An MLC Field Guide to Challenges and Opportunities in Medical Imaging, EHRs and Social Media

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Reviewed by the ACEP Board of Directors, November 2016

RECOMMENDATIONS: Choosing Wisely®

Executive Summary

- Choosing Wisely® initiatives and the driving force behind them are an increasingly important aspect of medical practice.
- Choosing Wisely® recommendations present a double-edged sword for clinicians; they do not offer definitive malpractice protection if followed and can be used against the physician if not followed.
- Choosing Wisely® recommendations can provide support for reasoned clinical decision-making.
- When applying Choosing Wisely®, it is recommended to document the clinical reasoning behind their application and/or why they do not apply.
- Choosing Wisely® recommendations do not replace clinical judgment.

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The Choosing Wisely® Campaign is one of the many evidence-based guidelines and recommendations that are increasingly important in the day-to-day practice of emergency medicine. There are benefits and also substantial risks to the individual clinician and patient if the recommendations are adopted uncritically. The individual clinician should understand both the benefits and limitations of Choosing Wisely® and implement safe practices consistent with the recommendations, without at the same time surrendering the most important single determinant of safety: good clinical judgment.

Intent of Choosing Wisely

The Choosing Wisely® Campaign was started by the American Board of Internal Medicine Foundation as a way to rally the house of medicine to adopt evidence based practices and reduce practices that were deemed unnecessary, dangerous, or outdated. Over 70 organizations have joined the initiative, including the American College of Emergency Physicians. Each organization is expected to release five additional recommendations per year.

Design, Scope, and Examples of Choosing Wisely® Recommendations

Choosing Wisely® recommendations are not protocols or mandates. They focus on specific areas where current practice is highly variable and prone to over-utilization. A typical recommendation lays out the present practice and why it is suboptimal; it then lays out an alternate, evidence-based practice pattern that is often less resource intensive. Especially well-done recommendations include primary reference sources.[1]

Contrary to popular belief, most recommendations do not involve imaging or diagnostic testing. One such example is to "[a]void placing indwelling urinary catheters in the emergency department for either urine output in stable patients who can void, or for patient or staff convenience." Examined closely, this recommendation gives the clinician freedom to place a catheter when it is clinically indicated, such as when the patient is unstable or can't void. The recommendations include eight primary and secondary references.

An example of an imaging-based recommendation is to "[a]void computed tomography scans in emergency department patients with minor head injury who are at low risk based on validated clinical decision rules." It references four large studies that validate clinical decision rules as applied to several

thousand patients. On the face of it, this initiative appears to restrict CT utilization, but its actual intent is to promote the use of validated clinical scales to help in decision-making. By using the word "avoid" instead of "don't," the recommendation allows the clinician to rely on clinical judgment and order the CT scan on a case-by-case basis.

Potential Benefits of the Choosing Wisely® Campaign

There are a number of potential benefits to the Choosing Wisely® Campaign. Helping clinicians and patients driving toward cost-effective, quality care is a real potential benefit. Additionally, with increasing payment reform focused on quality, the ability to develop evidence-based recommendations by clinicians has the possibility of developing better payment models. Recommendations like Choosing Wisely® also have the potential to reduce the practice of defensive medicine by helping to highlight to clinicians where such recommendations can give them evidence to avoid unnecessary testing. Finally, these recommendations can be discussed with patients and have the potential to build trust and strengthen the clinical relationship, a key benefit to avoid future litigation.

Driving Higher Quality Care. Decreasing unnecessary practice variation is a worthy goal, particularly with high-risk diagnoses. From a patient safety perspective, standardization can reduce medical errors and adverse outcomes, theoretically reducing malpractice exposure. For instance, through the use of guidelines like PECARN criteria for pediatric head injury, the Choosing Wisely® recommendation identifies the high risk patients who should be imaged as well as the ultra-low risk patients in whom the risk of radiation exceeds the potential benefit. By highlighting PECARN criteria, the Choosing Wisely® campaign, also serves a valuable educational function, disseminating important evidence and clinical decision support rules.

Incentivize and Align with Payment Reform. As we move away from high-volume testing to a capitated model, it will be part of our practice to justify the use of testing and avoid testing when it is safe and appropriate to do so. By defining in advance what is evidence based quality testing, we can help ensure that future payment models are built on clinical evidence, not arbitrary caps and rules. For example, CMS's proposed OP-15, which would have compared institutions' head CT utilization rates and become a pay-for-performance metric element, is a glaring example of what happens when arbitrary rules are placed to reduce utilization across the board. With guidelines like PECARN, clinicians and researchers can take the lead in establishing the basis for a safe future quality metric that is evidence based medicine and payment.

Reducing Defensive Medicine. A survey in 2009 showed that physicians attributed as much as 34% of the overall health care costs to defensive medicine. These tests lead to increased costs and may expose patients to potential complications. In that same study, emergency medicine was identified as one of the most likely specialties to practice defensive medicine along with obstetrics and primary care. Theoretically, the recommendations of Choosing Wisely® could reduce utilization of unnecessary laboratory testing, imaging, and admissions. By having a guideline that is nationally accepted to reference, clinicians would have the capacity to argue in any litigation that they were within the acceptable standard of care of their specialty. While this is not a prevention of litigation, it is a defense that might not be as well legitimized without the Choosing Wisely® campaign endorsement.

Building Trust with the Patient. A common misconception among patients and family is that all clinical diagnosis requires testing or imaging. In the ED where the time to establish rapport is short, desire to avoid conflict with patient expectations can drive overuse. Choosing Wisely® recommendations can mitigate resource utilization based on expectations. They can be discussed with the patient as the basis of a shared decision-making model, potentially offering some protection in the event of a malpractice claim.

To date, the use of guidelines and recommendations as a defense strategy has shown mixed success and is less successful than tort reform in reducing unnecessary testing and treatment.[2,3]

These benefits can be significant to both the clinician and patient in the future state of health care where quality and evidence-based medicine take on more significant roles. The clinician will benefit from reducing inappropriate testing, developing fair payment guidelines, and reducing the risk of litigation. The patient will benefit from less invasive and dangerous testing and treatments, potentially better relationships with their clinician, and receiving higher quality care. These benefits however may be offset by the limitations and dangers of the guidelines and recommendations.

Clinical Guidelines: A Double-Edged Sword

No matter how careful the research, formulation, and implementation of evidence-based guidelines, they cannot reduce risk to zero. Adhering to guidelines does not by itself provide malpractice protection. Though it may be a helpful malpractice defense strategy to cite guidelines when defending a provider's actions, such a defense is not definitive. Guidelines can expose providers to liability when followed as well as when not followed. The best protection is to understand guidelines and their function while consistently exercising careful clinical judgment (and documenting the same) in the care of patients. What follows is a non-comprehensive list of some risks inherent in adhering and not adhering to Choosing Wisely®.

Risks of Adhering to Choosing Wisely® Recommendations

According to an article in the *British Medical Journal*,[4] physicians who order more diagnostic testing may enjoy a lower overall malpractice risk. Thus, adhering to restrictive (ie, test-limiting) recommendations such as Choosing Wisely® could expose the clinician to additional risk. Furthermore, clinicians might reasonably deduce that decreasing diagnostics could result in lower patient satisfaction scores. Additionally, ignoring patients' expectations has the potential to trigger complaints. Thus, as clinicians incorporate Choosing Wisely® into daily practice, they should do so with an understanding of the risks.

Risk #1: Hoof beats, Zebras, and Acceptable "Miss" Rates. One size does not fit all. Subtle variations in provider interpretation of guidelines and recommendations, as well as patient presentations, can render even carefully researched guidelines ineffective in some scenarios. While the standard of care does *not* require an immediate, precise diagnosis of all conditions 100% of the time, one must acknowledge that delayed and/or "missed" diagnoses can sometimes be devastating for patients and families-- whether or not there is a deviation from a guideline or from the standard of care. Furthermore, physicians themselves suffer psychologically if one of their patients has a bad outcome.[5] Adverse outcomes be may be less palatable to patients and families if they associate them with denial of testing.

Risk #2: Patient Perception of Care. In addition to various post-encounter survey mechanisms, there are multiple venues for immediate dissemination of patient sentiment via social media that far exceed the scope of old-fashioned word-of-mouth. Many health systems already invest significant resources in perfecting the "patient experience," and this aspect of customer service is an increasingly large part of EP's medical interactions with patients. Many patients approach the Emergency Department encounter with preconceived notions of their diagnosis and expectations regarding diagnostic testing and interventions, and promptness of their delivery. Whether or not these expectations are correct and realistic does not mitigate the lay perception of the provider, the care team, and the health system if reality does not comport with expectation. At times, careful explanation at the bedside is insufficient to obviate the risk associated with unmet patient expectation and clinicians may find themselves subject to formal internal inquiry based solely on patient dissatisfaction. These situations are sometimes compounded by

subsequent providers who proceed with the desired testing or treatment. Being seen as the clinician who withheld testing or treatment is a risk of following Choosing Wisely®.

Risk #3: Shifting the Risk to the Provider. This disclaimer can be found at the end of any Choosing Wisely® recommendation: "*These items are provided solely for informational purposes and are not intended as a substitute for consultation with a medical professional. Patients with any specific questions about the items on this list or their individual situation should consult their physician."*[6] Furthermore, members of our own college have noted and published commentary on even stronger language that attempts to absolve ABIM of any liability stemming from reliance on these recommendations.[7] In the mostly unreformed medical malpractice/tort ecosystem in place, potential cooperation often becomes a prisoner's dilemma: none of the players will act to decrease risk overall if they perceive the act as increasing their own risk.[8] So long as these practices convey no perceived or real adaptive advantage in the malpractice ecosystem, adoption is problematic.

Risks of Deviating from Choosing Wisely® Recommendations

Risk #1: Complications of Testing and Treatment. The most obvious risk of deviating from Choosing Wisely® stems from complications of testing and treatment performed in spite of the recommendations. Regardless of the subtleties of a patient's presentation, it's to call a provider's care into question if the care deviates from Choosing Wisely® recommendations. This is the keen edge of the double-edged sword: one can readily imagine the legal scenario in which a recommendations is held up by plaintiffs as evidence that an EP did not meet the standard of care, particularly when some societies characterize practices in conflict with their recommendations and guidelines as "inappropriate, wasteful clinical actions that harm patients and lead to costly health care."[9] Regardless of the level of tort reform in individual states and the admissibility of various forms of evidence, it may well seem egregious to a lay jury when something as "simple" as five plain-language recommendations (ergo, "Doctor, you can count to five, can't you?)" is disregarded by an EP.

Risk #2: Interdisciplinary Overlap. An additional consideration is the implication that one specialty's set of endorsed recommendations has upon the clinical practice of another specialty's physicians. For example, the first four of the five Choosing Wisely® recommendations thus far set forth by the Infectious Diseases Society of America (ISDA) apply directly to Emergency Medicine physicians:

1. Don't treat asymptomatic bacteriuria with antibiotics.
2. Avoid prescribing antibiotics for upper respiratory infections.
3. Don't use antibiotic therapy for stasis dermatitis of lower extremities.
4. Avoid testing for *Clostridium difficile* infection in the absence of diarrhea.

This raises several immediate questions:

1. Are all providers expected to know and adhere to all Choosing Wisely® recommendations regardless of whether or not the recommendations have been endorsed by their own professional specialty's society or college?
2. If so, have each set of Choosing Wisely® recommendations been vetted by each specialty to which the recommendation is expected to apply?
3. If not, what are the ramifications of adhering to (and or deviating from) such broadly applicable recommendations?

There are 72 specialty societies listed on the Choosing Wisely® website. If each society promulgates at least five recommendations, a minimum of 360 recommendations could apply to an EP's practice. This will matter little, if at all, to a plaintiff's attorney. Non-emergency specialty societies drafting

recommendations may also be oblivious to the logistical challenges of emergency practice, such as unavailability of resources or follow-up. Even more poignantly, they may not be readily apparent to a jury retrospectively analyzing an EP's care. Finally, the EP may not be aware of, or be prepared to adhere to, recommendations that are not endorsed by his or her own specialty association. These factors combine to create significant additional risk associated with Choosing Wisely®.

Recommendations

Recommendation #1: Use Wisely

Choosing Wisely® must be applied with care. Clinicians should thoughtfully consider each recommendation, understand the specific circumstances where it applies, and adhere judiciously when it applies well to the clinical scenario and is supported by good evidence. Recommendations not specifically endorsed by ACEP should be held to a higher level of scrutiny before use in emergency practice.

Recommendation #2: Document Wisely

Whether the clinician feels it is best to follow or not follow Choosing Wisely®, good documentation is critical. When following the recommendations, it is protective to reference and briefly explain why they apply well. When not following the recommendations, it is prudent to document appreciation of the guideline and the relevant clinical facts that render it inapplicable. This practice will mitigate at least a portion of the malpractice risk and will be required in the burgeoning era of quality-based payments.

Recommendation 3#: Above All, Put Patients First

It is an ever-increasing challenge to advocate for patients in the setting of a healthcare system that demands more for less. Adoption of guidelines and recommendations is problematic in a tort system that can punish the clinician for following or not following them. EPs face escalating patient volumes, dwindling resources, and significant pressures to prioritize metrics above all else. As front-line providers to a disproportionate number of the medically underserved and as the gatekeepers to high-cost hospital admissions, EPs are uniquely positioned to carry the mantle of providing quality, cost-effective care. Thus, as EPs balancing evidence-based medicine with the cost-containment measures that are critical to the viability of our healthcare system, we must also remember that the view from the bedside is different than the one from the conference table; even well-intentioned, well-researched guidelines cannot contemplate every clinical scenario. Thus, it is our responsibility to apply guidelines and recommendations through the lens of clinical acumen, and continue to put patients first.

Conclusion

The Choosing Wisely® Campaign has potential benefits and hazards for the clinician and the patient. Its potential for changing practice will likely remain limited in the present unreformed malpractice system. Application of these recommendations is especially challenging in Emergency Medicine because it encompasses almost every specialty. Nonetheless, it is highly publicized and the greatest danger lies in ignoring it. EPs should understand the applications and limitations of Choosing Wisely®, and implement safe practices that comply with its recommendations *when appropriate*, and preserve and protect the Emergency Physician's primary responsibility to the patient.

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5. *See* "Physician Suicide" by Andrew et al, at http://emedicine.medscape.com/article/806779-overview. This article, a July 2015 Medscape article penned by members of our own college, estimates physician suicide rates as 1.4-2.3 times the average rate of the general population.
6. Society for Healthcare Epidemiology of America. Choosing Wisely Recommendations, October 1, 2015. http://www.choosingwisely.org/societies/society-for-healthcare-epidemiology-of-america/
7. *See* Sullivan, DO, JD, "Why Choosing Wisely Won't Protect You in a Lawsuit" at http://www.medscape.com/viewarticle/837399_3, stating: "The disclaimers contained in Choosing Wisely guidelines, such as 'use of this report is at your own risk' and 'the ABIM Foundation ... [is] not liable for any loss, injury, or other damage related to your use of this report,' also seem to show the ABIM Foundation's acknowledgement that the guidelines in its own initiative will not insulate practitioners from liability when a diagnosis is missed."
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EHR Liability and Risk Management Strategies

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For many physicians, electronic health records (EHRs) have been somewhat of a failed promise. The proposed benefits of these systems – eg, enhanced communication, broader research capabilities, standardized practice patterns, improved patient outcomes, and streamlined costs — often remain elusive or only partially realized. Clearly, EHR implementation has both pros and cons, and much has been written about the potential risks that these systems present.

As we approach a decade of EHR use, issues related to electronic records also have found their way into the courts. A recent PIAA study found that 53 percent of member companies had malpractice litigation directly related to EHRs.[2] Top issues noted in these cases include inappropriate use of copy and paste, failure to review available data, Health Insurance Portability and Accountability Act of 1996 (HIPAA) violations, and inability of systems to interface.[2] Others have pointed out the difficulty of defending cases in which electronic records include unexplained additions or deletions, late entries, subjective remarks, data entry errors, or alert overrides.

EHRs and e-Discovery

In 2006, e-discovery amendments were introduced to the Federal Rules of Civil Procedure. These amendments require production of electronically stored data and metadata if requested.[1] Metadata is the "hidden data" in electronic files, such as author of the entry, timestamp, changes to the record, etc. Metadata may not be easily accessible, and physicians and other providers may not always be aware of the content contained within metadata.

To address these issues, medical practices should develop policy statements that specifically define what each practice considers a "legal patient record." These policies will help practices track, preserve, and retain electronic records for business, legal, and compliance purposes. Each practice's policy should align with its respective hospital policy. Important considerations include the following:

- When are patient records considered complete for accreditation/compliance purposes?
- What data are disclosed upon request for medical records?
- What authorizations are required for release of protected health information?

Establishing a clear definition of the legal patient record and specific policies related to documentation will help medical practices respond to requests for disclosure, comply with state and federal medical record retention schedules, and safeguard records against breaches, tampering, and destruction.

Additionally, keep in mind that printed electronic records may look entirely different from the user interface that the practitioner sees. Knowing what the printed copy of the legal EHR record looks like will help raise awareness about the types of information available in print format and how it might appear to patients, legal counsel, and juries.

As EHR systems continue to mature and evolve, it is incumbent on physicians to identify emerging risks and put effective risk-prevention strategies in place to reduce liability exposure.

Top 10 EHR Emerging Risks

1. **Metadata:** Requests for the production of electronic records will include large amounts of hidden data, such as time stamps, author of the record, and changes to the record. Be aware of the information contained within metadata and its implication for workflow practices.

2. **Audit trails:** Every keystroke leaves an electronic footprint for potential audit and discovery. Medical practices should consider hiring an outside party to perform an annual audit and provide feedback about the quality of EHR documentation, adherence to regulatory standards, and billing/coding compliance.

3. **Paper:** Discovery requests for printed copies of electronic records can be problematic if the treating physician is unaware of what these records look like in print format. Further, cases have occurred in which multiple versions of the same record appear different due to software upgrades and time synchronization issues (eg, if patient care is documented before the actual provision of treatment). Review printed records on a quarterly basis to ensure familiarity with the print format. Does the record accurately reflect the care the patient received?

4. **Definition of the legal record:** Both physicians and hospitals should work together with legal counsel to define what constitutes the actual legal medical record. Written policies and procedures should address the following questions: When does the record begin and end? Who has access to the record? What should be disclosed during discovery? Consistency in the definition of the legal medical record is essential across the practice and the institution.

5. **Big data:** A common question since the widespread adoption of EHRs is who is responsible for the large volume of data? Data overload is a legitimate concern, and the ability to decipher meaningful information out of vast quantities of unstructured data is challenging. Recent court cases have held that physicians are *not* responsible for knowing the entire medical record of their patients. Grasping the breadth of electronic patient data is even more cumbersome when the patient has received care at multiple organizations within a healthcare system. The issue of big data should be closely monitored, as it is a moving target that continues to increase in complexity.

6. **Record preservation and retention:** Medical practices and hospitals have a clear-cut duty to preserve and maintain patients' medical records. Any modifications, tampering, or destruction of records can have both regulatory and legal ramifications. Practices and hospitals should develop written policies and procedures to address documentation best practices and record retention requirements.

7. **Embedded guidelines:** The practice of embedding guidelines, such as Choosing Wisely®, in EHR systems is a common concern among physicians. As a general rule, reducing practice deviation — particularly for high-risk diagnoses — by adopting best practices is both good medicine and sound risk management. The key is to follow and practice these guidelines in both principle and documentation. Adopting best practices that are not implemented, documented in the record, or followed in practice markedly increases legal exposure.

8. **Medical errors:** Adverse events, such as administering the wrong medication dosage or failing to document an allergy, can lead to poor patient outcomes and allegations of malpractice. Although human error cannot be completely prevented, EHR design is evolving to incorporate human factors engineering that both anticipates and mitigates the risk of errors.

9. **Data breach**: Data breach, both intentional and unintentional, is a serious concern with EHRs. As technology continues to progress and becomes more sophisticated, so do malicious attempts to steal data. Physicians and medical staff should seek education and training so they are aware of cyber risks, and they should implement safeguards to protect medical records from breach. Increasingly risky areas include email, texts, passwords, social media, and hardware (eg, stolen

smartphones, tablets, and laptops). Annual security audits and strategies, such as secure encryption, will help address this area of risk.

10. **Patient portals:** The intent of patient portals is to engage and empower patients, promote communication, increase transparency, and improve patient outcomes. To meet these objectives, medical practices should develop policies and procedures that address both the operational and legal aspects of portal use. Some important areas that polices should cover include terms of use, the physician–patient relationship, response times to queries and requests, emergency situations, and privacy/security.

Conclusion

Although EHRs have created new opportunities in healthcare, they are not without risk. Issues related to documentation, data overload, and privacy/security of health information represent some of the main concerns.

Physicians and healthcare organizations can mitigate EHR risks by (a) developing policies and procedures that address top concerns and emerging issues, (b) gaining familiarity with the concept of metadata and both the electronic and printed format of records, and (c) conducting regular audits to identify potential problems or gaps in policy.

Taking proactive steps can help physicians feel more comfortable with, and confident in, taking action when they receive a request for the EHR and/or discovery of imbedded electronic data.

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A Medicolegal Primer on Social Media for the Emergency Physician

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Executive Summary

- The risks of a social media presence are the same risks the emergency physician encounters in real life: inappropriate relationships, HIPAA violations, and presenting oneself and one's profession in an unfavorable light. However, *social media can amplify and extend errors in judgment, demeanor, and behavior far beyond the emergency physician's local environment.*
- HIPAA violations, inappropriate patient relationships and posts that reflect poorly on the emergency physician and the practice of medicine are relatively common, and can result in medical board investigations, peer review investigations, fines, and job termination.
- Before establishing a presence on social media, the emergency physician should be aware of the dangers.
- There are different social media classes. The safest is a physician peer-to-peer service like Doximity. Non-secure websites, such as LinkedIn, or Facebook, should only be used to discuss general issues, articles.
- The rules of prudence that dictate personal behavior in the ED or the community apply in social media, only more so, as an error can amplify far beyond the local environment.

Background

About 2 billion people worldwide use social media. There are different social media types the emergency physician may use:

- Blogs: websites where the author can post commentary, and articles, and encourages feedback. Posting, comments and replies provide open-ended interaction between the author and followers of the blog. An example of a physician blog is http://www.mommd.com/blogs/ which is a blog dedicated to supporting women in medicine.
- Micro Blogs: Similar to blogs, but restricted in length, such a Twitter. An example is a twitter account where family practitioners can post and spark debate. https://twitter.com/aafp
- File-sharing sites: These sites emphasize sharing media. The largest is www.youtube.com. An example of a physician youtube channel includes: John Bielinski MD, who gives clinical advice and education to EM residents. https://www.youtube.com/watch?v=EGNe_lzCDUA Many institutions, such a Johns Hopkins, have dedicated youtube channels.
- Integrated Social Media: The prototype is Facebook, which combines micro-blogging, full blogging, and file sharing. More professionally oriented sites include www.linkedin.com and www.doximity.com. Doximity is limited to verified doctors.

Content on any of these websites can be linked to others and rapidly disseminated to up to 2 billion internet users.

Potential Uses and Benefits of Using Social Media

There are positive uses and potential benefits to social media engagement. Social media may be used to promote the physician's practice group. Social media allows for broadcasting one's accomplishments, including papers, posters and videos, and can enhance one's professional profile and extend its reach. Social media are also an important method of networking and joining interest group. The best examples are LinkedIn and Doximity. Posting one's accomplishments and curriculum vitae can also be valuable for career advancement.

Social media can also provide a forum for discussion and for advancing topics of discussion. They allow the individual contributor to participate without having to attend meetings. Social media can also play and important educational role. A well-phrased post or a clever video can suddenly "go viral" and reach hundreds of millions.

Social media can also fill valuable group learning and educational needs. www.kevinmd.com and @kevinmd, who often posts on physician well-being, is an example of positive use of social media. There are many forums for discussion online, and even ways for physicians to "bounce" tricky cases off each other. So long as no patient-specific data is transferred or advice given, they can be valuable.

Risks of Using Social Media

Social media do not create any fundamentally new risk category, but they do extend the reach and permanence of the risk. In the past, an error or lapse in judgment in the social sphere had mostly local repercussions, unless egregious. In the social media age, a single error can be broadcast to hundreds of millions. Bad posts can be deleted, but archived records can still show up for years.

Errors around social media are similar to errors committed in the pre-social media world: violation of confidentiality, inappropriate patient contact, unprofessional language or demeanor, inflammatory language or topics, and conduct or behavior that otherwise reflects poorly on the practice of medicine and one's professional profile. Examples include physicians posting pictures of themselves in a state of intoxication or partaking in unsavory events.

The risks of social media aren't just "social" or even local. They can reach into career and licensing. A recent study of state medical boards demonstrated that a majority of medical boards take actions related to social media. Most common breaches of board standards include: inappropriate communication, prescribing without a license or appropriate doctor-patient relationship, misrepresentation of credential and giving advice without a proper doctor-patient relationship. A majority of boards also report significant disciplinary actions related to social media.

Conclusions

Social media provide benefits as well as hazards to physicians. The physician should engage social media strategically, with a specific goal in mind, knowledge of how social media can help achieve that goal, and knowledge of the risks. So long as the physician avoids the traps associated with social media, they can provide significant benefits.

Recommendations

- Engage social media strategically, with a clear purpose in mind. Avoid using it as a sounding board for anger or to "air out dirty laundry."
- Avoid inflammatory language or inflammatory websites.
- Be aware that offering advice about a specific patient is a violation of statutes regarding an appropriate doctor-patient relationship. If you offer advice offer it as general advice and not specific to the patient.
- Be aware of HIPAA and do not post any patient data, or any data that could be used to trace back to the patient.
- Do not engage in a relationship with a former or current patient through social media. You may exchange emails or converse, but make sure it is about medicine and not about your relationship. Also, be aware of HIPAA.

- Be aware that your post could reach as many as two billion people in seconds.
- Be aware that what you post on the internet is permanent and undeletable.
- Use common sense: if it would be questionable to say in person, it's all the more questionable to post on a social media site.