Digital Professionalism

Glen O. Gabbard¹

Received: 14 June 2018 / Accepted: 5 October 2018 / Published online: 15 October 2018
© Academic Psychiatry 2018

Digital Professionalism

The rise of professionalism within medicine has swept through the hallways and lecture rooms of academic centers in a way that has prompted a quiet revolution in how doctors are trained and how they are expected to behave in the workplace setting [1, 2]. Today a physician's technical skill involving diagnosis and treatment must be accompanied by a range of professional behaviors, such as being attuned to the management of healthcare resources in a manner that reflects fairness and integrity, behaving compassionately toward patients and families, treating coworkers with respect, observing the professional boundaries between doctors and patients, being accountable, being a good team player, and pursuing improvement in an ongoing way.

Today's psychiatrist must be alert to a myriad of concerns. Psychiatry as a specialty presents special challenges in implementing professionalism, partly because of the unusual focus on the doctor-patient relationship and the privacy required for psychiatric treatment to be effective. A great deal depends on the character of the psychiatrist or psychiatric trainee. Moreover, in psychiatry, negative feelings toward patients are not simply disavowed or suppressed but, rather, are viewed as important information that must be taken into account. Contemporary understanding of transference-countertransference feelings suggests that both patient and doctor contribute to the creation of the problems because the doctor-patient relationship is thought of as a two-person field. In concert with the increased awareness of professionalism, there has been an extraordinary impact of the digital revolution within all aspects of society. Turkle [3] has noted this transformation in her observation that the possibilities of Internet communication have led to multiple identities and a fluidity of self that are unprecedented. Psychiatrists routinely

receive texts and emails from patients now, and most psychiatrists would view online communication with patients as virtually unavoidable. The burgeoning flood of electronic messages has resulted in frantic efforts from psychiatric educators, as well as practicing psychiatrists everywhere, to engage in some form of standard operating procedure regarding how to deal with these communications. In a series of publications [4–8], I have tried to conceptualize the challenges presented by the digital era for psychiatry in general and for psychotherapy in particular. Digital communication is alive and well in the practice of psychiatry virtually everywhere at this point, but the consequences of that extensive use are often not taken into account. Much of this type of communication is helpful and is not necessarily unethical or unprofessional. However, one must be vigilant about the potential erosion of professional boundaries in the cyberspace medium. Moreover, as Fisher and Appelbaum [9] note, practitioners must be diligent about privacy, confidentiality, and professional respect for patients and their families.

The Decline and Fall of Privacy

Throughout the digital revolution, tech-savvy soothsayers have warned the public that nothing in any form that is mediated through digital technology is guaranteed to stay private. Cassandra-like warnings not to email, not to text, and not to send photos of oneself online have repeatedly been published on the Internet and elsewhere. However, psychiatrists and mental health professionals have often taken an attitude of "In my case, there will be no adverse consequences." Many have had experiences, however, that have made them think twice about their offhand disregard for these warnings.

In the much-acclaimed television miniseries "Mr. Robot," the title character regularly visits a psychotherapist, who is portrayed as thoughtful, caring, and astute. She is doing a reasonably good job with a very difficult patient. Nevertheless, in one session, her patient Elliot, the eponymous hero, informs her that he has hacked into her computer. He then matter-of-factly informs her about what he now knows about her. She does not

✉ Glen O. Gabbard
glen.gabbard@gmail.com

¹ Baylor College of Medicine, Houston, TX, USA

refill her Ativan as directed. He knows what coffee she buys and what kind of porn she accesses. He advises her of what she needs to do with some of her other patients. He also reveals that he is aware that she wishes her mother would die. This invasion of privacy, chillingly depicted in the episode, brings home the fact that the traditional anonymity of the therapist has largely disappeared. Patients can quickly access a picture of their therapist's home on the Internet, find out the cost of the house, and check out how much of the mortgage has been paid off.

Patients routinely search the Internet to find out how other patients have rated the psychiatrist they are seeing, not knowing whether the complaints by disgruntled patients are true, false, or exaggerated. Patients who do not search the Internet for information about their therapist are probably the exception rather than the rule in the current era. They often come to the first session with a great deal of information, some accurate, some inaccurate, that leads to certain expectations about the treatment they will receive. If a psychiatrist were to protest that he or she feels violated by the intrusiveness of the patient, the patient could simply respond that whatever appears on the Web is public information. If the psychiatrist attempts to forbid the patient from searching for information, it would be analogous to a mother telling a child not to open a particular door in the house. In both cases, the curiosity aroused by the dictum would be overwhelming. Even the most cooperative patient would be dying to know what the therapist was hiding.

Once upon a time, the Internet was a place where one could play with different identities in their email to others. Today it is more accurately characterized as a place where permanent records exist that are difficult to erase. Some of that information may be incorrect, and it may haunt a psychiatrist for years. Other problems arise from the fact that some practitioners have the same name, and confusion may arise about whether the person found in an online search is actually the person in question. A small industry is currently emerging involving companies that offer to identify negative information on the Web and prevent it from appearing in Internet searches. Nevertheless, some false information can be indelible, and the psychiatrist may be faced with simply exploring the reactions of the patient to whatever is found on the Internet [8].

Knowledge about the psychiatrist's family can be easily accessed, often with accompanying photos. Patients may follow their psychiatrists on social media. The extraordinary popularity of social media has created a norm of sharing private lives with anyone who cares to "tune in." Privacy settings are often not used, such that a psychiatrist's activities with his or her family and friends may be easily found with a few clicks of the finger. While some professionals have advocated for a distinction between personal Facebook pages and professional Facebook pages, for example, this distinction becomes more and more difficult as the continued blurring of private life and professional life increases. Psychiatrists in practice are increasingly facing situations where patients bring in outside

information about them and may comment on a picture they have seen or information upon which they have stumbled. Clinicians in such situations may have a difficult choice. Should they deny the truth of the information and sound defensive? Or should they choose to say nothing and perhaps increase the suspicion of the patient that what the patient saw is true? Perhaps the most professional course in such situations is simply to explore the patient's reaction to the material, much as one would work with the transference perception of a patient about a psychotherapist.

Some psychiatrists accustomed to traditional anonymity and privacy may feel terribly violated and may issue an edict that the patient should not intrude into the psychiatrist's private life and must avoid accessing information available on the Internet. The ethical principle of respect for autonomy makes it clear that psychiatrists should not be in the position of placing constraints on a patient's freedom to pursue public information in any way the patient wishes. In this context, it is important to clarify that the term boundary violation is not applicable to the patient who investigates the doctor online through public information. Patients have no ethics code and therefore are not violating professional boundaries when they seek out information about their doctor. Psychiatrists who feel that their personal space is being intruded upon by the patient must deal with this matter as a clinical issue, very likely involving countertransference. Some may wish to seek out supervision, consultation, or personal treatment while exploring with patients the meanings of their curiosity [6]. In other words, psychiatrists must grapple with their reaction within themselves. They are simply unable to block certain aspects of their personal life and their family life from their patients, and they must learn to adapt to the new world that cyberspace has created.

The Patient's Privacy

Confidentiality is a core ethical principle of all psychiatric treatment. However, psychiatrists and other mental health professionals face an extraordinary challenge in an era where communication by email and text message has become the expectation of most patients who come for help. Many patients are accustomed to texting professionals to confirm or change appointments. They may also send questions by email or text message. The huge increase in the emailing of physicians in the United States has led to the creation of laws by the US Health Insurance Portability and Accountability Act (HIPAA) to govern the use of email exchanges by doctors and patients. For example, encryption and the use of portals are strongly encouraged to protect privacy. Email, characterized by brevity, informality, haste, and incompleteness, is certainly the antithesis of the kind of communication that occurs in a psychotherapeutic relationship [10]. Despite the

widespread prevalence of email exchanges, one must keep in mind that emails are far from private. Emails can be read over the recipient's shoulder. They can be accidentally or intentionally forwarded to persons who should not see the confidential communication. Emails can also be read by someone who comes across a colleague's computer screen while that individual is away from his or her desk. Of great concern is the fact that emails can be mistakenly sent to the wrong person because of the autocomplete function that interrupts one's typing in the middle of one's efforts to address an email and completes it according to patterns of communication in the recent past.

Text messages are perhaps of even greater concern than emails. They are not archived in the way that emails are, but they can be accessed if there are legal proceedings. They are primarily suited for brief exchanges about appointment times or reminders. There is very little resemblance to the complex exchanges in a psychiatric appointment. They leave little time to reflect or contemplate, and in the new era of online discourse, they conform to the instant gratification expected by senders and recipients. Texting is now the most popular means of electronic communication worldwide, with 20 billion messages sent daily [11]. Sixty to 80% of physicians are using text messages for clinical communications, and the guidelines are unclear. Of particular interest in this regard is that the US Department of Health and Human Services, which enforces HIPAA compliance, maintains technological neutrality for texting. No meaningful compliance standards exist, so there is no such thing as HIPAA-compliant texting [11].

Many psychiatrists today have capitulated to texting with patients because there is an overwhelming expectation in many patients that brief messages about such matters as appointment changes or prescription refills are most easily handled through texting rather than phone calls, where there may be long waits or numerous exchanges of calls. Many psychiatrists feel that texting is attractive because it saves them time. However, there are concerns regarding patient privacy. If one has a cell phone on the table where others are present, a text from a patient can appear with a patient's name on it. In this manner, patients' confidentiality can be breached, because it may be clear that they are texting their doctor. In addition, the problem of "wrong texting" must be considered because of the auto-complete function that may "type in" the wrong recipient as the addressee on the text. A number of concerns have also been raised about the availability of the physician at times when the physician may have been drinking, resulting in "drunk texting." It is common now for a patient to text a psychiatrist in the late evening while the psychiatrist is at home in a relaxed state in which he or she might text things that are later regretted. Hence, the importance of implementing work-life boundaries cannot be overemphasized. Because of this set of problems, some physicians are now giving their patients guidelines that spell out what is and is not appropriate for texting and what the privacy risks are.

Patient-Targeted Internet Searching

The widespread Internet searching of doctors by their patients has been mirrored by an increasingly common practice of psychiatrists and other mental health professionals using the Internet to search for information about their patients [8, 9]. In light of the fact that most patients are searching the Internet for information about their doctors in the current digital era, is turnabout fair play? There is no clear consensus by experts. Patients who come to treatment are free to discuss their problem areas while leaving out matters that they prefer to keep to themselves. The patient may construct a boundary that excludes certain topics from the treatment process because it evokes shame or guilt or embarrassment in the patient. While the context of the treatment may influence the appropriateness of searching the Internet for information about a patient, psychotherapy is certainly not coercive, and patients have the right to keep some things to themselves if they prefer to do so.

A problem with searching the Internet for information about one's patients is that a dilemma may arise if something is discovered that the patient has chosen to keep out of treatment. Should the therapist bring it up in a direct manner? What if the patient feels violated by the therapist's intrusion into the patient's privacy and decides to quit treatment? Moreover, if a therapist discovers important information on the Internet that the patient has left out, does the therapist "lead the witness" by asking questions that might result in a discussion of the areas that have been cordoned off by the patient? Knowing secrets about the patient but not being able to discuss them places the clinician in a difficult situation. Clinicians who confront the patient about the secrets the patient is concealing may be viewed by the patient as playing a gotcha game that damages the therapeutic alliance or ends the treatment. The patient may also feel that the therapist is snooping into business that is none of the therapist's concern.

In surveys that have been published, one study of psychiatrists and psychologists at a particular academic institution found that 75% viewed online searches for patient information as ethical [12]. In a survey of psychology doctoral students in Canada and the USA, 67% of the respondents offered the opinion that it was "usually not" or "never" acceptable to search for information about a patient using Google [13].

Mental health professionals should be concerned about the countertransference that may be inherent in searching for information about the patient. What curiosity or voyeurism might lead a clinician to spend his or her evening at the computer running a search on a patient? Psychiatrists and other mental health professionals may have a degree of curiosity that led them to choose their profession, but this degree of intrusion into the patient's life suggests that something may be amiss. It certainly raises the issue of a potential boundary problem in the treatment. A useful exercise is to consider how psychiatry was practiced prior to

the existence of the Internet. Imagine, for example, that it is 1980. Suppose a psychiatrist spent his or her evening driving to a patient's neighborhood, slowly steering by the patient's home, peering through the windows of the patient's house, and taking in the characteristics of the children playing in the patient's yard. Most would agree that such a colleague had a boundary problem that required consultation. Some might even suggest ending the treatment. Does technology that allows this kind of intrusion into the patient's outside life make it acceptable to cross the boundaries that would be unacceptable in the pre-digital era? These are complex ethical problems that do not offer easy answers.

Some would say that the appropriateness of searching the Internet for information about a patient varies with the context of the treatment. A comatose patient in the emergency room that cannot answer questions and who may have overdosed represents a situation where seeking Internet information could be lifesaving. Some would also suggest that a forensic psychiatrist involved in a court-ordered evaluation may be justified in looking for aspects about the patient's activities that have not been offered up in the clinical interviews. However, it is well known that much of the information found when searching the Internet is inaccurate, and a conclusion reached on information that has not been verified could compromise the value of a forensic report.

Another problem to consider is that when one reads Internet information and communications of a patient, one may read messages that are from others who are not in treatment and that are meant to be read only by the patient. Hence, the privacy of third parties who are connected with the patient is compromised. There could be a variety of adverse consequences to reviewing online information about patients. The expectation of such a review might create an assumption in some patients that it is not necessary to tell the clinician everything. Patients might also view the clinician as someone who is "checking up" on them, a perspective that would likely cause damage to the therapeutic alliance [9]. One must also keep in mind that there is a possibility of learning something about one's patient on Facebook or other social media simply because the patient has posted something on a mutual acquaintance's Facebook wall, for example.

Many new developments within psychiatry are implemented before long-term consequences are thoroughly considered. A major concern in searching the Internet for information about a patient is that some may begin to think that there is an obligation to review online information [9]. It is even possible that a new clinical standard could be created where a psychiatrist might have liability if he or she did not do an online search and the patient ended up committing suicide. Moreover, if online searches became the standard of care, would clinicians then charge patients for the time spent in an online search?

Recommendations

Recommendations for digital professionalism are difficult to establish because of the rapid change in technology and the unseen consequences of digital activity that may not be accounted for. This paper concludes with some suggestions that may be useful without any implication that they are either binding or comprehensive. While this paper emphasizes the perils of the digital era, it must also be noted that social media may be used in a positive manner as a medium to promote accurate mental health information.

Education is essential, and psychiatric training programs should include material on how one manages boundary issues and clinical dilemmas in various online contexts, such as social media, dating sites, and search engines. Education regarding digital professionalism should probably begin in undergraduate medical education given its relevance at all levels.

Psychiatrists who use social media, such as Facebook, should be sure that they are activating privacy settings [6, 14, 15]. It is disconcerting to note that only 80% of Facebook users actively manage their privacy settings [16]. Moreover, a Florida study [17] found that only 37.5% of residents and medical students used their privacy settings.

Decisions regarding searching the Internet for information about patients must be thoughtfully considered, using consultation when necessary. If there is a strong argument for checking online information about a patient, such as with a patient who is comatose in an emergency room or a patient who is known to be suicidal, there may be compelling justifications for these searches. In cases that are less clear, such as ongoing psychotherapy or medication management, clinicians should consider standard consent practices involving signed agreements with patients [9]. In all cases, there must be a systemic weighing of risks versus benefits. Searching the Internet out of curiosity cannot be ethically justified.

Clinicians should regularly conduct Web searches to monitor false information about themselves and/or photographs. If there are concerns, they can contact the website administrator to remove problematic information.

Hospitals, clinics, and training centers should be active in developing policies about breaches of professionalism or ethics that involve Internet activity. Educational institutions should also provide didactic sessions where the ethics of online activity is discussed and guidelines developed.

All clinicians should be cautious about dual relationships on the Internet, especially involving "friending." If one must have a Facebook profile, for example, one should consider having one profile to be used with friends and another to be used professionally [6].

Trainees and clinicians who post to blogs or networking sites must always recognize the problem of confidentiality in advance and not include patient information, disparaging comments about groups of patients or colleagues, or

photographs that could cause embarrassment at some point in the future. One should never assume that something posted anonymously on the Internet will remain anonymous. One must be alert to unforeseen consequences.

The Council of Residency Directors Social Media Task Force [18] suggested a useful approach to social media guidelines and best practices. This group suggested that a residency program might wish to develop a social media policy and a training plan in concert with institutional officials, particularly via the designated institutional office, the public affairs department, the legal or privacy office, and the information technology department.

Finally, all psychiatrists must avoid the “Lone Ranger” syndrome [8], where one believes one can make complex ethical judgments on one’s own. The value of consulting with a colleague cannot be overstated.

Compliance with Ethical Standards

Disclosures The author states that there is no conflict of interest.

References

1. Byyny RL. Medical professionalism in the modern era. *Pharos*. 2018;81:2–11.
2. Gabbard GO, Roberts LW, Crisp-Han H, et al. Professionalism in psychiatry. Washington, D.C.: American Psychiatric Publishing; 2012.
3. Turkle S. Alone together: why we expect more from technology and less from each other. New York: Basic Books; 2011.
4. Gabbard GO. Cyberpassion: E-rotic transference on the internet. *Psychoanal Q*. 2001;70:719–37.
5. Kassaw K, Gabbard GO. The ethics of e-mail communication in psychiatry. *Psychiatr Clin N Am*. 2002;25:666–74.
6. Gabbard GO, Kassaw K, Perez-Garcia G. Professional boundaries in the era of the internet. *Acad Psychiatry*. 2011;35:168–74.
7. Gabbard GO. Clinical challenges in the internet era. *Am J Psychiatr*. 2012;169:460–2.
8. Gabbard GO. Boundaries and boundary violations in psychoanalysis: second edition: American Psychiatric Association Publishing; 2016.
9. Fisher CE, Appelbaum PS. Beyond googling: the ethics of using patients’ electronic footprints in psychiatric practice. *Harvard Rev Psychiatry*. 2017;25(4):1–10.
10. Kohn NV, Roth JD. The blank screen of cyberspace. *Psychoanal Inq*. 2012;32:426–37.
11. Drolet C. Text messaging and protected health information: what is permitted? *JAMA*. 2017;317:2369–70.
12. Deen SR, Withers A, Hellerstein DJ. Mental health practitioners’ use and attitudes regarding the internet and social media. *J Psychiatr Pract*. 2013;19:454–63.
13. DiLillo D, Gale EB. To Google or not to Google: graduate students’ use of the internet to access personal information about clients. *Train Educ Prof Psychol*. 2011;5:160–6.
14. Chretien KC, Greysen SR, Chretien JP, Kind T. Online posting of unprofessional content by medical students. *JAMA*. 2009;302:1309–15.
15. Glorindo T, Groves JE. Web searching for information about physicians. *JAMA*. 2008;300:213–4.
16. Stone B: is Facebook growing up too fast? *New York Times*, March 29, 2009, Sunday Business, p. 1.
17. Thompson LA, Dawson K, Ferdig R, Black EW, Boyer J, Coutts J, et al. The intersection of online social networking with medical professionalism. *J Gen Intern Med*. 2008;23:954–7.
18. Pillow MT, Hopson L, Bond M, Cabrera D, Patterson L, Pearson D, et al. Social media guidelines and best practices: recommendations from the Council of Residency Directors Social Media Task Force. *West J Emerg Med*. 2014;15:26–30.