Bridging Physicians and Patients with Social Media: The Good, the Bad, and the Ugly
Scarlett Kelly
Faculty of Management, Dalhousie University

ABSTRACT
Social media has fundamentally changed health care by enabling online multi-ways of seeking and sharing medical information and initiated borderless communications among physicians and patients. In a sense, the communications among physicians and patients induced by the wide use of social media in health care create endless possibilities in health behaviour changes. Currently there is a disconnect between physicians’ and patients’ use of social media and communication patterns. Bridging communications between physicians and patients proves to be an effective way of contributing to the quality of health information available on social media and improving health outcomes. However, benefits and risks come hand-in-hand. Unclear recognitions of the trade-offs between benefits and risks, uncertainty about social media, and over-strict legislation and policy only result in physicians’ and patients’, especially physicians’ decisions on not using social media at all for direct communication purposes as a measure of self-protection. Therefore, ongoing studies and more interdisciplinary research are required in order to provide evidence on the most effective ways of using social media. This paper will demonstrate how health policy and guideline-making are crucial in terms of creating incentives for physicians and patients to communicate directly via social media. This paper aims to examine the needs, benefits, risks, and feasibility of bridging communications between physicians and patients—to what extent can physicians and patients directly communicate with each other via social media? Methodology includes a systematic and in-depth review of literature with a focus on qualitative and quantitative studies. To close the discussion, the paper will identify the gaps that prevent direct communication and provide recommendations on how to fill the gaps in order to achieve two-way communication between physicians and patients.

Introduction
Kevin Pho, a physician who writes a well-known blog, Kevin MD, states that social media is where the patients are going to be in the future (Prasad, 2013). In fact, social media is already playing an important role in our health care culture. For example, according to United Kingdom (UK) statistics, Facebook is reported as the fourth most recognized source of healthcare information (Sharma & Kaur, 2017). The wide use of social media allows effective communication and results in ripple effects. For example, physicians are able to share health-related knowledge and information. By accessing this information, patients may change their health-related behaviours. Yet there are fundamental differences between physicians’ and patients’ choices and intentions when using social media for communication. A descriptive online survey of 139 patients and 153 health care professionals in obstetrics and gynecology shows that health care professionals primarily use LinkedIn (70.7%) and Twitter (51.2%) for communication with their colleagues as well as for marketing reasons, while patients primarily use Twitter (59.9%) to increase knowledge and exchange advice, as well as Facebook (52.3%) for social support and advice exchange (Antheunis, Tates, & Nieboer, 2013). Therefore, although both physicians and patients use social media, there is a disconnect between physicians’ and patients’ communication patterns. This paper aims to examine the needs, benefits, risks, and feasibility of bridging communications between physicians and patients—to what extent can physicians and patients directly communicate with each other via social media? To close the discussion, the paper will provide
recommendations on how to fill the gaps in order to achieve two-way communication between physicians and patients.

Potential benefits of bridging communication between physicians and patients include improving the quality of health-related contents online, targeting patient populations, specifying health topics, and improving health outcomes. However, risks outweigh the benefits. One of the major concerns is around privacy and security when using social media to communicate health topics. Since social media shatters the traditional restraints in face-to-face communication between physicians and patients, such as time and location, and initiates a more open and relatedly casual communication culture, the relations between physicians and patients change accordingly. Health policies and guidelines respond to the increasingly blurred boundaries between physicians’ private and public persona in terms of professionalism on social media (Pathiraja & Little, 2015). For example, in the UK, guidance on social media from the General Medical Council (GMC) and the British Medical Association states that standards do not change when doctors communicate through social media rather than face-to-face or through other traditional media (Pathiraja & Little, 2015). However, uncertainty of social media’s influence on health-related behaviour, as well as privacy concerns prevent physicians and patients from communicating directly with each other via social media channels. Ongoing research on benefits, evidence on behaviour influence, and policy making can offer solutions to these concerns.

Background: Social media in health care

Social media has fundamentally changed health care by breaking the traditional hierarchical structure of medical knowledge and enabling online multi-ways of seeking and sharing medical information for both physicians and patients (Sharma & Kaur, 2017). Social media also enables low costs when transmitting public health messages to large numbers of targeted individuals (Flaherty & Walden, 2015). For example, in 2014 during the Ebola outbreak in west Africa, global experts, including scientists, healthcare professionals, and policy makers, contributed to a productive online forum via Twitter (Flaherty & Walden, 2015). The Mayo Clinic has one of the most popular medical provider channels on YouTube, more than 260,000 followers on Twitter, and an active Facebook page with more than 65,000 fans (Prasad, 2013). It also creates the Mayo Clinic Center for Social Media, which demonstrates its leadership in implementing social media tools by commencing podcasting as early as 2005 (Prasad, 2013).

In a sense, social media has initiated borderless communications among physicians and patients (Pathiraja & Little, 2015). There are several benefits of such borderless communications. First, patients can access to health information, regardless of age, education, race/ethnicity, and locality (Syed-Abdul, Gabarron, Lau, & Househ, 2016). Second, health communication on social media provides valuable peer, social, and emotional support, as patients can share their experiences through discussion forums, instant messaging, or online consultation with a qualified clinician (Syed-Abdul et al., 2016). For example, blogs have been used to galvanize support for physicians and their patients (Peek, Richards, Muir, Chan, Caton, & MacMillan, 2015). Third, patient’s health-related behaviours can be influenced.
example, spreading organ donation information across Facebook users results in 22% increase in new online registrations on the day the initiative began (Sharma & Kaur, 2017). Social networks also contribute to behaviour influence in obesity, smoking cessation, eating behaviours, and sexual risk behaviours (George, Rovniak, & Kraschnewski, 2013). In this way, across the vast online networks, patients’ health behaviors can both influence and be influenced by the health behaviors and outcomes of others (George et al., 2013).

**How physicians and patients communicate via social media respectively**

Physicians use social media to communicate for educational purposes and to improve health outcomes. In general, learning provides incentive for physicians to participate in the social media communities because they will be able to access and share expertise, discover who knows what within the healthcare community, and access novel information through interactions with members who have diverse personal and professional backgrounds (Gilbert, 2016). For example, “tweeting the meeting” is a new trend of sending out tweets during conferences, as live tweeting during a formal medical presentation in the form of visual, chronological, and retrievable conversations benefit all levels of learners across vast geographic distances (Duricich & Zee-Cheng, 2015). Moreover, current and ongoing researches suggest that the continuously evolving social media in today’s technology-driven, ever-connected world provides motivations to lifelong learning, which is an integral part of medical education itself (Duricich & Zee-Cheng, 2015). Therefore, social media creates a great opportunity to promote better clinical practice by creating better dialogues among physicians and providing continuous medical education (Prasad, 2013).

Social media is also used to improve health outcomes. A qualitative survey of 24 physicians through snowball sampling in Australia, the United States, and Europe identifies six major themes associated with information encountering in social media: wider publicizing, faster dissemination, personalized and filtered feed, up-to-date, documentation of knowledge and experiences, and retrievability (Panahi, Watson, & Partridge, 2016). All six themes relate to the improvement of health outcomes by sharing existing knowledge/information and creating new tacit knowledge (Panahi et al., 2016). In Denmark, physicians use social media for follow-up treatments and for searching for information about their patients (Andersen, Medaglia, & Henriksen, 2012). For example, when a physician looks up a patient’s information on the patient’s Facebook profile, the physician can gather evidence on whether the patient is adhering to the treatments or has a complex medical history that the patient cannot explain (Andersen et al., 2012). Such information gathering from social media should not be a privacy concern but seen as a means to have an open dialogue with the patient in order to gather knowledge and improve health outcomes, as the Chief Consultant at Danske Patienter (Danish patients) identifies (Andersen et al., 2012).

Even though there are similarities between physicians and patients’ communications via social media in terms of learning and improving health outcomes, there are fundamental differences in motivations and methods. E-patient represents a fundamental change of the patient’s role in managing
their health, which reflects more collaboration and proactivity in a less hierarchical health delivery (Prasad, 2013). For example, e-patients can retrieve and contribute information and viewpoints as opposed to simply receiving them (Prasad, 2013). Patients are also more probable to seek medical advice from peers or patients affected from similar diseases (Sharma & Kaur, 2017). For example, in 2011, a study examined 17 Facebook groups that focused on diabetes management (Sharma & Kaur, 2017). Approximately two-thirds of the wall-posts included sharing of diabetes or blood-sugar management strategies, 14% of posts enclosed requests for personal information from Facebook participants, and other posts were related to emotional support and feedback (Sharma & Kaur, 2017).

Social media improves patients’ health through supportive online sharing. Social media enables anonymous and open dialogues, especially for patients with certain diseases that trigger taboos. For example, blogging enables patients with mental illness, who are among the most stigmatized, marginalized, and vulnerable members, to have a voice to share their experience in a field that lacks knowledge and support (Peek et al. 2015).

Elder adults, who are more vulnerable to illness and have more concerns about health conditions, benefit from social media because it typically has simple user interfaces and a vast amount of communication, support, and health information about certain lifestyle and health-related conditions (Dumbrell & Steele, 2014). In the case of Cystic Fibrosis (CF), many support seekers ask for support via social media regarding specific prescription medications and adherence behaviors, such as “what are some bad side effects of Orkambi” (Babyar, 2016). Another case happened in February 2011, when waiting for her husband’s melanoma resection, breast cancer survivor and patient advocate blogger Jody Schoberg used Twitter to communicate with messaging and pictures, and received priceless support from her virtual community (Lober & Flowers, 2011). In this way, her expanded network helped the couple to cope with illness and improved relationships with their medical providers. However, accurately measuring the health impact from similar will be challenging (Lober & Flowers, 2011).

The different usages of social media between physicians and patients result in an interesting phenomenon: physicians use social media professionally to communicate/network with colleagues and trainees, share health information and own researches, discuss practice management challenges, research medical developments, consult colleagues regarding patient issues, and engage in health advocacy or market their practice (Sharma & Kaur, 2017). However, they do not communicate directly with patients. In this way, a gap of communication between physicians and patients is formed: physicians tend to use social media among themselves for educational purposes and only promote patients’ health outcome from a distance, while patients tend to circulate information among themselves and improve health outcome through support-induced health behaviour changes.

Consider bridging communications between physicians and patients

Currently there is an inconsistency between physicians and patients’ opinions on the reliabilities and qualities of social media content. A survey shows that of the total 485 practicing oncologists and primary care physicians in the U.S. in March 2011 (28.61% response rate), 57.5% perceived social media
to be a good way to get current and high-quality information (McGowan, Wasko, Vartabedian, Miller, Freiherr, & Abdolrasulnia, 2012). In terms of usefulness, 57.9% stated that social media enabled them to care for patients more effectively, and 60.0% stated it improved the quality of patient care that they delivered (McGowan et al., 2012). The patients, however, think otherwise. In a Pew study of 3001 adults in 2010, only 30% thought that the medical advice or health information that they found were helpful, while 69% answered as “no,” “don’t know,” or “refused,” and 3% thought that they had been harmed by following medical advice or information online (Prasad, 2013). There is indeed an overabundance of different types of health-related social media, including forums such as Google health groups, social sharing such as Flickr and YouTube, social networking groups such as PatientsLikeMe and OrganisedWisdom, podcasts such as those by the Cleveland Clinic, blogs online such as WebMD, and microblogs such as Livestrong (Prasad, 2013). Since physicians and patients use different social media channels for different purposes, different levels of information quality on different online platform could result in different ratings of social media contents.

Needs

Information quality on social media presents challenges to meaningful communication. Information quality is particularly crucial for patients because information found on social media directly impact a patient’s health decision and behaviour in seeking health care (Jin, Yan, Li, & Li, 2016; Prasad, 2013). For example, there was a study that focused on users who tweeted pseudo-scientific vaccine claims (Dredze, Broniatowski, & Hilyard, 2016). By examining pseudo-scientific claims’ tweets in 2015 for English language anti-vaccine mentions, researchers found that 86% of those users tweeted about vaccines; at least 19% of the users tweeted an anti-vaccine message (Dredze et al., 2016). While the public health and medical communities view these sources as lacking credibility, they have contributed to lower vaccination rates, which resulted in infectious disease outbreaks such as the 2014−2015 Disneyland measles outbreak, and widespread concerns about vaccine safety (Dredze et al., 2016). In this sense, the unreliability of social media information is one of the main concerns for patients that use social media for health communication (Antheunis et al, 2013).

Unreliable health information is dangerous because it may change patients’ health behaviour and expose patients to unnecessary risks. Obtaining information on the latest treatment and technology from social media, which often prove to be lack of credibility or unproved by authorities, can result in patients’ self-diagnosis and adverse events (MacDonald, 2016). As social media is widely used in today’s society, any misleading or inaccurate information will impact a high percentage of users. Moreover, physicians are already using social media regularly. The same survey in the U.S. in 2011, as mentioned two paragraphs earlier, shows that among 485 practicing oncologists and primary care physicians, 24.1% used social media frequently every day with the purpose of scanning or exploring medical information and 14.2% contributed new information via social media on a daily basis (McGowan et al., 2012). On a weekly basis, 61.0% of the 485 participating physicians scanned medical information and 46.0% contributed new information (McGowan et al., 2012). Therefore, considering the negative
effects of low-quality information on patients and physicians’ frequent usage of social media, bridging the communication between physicians and patients is necessary and can be achieved.

**Benefits**

Bridging the communications between physicians and patients is the most effective way to improve information quality. Health organizations have realized the benefits of using social media to promote quality health information. For example, through search, 1229 hospitals could be found on one or more social networking sites in 2011, with over 4118 pages (Indes, Gates, Mitchell, & Muhs, 2012). Facebook was the most commonly used platform with 1068 pages, followed by Twitter with 814 accounts (Indes et al., 2012). Data also showed that 30%-50% of successful practices had a presence on one or more social networking sites, such as in the case of vascular surgeries (Indes et al., 2012). For example, the Miller Family Heart and Vascular Center at the Cleveland Clinic customizes patient-centered media approach by hosting their own Facebook page (www.facebook.com/clevelandclinic) (Indes et al., 2012). It allows patients, physicians, and hospital representatives to post messages on the wall in a continuously streaming nature (Indes et al., 2012). Links on the Facebook page can take patients to the hospital websites that enable patients to search for detailed information from A-Z with respect to only vascular diseases (Indes et al., 2012). A link to a Twitter account (www.twitter.com/ClevClinicHeart) allows representatives from their hospital to post tweets related to heart and vascular care (Indes et al., 2012). Other links, such as webchats (www.clevelandclinic.org/webchat), inform patients on various topics in vascular surgery or to videos that describe various milestones or procedures in vascular surgery; an active and evolving monthly blog, *The Beating Edge* (www.thebeatingedge.org), is designed to keep patients informed about cardiovascular and thoracic diseases and the institution’s research, as well as enabling patients to post comments, stories, and feedback in an attached forum (Indes et al., 2012). These examples present the most direct communications that have been achieved between physicians and patients. Quality of information on social media can be improved through these instituted communications.

However, such instituted communication could not be as targeting and effective as direct communication between physicians and patients. There are several benefits of direct physician-patient communications. First, direct communications between physicians and patients via social media channels will help to build trust, increase transparency and accountabilities in diagnosis, and allow patients to access first-hand medical knowledge and data (Andersen et al., 2012). Quality of social media contents will further improve when information come directly from physicians. Second, social media can provide new forms of network-based interventions (Rice & Karnik, 2012). For example, victims of bullying or cyberbullying among children and adolescent patients can be detected at an early stage through social media activities, which enable physicians to provide clinical supports (Rice & Karnik, 2012). Third, targeting specific patient population will result in more effective influence on behaviours, especially young patients that can be the reasons for public health related disease, such as teenager sexually transmitted infections (Dunne, McIntosh, & Mallory, 2014).
**Risks**

Despite the benefits of promoting direct communications, there are many risks that prevent physicians and patients from communicating in a more direct and even personal manner. The openness and transparency that social media brings become the obstacles of further communication and engagement. Physicians concern about the accountability involved with what they say and present on social media. Patients concern about the potential privacy loss when communicating health information with others, including physicians (Antheunis et al., 2013).

Anything that physicians say or do on social media will likely be seen and recorded and may be used as evidence against them (Prasad, 2013). According to a general practitioner, physicians who ask for advice from peers in a public forum are considered to acknowledge their own shortcomings and are likely to be challenged (Andersen et al., 2012). Therefore, in such a professional culture, being exposed to an online environment and potentially being monitored and held accountable prevent physicians from directly communicating with patients (Andersen et al., 2012). Online presence is another concern for physicians (Pathiraja & Little, 2015). As borderless communications open previously unavailable connections, managing one's online presence, such as adhering to professional and ethical duties, is important as it can be associated with one’s real-life reputation (Pathiraja & Little, 2015). In fact, residency programs in the U.S. have been surveyed about using social media to source background information on applicants (Pathiraja & Little, 2015).

Confidentiality and privacy are the biggest risks for both physicians and patients. Physicians cannot mention any patient identifiable information, as doctors have an ethical and legal duty to protect patient confidentiality (Pathiraja & Little, 2015). In reality, this is very hard, if not impossible, to achieve. For example, one study found that 40% of presentations posted online contain radiological images that include patients’ identifiable information either overlaid on the image itself or embedded in the Digital Imaging and Communications in Medicine (DICOM) data (Pathiraja & Little, 2015). Such abridging confidentiality is not intentional but due to the complexity of health information. On the one hand, health information must be shared for medical supports and diagnosis. On the other hand, any bit of health information, such as symptoms and drugs, can be identifiable information. Since one piece of information can be both the key for a health condition and a potential identifier, it seems to be impossible to initiate physician and patient communications without recognizing the risk—confidentiality can be breached and sometimes it is necessary to do so. Patients also do not wish their social media presence to be monitored by physicians. Even though patients’ views on privacy differ depending on factors such as education, ethnicity, personality, and relationship with their physicians, patients tend to control where and when they give information, what kind of information they give, and who will acquire and can use the information (DeJong, 2014).

All of these accountability as well as confidentiality and privacy concerns result in physicians’ caution and patients’ reluctance towards directly communicating on social media. Therefore, maintaining professional distance becomes necessary in order to maintain professional and ethical standards that protect both physicians and patients (Pathiraja & Little, 2015).
Recommendations for the next steps: Identify and fill the gaps of bridging communications

Re-examine benefits and risks

There are always trade-offs when adopting a new technology that changes the traditional relations and communications – which in this case is the use of social media. The trade-off is the benefits and risks when using social media to communicate. Unfortunately, there is no clear boundary between benefits and risks because they always come hand-in-hand. For example, the open dialogues that social media brings accompany the potential loss of privacy and anomality. Currently, there are many attempts to minimize risks of social media in order to maximize benefits. However, the result is not the elimination of risks but the loss of benefits. In other words, the excessive attentions on the risks of accountability, confidentiality, and privacy result in both physicians’ and patients’ withdrawal from using social media to communicate with each other. For example, despite that 305 (70.1%) of the 435 urologists currently practicing in Australia and New Zealand have an easily identifiable social media account—LinkedIn (51.3%) is the most commonly used form followed by Twitter (33.3%) and private Facebook (30.1%) accounts—only 26% of urologists use social media frequently given that they avoid it for professional use (Davies, Murphy, van Rij, Woo, & Lawrentschuk, 2015). Therefore, a systematic, holistic, and impartial benefit-risk analysis on social media must be conducted first in order to weigh benefits and risks and better understand the trade-offs based on evidence.

Benefits always comes with risks. When physicians’ and patients’ attentions are fixed on the social media’s effects on the changes, especially risks, to health service delivery in legislation, liability, scope of practice, access, confidentiality, privacy, safety, and time, benefits that social media brings are often not emphasized enough. Such benefits include efficient care delivery, affordability, accessibility, and user friendly characters. However, in front of the risks that social media brings, benefits is rhetoric and not demonstrated. Ongoing research must present evidence, such as cost-savings in the single-payer system in order to support evidence-based policy-making that encourages physicians and patients to communicate via social media (Knight, Werstine, Rasmussen-Pennington, Fitzsimmons, & Petrella, 2015). Partnerships with local health authorities, pilot studies on funding and billing options that compensate the time that physicians engage in social media and communicate with patients, will help demonstrate how theories can be applied into practice. Most importantly, future research needs to identify whether benefits can outweigh the potential risks, which will provide incentives for physicians to use social media to communicate with patients directly.

Uncertainties about social media and ongoing research

Currently, there are many uncertainties about social media. For example, in a review of 10 studies in the education category, researchers find that only one study in this domain suggested a positive impact from social media use (Patel, Chang, Greysen, & Chopra, 2015). Undefined (n=5) or neutral (n=2) impact were common, while 2 studies identified negative impact due to inaccurate information or biases (Patel et al., 2015). In 8 mixed-method studies, the overall impact of social media
on chronic diseases, such as type 2 diabetes management was rated as undefined (Patel et al., 2015). Medpedia used to be an open forum that enables both medical professionals and non-professionals at global level to discuss health and medicine using its three platforms—a collaborative encyclopedia, a network and directory for health professionals, and organizations and communities of interest (Prasad, 2013). The failure of Medpedia raises the questions of how to make credible health-related social media work. There are also concerns of social media’s impacts on patients’ health-seeking behaviours – patients may begin to rely on social media as a substitute for immediate communication with physicians, may skip office visits and phone calls, or could potentially delay diagnoses or treatments (Indes et al., 2012). To what extent patients triage themselves with physicians’ social media posts is also in question (Howell, 2011). In order to minimize uncertainly, studies on how social media works in physician-patient communications need to be holistic and in depth with a focus on how behaviour can be changed, especially with regards to the mechanism/process of behaviour changes when using social media to enable communication.

In order to fill the current gaps around the uncertainties about social media, theoretical models on how to effectively utilize social media and improve performance outcomes are in development. For example, Figure 1 is a conceptual model of physicians’ utilization of social media for patient interactions aims to moderate performance outcomes using the fit between social media, interactions, and social requirements (Dantu, Wang, & Mahapatra, 2014). The outcomes of physicians’ interactions with patients include improved care delivery with higher care quality and/or lower cost of care, patient satisfaction, compliance with treatment plans, trust, and overall quality of life (Dantu et al., 2014).

![Figure 1. Conceptual model of Fit and performance of Physician-patient's use of Social Media (Dantu et al., 2014).](image)

Such models provide frameworks for further research. However, quantitative studies on physicians’ and patients’ behaviour changes when using social media must supplement theories. For example, a 3-arm randomized controlled trial under the Australian New Zealand Clinical Trials Register (ANZCTR), ACTRN12614000536662 aims to evaluate the use of social media as a health promotion tool on dietary and physical activity changes for overweight and obese individuals (Jane, Foster, Hagger, & Pal, 2015). The trial aims to recruit 120 participants from the Perth community, who will be randomly assigned to one of the following three groups: the Facebook group, the pamphlet group, or a control...
group—the Facebook Group will receive the weight management program delivered via a closed group on Facebook, the Pamphlet Group will be given the same weight management program presented in a booklet, and the Control Group will follow the Australian Dietary Guidelines and the National Physical Activity Guidelines for Adults as usual care (Jane et al., 2015). Changes in weight, body composition, and waist circumference will be initial indicators of adherence to the program (Jane et al., 2015). Secondary outcome measures will be blood glucose, insulin, blood pressure, arterial stiffness, physical activity, eating behaviour, mental well-being (stress, anxiety, and depression), social support, self-control, self-efficacy, Facebook activity, and program evaluation (Jane et al., 2015). It is expected that this trial will support the use of social media - a source of social support and information sharing - as a delivery method for weight management programs, enhancing the reduction in weight expected from dietary and physical activity changes (Jane et al., 2015). Such studies are crucial to better understand social media induced behaviour changes and health outcomes, since evidence on health outcomes will prove to be highly valuable for physicians, patients, and other stakeholders to review the usefulness of social media. Therefore, more quantitative research with quality methodologies on the mechanism/processes of patients health behaviour changes need to be developed. This requires a relocation of research funding to support more interdisciplinary researches across clinical psychology, behavioural science, and social media related information studies.

**Health policy and guidelines**

Patient privacy and confidentiality could become a legal issue with certain online communications (Indes et al., 2012). Health care providers have a legal obligation to safeguard and protect patient information from disclosure to third parties without authorization, which is referred as covered entities under the Health Insurance Portability and Accountability Act (HIPAA) (Indes et al., 2012). One of the first cases involving disciplinary actions concerning the use of social media happened in April 2011, when the obligation was applied against a physician from Rhode Island after she posted specific medical information online about one of her patients; this ultimately resulted in the termination of her medical license (Indes et al., 2012). In this case, although the patient's name and other personal identifiers were not included, the judge ruled that it would be possible for the patient's small community to discover the patient's identity due to the specific medical information listed (Indes et al., 2012). This case shows that the courts had low/zero tolerance for violations of the obligation, which has resulted in the emergence of strict policies in many institutions that prohibit physicians from using the internet, especially social media to communicate about or with patients in order to avoid potential violations (Indes et al., 2012). However, a 2010 survey of state medical boards in the U.S. indicated that 92% of violations, ranged from inappropriate contact with patients to misrepresentations of credentials or clinical outcomes, were reported in their jurisdiction (Indes et al., 2012). This shows that strict legislation or policies cannot eliminate violations and potential privacy or confidentiality loss because of the complex, unstandardized, and subjective nature of privacy and confidentiality. For example, one patient’s identifier can be unique, such as a rare disease, but not enough to identify the patient because
this patient keeps his/her own disease as a private matter. Another patient may have a common disease but it is an obvious identifier because the patient’s condition is well known in the small community. These considerations are beyond physicians’ knowledge and control. In this sense, anything can become identifiers and can cause privacy and confidentiality loss.

The Canadian Medical Association has begun the process of developing social media practice guidelines for physicians in Canada (Knight et al., 2015). This is a good opportunity to review the current guidelines and policies in other countries and develop a framework that fits into the Canadian health care. Moreover, such guidelines should be for both physicians and for patients. In a time that patients are free to reveal any health information on social media, making physicians the sole safeguard of patients’ privacy and confidentiality is neither achievable nor creating incentive for physicians to communicate with patients via social media channels. Instead of creating policies that punish physicians more severely, best practice guidelines should aim at helping physicians use social media in an ethical, effective, and appropriate manner, apply common sense to specific situations, and continuously enhance professional integrity (Knight et al., 2015). In other words, communication on social media should mimic that in real clinic settings, including maintaining patient privacy, confidentiality, and best practices for professional conduct (Knight et al., 2015).

In this sense, even though communication between physicians and patients expands to the social media platform, the traditional regulations and guidelines are still applicable. There is no need for more strict policies only because communication on social media is a new and relatively less-known subject to the health care industry. At the same time, ongoing evaluation and risk management must be applied in order to detect any inappropriate conduct and intervene for better practices that benefit both physicians and patients. Physician education on social media is also necessary. Examining attitudes, self-reported behaviors, and intended actions, a study of first-year medical students’ use of social media after an educational intervention shows that attending a required session in a professionalism course led to thoughtful reflection, increased professional role awareness, and intention to edit and monitor future online presence (Lie, Trial, Schaff, Wallace, & Elliott, 2013). After four months, students reported that they continued monitoring and editing of their online presence (Lie et al., 2013). Therefore, guidelines, interventions, and education, instead of severe punishment, can better promote the direct communications and help physicians to adopt into the social media environment.

Conclusion

The wide use of social media and the convenient platform for communications provide opportunities for physicians and patients to directly communicate with each other. Such communications contribute to the quality of health information available on social media and also improves health outcomes. However, a holistic understanding of benefits, risks, and gaps is required in order to better measure to what extent physicians and patients can directly communicate with each other via social media. Otherwise, unclear recognitions of the trade-offs between benefits and risks, uncertainty about social media, and over-strict legislation and policy only result in physicians’ and
patients’, especially physicians’ decisions on not using social media at all for direct communication purposes as a measure of self-protection. Therefore, ongoing studies on benefit-risk analysis, social media’s impact on health behaviour changes, and policy and guideline-making that focus on guiding rather than punishing physicians will be valuable in terms of encouraging both physicians and patients to directly communicate.
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