

Informal online opinions

Medico-legal considerations in new and social media



Ruanne Brell

Background

Doctors are increasingly discovering that using social media, both via public platforms and closed forums, is a powerful tool to develop a professional presence, share information and network with colleagues. While new technology can open up opportunities to engage, educate and inform, it is important also to recognise that doctors' legal and professional obligations apply equally online.

Objective

The aim of this article is to raise awareness of and share information about legal and professional obligations when using social media, particularly in the context of seeking peer professional advice or informal input from colleagues.

Discussion

While doctors' legal and professional obligations continue to apply online, the technology can create additional complexities. Being aware of these complexities will assist doctors to optimise their use of social media while still complying with those obligations.

IN ITS ARTICULATION of doctors' professional obligations, the Medical Board of Australia's Code of Conduct includes consulting colleagues and using resources effectively and responsibly.¹ While social media is still uncharted territory for many doctors, prior research has shown that the medical profession's use of social media is increasingly common.² Those who have embraced it say that far from entering the domain of trolls, they have found collegial support and a wealth of expertise accessible for consultation.³

Social media technology and platforms may change the shape of professional interactions and open up new tools and support for the benefit of doctors and their patients. The technology does not change the fundamentals of the doctor-patient relationship – and social media platforms can be a great space in which to educate, engage and inform – but it does give rise to some complexities.

SCENARIO

Dr B is preparing to see the last patient of the day: a regular patient who has been presenting over the last few months with some complex symptoms that Dr B has been investigating. Dr B has received the last of the results that confirm the

diagnosis. Dr B has only ever had one other patient with the same condition, but that was a number of years ago, and current treatment guidelines may have changed since then. Dr B has recently joined a closed social media group for doctors and remembers seeing a recent post by another member in the same situation. Dr B logs into the group and posts a question asking for information regarding the current recommended treatment. Dr B includes the patient's age, gender, latest test results and the patient's diagnosis, as well as recollection of the treatment recommendations from the previous case. Someone else immediately responds with links to current medication recommendations and online resources about the condition.

In search of an analogy

Lawyers working in the medico-legal sphere often quote Justice Windeyer, whose description (from 1970) of 'law, marching with medicine, but in the rear and limping a little',⁴ still rings true today. As emerging technologies give rise to new legal issues, both case law and legislation may take some time to catch up. In the meantime, lawyers look to analogous situations for guidance as to how new situations might be decided.

In this scenario, a parallel can be drawn with the more familiar situation of an informal consultation with a professional colleague, currently referred to variously as corridor consultations,⁵ informal second opinions or, mainly in the US, curbside consultations.⁶ While the terms are not always used consistently, the essential element in the context of this paper is the informal nature of any opinion or advice being given and a situation in which there is no existing doctor-patient relationship, with no opportunity or prospect of one being established. This does provide a useful analogy for the social media scenario we have outlined. However, the social media context adds additional complexities in that collegial consultation is occurring in a virtual setting, often without an existing relationship between the professionals involved, and sometimes anonymously. This paper refers to these situations as informal online opinions.

Privacy and confidentiality

Sharing information online, particularly with interstate and international colleagues, can be helpful to gain insight from experts in the relevant field or to aid in diagnosis. However, this must be done within the context of doctors’ obligations of privacy and confidentiality. These concepts are often referred to interchangeably; however, there are in fact distinctions between them (Table 1).

The duty of confidentiality remains a fundamental requirement of the doctor-patient relationship.¹ In addition, the privacy legislation imposes further obligations on practitioners and practices in relation to health information.^{7,8} The Australian Privacy Principles (APPs) contained in the *Privacy Act 1988* (Cwlth) regulate the collection, use, storage and disclosure of personal information,

including health information. APP 6 limits how information can be used or shared.

What are the restrictions on sharing health information?

Information can be shared with patient consent. APP 6 also permits disclosure for the primary purpose for which the information was collected, which in this case was the provision of medical treatment to the patient. When a patient consents to treatment and collection of their information, in general terms this consent extends to disclosure to colleagues for discussion and clarification.⁷

In theory, if it is possible to sufficiently de-identify the patient information, then it can be shared without needing to obtain specific patient consent as privacy legislation does not apply to de-identified information.⁸ However, posting information online, even in a closed group or social media platforms, adds a layer of risk. This means that it is always advisable to seek specific consent from the patient before posting, even if identifying patient information has been removed.

Information will only be considered to have been sufficiently de-identified where there is no reasonable likelihood of re-identification.⁹ If a patient were able to be re-identified and had not consented to disclosure, the fact that the doctor had attempted to de-identify the information would not absolve the doctor of a breach of confidentiality or privacy.

De-identification, interconnection and the World Wide Web

Given the ease with which different pieces of information can be linked online, it may actually be relatively simple to re-identify a patient, particularly if the posting concerned a rare condition. In

some cases, an image of the patient’s presenting complaint, basic demographic information, or information that connected the doctor or their practice to an individual may be enough for someone to work out who the patient is. There have been instances of patients identifying themselves, or being identified by friends or family, from the information or image posted about them or because of the identity of the doctor posting the information. As the Australian Medical Association states, it is important to ensure that ‘any patient or situation cannot be identified by the sum of information available online’.² Therefore, the best approach is to consult with the patient, discuss their diagnosis and obtain their consent to consult colleagues, including those online, in a de-identified manner. This allows disclosure of the relevant demographic and other information to make any responses meaningful.

Documenting patients’ consent

Any discussion and resulting consent from the patient should be recorded in the patient’s clinical records.

The level of detail that should be included in the clinical record about the post is not prescribed. Ideally, the record would include details about which platform/s will be used to post the information, a screenshot or copy of the post itself and a note of the responses relied on. However, this level of detail is not strictly required; in practice it would be sufficient to document that the patient consented to the doctor consulting their colleagues, including in an online forum, and then add any responses that form part of the doctor’s subsequent consultation or treatment of the patient – for example, resources or guidelines recommended.

Keeping it professional

Even when posting to a closed group, the safest assumption is that any comments may somehow become public. This is in no way a reflection of the integrity of the group members or moderators, but rather recognition of the reality of online environments.

Table 1. Distinction between confidentiality and privacy¹⁹

| Confidentiality | Privacy |
|---|---|
| The duty owed by a practitioner to the patient regarding the information obtained from and about the patient. | The statutory regime that governs how confidential information should be collected and managed and the circumstances in which it can be used and disclosed. |

Security can be breached, and there exists the possibility that someone may take a screenshot of a post, or it may be copied, printed out or otherwise shared; this can sometimes occur unknowingly as platforms automatically update their settings.¹⁰ Colleagues who seek advice online may wish later to cite this advice as evidence that they sought the advice of their peers in a civil or professional conduct matter.¹¹ Further, it is becoming increasingly common for a person's social media to be used in litigation.^{12,13}

For all of these reasons, in addition to patient consent to postings, it is also important to consider the tone and language of your posting. Social media engagement needs always to be conducted professionally¹ and on the assumption that, at some stage, a patient or colleague may be able to see any social media activity. Therefore, it is important for doctors to consider whether they are comfortable with their patients or colleagues seeing their social media activity. This applies to both personal and professional online activity. Social media profiles will often connect a doctor's professional and private personas, and private actions may be seen as a reflection of their public persona.¹⁴

Responsibilities when providing an informal online opinion

If seeking informal online opinions, the responsibility for documenting the advice sought and obtained rests with the patient's treating doctor. However, a further question arises, namely: what professional responsibilities do those responding bear for the information they provide? The legal duty and standard of care that doctors owe to patients has been extensively considered, and a detailed discussion is unfortunately beyond the scope of this paper.^{1,15-17} For the purposes of this paper, it is accepted that as a general principle, a doctor's duty is to exercise reasonable care and skill in the treatment of a patient. Particularly in a social media setting, the law is still developing as to what, if any, liability could arise for a doctor from the advice or information provided and whether

it is foreseeable that the advice could cause damage, loss or injury to a patient. There is very little case law on point as yet, particularly in Australia. In NSW, the Health Care Complaints Commission¹¹ considered that it is reasonable and expected for practitioners to make contact with colleagues to seek advice through social media platforms and apps, in addition to more traditional methods, such as telephone and facsimile. The Commission in that case did not need to consider the relative obligations of the practitioner giving or seeking advice. However, there is some relevant judicial consideration from the US. In *Hill v Kokosky*,¹⁸ a patient's treating doctor had spoken with two colleagues about the patient, and both colleagues provided their opinions to the treating doctor. The court concluded that there was no doctor-patient relationship and therefore no duty to the patient, given that the opinions were addressed directly to the treating doctor as a colleague, and were not 'a prescribed course of treatment, but were recommendations to be accepted or rejected by [the treating doctor] as he saw fit'.

This suggests that professionals providing informal advice are unlikely to be seen as owing a duty to the patient. The treating doctor must use their own clinical judgement and acumen to determine the veracity of the advice or information posted and the relevance of the guidelines or resources shared, and then apply it to the patient's clinical scenario. Nevertheless, it would be wise to exercise a degree of caution when offering advice in this situation. These types of discussions are traditionally more likely to have occurred between colleagues who have an existing professional relationship and would therefore be more likely to be able to judge how their colleague would use or rely on their advice. In an online context, doctors may not have the same ability to foresee how their comments may be used, relied on or shared. It will also not always be possible to verify the skills of those providing opinions. Box 1 contains a summary of the key recommendations when providing informal online opinions.

Box 1. Key recommendations for providing informal online opinions

- Doctors should only respond to queries that are within the scope of their experience and skills.
- Respond to the information provided and be aware that any comments may ultimately be seen out of context.
- Always be professional; even in a closed group assume that the patient or their family or other colleagues may see any comments.
- If a doctor is offering their own clinical experience, they should ensure that they have appropriate patient permission to share any details.
- It can be helpful for responding doctors to post links to current guidelines or other useful resources for the treating doctor to pursue, which avoids the risk of exceeding professional expertise or the information provided.

Conclusion

The speed of the development of technology is faster than that of the law. This can create uncertainty regarding medico-legal risk when doctors wish to make use of the online environment. The judicial consideration, albeit limited, of analogous situations suggests it is very unlikely for a doctor to be found liable for providing an informal online opinion. The safest course of action when doing so is to comment only within the relevant area of experience and to provide information to colleagues regarding guidelines and resources, rather than one's own individual opinion. Bearing that in mind, as many general practitioners (GPs) are finding, social media can be a great space for 'GP advocacy and peer support for the uncertainty and complexities of clinical decision making'.³

Author

Ruanne Brell BA, LLB (Hons), senior solicitor, Medico Legal Advisory Service, Avant, NSW. Ruanne.Brell@avant.org.au

Funding: None

Competing interests: None

Provenance and peer review: Commissioned, externally peer reviewed.

Acknowledgements

Editorial and drafting assistance was provided by Catherine Hughes, Advocacy Communications Manager, Avant.

References

1. Medical Board of Australia. Good medical practice: A Code of conduct for doctors in Australia. Melbourne: MBA; 2014. Available at www.medicalboard.gov.au/Codes-Guidelines-Policies/Code-of-conduct.aspx [Accessed 18 September 2018].
2. Australian Medical Association Council of Doctors-in-Training, New Zealand Medical Association Doctors-in-Training Council, New Zealand Medical Students' Association, Australian Medical Students' Association. Social media and the medical profession: A guide to online professionalism for medical practitioners and medical students. Barton, ACT: AMA, 2010. Available at https://ama.com.au/system/tdf/documents/Social_Media_and_the_Medical_Profession_FINAL_with_links_0.pdf?file=1&type=node&id=35198 [Accessed 13 December 2018].
3. Price K, et al. GPs Down Under: Who are we and what do we do? MJA Insight [Internet]. 22 January 2018. Available at www.doctorportal.com.au/mjainsight/2018/2/gps-down-under-who-are-we-and-what-do-we-do [Accessed 18 September 2018].
4. Mount Isa Mines v Pusey (1970) 125 CLR 383.
5. Lowe S. The corridor consult. *Obstetric Medicine* 2017;10(4):155-56. doi: 10.1177/1753495X17739494.
6. Fox B, Siegel M, Weinstein R. 'Curbside' consultation and informal communication in medical practice: A medicolegal perspective. *Clin Infect Dis* 1996;23:616-22.
7. Commonwealth of Australia. Privacy Act 1988. Canberra: Commonwealth of Australia, 1988.
8. Health Records (Privacy and Access) Act 1997 (ACT); Health Records and Information Privacy Act 2002 (NSW); Health Records Act 2001 (Vic).
9. Office of the Australian Information Commissioner. De-identification and the Privacy Act. Sydney: OAIC, 2018. Available at www.oaic.gov.au/resources/agencies-and-organisations/guides/de-identification-and-the-privacy-act.pdf [Accessed 18 September 2018].
10. Avant. Be in the know: Privacy matters. Connect. Sydney: Avant, 2018. Available at www.avant.org.au/publications/ [Accessed 18 September 2018].
11. HCCC v Sheehan [2016] NSWCATOD 89.
12. Jones D. Social media as nonfiction: Using social media in litigation. *Inside medical liability*. 2018(Q3):27-29.
13. Foong v Ghaly; Foong v McLellan [2017] NSWDC 303.
14. Australian Medical Association NSW. Twitter in 2018. St Leonards, NSW: AMA NSW. Available at <http://www.amansw.com.au/twitter-in-2018/> [Accessed 10 January 2018].
15. Donoghue v Stevenson [1932] AC 561.
16. Rogers v Whitaker (1992) 175 CLR 479.
17. Civil Liability Act 2002 (NSW); Civil Liability Act 2003 (Qld); Civil Liability Act 1936 (SA); Civil Liability Act 2002 (Tas); Civil Liability Act (WA); Wrongs Act 1958 (Vic)
18. Hill v Kokosky 463 N.W.2d 265.
19. Madden B, McIlwraith J. Health care and the law. 6th edn. Pyrmont, NSW: Thomson Reuters (Lawbook Co), 2014; p. 312-17.