COURSE #97663 — 3 CONTACT HOURS/CREDITS RELEASE DATE: 05/01/21 EXPIRATION DATE: 04/30/24

Online Professionalism and Ethics

HOW TO RECEIVE CREDIT

- Read the enclosed course.
- Complete the questions at the end of the course.
- Return your completed Evaluation to NetCE by mail or fax, or complete online at www.NetCE.com. (If you are a physician, behavioral health professional, or Florida nurse, please return the included Answer Sheet/Evaluation.) Your postmark or facsimile date will be used as your completion date.
- Receive your Certificate(s) of Completion by mail, fax, or email.

Faculty

Alice Yick Flanagan, PhD, MSW, received her Master's in Social Work from Columbia University, School of Social Work. She has clinical experience in mental health in correctional settings, psychiatric hospitals, and community health centers. In 1997, she received her PhD from UCLA, School of Public Policy and Social Research. Dr. Yick Flanagan completed a year-long post-doctoral fellowship at Hunter College, School of Social Work in 1999. In that year she taught the course Research Methods and Violence Against Women to Masters degree students, as well as conducting qualitative research studies on death and dying in Chinese American families. (A complete biography appears at the end of this course.)

Faculty Disclosure

Contributing faculty, Alice Yick Flanagan, PhD, MSW, has disclosed no relevant financial relationship with any product manufacturer or service provider mentioned.

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The division planners and director have disclosed no relevant financial relationship with any product manufacturer or service provider mentioned.

Audience

This course is designed for physicians, nurses, social workers, psychologists, therapists, and mental health counselors who wish to increase their knowledge of how their online presence can affect their professional practice in terms of professionalism, ethics, and professional identity.

Accreditations & Approvals

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INTERPROFESSIONAL CONTINUING EDUCATION

In support of improving patient care, NetCE is jointly accredited by the Accreditation Council for Continuing Medical Education (ACCME), the Accreditation Council for Pharmacy Education (ACPE), and the American Nurses Credentialing Center (ANCC), to provide continuing education for the healthcare team.

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This course is considered self-study, as defined by the New York State Board for Social Work. Materials that are included in this course may include interventions and modalities that are beyond the authorized practice of licensed master social work and licensed clinical social work in New York. As a licensed professional, you are responsible for reviewing the scope of practice, including activities that are defined in law as beyond the boundaries of practice for an LMSW and LCSW. A licensee who practices beyond the authorized scope of practice could be charged with unprofessional conduct under the Education Law and Regents Rules.

NetCE is recognized by the New York State Education Department's State Board for Mental Health Practitioners as an approved provider of continuing education for licensed mental health counselors. #MHC-0021.

A complete Works Cited list begins on page 21.

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This course is considered self-study by the New York State Board of Mental Health Counseling.

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This course is considered self-study by the New York State Board of Marriage and Family Therapy.

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Successful completion of this CME activity, which includes participation in the evaluation component, enables the participant to earn up to 3 MOC points in the American Board of Internal Medicine's (ABIM) Maintenance of Certification (MOC) program. Participants will earn MOC points equivalent to the amount of CME credits claimed for the activity. It is the CME activity provider's responsibility to submit participant completion information to ACCME for the purpose of granting ABIM MOC credit. Completion of this course constitutes permission to share the completion data with ACCME.

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This activity has been approved for the American Board of Anesthesiology's® (ABA) requirements for Part II: Lifelong Learning and Self-Assessment of the American Board of Anesthesiology's (ABA) redesigned Maintenance of Certification in Anesthesiology Program® (MOCA®), known as MOCA 2.0®. Please consult the ABA website, www.theABA.org, for a list of all MOCA 2.0 requirements. Maintenance of Certification in Anesthesiology Program® and MOCA® are registered certification marks of the American Board of Anesthesiology®. MOCA 2.0® is a trademark of the American Board of Anesthesiology®.

Successful completion of this CME activity, which includes participation in the activity with individual assessments of the participant and feedback to the participant, enables the participant to earn 3 MOC points in the American Board of Pediatrics' (ABP) Maintenance of Certification (MOC) program. It is the CME activity provider's responsibility to submit participant completion information to ACCME for the purpose of granting ABP MOC credit.

This activity has been designated for 3 Lifelong Learning (Part II) credits for the American Board of Pathology Continuing Certification Program.

Successful completion of this CME activity, which includes participation in the evaluation component, earns credit toward the Lifelong Learning requirement(s) for the American Board of Ophthalmology's Continuing Certification program. It is the CME activity provider's responsibility to submit learner completion information to ACCME for the purpose of granting credit.

Through an agreement between the Accreditation Council for Continuing Medical Education and the Royal College of Physicians and Surgeons of Canada, medical practitioners participating in the Royal College MOC Program may record completion of accredited activities registered under the ACCME's "CME in Support of MOC" program in Section 3 of the Royal College's MOC Program.

NetCE designates this continuing education activity for 3 ANCC contact hours.

This activity was planned by and for the healthcare team, and learners will receive 3 Interprofessional Continuing Education (IPCE) credits for learning and change.

NetCE designates this continuing education activity for 3.6 hours for Alabama nurses.

AACN Synergy CERP Category B.

Social workers completing this intermediate-to-advanced course receive 3 Social Work Ethics continuing education credits.

NetCE designates this continuing education activity for 2 NBCC clock hours.

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This activity is designed to comply with the requirements of California Assembly Bill 1195, Cultural and Linguistic Competency.

About the Sponsor

The purpose of NetCE is to provide challenging curricula to assist healthcare professionals to raise their levels of expertise while fulfilling their continuing education requirements, thereby improving the quality of healthcare.

Our contributing faculty members have taken care to ensure that the information and recommendations are accurate and compatible with the standards generally accepted at the time of publication. The publisher disclaims any liability, loss or damage incurred as a consequence, directly or indirectly, of the use and application of any of the contents. Participants are cautioned about the potential risk of using limited knowledge when integrating new techniques into practice.

Disclosure Statement

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Course Objective

As Internet technologies increasingly become ingrained in our professional and personal lives, the issues of professionalism and ethics should be considered carefully. The purpose of this course is to increase practitioners' level of awareness and knowledge of how Internet tools impact professionalism and ethics in clinical practice.

Learning Objectives

Upon completion of this course, you should be able to:

1. Define Internet usage patterns and common Internet technologies.
2. Analyze how various Internet technologies are utilized in clinical practice.
3. Define professionalism.
4. Evaluate how the use of specific Internet technologies can affect professionalism and ethics.
5. Discuss how the use of Internet technologies can impact issues of boundaries, self-disclosure, privacy/confidentiality, and professional relationships.
6. Identify best practices for using Internet technologies as a clinical practitioner.

Sections marked with this symbol include evidence-based practice recommendations. The level of evidence and/or strength of recommendation, as provided by the evidence-based source, are also included so you may determine the validity or relevance of the information. These sections may be used in conjunction with the course material for better application to your daily practice.

INTRODUCTION

Professionals are increasingly entering the digital world to network both socially and professionally. Internet technology can be a powerful tool when job searching and developing and expanding professional networks; however, it is important for individuals to use discretion and judgment in the types of information they post, as the casual and informal nature of social networking sites can make it easy to inadvertently cross professional boundaries. The term "digital footprint" has been used to refer to the digital content and evidence left behind as a result of posting on discussion boards, social networking sites, blogs, and other Internet platforms [1]. These digital footprints can affect how the public, colleagues, supervisors, and employers will perceive an individual in the future. In fact, it is becoming increasingly commonplace for individuals to search online for information about another individual, particularly for professional reasons. For example, 19% of online adults in one study had searched the Internet for information about an individual with whom they had a professional relationship [1]. Some universities and colleges will look up their applicants on social media as part of the admission process [7]. What might a photo of an applicant partying, drinking, or using substances convey to the admissions panel [79]?

One of the hallmarks of curricula in graduate professional degree programs is to socialize novice professionals about the profession's identity, ethical practice within the field, and sense of professionalism. However, with the advent of technology and the era of online venues, the notion of professional identity and boundaries can become blurred. In 2000, there was little written on e-professionalism; since then, recommendations have been formulated to help professionals ensure their professional and personal identities are appropriately presented online [100]. A review found that 63% of employers decided to reject potential employees after finding inappropriate or unprofessional content in their

profiles on social networking sites [2; 79]. A nurse in Sweden was dismissed after she posted a photo of herself holding a piece of flesh during a brain operation [3]. Another nurse in New York was terminated for uploading a photo of an empty trauma room to her Facebook account [101]. Agencies and organizations have to weigh the risks and benefits of these online behaviors, including perceived professionalism and potential legal risks of compromising confidentiality [100].

In professions such as medicine, psychology, social work, mental health counseling, family therapy, and nursing, unprofessional online identities can have negative repercussions for both the client and practitioner. In addition, practitioners searching for information about clients on the Internet can result in damaged relationships and impact care. The Internet can be a powerful tool, but it is important to consider how appropriate it is to access information about a client who has not disclosed the information within the therapeutic setting. For example, what is the practitioner's ethical obligation if a client posts depressive thoughts that might be indicative of suicidal risk on a social networking site [5]? In one scenario, a clinician conducted an Internet search of a young client because the grandfather refused to elaborate about the trauma experienced as a result of the client's parents' plane crash [4]. When the clinician utilized the information during the search in the therapeutic process, the grandfather terminated the sessions. The grandfather perceived this as a violation of privacy, and ultimately the working alliance was adversely affected. Even something as seemingly innocuous as sending out an e-mail correspondence from an Internet hotspot or public terminal to a client or a clinical supervisor with the client's name could potentially violate issues of privacy [6].

The goal of this course is to raise awareness and build the knowledge base of psychologists, social workers, mental health counselors, family therapists, physicians, and nurses regarding the impact of Internet technology on professionalism and ethics [14]. Technology has become an integral part of the American lifestyle, and it is crucial for practitioners to determine how it impacts their professional lives. Of course, having an online presence is not necessarily negative. Instead of fear and abstinence from Internet and social media, practitioners should be thoughtful and fully evaluate the risks and benefits of developing and maintaining an online presence.

INTERNET AND DIGITAL TECHNOLOGY TRENDS

In order to understand the pervasive social, psychologic, and cultural impact of the Internet on the lives of individuals, it is important to obtain a brief glimpse of Internet and digital technology usage and consumption. In 2016 in the United States, it was estimated that 81% of households had Internet access [65]. In a 2018 study conducted by the Pew Research Center with adults 18 years of age and older, 89% reported Internet use, compared with 52% in 2000 and 76% in 2010 [8]. An estimated 73% of households in the U.S. had broadband Internet [8]. Individuals 18 to 29 years of age are the most likely to utilize the Internet (98%), while adults 65 years of age and older are the least likely (66%) [8]. There is no doubt that Internet technology has become a ubiquitous part of the American landscape. Although data published in the last several years is among the most current, the Internet landscape changes so rapidly that obtaining accurate data is nearly impossible.

SOCIAL NETWORKING

A huge number of individuals are using online social networking sites like Facebook and Instagram. As of 2010, the average American spends 6 hours and 35 minutes on blogs and social networking sites every month [9]. As of 2021, an estimated 69% of Americans 18 years of age and older used Facebook, 81% used YouTube, 40% had an Instagram profile, 31% used Pinterest, 28% reported using LinkedIn, 25% used Snapchat, and 23% used Twitter [76]. YouTube and Reddit were the only two platforms measured that saw statistically significant growth since 2019. Women and girls tend to use Facebook and Instagram at a slightly higher rate than men and boys, while men and boys are more like to report use of Reddit [76]. Instagram, Snapchat, and TikTok are more commonly used by younger individuals, while Facebook and WhatsApp appear to be more evenly used among all age groups [76].

The general belief is that social networking users are adolescents and young adults. While the percentage of adolescents and young adults using online social networking sites like Facebook and TikTok is higher compared to older adults, this is beginning to change. In 2021, 50% of adults 65 years of age and older used Facebook [76]. Older adults report using social networking technology to connect with people by sharing photos, personal news and updates, and links.

REVIEW OF INTERNET COMMUNICATION TOOLS

Before discussing how Internet technologies may impact professional ethics and conduct, it is important to have a clear understanding of the tools and terminology used. Each of the following applications presents unique benefits and challenges.

ELECTRONIC MAIL (E-MAIL)

E-mail is a form of electronic communication that involves sending messages over the Internet. It is one of the most commonly used Internet applications. It allows for the delivery of a message to another person or to a group of individuals rapidly, conveniently, and without incurring any per message charges (as with text messaging) [12].

CHATROOMS

A chatroom or chat group is a virtual community or venue in which a group of individuals can "dialogue" and share information about a common interest asynchronously (non-real time) or synchronously (real time). Chatrooms are often organized by specific topics or interests, such as a hobby, an illness, mental health disorders, or personal interests. For example, it is possible to find an online chatroom devoted to the discussion of depression.

BLOGS OR MICROBLOGS

Blogs are analogous to a website journal and generally consist of a log of entries displayed in chronologic order. Entries might include commentary, information about events, graphics, or videos posted by an individual or group. Blogs have become relatively popular and may be attractive to many partly because they require little technical expertise, are inexpensive, allow users to archive and refer back to previous entries, and facilitate connections with others, who may read and comment on entries [13]. Approximately 500 million blogs existed in 2019, and an average of 120,000 blog entries were generated each day [102].

There are many free services to develop and search for blogs, including Blogger, Google, Tumblr, WordPress, Wix, Weebly, Blogspot, SquareSpace, and LiveJournal [77]. Microblogging is similar to blogging, but with a limit on the number of characters that may be used. Twitter, for example, is limited to 140 characters [5]. According to Nielsen, women are more likely than men to blog, and one in three bloggers is a mother [10]. As of 2015, the top three blogging sites are Blogger, WordPress, and Tumblr [10].

INSTANT AND TEXT OR PHOTO MESSAGING

Instant messaging and text messaging are forms of synchronous communication whereby individuals communicate through text and/or photos using computers, cellular phones, or other devices. Text messaging has become one of the most popular forms of electronic communication, especially among adolescents and young adults. An estimated 81% of adults own a smartphone as of 2019 [78]. In a 2019 survey conducted by the Pew Research Center, 78% of cell phone owners in emerging countries use their phone for texting or messaging [58]. On average, persons 18 to 24 years of age send and receive 128 text messages every day [103]. Some estimate that they receive more than 2,000 texts monthly [104].

Applications that allow users to send photos or videos (usually modified with text and/or drawings) have also gained popularity since 2010. One popular example of this platform is Snapchat, which allows users to send images or videos and limit the amount of time they are available; after the set time, the file can no longer be accessed. Since 2019, the video-sharing platform TikTok has gained popularity. Teens are also likely to use apps such as Snapchat to send messages to friends (in lieu of or in addition to texting). Among cell phone owners 18 to 24 years of age, 65% were using this application as of 2021 [76].

SOCIAL NETWORKING WEBSITES

Social networking is a form of online communication that is comprised of "web-based services that allow individuals to construct a public or semi-public profile within a bounded system, articulate a list of other users with whom they share a connection, and view and traverse their list of connections and those made by others within the system" [15]. Examples of social networking sites include YouTube, Facebook, TikTok, LinkedIn, Pinterest, Twitter, Instagram, Snapchat, Tumblr, and Gab [76].

PHOTO OR VIDEO SHARING

Posting original photos and videos online is a common Internet activity, and there are a variety of ways that users may upload their images online. Most social media users include personal photos and videos on their online profiles; it is estimated that half of all persons using the Internet post original photos online [76]. A variety of photo- and video-based applications have been adopted by users, including Instagram, YouTube, TikTok, and Flickr.

WIKIs

Wikis, derived from the Hawaiian word for quick, are collaborative websites on which anyone with access can add, revise, or remove the content published [16]. The most popular wiki is Wikipedia, which is similar to a collaborative encyclopedia, but there are many specific wikis focusing on a single topic, such as suicide prevention or a video game. Often, access is not restricted, but in some cases, editing may be password restricted [16]. Wikis have grown tremendously popular, as they can be a vehicle to quickly access and share information [17]. Wikis have been developed in healthcare communities to promote continuing education and professional development [16].

USE OF INTERNET TOOLS IN CLINICAL PRACTICE

In addition to affecting personal life, recreation, and the dissemination of information, Internet technologies have also impacted the provision of health and mental health care. E-mail is one of the most commonly utilized web-based interventions in clinical practice [18]. E-mail-based counseling consists of asynchronous interactions between a counselor and client using text-based communications sent electronically. E-mail communications allow the client to provide brief narratives, and the counselor can structure the communication for exploration of the described symptoms with a problem-solving focus [19]. Some practitioners will use e-mail as a mechanism to provide support. The premise is that the opportunity to interact with another individual, even in writing, can help to mitigate maladaptive responses to stressors [20]. This may be the most useful for clients who cannot easily see a practitioner due to transportation issues or residing in remote areas. In addition, e-mail counseling or any type of counseling involving text-based communication may be cathartic for the client and allow him or her to control how much information to disclose and when to disclose it [80]. E-mail counseling has been likened to a journal, allowing clients to revisit conversations with counselors. E-mail counseling was also perceived as flexible and accessible [105]. Even with high risk and sensitive topics (e.g., suicide), e-mail counseling may be preferred to phone counseling if the client feels better able to express him/herself through writing [106].

In one study of abuse survivor care, nurse practitioners reported that e-mail technology allowed for immediate referrals, education, support, information, and guidance, improving their practice and level of care [20]. E-mails have also been used as a supplement for supervision, and they can serve as a journal of thoughts and questions between an intern and a supervisor to stimulate reflection [21].

Due to the convenience of e-mails and the ability to aggregate lists of e-mail addresses (e-mail distribution lists), forming groups in which participants interact through e-mail has proliferated [12]. A single individual can physically set-up distribution lists and send mass e-mails, or the distribution of the e-mails can be moderated through special software. E-mail software application systems are available to handle the task of subscribing or unsubscribing persons from the e-mail distribution list (LISTSERV) [12]. Such applications are often developed for the purpose of disseminating information or providing support for a specific issue [22]. They can be particularly helpful in keeping practitioners abreast of current information and connected with colleagues. These distribution lists may also be beneficial for training and continuing professional development [23]. In a study conducted by Cook and Doyle about the motivations of using e-mail-based counseling, many of the participants indicated that they preferred it to face-to-face counseling because it was less embarrassing and they had the ability to read and reread e-mails and reflect on the counseling sessions [59].

Online chatting, texting, and instant messaging refers to the exchange of brief written messages in quasi-real time (i.e., quasi-synchronously) between two phones or computers [80]. Common platforms for online counseling may include MSN, WhatsApp, SMS, or IMessage [81]. While online chatting is slower than talking, clients appear to disclose the problem more quickly, which may be attributable to characteristics of chatting that promote disinhibition [82]. In a qualitative study examining counselor/client e-mails and online chats, clients tended to get to the point of the problem more quickly in chats, while in e-mail counseling, clients wrote longer narratives with greater detail [82]. In e-mail counseling, there was more interactional space, while in online chat, there was more real-time interaction. Texting may also be used as an adjunct to traditional psychotherapy, particularly as a means of providing appointment reminders to increase treatment compliance [107]. Text messages can also increase rapport between the client and the counselor [107].

Chatrooms or discussion groups may be established to address specific topics or interests (e.g., surviving cancer, coping with depression). Ideally, these websites will have experienced practitioners acting as facilitators who may observe and guide the "conversations" [24; 25]. Benefits of discussion groups include lasting documentation of discussions (in the form of archived transcripts), the creation of a supportive environment, and a minimization of isolation. Online discussion boards offer an opportunity for members to be heard and to relate to others, reducing feelings of isolation [108]. In a study of a real-time chatroom offering peer counseling on a variety of emotional issues, the online peer counseling was found to be person-centered [60]. The youths who participated were satisfied with their counselor's ability to provide support. However, the counselors had difficulty providing solutions and assisting participants to think critically and generate solutions.

Blogs have traditionally been used in clinical practice in one of two ways [26]. First, they may be used as an online journal of life events, feelings or emotions, and personal views or belief systems. A community of readers and fellow bloggers may comment and share their life experiences with each other. These responses can be empathic and sincere, giving the blogger a sense of community, understanding, and support [109]. In this way, the blog can act as a record of symptoms and triggers and also as a support group of sorts. Second, blogs may be used by professionals to discuss a particular topic, with readers or other bloggers providing recommendations and feedback [26; 109]. In a 2005 study, researchers found that half of all evaluated blog posts were written with the purpose of self-help or self-therapy [27]. Third, blogs may be used as a form of social justice activism, encouraging people into social action and change [83].

A 2010 study analyzing 951 blogs related to health during a two-year period found that women wrote more than half of blogs, and almost half of the blogs were written by those in the health professions [28]. Typically, the blogs included links, archives, and comments sections, and most of the topics revolved around mental health. For example, more than one-quarter focused on autism, while another quarter concentrated on bipolar disorders. The blogs were informational but also contained personal experiences. They obtain support and help patients and caregivers cope. However, it could also be a cathartic mechanism for health professionals dealing with workplace stress to share challenges experienced in the healthcare sector.

Social networking sites are being used in the health and mental health fields to build and connect members within a community. These sites often collect information about their members by having them create profiles. Members then connect with each other based on information from their profiles [29]. In a survey study of 658 nurses, 85% indicated that social media was beneficial for work-related activities. Many received work-related messages online, and more than 50% subscribed to a medical-related social media site [110].

Because social support is an essential factor in helping people cope with medical conditions, social networking may be an important tool. The U.S. Department of Health and Human Services and the National Suicide Prevention Lifeline partnered with Facebook in an initiative to prevent suicide. As part of this program, if a Facebook user notices that a "friend" posted a suicidal comment or a post that alluded to suicidal intent, the comment could be reported to the National Suicide Prevention Lifeline, with the "friend" then contacted via e-mail or an instant chat [61]. The Italian Service for Online

Psychology (SIPO) also employs Facebook as a means to provide free online psychologic consultations [84]. Between November 2011 and June 2014, 284 individuals used Facebook for 30-minute consultations with an SIPO clinician. Depression was the most common reported presenting problem. In this example, Facebook chat offers a convenient and nonstigmatizing way to access mental health assistance, thereby eliminating barriers to access to traditional mental health care [84].

Video technology may be used to facilitate long-distance therapeutic interventions as well as to share repetitive therapeutic information. Real-time video conferencing, using secure networks or online technology like Zoom, Skype, Google Hangouts, Microsoft Teams, or FaceTime, can allow practitioners to provide care in underserved areas or to persons who are unable to travel even small distances to receive therapy [81].

Using technology, people can more easily provide both emotional and informational support to each other regardless of geographic or other barriers. One example of a social networking site for patients focusing on health and medical conditions is PatientsLikeMe (https://www.patientslikeme.com). There are also social networking sites specifically developed to allow healthcare professionals to connect with each other and share information. Examples include AllNurses (https://allnurses. com), Sermo (https://app.sermo.com), and Doximity (https://www.doximity.com).

OVERVIEW OF PROFESSIONALISM AND ETHICS

DEFINING PROFESSIONALISM

As noted, one of the hallmarks of curricula in graduate professional degree programs is to acquaint novice professionals about the profession's identity, ethical practice within the field, and sense of professionalism. Professional identity has been defined as a "frame of reference for carrying out work roles, making significant decisions, and developing as a professional" [30]. The developmental process of a practitioner's professional identity is a continual process involving attitudinal, behavioral, and structural changes that result in an understanding and acceptance of what is involved in being a professional. The development of a practitioner's professional identity begins in graduate school, and the process continues to affect future professional behaviors [30]. This dynamic process includes teaching knowledge, development of a professional identity, and socialization into the group or profession's norms and values [62].

To be even more exact, it is important to have a clear definition of what constitutes a profession. A profession is defined as involving, "the application of general principles to specific problems, and it is a feature of modern societies that such general principles are abundant and growing" [31]. Professions are characterized by two major dimensions: the substantive field of knowledge that the specialist professes to command, and the technique of production or application of knowledge over which the specialist claims mastery [31]. Therefore, professionals have or claim to have knowledge and apply this knowledge to specific problems.

Professionalism is defined as a set of norms endorsed by a collective community and is characterized by "a personal high standard of competence," including "the means by which a person promotes or maintains the image" of a profession [32]. Professionalism involves a set of qualities, including not only knowledge and clinical skills but commitment, integrity, altruism, individual responsibility, compassion, and accountability [33]. In health care, professionalism often involves employing and applying a unique set of clinical skills and scientific knowledge base [85]. In the helping professions, professionalism is designed to promote patient/client autonomy, protect the public, improve access to care, distribute constrained resources in a just and equitable manner, and ensure professional accountability to the public [34; 35].

In the past, and to some degree today, professional organizations defined specific behaviors and characteristics that conformed to the standards of a particular profession. Consequently, many graduate programs selected and screened students determined to be the "right kind" of person, one who met a set list of characteristics and behaviors that conformed to the standards of competence, ethics, and professionalism within the field [36]. In addition, there are codes of conduct to regulate behavior and supervisory processes to ensure appropriate use of autonomy [86]. Therefore, many argue that merely compiling a list of behaviors and characteristics does not allow for the fact that professionalism is field- and context-independent. The standards of professionalism, ethics, and competence are influenced by a range of external factors, such as the social, political, economic, and cultural goals of the professional institutions and organizations, social norms, and the experiences of clients/patients and their families [36]. There are also factors in the presentation of professionalism that can be more easily controlled. First impressions can be extremely influential in how a professional is perceived [37]. Professional appearance (e.g., clothing, hygiene, presentation) and behavior (e.g., language use, nonverbal cues, etiquette) are vital components of a positive first impression [37; 85]. Ultimately, professionalism forms the foundation of trust between the client/patient and practitioner [63].

E-professionalism is a set of online attitudinal and behavioral standards that conforms to the expectations and values of a profession (e.g., integrity, competence, confidentiality, beneficence) [111]. Unfortunately, it is not clear if one can simply apply traditional professional principles directly in the online environment [111]. Breaches of privacy and confidentiality on social media, blurring of personal and professional relationships, online civility, and violations of agency/organizational policies are common issues that should be addressed in e-professionalism guidelines [112].

ETHICS AND CODES OF ETHICS

It is not possible to talk about professionalism without a discussion of ethics. The code of ethics in a profession has been said to be the "hallmark of professionalism" [64]. Codes of ethics provide guidance to the public and professionals regarding the responsibilities of professionals. They also serve as vehicles for accountability in the profession and as a means for practitioners to self-monitor and enhance practice [87].

Ethics are beliefs about what constitutes correct or proper behavior, the principles of right conduct and how to live as a good person [38]. Ethical principles are statements that reflect one's obligations or duties [39]. General ethical principles common to the helping profession include [39]:

- Autonomy: An individual's right to make his or her own decisions
- Beneficence: The duty to do good
- Confidentiality: The duty to respect privacy and trust and to protect information
- Fidelity: The duty to keep one's promise or word
- Gratitude: The duty to make up for (or repay) a good

- Justice: The duty to treat all fairly, distributing risks and benefits equitably
- Nonmaleficence: The duty to cause no harm
- Ordering: The duty to rank the ethical principles that one follows in order of priority and to follow that ranking in resolving ethical issues
- Publicity: The duty to take actions based on ethical standards that must be known and recognized by all who are involved
- Reparation: The duty to make up for a wrong
- Respect for persons: The duty to honor others their rights and their responsibilities
- Universality: The duty to take actions that hold for everyone, regardless of time, place, or people involved
- Utility: The duty to provide the greatest good or least harm for the greatest number of people
- Veracity: The duty to tell the truth

Based on these ethical principles, professions develop ethical codes that embody the values of the profession and guide behaviors of members. In an analysis of the codes of ethics of diverse professions, researchers were able to classify the codes into four domains [40]:

- The professional's qualities and characteristics
- Behaviors toward other professionals and colleagues
- Behaviors of professionals in a range of situations
- The responsibility of the profession and the professional to society and the common good

These same principles and values apply online. For example, if a practitioner posts unprofessional content on social media (e.g., a photo of him/herself surrounded by alcohol), how could this potentially affect his/her work with patients with alcohol use disorder? Could it harm the therapeutic goals? If so, this would violate the ethical principle of beneficence [79].

Although ethics and professionalism are different, there is considerable overlap. Acting professionally entails adhering to accepted codes of conduct and ethics within a given field, and acting in an ethical manner in online interactions is a good first step in ensuring online professionalism.

The International Society for Mental Health Online (ISMHO), established in 1997, formulated the Suggested Principles for the Online Provision of Mental Health Services in 2000 [88]. Many professional organizations have attempted to keep abreast advances in digital technology and its impact, and many have begun to revise their ethical standards to reflect the ubiquitous nature of technology in modern society. The American Counseling Association (ACA) added an addendum to their code of ethics in 1999 and, in 2005, finalized comprehensive guidelines for Internet counseling [88]. In the field of psychology, Guidelines for the Practice of Technology were developed by the American Psychological Association (APA), the Association of State and Provincial Psychology Boards, and the APA Insurance Trust [89]. In 2017, the National Association of Social Workers (NASW) Delegate Assembly approved updates to the NASW Code of Ethics, including new guidance regarding the role of technology in informed consent, privacy, confidentiality, competency, supervision, and client records [90]. In addition, in 2017 the NASW, in conjunction with the Association of Social Work Boards, the Council on Social Work Education, and the Clinical Social Work Association, published specific guidance in its publication Standards on Technology and Social Work Practice [91]. The American Nurses Association and the American Medical Association have developed opinion statements and toolkits for the appropriate use of technologies such as social media in their respective professions [92; 93].

INTERNET TECHNOLOGIES AND PROFESSIONALISM AND ETHICS

Internet technologies can be powerful tools when job-searching, developing and growing professional networks, promoting health and mental health, and providing support to clients. As a result, e-professionalism, or professionalism in the Internet world, should be instilled in practitioners [3; 94]. Some maintain that e-professionalism, the application of ethics online, and digital literacy should be essential components of the knowledge and skill of practitioners [83]. It is important, for example, to use discretion and judgment in the types of information made public online. The casual and informal nature of social networking sites, for example, can cause practitioners to inadvertently cross professional boundaries, which can negatively affect their professional identity and may breach ethical standards. If practitioners discuss work-related problems (e.g., difficult clients, conflicts with colleagues) on social media, it could disclose confidential information or qualify as abuse [95]. Not everyone considers how the image or persona portrayed online may be perceived in the future. Because the Internet can be a public forum, viewers do not necessarily avoid viewing personal, intimate, and/or embarrassing behaviors [41]. The issue may not be the ever-growing presence of Internet communications, but rather the seeming mindlessness or carelessness with which information is shared; this has been referred to as the diminishing of intentionality of online communication [42]. Practitioners may adhere to strict guidelines for self-disclosure in "real" life, but the Internet may defy practitioners' best intentions. Some have likened the Internet to a clinical practice in a rural area, where practitioners inevitably have unplanned encounters with their clients/patients due to the size of the community [42]. In some cases, individuals may inaccurately believe that the privacy settings will ensure confidentiality [95; 110]. With the Internet, practitioners have minimal control over when and how clients encounter information about them online [42]. The Internet has no expiration date, and anything posted online should be assumed to be permanent [66]. Unfortunately, many codes of ethics in fields such as medicine, psychology, social work, nursing, and counseling have struggled to keep up with these technologic changes [41]. In some cases, standards have been established for the provision of technology-assisted services (such as online counseling), but not for online professional conduct [43].

SOCIAL NETWORKING SITES

The use of social networking platforms can affect professional relationships and boundaries. In a 2013 survey of psychologists, social workers, and physicians, 59% of the practitioners indicated they maintained a Facebook account and 75% of users reported using a privacy setting [67]. Similarly, in a survey study with 695 psychology students and psychologists, 77% indicated they had an account on a social networking site, and of these users, 85% used privacy settings [42]. In a 2018 study with nursing students, 96.6% reported having a Facebook account [96]. However, practitioners were ambivalent about what to do when clients contacted them through a social networking site. It may appear to be an innocuous request, but it can bring up many ethical issues. If the practitioner accepts the client as a friend, the client may have access to personal information, blurring professional boundaries. If the practitioner does not accept the request, the client might misconstrue this as rejection, potentially harming the therapeutic relationship.

Similar issues may arise if information about a client is gleaned from a social networking site. In a study of 302 graduate psychology students, 27% had reported actively seeking out client information on the Internet; most stated they wanted to verify the clients' claims [41]. In a study with 346 undergraduates, participants were asked to evaluate their likelihood of posting different types of "problematic" information in their Facebook profiles and their perceptions of how others would view their image after seeing their profiles [44]. Gender differences were found; specifically, undergraduate men were more likely to report that their Facebook profile contained an image that was sexually appealing, wild, or offensive. Men were also more likely to post "problematic" content in their profiles compared to their female counterparts. In a qualitative study of 813 medical students and residents, 44% were found to have an account and only 33% of these profiles were made private [45]. Of the profiles that were not private, the researchers found that more than half included overt mentions of personal and/or ideologic views, such as political affiliation (50%), sexual orientation (52%), and relationship status (58%). In some cases, the medical students and residents had uploaded photos that could be interpreted negatively (e.g., photos with alcohol, excess drinking, drug use). In the study of graduate psychology students, 81% confirmed having some sort of online profile, with 37% reporting having a social networking page [46]. Of the students who used social networking, more than 65% used their real names and 13% stated they posted photos they would not want their faculty members to see. Nearly 30% stated they posted photos they would not want their clients to see, and 37% posted information they would not want to their clients to read. A study of first-year nursing students, participants reported ambivalence regarding patients seeing their posts in Facebook, perhaps because they lack clinical experiences [96]. In a content analysis of Facebook profiles of nurses in the United Kingdom and Italy, the researcher looked at photos posted and classified them according to the content [68]. Approximately 18.5% of the profiles included photos of the nurse engaged in unhealthy behavior, including smoking and drinking alcohol [68]. The representations of professionals' behaviors on social networking sites could inadvertently have a negative effect on the integrity of the profession [69].

Therapeutic boundaries are established to promote client beneficence and define the client/practitioner relationship. Informed consent, single-role relationship, and confidentiality support these boundaries [70]. The boundaries of the client-practitioner relationship will get blurred as online friendship interactions can lead to sharing of private information on the part of both parties, which may negatively impact the professional relationship [47; 79]. If practitioners find sensitive or embarrassing information about clients, they may be conflicted regarding the appropriate way to use this information. For example, a practitioner may be working with a client on abstaining alcohol, and in the session, the client denies having used alcohol in the past 24 hours. However, if the client and practitioner are linked on a social networking site, the practitioner may stumble onto a photo of the client at a party holding a beer bottle. There is no clear correct course of action. Should the practitioner utilize this information in the next clinical session? If the practitioner does bring it up, does it violate privacy issues? Will it affect the clinical rapport and relationship?

In some cases, social media profiles have been used by law enforcement or social service providers to guide their interactions with clients. For example, there have been reports of social workers "friending" a youth in foster care in order to keep track of them, using a client's social media post to demonstrate his/her lack of progress or faulty character, or using an online profile picture to search for someone [94].

A good first step is to consider the ethical ramifications of each action utilizing the ethical principles identified in many of the professional codes of ethics [41]:

- Beneficence (the duty to do good): How would the information obtained from a social networking site promote the well-being and welfare of the client?
- Fidelity (the duty to keep one's promises): How would the information gleaned about a client on a social networking site help promote trust?
- Nonmaleficence (the duty to do no harm): What harm might emerge from using social networking sites to find information about the client? How might this unintentionally harm the client?
- Autonomy (the individual's right to make his or her own decisions): How does the information found on a social networking site help to promote the client's ability to make his or her own choices about what to share or not in the clinical sessions? Will seeking information on the Internet without the client's consent violate autonomy and respect for the client?
- Justice (the duty to treat everyone fairly): How will the practitioner's being able to find information (or not) on a social networking site provide clues to the client's gender, race, sexual orientation, socioeconomic status, religion, ability, etc.? How might this information affect how the practitioner treats the client?

The same questions can be asked when practitioners use social networking sites to create profiles and post information. How might this information harm the client or jeopardize trust, credibility, and the working the relationship? If a practitioner is a supervisor, what issues of subtle coercion may arise [5]? Of course, each practitioner's behavior on social networking sites must be in accordance with the profession's ethical codes. Befriending a client or patient on a social networking site could potentially violate standards regarding multiple relationships or dual relationships [48].

Practitioners should use their self-reflective skills to ask themselves the following questions in order to guide the information they post on social networking sites [71; 95]:

- What information do you want to share? Is this information important, harmful, protected?
- Why do you want to share this information? What are the benefits and consequences of sharing the information?
- Who needs to see this information? Why?
- Where do I want to share this information?
- What professional boundary issues might "friending" someone pose?
- How might any "off-duty" conduct be perceived?
- How might a photo or post be taken out of context?
- How does my professional code of ethics or other organizational policies guide sharing this information?

E-MAIL DISTRIBUTION LISTS

The main ethical issues associated with e-mail distribution lists concern risks to confidentiality and privacy. Mass e-mail communications can be intercepted at four different points: prior to being e-mailed from the originating computer, during transmission, upon receipt, and when subpoenaed [24]. In one study, 10% of social workers reported having e-mailed something to the wrong person [97]. Some practitioners may utilize this technology to solicit professional consultation from their colleagues. If this is the case, they may describe a case in detail. Even if the client's name and specific identifying information are excluded, the details provided could increase the risk to violating confidentiality.

This risk is further increased with the advent of data mining software, which can analyze and search e-mails for certain content or key words [23].

In addition, there is no insurance that the sender or receiver is the person whom they claim to be. A best practice to reduce these risks is to encrypt the e-mail, to alert the client that an e-mail will be sent, or to ask for a phone confirmation that the e-mail has been received [97].

One of the main applications of the ethical principle of respect for persons is informed consent. When seeking consultation from another colleague on the phone or face-to-face, practitioners obtain informed consent from their clients; the same is true when using e-mail distribution lists for this purpose. Practitioners should inform clients they plan to use e-mail for the purpose of consultation and that certain details of the case will be provided. The potential for violations of privacy and confidentiality using this technology should be outlined [23].

CELL PHONES

Cell phones and smartphones are commonplace, and it is important to carefully consider the possible benefits and consequences before providing a personal cell phone number to a patient or client. First, conversations on cell phones cannot be guaranteed confidentiality, as it possible that the conversation will be intercepted by another device (e.g., baby monitor) [70]. Perhaps more importantly, cell phones can imply some level of personal familiarity that goes beyond the client/practitioner relationship [70]. Finally, giving a cell phone number may imply that the practitioner will be available at any time, including after professional hours. To create boundaries, practitioners may inform the client that messages will only be checked during work hours [97].

It is important to be upfront with clients regarding the use of a cell phone in order to clarify the policies and to obtain informed consent form [70]. Practitioners should explicitly discuss the circumstances under which a client may call the practitioner on his/her cell phone, when he/she would not be available, any additional fees involved, and the amount of time he/she will spend on the cell phone with the client.

BLOGS AND ONLINE DISCUSSION GROUPS

Concerns about privacy and confidentiality also apply to blogs and online discussions. Practitioners who write or comment on blogs must be sensitive to revealing personal identifiers of clients, which could violate practitioner/client confidentiality and privacy. Practitioners in the health fields should keep the Health Insurance Portability and Accountability Act (HIPAA) in the forefront of their minds when blogging or posting in online discussion groups. HIPAA privacy rules protect any identifiable health data, including any past, present, or future health information that can be used to identify an individual [49]. For example, a practitioner might blog about a difficult client who was treated at his or her workplace at a particular time and date [50]. Even if the client's name is not provided in the blog, if the blog author is not anonymous, it is possible that the workplace could be traced and the identity of the client linked back to the appointment book. Or a practitioner could post a message to his or her friends on a discussion board describing clinical experiences, but in doing so, express enough information about a client to be identifiable [49; 72]. It is also important to be careful of how clients or patients are depicted, including the tone and content of postings, so as not to threaten or damage the integrity of the professional field or discipline [51].

Conflict of interest is another ethical issue that may arise when using blogs or discussion boards. A practitioner should be cautious of openly endorsing any products or services. Some blogging software platforms, particularly free ones, automatically display advertisements along with the platform. It is vital to avoid dual relationships or have the appearance of having a conflict of interest with service providers. Some experts recommend limiting blog content to announcements about conferences, events, and professional organizations that represent the practitioner's field [26].

In a 2008 study involving 271 medical blogs, individual patients were described in 42% of the blogs, and 16.6% of these had sufficient identifiers, revealing the identity of physicians or patients [51]. The researchers found that 17.7% of the blogs depicted patients in a negative manner (by tone or content), and 11.4% contained product promotions, either by images or direct content. There is a definite need for practitioners to practice self-regulation and self-monitoring, carefully considering ethics and professionalism while blogging, so the ethical principles of respect for persons and beneficence are not compromised.

ONLINE SELF-DISCLOSURES

Much of science and medicine in Western culture is premised on the tenets of logical positivism, advocating for quantification and objectivity [52]. The psychology, counseling, mental health, and social work fields have followed suit, and as a result, paternalism has become the backbone of the patient/client and practitioner relationship. For example, the physician/patient relationship is typically characterized as hierarchical, with the physician viewed as the "expert." Many counseling and social work models, with the exception of feminist and humanistic orientations, similarly espouse this hierarchical relationship. Traditionally, practitioners are positioned as the "objective" experts, disclosing very little about themselves. In the Freudian tradition, therapists are supposed to present as a blank slate to reflect the client's image [79]. However, the extent to which practitioners self-disclose has changed with the growth of the Internet. With the prevalent use of Internet technologies, the client/patient is now an active consumer of health and mental health services, and they are more likely to use the Internet to research or share information about practitioners, services, and facilities [53]. Therefore, the question is not to what extent practitioners should disclose private information to their clients, but rather how to manage the Internet-driven self-disclosure that has become almost inevitable [54]. It is ultimately the practitioner's responsibility to develop the tone of the professional relationship [66]. Therefore, when disclosing information on social networking sites, the practitioner should take time to reflect on how it may affect the client and the therapeutic relationship.

There are three main types of self-disclosures, and the Internet can affect each of these types [53]:

- Deliberate self-disclosure: The practitioner intentionally discloses certain information, verbally or nonverbally. Internet examples include uploading a photo on LinkedIn, a professional social networking site, or posting information on a commercial website about one's professional background, training, and experiences.
- Accidental self-disclosure: Personal information about the practitioner is inadvertently revealed to the client. For example, a client sees his or her therapist at a boutique, which may reveal information that the practitioner had no plan of sharing. On the Internet, accidental self-disclosures can occur when clients inadvertently come across photographs of their practitioner in a non-professional setting or personal blog posts on a social networking site.

- Unavoidable self-disclosure: These types of revelations are not deliberate but are related to information conveyed by conducting the normal affairs of life. For example, wearing a wedding ring indicates one's marital status. Of course, one can argue whether this is deliberate or unavoidable. Again, photos uploaded on a website or a professional social networking account can reveal information that the practitioner has no control over.

There are two types of anonymity: visual anonymity and discursive anonymity [113]. Visual anonymity refers to a lack of physical or visual cues (e.g., a photo in an online profile) to provide the other party a sense of who is being represented online. Discursive anonymity refers to a lack of textual cues (e.g., use of an online pseudonym) to give a sense of who is being represented. It does not appear that type of anonymity affects the extent of online disclosure.

The most typical disclosures via Facebook profiles are of one's age, gender, education, and relationship status [98]. In the past, if a client asked about a practitioner's background, this could be used as an opportunity to understand the underlying dynamics of the client's interest. Ultimately, practitioners must be diligent in managing their images in both the face-to-face and Internet worlds. Issues of self-disclosure and transparency have moved outside the therapeutic encounter and onto the Internet, and online posts, blogs, threads in discussion forums, and mass e-mails will for the most part stay "alive" in the virtual world [54].

ONLINE SEARCHES FOR INFORMATION ON PATIENTS OR CLIENTS

Conducting online searches, commonly referred to as "Googling," is a common part of modern Internet use. Some practitioners engage in patient-targeted Googling, searching for a specific patient or client on the Internet [73]. In a 2014 study involving counseling graduate students, 75% reported using the Internet to search for information about a client, with 29.2% using Google and 19.5% using a social networking site. Of those who searched, more than 80% stated that they did not obtain informed consent from the client, did not document the search in the client's file, and did not consider this to be a confidentiality issue [73]. In a 2016 survey study, 39.4% of psychotherapists reported having looked online for additional information about their clients; 75% had not obtained client consent to do an online search [99].

There are cases in which patient-targeted Googling may have yielded fruitful clinical outcomes, such as locating family members of a patient with dementia after all other venues have been exhausted [73]. Searching online to obtain information about an individual's home has become a common Internet activity, but there may not be a place for such activity in the clinical encounter. It is vital for practitioners to draw a line between voyeurism and a clinical constructive goal [11; 73]. Although the Internet is considered public, for practitioners to make an active decision to search for additional information not given by the client may be a violation of his or her rights [74]. This continues to be an issue when considering what to do with information obtained online. If search results are documented in the client's record, it may impact their future care or insurance coverage [73]. In addition, it can undermine the therapeutic relationship and the client's trust in the practitioner and cause boundary issues [114]. Some experts assert that it may be inappropriate to search for online information about a client unless there is a clinical emergency [114].

The following questions may be useful when considering searching for client information on the Internet [94; 114]:

- Why do I want to conduct this search?
- How will the information obtained from the search affect engagement and treatment?
- Is an informed consent needed from the client before searching?

BEST PRACTICE GUIDELINES

In today's environment of technology and information proliferation, it is important to balance the amount of information available to clients and to carefully consider one's online persona as an extension of one's professional identity [55]. Practitioners must now actively manage their virtual identities and reputations. In order to do so, the following best practice guidelines have been established for practitioners when using Internet technologies for both personal and professional reasons.

The American College of Physicians and the Federation of State Medical Boards assert that standards for professional interactions should be consistent across all forms of communication, and care should be taken to preserve the relationship and maintain confidentiality, privacy and respect.

(https://www.acpjournals.org/doi/10.7326/0003-4819-158-8-201304160-00100. Last accessed April 25, 2021.)

Level of Evidence: Expert Opinion/Consensus Statement

USE PRIVACY FILTERS

When using social networking sites and/or blogs, practitioners should use a pseudonym, check their privacy filters, block certain personal information (e.g., birthdates, marital status, hometown), and research the restrictions in place for their online profiles in order to exercise control over who can access the information [79]. Most social networking sites and blog platforms have some kind of privacy filter available, but even when in use, clients may be able to view limited information (e.g., a profile picture). Practitioners should remember that privacy controls are subject to change at the discretion of the social media company [66]. Some experts recommend checking privacy settings every three to six months or with every software update [112].

POST CAUTIOUSLY

Practitioners should be cautious regarding posting client/patient information. The Internet has made the world smaller, and it is not difficult to trace the identity of the author of online postings. Furthermore, it is easy to inadvertently post information online that may violate a client's/patient's confidentiality and privacy [5]. Along these same lines, think twice about sharing personal information or photos online. The concept of digital footprints should be at the forefront of practitioners' minds. If any uploaded photos can be professionally compromising, they should not be posted. Consider the underlying message any information might convey [56; 112]. Certainly, photos that could endanger the privacy of clients or violate HIPAA rules should not be uploaded. Carefully weigh the costs and benefits of posting various information [46]. It is wise to assume that online forums are public, even if it says it is closed and private [100].

It is also important for practitioners not to use online platforms as mechanisms to vent about professional issues. Venting feelings of frustrations with clients, employers, supervisors, salaries, or an agency/organization are likely to be perceived negatively by colleagues and conveys a message of unprofessionalism [50; 115]. Reflect on how information posted on the Internet could undermine one's professional credibility as well as the legitimacy of the professional field [46].

THE "FRIEND" DILEMMA

As discussed, the issue of dual relationships is at the heart of deciding whether or not to accept patients/clients as "friends" on social networking sites [66]. The risks and the benefits should be weighed. If a patient or client invites a practitioner to be an online "friend," the practitioner can discuss dual relationships and the reasons why this is unprofessional and unethical; this request could become part of the clinical work [46; 47]. If the client becomes angry that the practitioner has "rejected" him or her or ignored the invitation, this could be discussed within the context of the client's previous experiences with loss, rejection, and self-esteem [97].

Consider crafting a professional statement about why accepting patients/clients as online friends is inappropriate. If this is an issue affecting your practice, spend time writing a standard statement to send to clients/patients regarding the professional policy not to accept clients as online friends [50]. This statement can be friendly but firm and should indicate the reasons it is not wise to establish this online relationship due to privacy and confidentiality issues. However, clients should be encouraged to discuss any issues with the practitioner during a scheduled session within the context of the therapeutic setting.

SEARCH WISELY

Practitioners should reflect on the underlying motivations for searching for client information on the Internet and how this information could be used positively. Therefore, searching for information about a client or patient is not necessarily unethical. Rather, consider how clients or the therapeutic relationship could ultimately be negatively affected by any information found and how the information can help the client [11; 46; 114]. In general, it is best to avoid searching for client information online.

However, practitioners should search for themselves on the Internet. Many professionals believe that everyone experiences some level of privacy through online obscurity, and in general, individuals take the path of least resistance in monitoring their online presence [57; 79]. This can be detrimental and may limit the practitioner's ability to control disclosures. Practitioners should conduct Internet searches regularly to monitor the information available about themselves and to have better control of the content [42]. Furthermore, if clients raise information they found on the Internet in a clinical session, this will prevent practitioners from being caught unaware.

SOCIAL MEDIA AND TECHNOLOGY IN INFORMED CONSENT

The content of informed consent forms should reflect the changing technologic times. The following points should be incorporated into informed consent forms [70; 72; 75; 79; 107]:

- How cell phones, e-mails, and social media will be used with the patient/client
- Whether the practitioner will search for information about the patient/client on the Internet
- How the practitioner will respond if contact is made by the patient/client on a social media site
- If the practitioner will take cell phone calls and, if so, parameters for use
- Whether there will be additional fees if the client makes contact with the practitioner via phone, e-mail, and/or social networking site
- Whether therapeutic issues will be discussed via e-mail
- If the practitioner does respond via e-mail, expected response turnaround time
- Risks and benefits of clients using social media within the therapeutic context

CONCLUSION

The landscape of professional practice has changed with the increasing use of Internet technology by both practitioners and clients/patients. The opportunities that the Internet affords are endless, and practitioners should reflect on how information posted online can have implications on their professional practice and their relationships with clients/patients. The codes of ethics and professional standards may not have necessarily kept up with the technologic changes, and therefore, there may not be clear guidelines on how to behave online.

Ultimately, more education is needed for professionals entering the fields to prepare to make the complex ethical decisions they will face using new technologies. Clinical supervisors should initiate conversations with their supervisees regarding how online personas and identities can affect professional identities, credibility, and roles. Finally, psychologists, social workers, counselors, therapists, physicians, and nurses must take an active role in shaping the development of professional standards for the provision of services in the new online environment, conforming to the ethical and professional best practices in their respective fields.

Implicit Bias in Health Care

The role of implicit biases on healthcare outcomes has become a concern, as there is some evidence that implicit biases contribute to health disparities, professionals' attitudes toward and interactions with patients, quality of care, diagnoses, and treatment decisions. This may produce differences in help-seeking, diagnoses, and ultimately treatments and interventions. Implicit biases may also unwittingly produce professional behaviors, attitudes, and interactions that reduce patients' trust and comfort with their provider, leading to earlier termination of visits and/or reduced adherence and follow-up. Disadvantaged groups are marginalized in the healthcare system and vulnerable on multiple levels; health professionals' implicit biases can further exacerbate these existing disadvantages.

Interventions or strategies designed to reduce implicit bias may be categorized as change-based or control-based. Change-based interventions focus on reducing or changing cognitive associations underlying implicit biases. These interventions might include challenging stereotypes. Conversely, control-based interventions involve reducing the effects of the implicit bias on the individual's behaviors. These strategies include increasing awareness of biased thoughts and responses. The two types of interventions are not mutually exclusive and may be used synergistically.

FACULTY BIOGRAPHY

Alice Yick Flanagan, PhD, MSW, received her Master's in Social Work from Columbia University, School of Social Work. She has clinical experience in mental health in correctional settings, psychiatric hospitals, and community health centers. In 1997, she received her PhD from UCLA, School of Public Policy and Social Research. Dr. Yick Flanagan completed a year-long post-doctoral fellowship at Hunter College, School of Social Work in 1999. In that year she taught the course Research Methods and Violence Against Women to Masters degree students, as well as conducting qualitative research studies on death and dying in Chinese American families.

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