Live tweeting by ambulance services: a growing concern

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Abstract

Despite advances in technology being a driver of paramedic professional development, particularly over the past decade, the introduction of new forms of technology appears to have presented paramedics with some professional challenges. Paramedics, pre-hospital clinicians, and ambulance service providers in both the United Kingdom and Australia, have begun using social media technology to communicate what they do to the general public. Unfortunately some of the material that has been communicated appears to breach professional standards of practice, and therefore has the potential to cause harm to the patient, the individual paramedic, and the paramedic profession more broadly. This article will present the rationale behind why this behaviour is unprofessional, ethically and legally unsound, and why it must cease. We offer a tool that will assist paramedics, and other healthcare professionals, to practise safe and professional social media use in their workplace.

Key words

Social Media • Tweeting • Twitter • Medicolegal • Ethics • Professional

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As registered health professionals, paramedics in the United Kingdom are required to conduct themselves in a manner that aligns with their professional code of conduct (Health and Care Professions Council, 2016). This code specifies ethical and legal standards, which must be upheld in paramedic practice. These codes sit alongside various other legal and policy instruments that regulate paramedic practice such as the Health and Social Work Professions Order 2001 (UK Parliament, 2001); HCPC Standards of Proficiency (Health and Care Professions Council, 2014), and local social media policies (London Ambulance Service, 2013).

Together these regulations provide guidance for practitioners about how to practise as a professional, and thus provide competent and safe care that maintains the protection of the patient, the individual paramedic, and the paramedic profession more broadly. However, recent examples have demonstrated that some paramedics appear to be unclear about how to professionally engage the use of social media in their practice and in so doing put patients, themselves, and the profession more broadly at risk.

Healthcare professionals are among many communities to have embraced the power of social media as a medium for rapid communication, learning, and establishing relationships both within peer groups and with the broader public. There is a well-established evidence to support the use of social media as a powerful peer-to-peer tool for education. For example, in Free Open Access Medical Education (FOAM) groups (Casey and Wells, 2015), as well as the use of social media platforms by public agencies to communicate and disseminate information to the public during a crisis (Palenchar and Freberg, 2013). It can also be used effectively to engage the wider community in both broad and specific public health promotion programmes (Gold et al, 2012). Indeed ‘live tweeting’ — the contemporaneous sharing on Twitter of an event within a short time of its occurrence — has been validated in its usefulness during emergencies, educational activities, and public events. Recent terrorist events and public disasters have demonstrated the value of live-tweeting as a tool for multi-directional crisis communication (Simon et al, 2014; Eriksson and Olsson, 2016).

Despite its demonstrated usefulness in these discrete areas, there are limits to the ways in which social media, including ‘live tweeting’ can be used by health practitioners. The most worrisome example is the misuse of this technology to inappropriately publicly publish individual patient information.

Analysis

A brief analysis of a convenience sample of existing tweets found numerous breaches of professionalism and potential risks to public confidence using the legal and ethical measures identified above. The following types of tweets were most common:

- Tweeting photos or videos from the scene of a patient encounter such as a motor vehicle collision, crime scene, and aeromedical landing zone, which contain geographically identifying data;
- Tweeting of images that include any form of documentation related to patient care that has not...
been totally de-identified (including time, date, location, agency) i.e. dispatch screens, patient care reports, medical forms, ECG traces;

- Including more than one identifying feature such as gender, age, location, region, approximate time of occurrence, date of occurrence, medical history, mechanism of injury, or easily identifiable case features (i.e. train stations, major intersections, helicopter landings and hospital transferred to) when tweeting about a patient encounter. This includes the individuals tweeting their NHS trust, region, or local hub/station, shift times, vehicle identification, or easily identifiable role or feature which may be contained in that post, in the user’s Twitter bio, or in previous tweets;

- Immediate tweeting of patient care whilst the patient interaction is still ongoing regardless of whether patient handover has occurred yet;

- Tweeting patient details for no apparent benefit to the patient.

**Discussion**

The handling of a patient’s ‘personal information’ (defined by the European Union GDPR (General Data Protection Regulation, 2016) to come into effect in 2018 as “any information relating to an identified or identifiable natural person”) is currently governed by a number of regulations both legal and ethical (Data Protection Act, 1998). Additionally, the UK is a human rights jurisdiction which recognises privacy as a human right (Human Rights Act, 1998) and a basic need “essential to the development and maintenance both of a free society and of a mature and stable individual personality” (Woogara, 2001). There are therefore strict legal provisions that protect the way in which patient information (data) is collected, stored and used by healthcare providers. Personal patient information is only able to be shared with others directly involved in the patient’s care. Patient information can be shared with others not directly involved in the patient’s care provided the patient (or their lawful surrogate) gives permission to do so. A patient has a right to object to the sharing of their personal information with anyone, including other health and/or social care professionals.

The information ‘tweeted’ by paramedics about the cases they are attending do not fall under the ‘direct care’ purpose of information sharing permitted under the Data Protection Act. There is however, provision for the sharing of information collected by healthcare practitioners and providers for ‘indirect care’ purposes.

‘Indirect care’ here refers to the use of information for secondary use purposes. That is, for a purpose not immediately concerning the care and treatment of a particular patient and includes, for example, de-identified patient information used for the purposes of educating other healthcare professionals (Data Protection Act, 1998). There are tight limits to this provision. The law does not make provision for the sharing of patient information for the purpose of promoting a health organisation.

In addition to the legal restriction on the dissemination of a patient’s identifying information, there is an ethical restriction placed on healthcare practitioners not to share even de-identified personal and sensitive information about patients to others without permission. This is an old and perpetual obligation of confidentiality that continues to be relevant because it recognises the importance of trust in establishing and maintaining the practitioner-patient relationship (Gillon, 1985). It is also used to maintain trust in the profession as a whole, and in so doing, to ensure that access to healthcare is not limited as a result of concerns by the public that their personal sensitive information will be shared with others.

**Importance of trust and confidence**

It has been acknowledged that trust and confidence in the competence and conduct of healthcare practitioners is essential to ensure that patient autonomy (the ability to choose who knows what information about them) rights and access to care are protected (Braunack-Mayer and Mulligan, 2003). This principle underpins the foundation of the healthcare practitioner regulatory scheme (UK Parliament, 2001), which recognises that trust and confidence by a patient in a practitioner is essential to the effective and efficient functioning of the healthcare system. In diminishing the trust and confidence that patients have in healthcare practitioners, there exists the risk that patients will have their access to healthcare limited. Indeed, in response to a tweet issued by a paramedic working for a UK ambulance service that revealed a patient’s age, geographical location, condition, outcome of treatment and the hospital the patient was transported to (Anonymous, 2017). Another Twitter user responded by saying words to the effect of, “I find this horrifying. I would be mortified to find that I had been tweeted about, anonymised or not… My misfortune should not be used as a PR exercise… that’s another reason to be afraid to call for help next time I need it…” (Anonymous, 2017).

This is, in part, why professional practice standards and codes of conduct make reference to not only promoting and protecting the interests of services users as an objective, but also requires that the behaviour of a practitioner ‘does not damage the public’s confidence in you or your profession’ (Health and Care Professions Council, 2016). It is critical that both paramedics and paramedic employers conduct themselves in such a way as to protect and preserve the public’s confidence in the profession and not to limit access to care.
Conflict of interest

Using Twitter to ‘live tweet’ patient care and medical cases was begun by charitable air ambulance services in the UK in an effort to increase their profile, thereby increasing fundraising successes and donations (Mercedes, 2015; Steele et al, 2016). This culture of live tweeting then transitioned to use by publicly funded NHS ambulance trust employees among other associated organisations. Many individuals use this platform to establish positive interagency relationships with staff of other emergency services and colleagues in other regions. Twitter is also used as a medium for public health promotion, education, and awareness around the appropriate use of emergency medical services (Health and Care Professions Council, 2016). As noted above, there may be limited cases where this indirect use of patient information is acceptable. However, the risk for development of a conflict of interest arises when organisations use patient healthcare data for their own gain.

Patients and members of the public have commented online (Anonymous, 2017) that the sharing of patient information by paramedics and pre-hospital care providers risks being seen as an exercise in self benefit rather than as an exercise in patient benefit. The underlying and primary principle of the regulation of health practitioners is that they will put the interests of the patient first. In sharing information about a patient to further the ends of the ambulance service or the individual paramedic, is exploiting and abusing the privileged position that those particular groups find themselves in. In weighing up the risks of harm to the patient and the patient-practitioner relationship versus the benefits of tweeting a patient’s personal information, the scales fall to the risk side of the equation. There are instances where practitioners have claimed that their position is justified because news outlets have already published location, accident or event information. This is a false equivalency. News outlets have a purpose to report the news. Paramedics have a purpose to protect and act in the best interests of their patient. Even where a practitioner receives consent by the patient to publish their personal details on Twitter and thus avoid a legal breach of duty in one sense, there is unlikely to be a legitimate justification of the behaviour that would be consistent with the intention of the law governing the conduct and performance of health professionals in an ethical sense – that is, amongst other things, to protect not only the public but public confidence in the profession (Health and Social Work Professions Order 2001).

Further, it could appear that the live tweeting of one’s personal involvement in specific patient cases may be viewed as self promotion or providing a sense of ‘spectacle’ for a public following by a professional disciplinary panel and such claims would likely be difficult to defend. The defence of providing public education may not be sufficient if it can be shown that the equivalent educational benefit could have been achieved in a less public forum with less risk to the patient and the profession.

The concern is that despite local policies and guidelines existing which do not support this behaviour (London Ambulance Service, 2013; West Midlands Ambulance Service NHS Foundation Trust, 2016), it persists. This may be as a result of non-healthcare professionals, that is, media staff employed by ambulance services, publishing this information. This is potentially a legal risk for those ambulance services. Registered paramedics, individually and separately from their employer, have an obligation to put the patient’s interest ahead of their employer’s and indeed, ahead of their own. It is the role of the professional paramedic to advocate for their patient, including advocating for the protection of their patient’s personal information, even when under pressure to do otherwise. As such they should refrain, as a matter of professionalism, from engaging in tweeting patient information even if de-identified, unless it is in the context of an educational session, or the patient or privacy commissioner has given permission to do so. Even then, as noted above, this should be considered in light of the potential risks publishing such information may do to the public’s confidence in the profession to keep patient information private. Encouragement by their employer’s service media and public relations departments to participate in this exercise could provide paramedics with a false sense that the action is ethical. However, autonomously regulated health professionals cannot rely on a ‘following orders’ excuse to defend a breach of professional duty.

It is acknowledged that technology and innovation in healthcare are an ever more complex and unstoppable force. Regardless of the changes in how healthcare is delivered, there are fundamental and universal ethico-legal principles related to the professional delivery of healthcare that are constant and immutable. They include the protection of patient privacy and confidentiality, and placing the patient’s interests above all others.

Promoting good practice in information governance

Responses to concerns raised about these incidents suggest that there is a lack of understanding of the legal and ethical issues associated with live tweeting and the reason why the rules exist. Further education via modes like this article may assist. We have also developed a decision matrix that is easy to use and may be helpful.

We therefore propose the use of a novel two-stage process, which includes a self-analysis of intention-to-
tweet, followed by a criteria-based scoring system - the Baron-Townsend Intention-To-Tweet (BITT) Decision Matrix. This allows for an assessment by practitioners of the nature and purpose of the information shared. We applied this novel scoring system to a convenience sample of tweets contemporary to the authorship of this review and found that it assisted in identifying tweets which, despite appearing to be of benevolent intention, breached the ethical and legal principles mentioned above. Often relatively benign information in isolation, shared through live-tweeting by paramedics was, in the context of contemporary events, other tweets, and biographies, too personal to not be considered a legitimate risk of harm to the patient, the paramedic, and the paramedic-patient relationship more broadly. This scoring system had high sensitivity and good specificity in identifying such tweets from our convenience sample.

Conclusion
The unethical and inappropriate use of social media by paramedics has negative implications for the patient, the individual paramedic, and the paramedic profession. Although community confidence in the paramedic profession may seem removed from the primary concerns of patient rights and safety, there is evidence that suggests that when community confidence in a profession weakens, access to healthcare declines. Limiting access to healthcare can produce a harm to the patient. The use of social media by paramedics and ambulance services should be limited, with consideration given to the purpose of the publication before it is released. Publication of patient exchanges should only contain content or materials that is de-identified or that the patient has given permission to share (remememering that patient data is the patient's data to share – not the paramedics), and where publication is in the patient's best interest, and will not diminish confidence in the profession. The argument that the publication of patient data is for the greater good (ie to tell the community the work that paramedics and ambulance services do) is not a justification for the use of private data alone. Paramedics, prehospital clinicians, and ambulance service departments must be alert to the legal, ethical, professional and social issues associated with the publication of patient information on social media so as to avoid causing damage to the nature of the therapeutic relationship between paramedics and patients and the profession as a whole.

Whilst this article focuses on the use of Twitter by paramedics, the findings and rationales presented are translatable across all domains of publicly accessible social media and applicable to all disciplines of health and social care professionals and employees.

Table 1. Baron-Townsend Intention-to-Tweet Decision Matrix

<table>
<thead>
<tr>
<th>Why am I tweeting this?</th>
<th>Stage 1</th>
</tr>
</thead>
<tbody>
<tr>
<td>Does this tweet:</td>
<td></td>
</tr>
<tr>
<td>1. Promote my own account or the service I work for?</td>
<td></td>
</tr>
<tr>
<td>2. Does this tweet tell people what specific types of incidents I have been involved with?</td>
<td></td>
</tr>
<tr>
<td>3. Aim to inform or educate the public about what I do using specific examples?</td>
<td></td>
</tr>
<tr>
<td>4. Aim to raise the profile of my charitable organisation?</td>
<td></td>
</tr>
</tbody>
</table>

This is exploitative: Do Not Tweet.

Am I tweeting about my work to:

- Benefit public safety (generic hazard warning)
- OR
- Educate peers (generic disease education)

Proceed to criteria below

<table>
<thead>
<tr>
<th>Red Criteria</th>
<th>Orange Criteria</th>
<th>Green Criteria</th>
</tr>
</thead>
<tbody>
<tr>
<td>Photo(s) from the scene</td>
<td>Photo of patients medical records, care reports, or dispatch screens</td>
<td>Photo of patients medical records, care reports, or dispatch screens</td>
</tr>
<tr>
<td>3 points Do Not Tweet</td>
<td>2 points Consider carefully And have someone else proof-read before tweeting</td>
<td>1 points Re-Read and Re-Check</td>
</tr>
</tbody>
</table>

- Location or Region (either in the tweet or in your bio)
- Tweeting on the same day /date the incident occurred
- Referring to the time/date when the incident occurred long afterwards

- The mechanism of injury or illness
- Gender
- The care the patient received
- De-Identified ECG for educational use with a specific learning outcome

3 or more points = Do Not tweet

References:
Anonymous (2017) Tweet by member of the public.
Key points

- Advances in technology have proven to be a driver of paramedic professional development.
- Some social media posts breach professional standards of practice, and can cause harm to the patient and the paramedic.
- This article presented the rationale behind why this behaviour is unprofessional, ethically and legally unsound, and why it must cease.
- We offer a tool that will assist paramedics to practise safe and professional social media use in their workplace.

Correspondence

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