We were not surprised to read the survey results reported by Cook and Ross in this issue of *The Journal* that many young physicians do not feel adequately prepared to deal with the ethical challenges of social media. As program directors, we have faced a number of incidents in which residents used social media inappropriately. One resident posted a picture of herself pole-dancing while scantily clothed. Another made comments on his Facebook page boasting that after a night out with friends, he slept only 4 hours before a 24-hour shift in which he did not sleep at all. Some residents made negative comments about patients who were admitted in the middle of the night. Others criticized faculty and described events that could be construed as harassment.

As we responded to these incidents, we were somewhat surprised by the residents’ responses to us. Although all of the incidents were reported to us by other residents, faculty, or staff members, the involved residents had a different perspective on their postings than most, viewing them as harmless, deidentified, private, or just not that big of a deal.

We discovered that new developments bring new challenges. Rules, guidelines, and education lag behind. Our hospital, fortunately, has a social media policy. We review it annually with the pediatric residents and medical students. Still, the policy must be interpreted. Trainees do not always understand when a particular social media posting crossed the line. Perhaps the most effective way that we have developed to address these issues is to review particular postings in light of our hospital’s policy that every employee is an ambassador of the hospital. Faced with the question of whether a posting would be viewed as inappropriate from an ambassador of the hospital, many acknowledge that perhaps they had not put their best foot forward.

The new challenges to professionalism, such as those associated with social media, are an example of a larger problem facing the medical profession and medical educators. It is not easy to develop curricula for residents in ethics and professionalism. It is particularly challenging because, as Lang et al showed in a previous survey, there is more and more to teach and less and less time in which to teach it. In that survey, three-quarters of program directors identified “crowding in the curriculum” as the most significant barrier to developing or maintaining a curriculum in ethics or professionalism. This situation will only get worse. The survey of Lang et al was conducted in 2008, before the even more restrictive resident work hour rules went into effect in 2011.

Moreover, unprofessional and unethical behavior is not a problem that first comes to attention in residency. Studies indicate that unprofessional behavior during medical school is associated with future disciplinary action by state medical boards. With regard to social media use, some medical students are posting unprofessional comments, photos of drunken behavior or overt sexuality, or messages that violate patient privacy.

Some residency program directors are now reviewing social media sites of their resident applicants; the implications of this type of screening are not yet well known.

Given these challenges, the recent survey by Cook and Ross delivers both good news and bad news. The good news is that pediatricians who were trained recently report better education on these topics compared with those who preceded them. Moreover, most young pediatricians felt that they were adequately prepared to address issues of consent, privacy, truth-telling, and child abuse/neglect.

The bad news is that they did not receive as much training on professional boundary issues, including the use of social media or responding to requests by friends and family members for prescriptions. Furthermore, many young physicians report that much of their education about ethics and professionalism came from observing colleagues rather than from formal curricula.

These 3 problems—less time to teach, more topics to cover, and more informal than formal learning—are intertwined. The only solution is to think of formal education in ethics and professionalism as something that begins in medical school (or earlier) and continues during residency and beyond into fellowship and clinical practice. It cannot simply be seen as a problem for residency and fellowship program directors to solve. It also is a challenge for those who organize continuing medical education and maintenance of certification. We can never teach—or learn—all that we need to know during a jam-packed 3-year residency.

How then should ethics and professionalism be taught? In 2008, the Association of Pediatric Program Directors released *Teaching and Assessing Professionalism: A Program Director’s Guide*. The purpose of this workbook was to assist program directors in answering 3 questions: (1) What are the important elements of professionalism?; (2) how can expectations regarding professional conduct be communicated to pediatric residents?; and (3) what methods are appropriate for assessing professionalism.
during residency training? The guide provides a very good structure from which to build a professionalism curriculum and address breaches of professionalism, but even in its professionalism vignettes, it does not touch on the newer problems related to social media. The Association of Pediatric Program Directors is attempting to stay ahead of the issue with pertinent workshops at their annual meeting, such as “Social Media and Medical Professionalism: How I Tweeted My Way Out of Pediatrics,” by Brindle et al.\(^\text{10}\)

The next important steps in learning how best to teach ethics and professionalism will require an assessment of different modalities of pedagogy. We need to understand the efficacy of written or video vignettes, small group discussions, self-reflection, and ethics conferences to provide a foundation. We need to understand how physicians incorporate lessons into their own professional identity. The data from Cook and Ross, along with that reported by Kesselhein et al,\(^\text{11}\) can help us move forward. These authors identify topics that need more attention. They emphasize that not everything can be covered adequately during residency. Furthermore, because residents learn by example, these topics need to be included in the curricula of continuing medical education and maintenance of certification programs. Education and certification in ethics and professionalism needs to be an essential element of lifelong learning.

Perhaps most importantly, given the degree of informal modeling that takes place, the professionalism of the academic medical centers should be at a level that sets a proper standard for trainees to emulate. Our attitudes and behaviors affect trainees positively and negatively. We must exhibit professionalism ourselves if we expect it to be modeled by others.\(^\text{12}\) We have had to speak with residents about not using their cell phones to play Angry Birds and update Facebook pages while attending noon conference, and yet faculty members often are buried in their phones doing similar things during grand rounds.

Two things are clear. First, these issues are at the core of what it means to be a competent professional. They are as important as medical knowledge or technical skills. As in those domains, lifelong learning is crucial, because role models always will be more important than didactic curricula. Formal curricula are still important, however. They supply the foundation and the framework on which to build a professional identity, and provide anticipatory guidance as to how to avoid pitfalls that may be encountered. But they must be complemented by discussions with senior faculty about the conflicts and dilemmas that arise in the day-to-day lives of physicians. This modeling takes place during the care of patients on a daily basis. The Accreditation Council of Graduate Medical Education changes that take effect on July 1, 2013, reflect a concern that residents finish their training ill-prepared for their next position, whether that is practice or subspecialty training. The individualized educational units are an attempt to better prepare residents for their next phase, but effective mentoring is needed to avoid further dilution of the “modeling” curriculum.

Second, no guideline will tell a resident how to strike a balance between the need to spend time with a dying patient while 3 new admissions are waiting and he or she is in danger of violating duty hours; or precisely what should or should not be posted on a social media page, or where to draw the line when family members ask for medical advice. As Huddle noted in 2005, “Committed observance of professional norms cannot be coerced but may emerge among trainees through their responsiveness to the lived moral life of virtuous faculty, encouraged by the tacit and explicit invitation of such faculty to imitation over time.”\(^\text{12}\)

Amber Hoffman, MD
Denise Bratcher, DO
Department of Pediatrics
Pediatric Residency Program

John Lantos, MD
Children’s Mercy Bioethics Center
University of Missouri-Kansas City School of Medicine
Children’s Mercy Hospital and Clinics
Kansas City, Missouri

Reprint requests: John Lantos, MD, Children’s Mercy Bioethics Center, University of Missouri-Kansas City School of Medicine, Children’s Mercy Hospital and Clinics, 2401 Gillham Rd, Kansas City, MO 64108. E-mail: jlantos@cmh.edu

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