From Baylor College of Medicine

Clinical Challenges in the Internet Era

Glen O. Gabbard, M.D.

Case Presentation

"Mr. R" is a 20-year-old man with severe schizophrenia who initially presented, accompanied by his parents, for medication management at the outpatient clinic of an academic medical center ("the Center") after discharge from an inpatient facility at the Center. Mr. R was interviewed separately from his parents, during which he denied having any mental illness. His chief interest in attending the appointment was "so you can explain to me what my medication does." He could explain neither his recent psychiatric hospitalization nor his parents' concern for his well-being.

Mr. R's illness developed when he was 17 years old. In trials of four antipsychotics, he had either not responded to the medication or been unable to tolerate it. A trial of clozapine had been considered but was never initiated because of concerns about neutropenia while the patient was being treated with olanzapine. The patient's family reported that he had at least 10 hospitalizations, mainly related to medication nonadherence, before he established care at the Center. During his first hospitalization at the Center, Mr. R was started on treatment with a long-acting injectable antipsychotic.

Mr. R reported getting along well with his parents and his several younger siblings. He had graduated from a competitive high school and, according to his mother, won a prestigious scholarship to attend college. He was active in both athletic and artistic endeavors.

Mental Status Examination

Mr. R is a thin, energetic-appearing young man. He was casually dressed in a bright green and yellow T-shirt and white jeans and wore a metallic necklace. His thought process varied from overly abstract to overly concrete. The patient was suspicious about the resident's intentions in prescribing medication but denied ideas of reference and auditory or visual hallucinations. His affect was blunted, and he denied suicidal ideation. However, he responded in bizarre ways to some questions. For example, when asked about peer relationships, he said, "It's just trailer trash to me." He also expressed a desire to convert to another religion and undergo circumcision.

Course

At Mr. R's intake appointment, his mother explicitly acknowledged his diagnosis of schizophrenia and was particularly troubled by his delusions and disorganization of thought. Hence, she agreed that treating him with antipsychotic medication was necessary. She brought him to subsequent outpatient visits at the Center, which included injections of the depot antipsychotic. She engaged actively in discussion with the treating resident and the attending psychiatrist about the management of her son's illness and seemed pleased with his care.

Much to the treatment team's surprise, within a week of Mr. R's first outpatient appointment, Mrs. R had begun posting disparaging comments on various web sites about the quality of her son's care, specifically naming the treating resident. The comments described the treating resident as well as other members of the treatment team in derogatory terms. In addition, Mrs. R made comments that were vehemently antipsychiatry, including a statement that psychiatrists collude with pharmaceutical companies to generate profit rather than treat illness. She posted multiple comments in the days following certain clinic visits; the comments could be found easily by anyone who did a Google search using the treating resident's name. The comments initially appeared on both a personal blog and a highly popular web site, later cropping up also on web sites that serve as general forums for consumer dissatisfaction and on news outlets as user-generated content.

When the resident learned of these comments, he was surprised by the contrast between the dissatisfaction they conveyed and the agreeable, collaborative attitude Mrs. R had presented in person. The resident could easily imagine how her feelings might complicate or even hinder Mr. R's treatment, leading the resident to feel annoyed and disappointed in the mother's inability to express her disagreement directly and constructively. In addition, he perceived an implicit personal attack in her comments' negative content and hostile tone. He felt this criticism was undeserved. Unsure of how best to address the situation, or whether he should address it at all, the resident notified the attending psychiatrist. Their deliberations expanded to include other clinic attendings, the outpatient clinic chief, the medical director of the psychiatric institution, and representatives from the Center's legal and risk management departments.

Two main concerns arose from the ensuing dialogue. Foremost was the potential for the mother's online comments to undermine Mr. R's care. For example, awareness of his mother's comments could exacerbate Mr. R's paranoia, leading to a disruption in his trusting relationship with the resident and a possible interference with his adherence to treatment. Moreover, the tone of the mother's comments suggested a fundamental disagreement with the treatment team's approach to her son's care, one that could potentially lead to an impasse. In the absence of a satisfactory working relationship with Mr. R's mother, the team would need to consider discharging him with a referral to another provider. Were they to do so, however, apart from feeling disappointed

at not being able to continue providing Mr. R's care, the team would risk appearing either to be punishing him for his mother's actions or abandoning him for no clear reason. Either interpretation might fuel the paranoid perceptions he had regarding mental health care providers.

The second concern was that the mother's comments could damage the reputation of the treating resident. The resident initially did not think to be worried about his reputation, since he felt confident that he was well regarded by those who knew him and had observed his work with patients. Once this concern was raised, however, the resident thought of the potential impact the mother's public comments might have if he sought employment or further training outside his current institution. Given the fact that there is only limited public commentary concerning residents, a few negative Internet postings might adversely affect the opinions of potential patients, peers, or employers. Hence, the situation presented a quandary regarding how to respond to the comments posted online by Mr. R's mother while trying to avoid both potential harm to the patient and potential harm to the resident.

After deliberation, the team concluded that the best course of action was to address the mother's concerns directly in a neutral, inquiring manner. To continue treatment without mentioning the postings, the team believed, would ignore an opportunity to explore a clear signal of trouble in the patient-resident relationship. Accordingly, the resident invited Mr. R's mother—as well as his father, who previously had not interacted with the treatment team—to meet with the attending psychiatrist and him to attempt to develop mutually acceptable treatment goals and methods.

The attending psychiatrist led the family meeting. He emphasized to the parents the importance of working collaboratively with the team to help Mr. R, and he reviewed the treatment plan, which included completing the trial of the long-acting antipsychotic agent and then considering treatment with clozapine. The parents expressed no disagreement. The attending then raised the team's concerns about the mother's Internet postings and expressed the team's desire to hear directly about her dissatisfaction. Mrs. R rejected the suggestion that her comments were critical; in her view, they were statements of fact and could not reasonably be perceived as offensive. She also expressed disbelief that her comments could undermine the efforts or injure the feelings of experienced mental health professionals. The attending psychiatrist then offered to refer Mr. R to another provider if she were to continue to express her dissatisfaction publicly in such stark terms. In response, she became enraged. She interpreted the offer to refer Mr. R as an attempt to coerce her to refrain from posting on the Internet. Within minutes she stormed out, bringing the meeting to an abrupt end. Mr. R's father said nothing and left with her.

In the aftermath of the meeting, the resident noticed other reactions to the situation within himself. He felt some degree of resentment toward Mrs. R because she rejected an attempt to engage in open, rational dialogue, which had been offered by a respected senior attending psychiatrist in as compassionate a manner as possible. More than resentment, though, the resident felt sadness for Mrs. R, as he had the impression that she had some psychopathology herself—possibly cluster A personality traits in light of her son's diagnosis. The resident felt disappointment that although the mother needed treatment as much as her son did, she was unlikely to receive it because of the rigidity of her views and her lack of openness to dialogue with the clinicians at the Center.

Arrangements were made to transfer Mr. R's care to a psychiatrist at another institution.

Discussion

When I was asked to consult on this case, I felt a good deal of empathy for the resident. Here he was, delivering good psychiatric care to a young man with severe illness, but receiving criticism rather than appreciation from the family. I recognized that there is now a public exposure inherent in psychiatric practice that can be daunting even to experienced clinicians but may be especially painful to vulnerable residents who are striving to become competent psychiatrists. Those of us involved in training hope to protect our residents from the most difficult clinical situations, but there is little we can do to foresee these kinds of developments.

The cyberspace revolution in the past two decades has presented a new set of problems for psychiatric practice (1). This clinical example illustrates some of the complex challenges that psychiatric residents and faculty in an academic medical center are encountering in the Internet era. Both clinical and ethical/legal challenges are raised by this case, but there is little in the way of consensual policy within or across institutions on how to respond to such challenges. To a large extent, academic centers are improvising as these situations arise. In this case, a veritable ad hoc committee, including the medical director of the institution, the director of outpatient services, assorted attendings, and a legal/risk management team, was assembled to brainstorm about the optimal response to the dilemmas presented by Mr. R's mother's postings on the web.

Two decades ago, Mrs. R's negative feelings would most likely have remained hidden from view. Mrs. R would not have had access to web sites that were in the public domain, so her criticisms of the resident and treatment team would not have come to the attention of those who treated her son. She would have been cooperative and polite with the resident at the Center, and her negative feelings about the clinicians would have been voiced out of their earshot, outside the facility.

But today we live in a different era. The advent of the web has allowed for the dissemination of useful psychoeducational information on diagnosis and treatment and participation in support group discussions that transcend geographical location, socioeconomic categories, and educational background. However, these same sites have become public forums used by both patients and families to ventilate about the treatments they are receiving and the clinicians who are administering those treatments.

The case presentation reflects a frequent form of compartmentalization. I have previously reported (2) on the potential for a patient in a psychotherapeutic or psychoanalytic setting to present one version of the self in person and another via e-mail, with an accompanying expectation that the two will remain unintegrated in the treatment setting. This same phenomenon can occur in a center that treats severe mental illness with medications and family psychoeducation. One set of attitudes, beliefs, and feelings is presented in the psychiatrist's office, while another set appears on a web site. The potential for this form of splitting or compartmentalization to create problems for the treatment is considerable. For example, from Mrs. R's perspective, her public persona with which she interacts with the treatment team is how she wishes to be viewed by the professionals who treat her son. When she is ventilating about the treatment her son is receiving, on a web site with other families of patients with severe mental illnesses, with "friends" in a social media setting, or with any other support group in cyberspace, she is "letting her hair down" with like-minded "cybermates." Families of patients may feel less conflicted about attacking a clinician when the criticism is expressed indirectly through the web. The anger in the postings may reflect the understandable pain the mother feels in dealing with a severe mental illness as well as her need to direct blame onto someone. To her, at some level this form of communication is experienced as a private discussion out of view from the Center.

Both clinical and ethical/legal challenges are raised by this case, but there is little in the way of consensual policy within or across institutions on how to respond to such challenges.

However, the distinction between "private" and "public" has been redefined by the past two decades of exponential growth in Internet life. Virtually anyone can access Mrs. R's postings. The "private" versus "public" nature of what is posted, however, is far more complex for those who treat patients. Is it ethical for the psychiatrist to look up a patient or that patient's family on the web? Some (3) have suggested that seeking this information might violate professional boundaries of the doctor-patient relationship. Should we respect the patient's (and family's) right to "private" expressions of concern in a context where they assume they are not being observed by treating clinicians? Are we likely to damage the therapeutic alliance if we surprise the patient or family by revealing that we have been "snooping" into their web postings? Or, on the other hand, are we colluding with a destructive form of splitting if we allow a parallel narrative on the Internet to coexist with what we hear in the treatment setting itself? If we are aware of the criticisms, isn't it better to bring them into the office so we can constructively address them with the patient and family? Disembodied words appearing on a screen may provide a fertile field for the generation of transference or countertransference distortions (4). Isn't it preferable to clarify the specific intent and meanings of the postings with those who post them than to continue to assume and infer in silence? Perhaps we are even being deceptive to the patient and family if we proceed with treatment while pretending not to know about the postings.

There is not one simple answer to these questions. The decision made at the Center was to bring up the web postings and try to discuss Mrs. R's concerns in a constructive manner. A senior attending psychiatrist was brought in to assist the resident in this task. This strategy led to an angry reaction on the part of Mrs. R, who apparently felt criticized, falsely accused, perhaps violated, and certainly persecuted. She even felt that her right to free speech on the web was being challenged, as she experienced the meeting as an attempt to make her suppress her opinion of the treatment her son was receiving. Any limited therapeutic alliance that was present was disrupted, and the treatment ended. Was it a mistake? It is hard to fault the resident and attending for their efforts. They rightly expressed concern about the effect on Mr. R if he came across the material on the web. Furthermore, the treatment may have been undermined anyway by leaving the mother's criticism unaddressed. We can never know in advance how patients or families will react to our choices.

A second thorny problem was posed by the potential impact of the critical postings on the resident's reputation. This problem has mushroomed in recent years with the popularity of web sites that invite patients to rate their physicians. As patients and families are not bound by any form of professional ethics code, they are free to say whatever they like about their physician, much as consumers complain about a product or service that was less than optimal. However, these criticisms may damage the reputation of the doctor and may not be easily expunged. What is said about us in cyberspace may be indelible and permanent (5). In fact, a new breed of experts is now emerging who spend their time identifying negative information about their clients and doing what they can to prevent it from appearing on Google searches.

Health professionals, of course, cannot defend themselves in response to specific postings. Such behavior would be a breach of confidentiality. Psychiatrists and other mental health professionals cannot even acknowledge whom they treat, let alone dispute what a patient or family member is saying about them. A resident starting out in the field may be particularly vulnerable as he or she has not yet had time to build up a positive reputation through word-of-mouth from patients who are content with their treatment. In any case, even those psychiatrists and other mental health professionals who are disparaged on a web site cannot rely on other patients they treat who

have had positive experiences in treatment to come to their defense with positive postings. Some clinicians have been tempted to ask other patients to provide a countervailing opinion. Other clinicians have even posted vehement defenses of their own skills and professionalism by posting under a pseudonym. Some criticisms, of course, are well warranted. We can all see the potential for these sites to do a public service by warning potential patients to stay clear of a professional who is providing inept treatment. On the other hand, we all know of patients who are outraged when a physician sets entirely appropriate limits on a patient who is seeking controlled substances, for example, or special treatment that is unreasonable, from the physician (1).

The resident treating Mr. R was concerned about the effect these postings about him might have on his future employment and his applications for further training. It has become routine in some places for potential employers or those working on admission committees in educational settings to do Internet searches on applicants. Unfortunately, those who are considering hiring a potential employee or accepting an applicant have no way of determining the truth of what they read on the web. Similarly, prospective patients frequently Google the professionals they are planning to call for treatment to investigate their reputations. Material that turns up on a search, often unknown to the prospective clinician, may prevent a patient from calling that clinician.

What can we do as a profession in the face of these challenges? The proliferation of Facebook, Internet forums, Twitter, blogs, and chat rooms is a juggernaut that cannot be stopped. We must live with these new intrusions into our professional lives and develop creative solutions. Institutions can develop policies so that ad hoc groups do not have to be assembled whenever delicate situations with potential liability arise. Psychiatrists and other mental health professionals can do periodic Internet searches of themselves to keep abreast of any personal or professional information about them that may have implications for their reputation. In some cases, web site administrators may be contacted who will remove what is posted. Those who use social networking sites like Facebook should probably use all available privacy settings so that personal information about them is not available to the public.The education of psychiatric residents and other mental health professionals should include discussions of common challenges that occur in the Internet era so that clinicians have some preparation for dealing with them when they emerge. Finally, guidelines regarding how to continue the treatment and how to respond to the attacks should be developed. Academic psychiatry has a long tradition of establishing protocols to deal constructively with difficult events in the trainee's life, such as patient suicide or assault. Similar forms of support and assistance can be brought to bear to assist with challenges stemming from the Internet.

Received Oct. 29, 2011; accepted Nov. 7, 2011 (doi: 10.1176/appi.ajp.2011.11101591). From the Department of Psychiatry, Baylor College of Medicine, Bellaire, Texas. Address correspondence to Dr. Gabbard (ggabbard12@aol.com).

Dr. Gabbard reports no financial relationships with commercial interests.

References

1. Gabbard GO, Kassaw K, Perez-Garcia G: Professional boundaries in the era of the Internet. Acad Psychiatry 2011; 35:168–174
2. Gabbard GO: Cyberpassion: e-rotic transference on the Internet. Psychoanal Q 2001; 70:719–737
3. Huremovic D, Rao NR: Beyond doctor-patient relationship in cyberspace: pitfalls, transgressions, and guidelines (when therapists and patients Google each other), in 2009 Annual Meeting Syllabus and Scientific Proceedings. Washington, DC, American Psychiatric Association, 2009, pp 212–213
4. Kassaw K, Gabbard GO: The ethics of e-mail communication in psychiatry. Psychiatr Clin North Am 2002; 25:665–674
5. Rosen J: The web means the end of forgetting. New York Times Magazine, July 21, 2010