Social media pervades all aspects of our lives. In medicine, it has changed the ways that patients and parents get health information, advocate for particular treatments for themselves and their children, and raise money for expensive treatments. In this Ethics Rounds, we present a case in which the use of social media seemed to cross the boundaries of acceptable professionalism. What should the ground rules be for doctors who are tempted to give medical opinions online about patients whom they have never seen?

THE CASE

While on vacation, a 13-year-old boy presents to the local emergency department (ED) with fever, cervical lymphadenopathy, and abdominal pain. The ED physician on duty thinks that his clinical picture is most consistent with infectious mononucleosis. A rapid test result for infectious mononucleosis is negative, but because the boy is stable, the physician recommends that they follow-up with their primary care doctor while awaiting the results of additional laboratory testing.

His worried parents, who are both physicians themselves, log onto a popular social media group for doctor parents and post a message requesting opinions about the diagnosis. The group has >70,000 members. Discussions involve a mix of personal and professional subject matter, including the management of specific clinical cases. Many members state that the group helps their clinical decision-making, whereas others have raised concerns about the ethical and professional risks of giving opinions about patients on social media. In this case, while still in the ED, the patient’s parents receive a range of responses from the group on their smartphones, including some suggesting that cancer should be ruled out. The parents request that their son be admitted for additional laboratory testing.

Upstairs, they meet the pediatric hospitalist, who tries to reassure them. The pediatric hematologist-oncologist on call also recommends observation for now rather than a biopsy of 1 of the enlarged lymph nodes. Their son continues to have high fever through the night.

abstract

Social media pervades all aspects of our lives. In medicine, it has changed the ways that patients and parents get health information, advocate for particular treatments for themselves and their children, and raise money for expensive treatments. Social media is so pervasive that we sometimes accept its presence in our lives when it is used for purposes that, on closer examination, are not acceptable. In this Ethics Rounds, we present a case in which the use of social media seemed to cross the boundaries of acceptable professionalism. We then speculate on what the ground rules should be for doctors who are tempted to give medical opinions online about patients whom they have never seen.

Dr Caruso Brown co-conceived the idea for the Ethics Rounds, wrote the initial case description and 1 of the 3 commentaries, and provided feedback on all the commentaries; Dr Arthur revised the case description, wrote 1 of the 3 commentaries, and provided feedback on all the commentaries; Dr Mutrie co-conceived the idea for the Ethics Rounds, revised the case description, wrote 1 of the 3 commentaries, and provided feedback on all the commentaries; Dr Lantos revised the case description and all of the commentaries and wrote the introduction and conclusion; and all authors approved the final manuscript as submitted and agree to be accountable for all aspects of the work.

DOI: https://doi.org/10.1542/peds.2019-0817

Accepted for publication Mar 13, 2019

Address correspondence to Amy E. Caruso Brown, MD, MSc, MSCS, Center for Bioethics and Humanities, State University of New York Upstate Medical University, 618 Irving Ave, Syracuse, NY 13210. E-mail: brownamy@upstate.edu

PEDIATRICS (ISSN Numbers: Print, 0031-4005; Online, 1098-4275).

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FINANCIAL DISCLOSURE: The authors have indicated they have no financial relationships relevant to this article to disclose.

FUNDING: No external funding.

POTENTIAL CONFLICT OF INTEREST: The authors have indicated they have no potential conflicts of interest to disclose.

the night. His parents become even more anxious. They reach out on social media again, asking if anyone in the group works at the hospital where their son is admitted. They connect with another pediatric hospitalist, a colleague of the admitting pediatrician, who offers to intervene and arrange a biopsy.

**QUESTION**

Is it ethically permissible for physicians to respond to requests for second opinions on social media?

**JOSHUA ARTHUR, MD, COMMENTS**

This case draws attention to the manner in which one’s professional identity follows one into the labyrinthine world of social media. The central question is whether a physician’s medical opinion about a specific case, posted on social media, should be taken as more authoritative than the opinion of a layperson. In this case, it seems that the on-site doctors responded to another doctor’s social media posting almost as if it was a consultation, although the doctor on-site had not solicited the opinion and the online doctor had not seen the patient.

The online consultant is practicing in an unorthodox manner. In most clinical environments, physicians practice within a relatively rigid structure that ensures compliance with what is broadly considered the standard of care. The majority of physicians will have their charts monitored on a regular basis and will document their decision-making for the use of patients, administrators, physicians, support staff, and lawyers. They are certified by professional organizations and medical institutions that provide oversight on their body of knowledge and clinical expertise. Thus, practicing medicine is a communal activity, with colleagues acting both as guides for and limits on medical decisions.

Being a physician entails more than the possession of medical knowledge alone; there is a difference between consulting an online medical database and consulting a practicing physician. Doctors are expected to thoroughly evaluate a patient so as to not offer an opinion prematurely or one that is based on partial or biased information. Usually, this requires an interview and examination of the patient. Other times, it requires a close review of the patient’s medical history and laboratory data as well as a discussion with another medical provider. These are well-established norms for what would be considered ethical medical practice and a professional relationship with patients. These practices give doctors’ medical opinions credibility. They enable patients to trust the decisions that a physician makes because patients know that the doctor did what was required to competently form an opinion.

Technological advances such as telemedicine may allow physicians to perform assessments virtually. Although the patient may be far away, the physician is still able to see and speak directly to them. It appears that social media may be evolving into a useful place for physicians to provide this type of credible medical decision-making within the constraints of the standard of care. However, because such applications extend social media’s reach into the health and bodies of the population, it becomes increasingly important for physicians to maintain clarity about the roles that they are playing within those communities, whether as a social media “friend,” as a parent, or as a physician.

This tension between these different online roles is evident in the social media group described in the case. Given the culture of the physician community, it is natural that a physician might desire to join a social media group of other physicians as a place to practice collegiality, receive encouragement, practice information sharing, and have an occasional catharsis. However, given the primarily social nature of the group, members should not view that online community as an environment where they can practice medicine. When a physician on social media gives a specific medical recommendation regarding a patient who they have never evaluated, they are stepping outside of the standards of peer and institutional accountability that are part and parcel of considering oneself a physician.

In this case, medical opinions from social media played a key role in altering the management of a child. This potentially exposed the child to the risks of excessive evaluation and interventions. If physicians are willing to make comments that put a child at risk, they should also be expected to be accountable for their recommendations. Such accountability can take place only within the structure of a formal patient-physician relationship.

It is possible that as social media evolves, settings can be created through which physicians are able to render clinical opinions in ways that honor the protections created for patients. However, until structures that ensure peer review and accountability are in place, rendering opinions on social media places patients at risk, potentially undermines the clinical expertise of colleagues, and threatens the clinical integrity of those who are providing the medical recommendations.

**LAUREN H. MUTRIE, MD, MSC, COMMENTS**

In this case, the clinical and professional judgment of these physician parents is overwhelmed by anxiety. The child has a common, nonemergent presentation of fever and lymphadenopathy. This should not warrant immediate admission or
biopsy. However, the social media consultation creates pressure on the ED physician to admit the child and on the pediatric hospitalist to accept the admission.

Professionalism is a major concern here. Specifically, the case raises questions about whether traditional ideas of professionalism apply in the uncharted realm of social media, where physicians may gather to learn, reflect, debate, advocate, and perhaps voice concerns about perceived inadequacies or dissatisfaction in care. As physicians, we routinely reach out to our clinical colleagues, researchers, educators, and mentors for guidance with challenging cases. We also support our clinical partners in good faith and expect their support in return. Our responsibilities to one another as physicians, to keep medical practice in check with the evidence base and to nurture healthy collegiality, must also be at the forefront of professionalism. Good camaraderie and communication in the professional realm reduce burnout and lead to better outcomes for children and families.

But the world of digital media is different. When physicians (possibly remotely) advise parents or patients online, they are inserting themselves into existing relationships between patients and providers. They are not consulting with professional colleagues in traditional ways. Instead, they are undermining collegiality in ways that may lead to misuse of resources, wasted time, and fragmented care. In person, physicians are exposed to the real-time, contextual circumstances of illness at the bedside. These include not only the details of the history and physical examination but also the social circumstances and family dynamics that may contribute to the success of a management plan.

Although there are clear institutional guidelines prohibiting the publication of protected health information on social media, those guidelines only apply to providers. Parents can post whatever they want, but the information that they post may not be accurate or complete. Routine use of social media as a resource for second opinions or decision aid is not the standard of care. Families are entitled to second opinions, but when those second opinions are given via social media by doctors who have never seen the patient, they carry risk of harm to patients and professionals. As a self-regulating profession, we should question how communication with and among physicians on social media is monitored and vetted for inaccurate information. We must find ways to ensure that these forums are safe places where both physicians and parents can find information, education, and support. Rules for appropriate use of social media in a clinical context should insist on the same levels of professionalism that are required for doctors who perform face-to-face consultations. At the very least, they should not offer medical opinions until they have spoken to the attending physician. Social media is ubiquitous. Guidelines for its use can try to maximize the benefits and minimize the harms.

AMY CARUSO BROWN, MD, MSC, MSCS,

Comments

The issue of justice is key in thinking about the concerns that arise when physicians respond to requests for second opinions on social media. Parents who are also physicians are more likely to have access to other doctors on social media than parents without medical training. I suspect that physicians are more likely to consider responding when such requests come from other physicians. This may be due to a sense of professional respect and reciprocity inextricably linked with the ease with which we can identify with a fellow doctor. It is easy to imagine the hospitalist who agreed to facilitate the biopsy asking herself or himself, “What kind of response would I want if this were my child and I felt he was not getting the care he needed?”

Most health care professionals are rightly cautious about providing medical advice over the Internet. They realize they do not have access to the whole story. They might thus inadvertently provide inappropriate or even harmful suggestions. Furthermore, even good advice might be misinterpreted or misapplied, potentially harming the patient or causing undue stress for both the patient and family. The fact that the parent or another information seeker has medical training (or claims to have such training) might lead physicians to downplay such concerns. They should not. In this case, I would have cautioned everyone involved to avoid assumptions about how responsibly the physician parents would use the information and advice that they received online.

Physicians have always had privileged access to health care compared with other groups. A 1993 review of the practice of professional courtesy, defined as “providing free or discounted health care to physicians and their immediate families,” noted that the practice was not just tolerated but considered ethically obligatory in the early 19th century before later disappearing from medical ethics codes.2 A few years later, Diekema et al3 studied how children in the ED were treated when their parents were physicians. They found that children of physicians were less likely to see trainees but were not more likely to have shorter stays or more procedures.3 These types of injustices will always persist; experts in any field will always have an advantage when they need to obtain services from that same field. But in this situation, there are other important considerations.

“VIP (very important person) syndrome” is a term coined to
describe a “cycle of patient demands resulting in unsound clinical judgment in efforts to meet unrealistic expectations resulting in deleterious outcomes.” The term was coined to highlight the ways that special treatment of patients who are perceived as important is often worse treatment. This is true whether the patients (or parents) are fellow physicians and their family members, celebrities, or other figures of prominence, power, and/or wealth. In this case, it might mean that the child suffers harm from unnecessary tests, especially invasive ones, because the team’s focus is now on acceding to the parents’ wishes and assuaging their concerns rather than promoting the patient’s best interests.

At first blush, these parents’ sole obligation is to their child. However, all physicians have some obligation to ameliorate, rather than promulgate, hierarchy within medicine; to create practice environments in which all team members feel that their voices are heard; and to advocate for their patients. The parents in this case are heard; and to advocate for their child. However, they are simply anxious, loving parents trying to protect their child.

Digital forms of media can be seen as democratizing health care by allowing parents to have real-time access to information that would otherwise be unattainable, providing a much larger proportion of patients and families with access to a much deeper fount of information than ever before: connections to other patients with similar conditions, medical information written in lay language, and formal or informal second opinions. However, they can also spread disempowering false news and perpetuate existing hierarchies and power structures, as in this case, in which social media provided yet another forum in which physicians could exercise their professional privilege. Given the double-edged sword, health care providers should treat this new communication tool as they treat old tools: with caution and self-awareness. The fact that the request for a second opinion comes from another physician does not obviate the ethical burden on the responding physician.

JOHN D. LANTOS, MD, COMMENTS

The doctors in this case who gave opinions, online, about the appropriate treatment of a child whom they had never seen were, no doubt, motivated by a desire to help. The physician parents reached out to a digital community, and their colleagues responded with advice that must have seemed reasonable. But what they did was neither helpful nor collegial. In this case, it seemed to cause more harm than benefit.

What could have been done differently? One simple rule might avoid such transgressions. Doctors should not offer medical opinions about patients they have not seen. A caveat to the rule might also help. If they are tempted to do so, they should first speak to the doctor who has examined the patient and find out what that doctor has done and what he or she is thinking.

It may seem like the easy communications enabled by digital media make such old-fashioned notions of professionalism obsolete. In fact, the opposite may be true. In an age of digital media, we should be more attentive than ever to the obligations of professionalism if only because digital media make it seem as if those obligations are outdated.

ABBREVIATION

ED: emergency department

REFERENCES

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Amy E. Caruso Brown, Joshua D. Arthur, Lauren Hall Mutrie and John D. Lantos
Pediatrics 2019;144;
DOI: 10.1542/peds.2019-0817 originally published online October 9, 2019;

The online version of this article, along with updated information and services, is located on the World Wide Web at:
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