselves, it is reasonable to infer that James Parkinson took the initiative to approach these persons. Thus, Parkinson himself seems to offer us a characteristic historical example of the issue of UMO.

The literature regarding the problem of UMO in neurology is scarce. One article describes the moral struggle of a physician who noticed a facial palsy in a stranger which turned out to be a malignant tumor of the parotid gland.⁸ An additional article presents an example of an incidental observation of chorea in a person sitting in front of a neurologist in a theater who considers the possibility of Huntington’s disease.⁹ These two articles briefly elaborate on the arguments for and against providing UMO and the underlying ethical principles. In this article, we provide an ethical-professional approach to the problem of UMO in movement disorders.

their expertise at will and disregard their medical responsibilities while not on duty. Thus, a medical observation is never value-neutral, and conscientious professionals may feel morally required to act on their incidental observation. Since observation is such an important skill in the field of movement disorders, we expect that many of our colleagues may have experienced the problem of UMO. When discussing this phenomenon in movement disorders specifically, additional nuances should be considered. First, there is usually no emergency that would justify providing direct assistance. The absence of disease-modifying treatment in some conditions and the lack of pathognomonic findings in ancillary examinations should also be considered. Thus, when an incidental observation is made, conflicting arguments concerning the provision of a medical opinion may appear. The problem of UMO centers around this moral conflict.

The Ethical Problem of UMO in Movement Disorders

Physicians use their observational skills to diagnose medical conditions with the aim of helping people. They cannot “turn off”

The Arguments for and Against Providing UMO

The moral problem of UMO is triggered by the existence of opposing options that each have their arguments for and against. These arguments are *moral* arguments because they refer to moral considerations like rules, principles, values, or virtues. The four principles approach by Beauchamp and Childress¹⁰ affords a

widely accepted framework for “doing good medical ethics”.¹¹ We provide some examples below and discuss the arguments in favor and against providing UMO (Table 1). Even though the examples are diverse, similar arguments may apply. However, the relative weight of each argument may differ for each of the examples, or for each clinician who is confronted with a UMO, and such factors could lead to a different judgment. Readers are invited to think critically for themselves.

Example 1: A middle-aged man is having dinner in a restaurant. He has an abnormal posture of the head compatible with a cervical dystonia. He is eating with other people, and despite the clear twisting of the neck he appears not to be disturbed by the dystonia. No swallowing or speech impairments were evident.

In this situation, it is unclear whether this person was already under specialist care, so, providing UMO could lead to an earlier diagnosis (#2), since dystonia is often underrecognized in non-specialist settings (#8). On the other hand, it could cause considerable and avoidable stress (#13), since he seemed unaffected and was enjoying a private moment with friends or family, which may end up ruined (#9). Also, specific treatment may not be indicated since the person did not seem to be hampered in any obvious way by the dystonia (#18). In this example, it is conceivable that the weighing of the arguments would favor the option of not providing UMO.

Example 2: A neurologist is leaving the clinic and notices a young person leaving the Orthopedic Surgeon’s examination room. The person displays hypomimia, reduced arm swing, and foot dystonia. The neurologist considers the possibility of early-onset parkinsonism. The observation was brief, as the patient was clearly in a hurry.

Some pro-UMO arguments are relevant. People with parkinsonism and dystonia sometimes experience regrettable delays in diagnosis, and their symptoms are often mistaken for orthopedic injuries (#1). A UMO in this situation could lead to an earlier diagnosis (#2), installment of treatment (#6), and fewer redundant observations and examinations (#5). On the other hand, the observation was very brief, and the observer could be wrong (#16). Also, the colleague could have already referred him to Neurology (#12), or he could have been referred to the surgeon for a legitimate Orthopedics-related problem. If the professional had been able to make a more thorough observation and was given a chance to approach the patient in a private manner, it is possible that the arguments in favor of providing UMO could outweigh those against it.

Example 3: A patient presented for a medicolegal report specifically following a whiplash injury from a car accident resulting in neck pain. The neurologist incidentally notices several features suggestive of a diagnosis of multiple-system atrophy.

On the one hand, the person deserves to know about his health condition (#1), and could also benefit from specific treatment (even though dopaminergic therapy is generally less effective in multiple system atrophy than it is for patients with Parkinson’s disease) (#6). On the other hand, a diagnosis of a

neurodegenerative condition is likely to raise a red-flag in terms of liability and compensation, which is a case-specific non-maleficence argument. Also, the patient did not seek medical attention for situations other than the ones directly related to the car accident and may not be interested in pursuing further possibilities (#10,11). It is conceivable that disclosing the unrelated diagnosis in this setting could be more detrimental to the patient than not sharing it immediately. An acceptable solution would be to organize for a neurology consult outside the medicolegal context as soon as possible.

Example 4: A neurologist is at a wedding where he meets the father of a distant acquaintance. The father shows signs suggestive of Huntington’s disease, but they both seem unaware of his condition. The acquaintance is talking about his own personal plans, specifically starting a family soon.

There may be advantages in alerting the person and his father, for example, preconceptional counseling (#1,2,3). However, the neurologist can be wrong about the diagnosis (#16), causing extreme emotional distress (#3). Another consideration would be that they know about the father’s diagnosis, and the son decided not to know his genetic status (#10), or they may already be receiving adequate prenatal care (#12). Disclosing one’s serious suspicions on a festive day could be perceived as an unwelcoming invasion of privacy (#9). A possible solution would be to kindly and privately offer the possibility of arranging a neurology appointment for the father in the following days or weeks, if the family is interested.

Weighing Arguments and Judging How to Act in Specific Situations

In all examples, the judgment about UMO should be the result of a careful weighing of arguments. Occasionally, there may be more than one way to act in an ethically responsible manner. Also, it is important to realize that arguments do not only relate to decisions about *what* to do. From an ethical perspective, *how* you do what you decide to do is also important, and this is how *virtues* also play a role in UMO. Unsolicited advice given tactfully may be ethically praiseworthy, whereas the same advice delivered without tact, care, and discretion could be ethically unjustified, regardless of the context where it is given.

Several aspects will contribute to a different weighing of arguments in a specific situation. First, aspects related to non-maleficence (“first do no harm”) are traditionally given higher importance, but we propose that each situation should be judged on its own merits. Second, social and cultural aspects are also likely to influence the decision to provide a UMO. If, for example, a condition is heavily stigmatized within society, the recipient is more likely to be troubled by the UMO. This may also occur when the incidental observation occurs in a culture where social interactions are subject to strict moral or religious scrutiny.

Third, the extent of medicolegal repercussions, eg, fear of litigation, is also a factor. This issue is likely country- and culture-specific, and its detailed discussion is outside the scope of this article. If the observation occurs in a context where legal consequences have considerable weight in the medical decision-making process and avoidance of litigation is a priority (as often occurs in the United States of America), the observer is likely to give more weight to the consequences of giving information that is wrong or harmful. Also, the issue of whether “good Samaritan” laws apply to UMO in neurology is a complex topic to be discussed elsewhere. On the other hand, other cultures may place less weight on the legal consequences of a well-intentioned medical action (as seems to be the case in for example, the Netherlands and also in the rest of Europe). It is important to remember that making a UMO does, by its nature, result in a form of doctor-patient relationship with associated medicolegal implications. Fourth, the timing and nature of the observation are also important. Most incidental observations will occur in passing, with a small window of opportunity for interaction, and the observer may not be able to consider the full range of arguments at that moment. That is why it is important to be aware of the pros and cons of a UMO in advance and to think ahead about how to approach its potential occurrence (to the extent possible). Finally, it is possible that different experts would make different judgments even when placed in a comparable situation. Professionals would be wise to enter a deliberative dialogue with a public of peers and to assess each other’s arguments. We propose that, in the same way that professionals discuss complex clinical scenarios with arguments in favor and against a particular diagnosis and therapeutic strategy, they should also discuss among themselves their views and experiences with UMO, particularly in situations when the observation is expected to happen frequently. The clinical ethical method of Moral Case Deliberation may be useful to this effect.^{16,17}

I Have Made an Incidental Medical Observation. May I Share it with You?

Considering that the arguments should be weighed anew in each situation, we propose a set of generic conditions based on the previous work of Moseley,¹⁸ Ratzan¹⁹ and Adler² to help professionals decide to provide or withhold UMO in movement disorders (Supplementary File S1). Our conclusion is that it may sometimes be ethically justified for a healthcare professional to provide UMO, especially when all those conditions can be met. When such a delicate decision has been made, disclosing the observations should be done tactfully, ie, by disclosing first that a medical observation of sorts has been made. This would also likely reduce the possibility that the information could be ill-received. It is also crucial to guarantee that the proper care can be arranged, namely by clarifying which medical steps should be taken next, and where this can be organized.

Author Roles

(1) Research project: A. Conception, B. Organization, C. Execution; (2) Statistical Analysis: A. Design, B. Execution, C. Review and Critique; (3) Manuscript: A. Writing of the first draft, B. Review and Critique.

R.A.: 1A, 1B, 1C, 3A

J.J.K.: 1B, 1C, 3A, 3B

J.J.F.: 1A, 1B

B.R.B.: 1B, 1C, 3A, 3B

R.A. and J.J.K. provided substantial contributions to the conception and design of the work and significant contributions to early and late versions of the manuscript. R.A. provided original concept. J.J.K. provided critical contributions regarding ethical reasoning. Together, R.A. and J.J.K. wrote the first versions of most sections of the article. R.A. and J.J.K. contributed equally to the final work. J.J.F. provided substantial contributions to early versions of the manuscript. B.R.B. provided substantial contributions to early and final versions of the manuscript and critical revision for intellectual content.

Disclosures

Ethical Compliance Statement: The authors confirm that the approval of an institutional review board was not required for this work. Also, patient consent was not required. We confirm that we have read the Journal’s position on issues involved in ethical publication and affirm that this work is consistent with those guidelines.

Funding Sources and Conflicts of Interest: None relevant to the manuscript.

Financial Disclosures for the Previous 12 Months: R.A. has received fees from serving on a scientific advisory board for Bial, and has received fees for speaking at conferences from Roche and Bial. J.J.F. owns stocks in and reports consultancy fees from Ipsen, GlaxoSmithKline, Novartis, Teva, Lundbeck, Solvay, Abbot, Bial, Merck-Serono and Merz. J.J.F. reports grants from GlaxoSmithKline, Grunenthal, Teva, Fundação Merck Sharp Dome. J.J.K. reports no disclosures. Prof. Bloem serves as the co-Editor in Chief for the Journal of Parkinson’s disease, serves on the editorial board of Practical Neurology and Digital Biomarkers, has received fees from serving on the scientific advisory board for UCB, Kyowa Kirin, Zambon and the Critical Path Institute (paid to the Institute), has received fees for speaking at conferences from AbbVie, Biogen, UCB, Zambon, Roche, GE Healthcare, Oruen and Bial (paid to the Institute), and has received research support from the Netherlands Organization for Health Research and Development, the Michael J. Fox Foundation, UCB, the Stichting Parkinson Fonds, Hersenstichting Nederland, de Stichting Woelse Waard, Stichting Alkemade-Keuls, de Maag Lever Darm Stichting, Parkinson NL, Davis Phinney Foundation, the Parkinson’s Foundation, Verily Life Sciences, Horizon 2020, the Topsector Life Sciences and Health, Nothing Impossible and the Parkinson Vereniging,

outside the submitted work. Prof. Bloem does not hold any stocks or stock options with any companies that are connected to Parkinson's disease or to any of the topics in this paper. ■

References

- Clarke RS, Drance T. How Kraken fan Nadia Popovici, 22 words and a lifetime of motivation saved a Canucks staffer's life; 2022. <https://theathletic.com/3046052/2022/01/02/how-kraken-fan-nadia-popovici-22-words-and-a-lifetime-of-motivation-saved-a-canucks-trainers-life/>. Accessed December 26 2022.
- Adler NR, Mahar PD, Kelly JW. You should get that mole checked out: ethical and legal considerations of the unsolicited clinical opinion. *Aust Fam Physician* 2017;46(12):949–951.
- Bercovitch L. Should one offer an unsolicited dermatologic opinion? Ethics for the locker-room dermatologist. *J Am Acad Dermatol* 2011; 65(1):134–136.
- Sirven JI. "is there a neurologist on this flight?": an update. *Neurol Clin Pract* 2018;8(5):445–450.
- Araújo R, van de Warrenburg B, Lang A, Lees A, Bloem B. The waiting room: neurological observations made outside the movement disorder specialist's consulting office. *Pract Neurol* 2019;19(4):295–301.
- Parkinson J. An essay on the shaking palsy. 1817. *J Neuropsychiatry Clin Neurosci* 2002;14(2):223–236.
- Kempster PA, Hurwitz B, Lees AJ. A new look at James Parkinson's essay on the shaking palsy. *Neurology* 2007;69(5):482–485.
- Kitsis EA, Fleischman AR. If you see something, say something. *JAMA Neurol* 2019;76(5):519–520.
- Mitchell EW. The ethics of passer-by diagnosis. *Lancet* 2008;371(9606): 85–87.
- Beauchamp T, Childress J. *Principles of Biomedical Ethics*. 1st ed. New York, Oxford: Oxford University Press; 1979.
- Gillon R. Defending the four principles approach as a good basis for good medical practice and therefore for good medical ethics. *J Med Ethics* 2015;41(1):111–116.
- Schaeffer E, Rogge A, Nieding K, Helmker V, Letsch C, Hauptmann B, Berg D. Patients' views on the ethical challenges of early Parkinson disease detection. *Neurology* 2020;94(19):e2037–e2044.
- Zwitter M, Nilstun T, Knudsen LE, et al. Professional and public attitudes towards unsolicited medical intervention. *BMJ* 1999;318(7178): 251–253.
- Ruiz-Lopez M, Freitas ME, Oliveira LM, et al. Diagnostic delay in Parkinson's disease caused by PRKN mutations. *Parkinsonism Relat Disord* 2019;63:217–220.
- Kremer JA, Van Der Eijk M, Aarts JW, Bloem BR. The individual formerly known as patient, TIFKAP. *Minerva Med* 2011;102(6):505.
- Tan DY, Ter Meulen BC, Molewijk A, Widdershoven G. Moral case deliberation. *Pract Neurol* 2018;18(3):181–186.
- Inguaggiato G, Metselaar S, Molewijk B, Widdershoven G. How moral case deliberation supports good clinical decision making. *AMA J Ethics* 2019;21(10):913–919.
- Moseley R. Excuse me, but you have a melanoma on your neck! Unsolicited medical opinions. *J Med Philos* 1985;10(2):163–170.
- Ratzan RM. Unsolicited medical opinion. *J Med Philos* 1985;10(2): 147–162.

Supporting Information

Supporting information may be found in the online version of this article.

Supplementary File S1. Suggested conditions for providing unsolicited medical opinions to persons with probable movement disorders in which the disadvantages of disclosing advice would be reduced.