# Online Medical Professionalism: Patient and Public Relationships: Policy Statement From the American College of Physicians and the Federation of State Medical Boards

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User-created content and communications on Web-based applications, such as networking sites, media sharing sites, or blog platforms, have dramatically increased in popularity over the past several years, but there has been little policy or guidance on the best practices to inform standards for the professional conduct of physicians in the digital environment. Areas of specific concern include the use of such media for nonclinical purposes, implications for confidentiality, the use of social media in patient education, and how all of this affects the public's trust in physicians as patient–physician interactions extend into the digital environment. Opportunities afforded by online applications represent a new frontier in medicine as physicians and patients become more connected. This position paper from the American College of Physicians and the Federation of State Medical Boards examines and provides recommendations about the influence of social media on the patient–physician relationship, the role of these media in public perception of physician behaviors, and strategies for physician–physician communication that preserve confidentiality while best using these technologies.

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**B**ecause of the creation and use of information online and the widespread use of the Internet and Web 2.0 platforms, physicians and others are increasingly required to consider how best to protect patient interests and apply principles of professionalism to new settings (1). As new technologies and practices, such as social networking, are embraced, it is paramount to maintain the privacy and confidentiality of patient information, demonstrate respect for patients, ensure trust in physicians and in the medical profession, and establish appropriate boundaries (2). To protect patients and the public and promote quality health care, it is critical to strike the proper balance to harness opportunities while being aware of inherent challenges in using technology. But as others have pointed out, "Connectivity need not come at the expense of professionalism" (3).

Organizational statements addressing these issues are starting to appear, but they may not provide specific guidance to deal with and anticipate concerns. Innovations often bring benefits, but rapid introduction of technology sometimes outpaces existing policies, laws, and guidelines. This article provides a framework for analyzing medical ethics and professionalism issues in online postings and interactions, including the use of electronic resources for clinical or direct patient care involving patient information outside of the electronic health record, and the nonclinical or personal use of these media. It presents the implications of online activities for patients, physicians, the profession, and society and contains recommendations (**Table**) that address online communication with patients, the use of social media sites to gather and share information about patients, physician-produced blogs, physician posting of personal information that patients can access, and communications among colleagues about patient care.

Here, "online" or "digital" refers to the electronic posting of information and its exchange using computers and phones. "Web 2.0" refers to those resources in which self-created content by users is made and posted for public dissemination by means of media sharing platforms. This article provides guidance for practitioners, trainees, and medical students in navigating the digital world, including the use of social networking, blogging, online forums, media sharing sites, cell phone photography, electronic searching, texting, and e-mailing. It does not examine issues of

**Table.** Online Physician Activities: Benefits, Pitfalls, and Recommended Safeguards

| Activity | Potential Benefits | Potential Pitfalls | Recommended Safeguards |
|---|---|---|---|
| Communications with patients using e-mail, text, and instant messaging | Greater accessibility<br>Immediate answers to nonurgent issues | Confidentiality concerns<br>Replacement of face-to-face or telephone interaction<br>Ambiguity or misinterpretation of digital interactions | Establish guidelines for types of issues appropriate for digital communication<br>Reserve digital communication only for patients who maintain face-to-face follow-up |
| Use of social media sites to gather information about patients | Observe and counsel patients on risk-taking or health-averse behaviors<br>Intervene in an emergency | Sensitivity to source of information<br>Threaten trust in patient–physician relationship | Consider intent of search and application of findings<br>Consider implications for ongoing care |
| Use of online educational resources and related information with patients | Encourage patient empowerment through self-education<br>Supplement resource-poor environments | Non–peer-reviewed materials may provide inaccurate information<br>Scam "patient" sites that misrepresent therapies and outcomes | Vet information to ensure accuracy of content<br>Refer patients only to reputable sites and sources |
| Physician-produced blogs, microblogs, and physician posting of comments by others | Advocacy and public health enhancement<br>Introduction of physician "voice" into such conversations | Negative online content, such as "venting" or ranting, that disparages patients and colleagues | "Pause before posting"<br>Consider the content and the message it sends about a physician as an individual and the profession |
| Physician posting of physician personal information on public social media sites | Networking and communications | Blurring of professional and personal boundaries<br>Impact on representation of the individual and the profession | Maintain separate personas, personal and professional, for online social behavior<br>Scrutinize material available for public consumption |
| Physician use of digital venues (e.g., text and Web) for communicating with colleagues about patient care | Ease of communication with colleagues | Confidentiality concerns<br>Unsecured networks and accessibility of protected health information | Implement health information technology solutions for secure messaging and information sharing<br>Follow institutional practice and policy for remote and mobile access of protected health information |

telemedicine (the care of a patient in an area remote from the consulting physician using the transmission of imaging and health data from 1 site to another), the use of electronic resources to prescribe medicine or diagnose illnesses, social networking resources for patients' therapeutic benefit, or general issues about the electronic health record.

## METHODS

This position statement was authored on behalf of the American College of Physicians (ACP) Ethics, Professionalism, and Human Rights Committee, the ACP Council of Associates, and the Federation of State Medical Boards (FSMB) Special Committee on Ethics and Professionalism. They and the authors developed the statement between May 2011 and October 2012. After literature reviews and an environmental assessment to determine the scope of issues, drafts were debated, and a consensus was reached on issues through facilitated discussion. A draft then underwent external peer review and review by the College and FSMB committees, councils, and leadership, as well as journal peer review. After revisions based on those comments, the position paper was reviewed and approved by the committees and the FSMB Board of Directors and ACP Board of Regents. The position paper is official ACP and FSMB policy.

## POSITIONS

*Position 1: Use of online media can bring significant educational benefits to patients and physicians, but may also*

*pose ethical challenges. Maintaining trust in the profession and in patient–physician relationships requires that physicians consistently apply ethical principles for preserving the relationship, confidentiality, privacy, and respect for persons to online settings and communications.*

### The Patient–Physician Relationship

Standards for professional interactions should be consistent across all forms of communication between the patient and physician, whether in person or online. Encounters between patients and physicians should only occur within the bounds of an established patient–physician relationship, which entails rights and obligations for both parties. As stated in the ACP Ethics Manual, physicians "must be careful to extend standards for maintaining professional relationships and confidentiality from the clinic to the online setting" (4). E-mail and other electronic means of communication can supplement, but not replace, face-to-face encounters.

Establishing positive patient–physician relationships and maintaining professional decorum are core elements of training that should be fostered from medical school through all stages of professional development. Online professionalism can pose challenges because of the ambiguity of written language without the context of body language or lack of awareness of the potential abuses of such media (5). The ease of use and immediacy of social media tools—especially if users do not engage in "pausing before posting"—can lead to unintended outcomes or messages.

Many state medical boards have received reports of violations of online professionalism (6).

The initial decision about whether to extend the patient–physician relationship to the online setting includes the following factors: the intended purpose of the exchange and the content of conversation; the immediacy of electronic media and expectations, including response time; how communication will take place (for example, through social networking sites, microblogging, or professional e-mail on a protected server) while maintaining confidentiality; and how emergency or urgent situations will be managed.

### The Patient–Physician Relationship: To Friend (and Google) or Not to Friend (and Google)?

Patients will sometimes initiate online communication. One recent study suggested that many patients extend online "friend" requests to their physicians, although very few physicians reciprocate or respond (7). Organizational policy statements increasingly discourage personal communication between physicians and patients online (8). The FSMB specifically discourages physicians from "interacting with current or past patients on personal social networking sites such as Facebook" (9).

Information exchanged on the Web is at least a 2-way street because it may also be available to the general public. Just as patients may learn about the personal behavior of physicians, physicians may observe patients participating in risk-taking or health-averse behaviors. Information about a patient from online sources may be helpful in the care of that patient, but physicians should be sensitive to the source. They should use clinical judgment in determining whether and how to reveal it during their management of the patient.

This online practice, known as patient-targeted Googling, has been described in many settings, including an attempt to identify an unconscious patient in the emergency department. But often, it instead can be linked to "curiosity, voyeurism and habit" (10). Although anecdotal reports highlight some benefit (for example, intervening when a patient is blogging about suicide), real potential exists for blurring professional and personal boundaries. Digitally tracking the personal behaviors of patients, such as determining whether they have indeed quit smoking or are maintaining a healthy diet, may threaten the trust needed for a strong patient–physician relationship (11). Commentators encourage physicians to consider the intent of the search, whether it affects continuing therapy for the patient, and how to appropriately document findings with implications for ongoing care.

### Patient and Physician Education

The Internet can be a powerful tool for education. Patients can share and discuss information using illness-specific social networking pages (10). The Pew Internet and American Life Project estimates that 8 in 10 Internet users go online for health information, making it the third most popular activity online among those in Pew Internet surveys (12).

Physicians should consider the quality of online resources they recommend and guide patients to peer-reviewed media and Web sites where the quality control of information can be checked. Using and sharing recommendations from state medical boards or the College may help direct physicians and patients to resources that are more accurate and objective.

Online learning opportunities can be used by patients and physicians. New care delivery models embrace social media, especially for sharing resources in resource-poor environments (13, 14). Online decision aids are growing in popularity among motivated patients seeking health information, and they warrant familiarity by physicians (15). Continuing medical education and faculty development activities are now on the Web, with online learning modules and social media platforms available for specialists and generalists to share experiences and network.

The Internet and social networking can also serve the public health (16). For example, text messaging on a public health level can bring health benefits. But online activities also bring ethical challenges for the profession and individual physicians. Digital media may help to increase physician–physician interaction and education via online discussion communities and similar means; however, it is the responsibility of physicians to ensure to the best of their ability that professional networks are secure and that only verified and registered users have access to shared information. Online postings can also be used to help advocate for public health issues and broadly educate groups of patients on specific conditions and treatment. Clinical vignettes, however, must have all personal identifying information removed, including any revealing references to a patient who serves as the basis for an illustrative narrative. Consent from the patient to use his or her personal story online should be obtained.

Just as with informal in-person discussions among colleagues, the airing of frustrations and "venting" may occur in online forums. The ACP and the FSMB recommend against this practice, even among close contacts, as it may be disrespectful and undermine professionalism. We also caution against this practice in other forums, specifically blog postings or microblog sites, such as Twitter, as the material may present the physician or physician-in-training in an inappropriate or unprofessional light (17). Physicians criticizing late-arriving patients or disparaging patients for not adhering to behavior changes (such as diet and weight loss) can undermine trust in the profession.

### Confidentiality

Confidentiality respects patient rights and privacy, and this encourages patients to seek medical care and openly discuss issues. Confidentiality may be hard to maintain given electronic health records, electronic data processing, e-mail, the faxing of patient information, third-party pay-

ment for medical services, and the sharing of patient care and information among several health professionals and institutions; therefore, "Physicians must follow appropriate security protocols for storage and transfer of patient information to maintain confidentiality, adhering to best practices for electronic communication and use of decision making tools" (4). In addition, they should be aware of state and federal legal requirements, including the privacy rule from the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and updates to the rule (18).

In digital environments, the sharing of patient information must always be held to a higher level of security than standard residential Internet connections. Encrypted or virtual proxy network connections in hospital-based information technology systems should be used for all patient information exchange and review to ensure a secure digital environment. Institutional-based policies on home access of the electronic health record should be reviewed before use, specifically maintaining the level of security required for use on personal devices. Many institutions use mobile device management systems for smartphones and tablet devices. This allows for remote monitoring of the hospital's digital "perimeter" and remote disabling of devices that are lost or confiscated.

Because many physicians use mobile devices to help manage their professional careers, mobile solutions are required to ensure confidentiality, especially when such devices or tablet computers are used to access electronic medical records. Digital devices must be configured to protect patient information should the devices be misplaced or stolen; mobile management solutions can help provide such a safety net (19). In addition, the use of public, unsecured wireless networks and cellular device networks is discouraged given their inherent public accessibility and the potential for patient information to be compromised. The recent Imprivata study of text messaging in health care settings echoes these concerns, with 64% of physician respondents classified as very concerned over HIPAA compliance when sending patient health information by text. Nearly 72% believed that secure text messaging solutions would replace standard numerical pagers in current use within 3 years (20). The disposal of old devices with hospital-based connectivity or access to the electronic health record should be managed on the basis of institutional policy.

With respect to more specific use and sharing of digital media, cell phone photography, for example, is still considered a form of photography. Despite its ease of use and ubiquity, it requires obtaining formal written consent from the patient. In taking a patient photograph or radiographic image, the physician is accepting responsibility to protect this information just as for all health records. Deidentification of radiographic images in the context of educational lectures must be ensured (21).

## Medicine and Society

Professionalism is the foundation for the social contract between physicians and society (22). In exchange for the privilege of caring for patients, as well as the status, respect, and financial compensation that accompanies that privilege, society expects physicians to practice in a professional and empathetic manner (23) and to self-regulate (4).

The intimate nature of the relationship between physicians and patients results in the expectation of high ethical behavior by physicians (24). Societal expectations often extend beyond professional practice and into the daily activities of the physician. Poor judgment reflects not only on the individual physician but also on the profession. State medical boards have the authority to discipline physicians, including license restriction, suspension, or revocation, for inappropriate uses of social media, such as improper communication with patients (for example, sexual misconduct), unprofessional behavior, and misrepresentation of credentials.

The ACP Ethics Manual requires that "physicians' conduct as professionals and as individuals should merit the respect of the community" (4). Explicit definitions and expectations of physician behaviors, both in and outside the presence of patients, have been defined by organizations, such as the United Kingdom's General Medicine Council (25).

*Position 2: The boundaries between professional and social spheres can blur online. Physicians should keep the 2 spheres separate and comport themselves professionally in both.*

## Role and Representation

The ACP Ethics Manual stresses the importance of maintaining public trust in the medical profession and in patient–physician relationships. To maintain the respect of the community as individuals and as members of a profession, not only should the content of all online postings be considered but also the *role* of the individual posting the information. Are individuals posting material in their role as physicians, or are they merely stating opinions and also happen to practice medicine? Can this distinction be maintained?

The American Medical Association strongly suggests divorcing public and professional digital identities, specifically maintaining separate online sites or identities for the separate roles (16). This underscores the importance of education on the use of digital media and pertinent issues of confidentiality. The ACP Ethics Manual states, "Physicians who use online media, such as social networks, blogs, and video sites, should be aware of the potential to blur social and professional boundaries" (4). Problems occur when individuals post questionable material while identifying themselves as a physician or physician-in-training (26–28).

At times, physicians may be asked or may choose to write online about their professional experiences, or they

may post comments on a Web site as a physician. When doing so, they must disclose their credentials and any conflicts of interest. They should consider the dangers of posting or responding to comments on the Web. Truly anonymous postings do not exist on the Web, and with the increased sophistication of searching and search engines, the ability to link posts or comments to the original contributor has expanded (29). Physicians should be aware that information posted on a social networking site may be disseminated (whether intended or not) to a larger audience, be taken out of context, and remain publicly available or retrievable online in perpetuity. Physicians should follow their institutional policy on digital media (30) and seek guidance from professional societies and state medical boards.

### Maintaining Boundaries

The ACP and the FSMB advise against including patients in the physician's personal and social interactions online. Professional distance and privacy are appropriate for both physician and patient. Physicians should not "friend" or contact patients through personal social media. Physicians should familiarize themselves with the privacy settings and terms of agreements for social media platforms to which they subscribe, and they should maintain strict privacy settings on personal accounts. Professional profiles should be constructed with an explicit purpose (such as networking and community outreach).

### Public Consumption

Physicians-in-training, who at present are most apt to use social media platforms, agree on the responsibility to represent themselves professionally online and are aware that they, and the profession, are being assessed by their online behaviors (7). Although narrative work has described the psychological benefit of "collective venting toward the process of being doctored" (31), the public availability of online medical class skits, songs, shows, and other material previously intended for sharing in private, physician-only audiences has called into question these traditions.

Although we will not attempt to dissect the implications of such offerings, it is clear that these are experiences that are not generally intended for public consumption and, despite any value to the psyche of the trainees, should be examined more closely by medical educators and not shared online or in other mass media. It is prudent to consider the effect of publicly posting something that initially seems like harmless medical humor. Consideration should be given to how patients and the public would perceive the material and what effect this may have on the individuals involved as well as their institutions and the medical profession. Many institutional policy statements encourage a "pause-before-posting" moment where medical professionals are asked to reflect on how the general public may perceive the content.

### Interprofessional Relationships

Another issue requiring consideration is online relationships between physicians of varying levels of training, specifically, attending physicians and their students and residents. Attending physicians frequently receive online "friend" requests from students and residents (32). These digital "relationships" can also blur professional and personal boundaries, especially when the faculty physician is in the role of evaluator. Faculty and trainees should examine the purpose of initiating an online relationship and decide whether it is for ongoing mentorship, research work, or career advice (32). Regardless of intent, the traditional boundaries encouraged in trainee–faculty relationships should apply when those parties interact through social media. These boundaries should also apply with staff, other clinicians, and allied health professionals.

*Position 3: E-mail or other electronic communications should only be used by physicians in an established patient–physician relationship and with patient consent. Documentation about patient care communications should be included in the patient's medical record.*

Effective communication is a foundation of a strong patient–physician relationship. E-mail or other electronic communications can supplement face-to-face encounters if done under guidelines (4, 33). Using e-mail to provide therapeutic advice is not recommended when a patient–physician relationship has not been previously established. Some state laws (for example, those in Hawaii) do not require a preexisting relationship for e-mail or other electronic consultation between a physician and a patient (that is, the physician has not met or examined the patient) (34); however, the ACP and the FSMB do not support this practice.

Documentation of communications in an established patient–physician relationship, including those done electronically, should be maintained. "Medical records should contain accurate and complete information about all communications, including those done in-person and by telephone, letter or electronic means" (4).

Situations in which a physician is approached by electronic means for clinical advice in the absence of a patient–physician relationship should be handled with careful judgment; they should usually be addressed with encouragement that the individual schedule an office visit or, in the case of an urgent matter, go to the nearest emergency department.

### E-Communication and Established Relationships

E-communication between patients and physicians with an existing relationship requires discussion and previous agreement before electronic exchange is initiated. Guidelines exist for interactions with patients via e-mail (33), including the appropriate type of information to share and the expectations about turnaround time. The nature of e-mail communication ensures a written copy of

the exchange, but patient confidentiality must be assured, such as through the use of a hospital-based server. A discussion of the protections in place to ensure patient privacy must also occur.

Documentation of the patient's consent and awareness of the security and risks associated with the use of patient–physician e-mail should be included in the medical record (35). Physicians should not use personal e-mail accounts for these communications but rather encrypted messages over secure network connections. Web-based portals offer messaging through secure accounts on the portal. Physicians must maintain appropriate boundaries (36) and recognize that electronic communication merely supplements face-to-face encounters.

Electronic communication with patients, if done in a systematic and thoughtful way, can improve patient care and outcomes. Studies have demonstrated that in patients with chronic disease management needs, supplemental electronic communication served as a "booster" to physician advice and improved adherence to therapy (37, 38). It may also improve patient and physician satisfaction by increasing the actual or perceived time spent communicating and having questions answered (39). As other Web tools begin to show promise, this communication is often not limited to standard e-mail (40). Physicians and patients should be discouraged from communicating on health matters through social media tools that are publicly viewable, do not ensure patient confidentiality, and are not readily recordable or admissible to the medical record.

Physicians should be aware of legal requirements in their states about these communications and the risk for state medical board violations or other issues if the physician is not licensed in the state in which the electronic communications are received.

### "The MD Will BRB [Be Right Back]"

Expectations for immediate access have led to non–Web-based forms of communication by means of multimedia messaging services and short or text messaging services (41). Several large pharmacies and insurers have piloted systems for prescription refills and appointment updates (42); however, these interactions are largely unidirectional (such as update or reminder texts) with several layers of encryption for security. Despite these advances, current technology does not provide adequate security to prevent third-party access to information. Also, text messaging is not analogous to e-mail because of its abbreviated format and the greater possibility of missed messages. Therefore, physicians should not use text messaging for medical interactions with even established patients except with extreme caution and with patient consent.

*Position 4: Physicians should consider periodically "self-auditing" to assess the accuracy of information available about them on physician-ranking Web sites and other sources online.*

Ranking, feedback, and other Web sites may offer patients insight into physician training and office practices. Physicians and patients should recognize that this information may not be complete or accurate. Physicians may have little recourse in deleting misrepresentations (43–45). Establishing a professional profile so that it "appears" first during a search, instead of a physician-ranking site, can provide some measure of control that the information read by patients before and after the initial encounter is accurate. Physicians should consider doing routine surveillance (46) of their online presence by searching for their names, and they should correct inaccurate information.

*Position 5: The reach of the Internet and online communications is far and often permanent. Physicians, trainees, and medical students should be aware that online postings may have future implications for their professional lives.*

How one is represented affects public, patient, and peer perceptions. Colleagues may often be superiors or those in an evaluative capacity. The online behaviors an individual displays may harm employability and recruitment, may result in limitations in professional development and advancement, and may reflect poorly on the profession as a whole.

Many institutions have begun to harness the power of digital media to attract patients, new faculty, or trainees, especially in allied health professional education (47). These technologies can be used as recruitment or screening tools. Employers have turned away job applicants on the basis of questionable digital behavior, including provocative or inappropriate photographs or information, content that displays drinking or drug use, and evidence of poor communication skills (48). Anecdotal reports indicate that medical school admissions offices and residency training programs are increasingly using the Web to prescreen candidates. Many trainees may inadvertently harm their future careers by not responsibly posting material or not actively policing their online content. Educational programs stressing a proactive approach to digital image (online reputation) are good forums to introduce these potential repercussions.

The implications for professional life extend beyond being a prospective applicant to career advancement. A physician's digital image can have positive or negative career repercussions. Several very public missteps have been documented, including physicians taking digital photographs during surgery (49), posing with weapons and alcohol (in some instances during humanitarian work) (50), and unprofessional microblog posts (for example, "tweets") (51) that may ultimately harm both the individual and the profession. One's digital image should be actively managed beyond training by maintaining the separation of professional and personal images and the clinical and nonclinical use of social media. Being proactive by controlling posted content, using privacy settings, and limiting access to per-

sonal information is in the best interest of both the profession and the individual physician.

## CONCLUSION

Online technologies present both opportunities and challenges to professionalism. They offer innovative ways for physicians to interact with patients and positively affect the health of communities, but the tenets of professionalism and of the patient–physician relationship should govern these interactions. Institutions should have policies in place on the uses of digital media. Education about the ethical and professional use of these tools is critical to maintaining a respectful and safe environment for patients, the public, and physicians. As patients continue to turn to the Web for health care advice, physicians should maintain a professional presence and direct patients to reputable sources of information.

Digital media use for nonclinical purposes may affect societal perceptions of the profession, especially when questionable content is posted by physicians in their personal use of the Web. Maintaining separate personal and professional identities in Web postings may help to avoid blurring boundaries in interactions with patients and colleagues.

The ACP and the FSMB recognize that emerging technology and societal trends will continue to change the landscape of social media and social networking and how Web sites are used by patients and physicians will evolve over time. These guidelines are meant to be a starting point, and they will need to be modified and adapted as technology advances and best practices emerge. Physicians are encouraged to take a proactive approach to managing digital identity by routinely performing surveillance of publicly available material and maintaining strict privacy settings about their information. Physicians also need to familiarize themselves with these technologies to guide themselves, and their patients, as they navigate the online terrain.

Current author addresses and author contributions are available at www.annals.org.

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