Patient-Targeted Googling: The Ethics of Searching Online for Patient Information

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With the growth of the Internet, psychiatrists can now search online for a wide range of information about patients. Psychiatrists face challenges of maintaining professional boundaries with patients in many circumstances, but little consideration has been given to the practice of searching online for information about patients, an act we refer to as patient-targeted Googling (PTG). Psychiatrists are not the only health care providers who can investigate their patients online, but they may be especially likely to engage in PTG because of the unique relationships involved in their clinical practice. Before searching online for a patient, psychiatrists should consider such factors as the intention of searching, the anticipated effect of gaining information online, and its potential value or risk for the treatment. The psychiatrist is obligated to act in a way that respects the patient's best interests and that adheres to professional ethics. In this article, we propose a pragmatic model for considering PTG that focuses on practical results of searches and that aims to minimize the risk of exploiting patients. We describe three cases of PTG, highlighting important ethical dilemmas in multiple practice settings. Each case is discussed from the standpoint of the pragmatic model. (HARV REV PSYCHIATRY 2010;18:103–112.)

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The Internet has changed the way that medicine and psychiatry are practiced, as patients and physicians now routinely search online for medical and personal information. In the literature, physicians have considered the pros and cons of online searches for information regarding diagnosis, treatment, and research.[1–7] Recently, others have considered the complexities of patients' searching online for information, both professional or personal, about physicians.[8–10] Little consideration has been given, however, to the converse situation—namely, to physicians' searching online for information about patients. We believe that this practice—which we call *patient-targeted Googling* (PTG)—is widespread and deserving of professional and ethical consideration. Throughout this article, we will use the words "Googling" or "to Google" to refer to the practice of online searching, whether or not that practice involves the Google search engine. In popular usage, "Googling" has become synonymous with "Internet searching."

Through informal surveys of several dozen of our colleagues over the past year, we have learned that most psychiatrists have engaged in PTG. We have (ourselves) searched for patient information, and we have witnessed groups of other physicians Google patients—for example, during formal clinical rounds. We have witnessed and heard reports of PTG across diverse practice settings, including emergency rooms, inpatient units, and long-term outpatient psychotherapy relationships. In the course of such searches, physicians obtain a broad range of personal information about patients: photographs, videos, news stories, criminal records, and details of substance use, intimate relationships,

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sexual activity, and finances.[11–13] Content may also include clinically important material such as suicide plans.[14] Social-networking Web sites, such as MySpace and Facebook, have provided popular forums in which personal information can be both easily posted and searched online. Recent surveys report that approximately one-third of adult Internet users have profiles on social-networking sites, with higher rates among younger adults (for example, half of adults aged 25–34 and three-quarters of adults aged 18–24).[15]

Although we have noted PTG occurring among all types of physicians, the practice is especially complicated in a relationship between a patient and a psychiatrist (or other mental health clinician). In addition to taking into account medical information, such relationships focus on personal details and often deal with analysis of transference and countertransference as a key element of the treatment. PTG has the potential to either enhance or interfere with this process, depending on a particular patient's circumstances. For example, a patient who tends to attract exploitative relationships might enact this pattern by tempting the psychiatrist to engage in unnecessary PTG. By contrast, if a patient with rejection sensitivity and fear of abandonment asks a psychiatrist to explore a personal Internet site, a clinician's refusal might have a deleterious impact on the therapy relationship. Due to these unique characteristics, psychiatry has a long history of carefully framing treatment relationships and discussing boundary crossings and violations[16]—which highlights the special need to consider the impact of PTG in our discipline.

The lack of commentary on the practice of PTG may reflect the delayed emergence of the Internet as a source of detailed personal information, relative to its earlier evolution as a source of useful, but impersonal, information. Psychiatrists, particularly younger physicians and trainees, embrace the power of Internet searches in every aspect of their lives but may be naive to the impact of the Internet searches on their professional relationships. Consistent with the previously noted Internet usage trends, PTG is likely becoming commonplace as a new generation of physicians and trainees, who use Internet search technologies and social-networking sites on a frequent and routine basis, move into professional practice.[17–19] The omnipresence of the Internet in our daily lives may lead psychiatrists to engage in PTG without considering the unique ethical questions and concerns posed by its practice.

Psychiatrists search online for patient information for a variety of reasons. PTG includes ethically problematic situations as well as those that are required clinically. As an example of the latter, we have experience working with an elderly patient with dementia who had been admitted to an inpatient psychiatric unit after having lost contact with his family. We were able to locate his family members and develop an optimal treatment plan for him only through PTG, after all other traditional measures for contacting his family members had failed (e.g., searches of hospital records and telephone books). In this case, we conducted PTG with a focused goal and without any obvious adverse consequences. Similarly, the psychiatric literature has commented briefly on the use of the Internet as a source of important collateral information. One case example reports that a resident searched online for collateral information, aiding in the safety assessment of a suicidal patient in an emergency room.[20] Another article considers forensic evaluations of problematic Internet use and suggests that PTG can be a useful tool for forensic psychiatrists.[21] Based on these examples, the outcome of PTG appears to be beneficial, but these select cases do not demonstrate the diverse ethical challenges of PTG in psychiatric contexts.

Among the ethically problematic motivations are curiosity, voyeurism, and habit. Some searches by psychiatrists may start with a clear empathic goal, such as gaining an appreciation of a patient's online persona in order to enhance treatment, but may grow more troublesome due to unexpected findings. PTG may occur with or without a patient's consent and with or without the patient in the room. Unexpected findings, such as the discovery of photographs of a patient engaged in substance use or sexual activity, may lead to unforeseen ethical dilemmas, including questions about whether to share knowledge of the online material with the patient or to document the findings in the patient's medical record.

Although Internet postings are considered to be in the public domain, the viewing of any information that a patient has not specifically shared in a treatment setting requires careful ethical consideration by clinicians. For example, discovering details about a patient's home (e.g., address, value of the home, or real estate taxes) or viewing photographs of the home (e.g., through satellite images on Google Maps) has become nearly effortless. Due to the ease and ubiquity of such searches, psychiatrists may engage in these examples of PTG without thorough ethical consideration. Such searches could be analogous, however—prior to PTG—to driving by a patient's home or otherwise infringing on a patient's privacy in a way that most psychiatrists would view as a boundary violation. The accessibility, anonymity, and universality of the Internet have made it easier, and perhaps more tempting, for psychiatrists to engage in such ethically questionable activity.

The practice of PTG has received little consideration in the psychiatric literature, with a notable absence of discussion of the more ethically challenging types of cases we have described. No formal or professional guidelines have dealt with PTG—likely due, in part, to its recent emergence, but possibly also due to potential feelings of shame and guilt associated with admitting to the practice of PTG. As Internet searching continues to grow and becomes an almost

reflexive behavior, psychiatrists will benefit from an ethical framework for considering PTG in clinical practice and also, in turn, for training residents and students, the populations most likely to engage in the practice.

Before searching online for patients, psychiatrists should consider the intention of the search, its potential value or risk to the patient, and the anticipated effect of gaining previously unknown information. The psychiatrist is obligated to act in a way that will respect the patient's best interests and that adheres to professional ethics. However, the results and potential dangers of PTG are not always intuitive or consciously available prior to searches. Abstract moral principles such as beneficence provide insufficient guidance to clinicians in particular PTG scenarios. By avoiding PTG altogether (as some clinicians might choose to do), psychiatrists can avoid the associated risk of exploiting their patients, but this approach ignores the current reality of clinical practice and the further intertwining of the Internet and clinical practice that is likely in the future. It also violates other important principles of clinical ethics, such as flexibility in the service of a particular patient's best interests at a particular moment. For example, if a patient's asking a therapist to look at his online profile represents a significant therapeutic step toward the patient's understanding his view of himself and his interactions with friends, would the clinician want to avoid this search on the general principle that PTG may exploit some patients in other situations? Considerations of PTG need to be examined on a case-by-case basis, supporting the need for a consistent framework for evaluating the ethics of searching online for patients.

In this article, we propose a pragmatic model for considering PTG that focuses on practical results of searches and that aims to minimize the risk of exploiting patients. This framework of "clinical pragmatism" has been applied to other ethical issues in psychiatric practice, such as accepting gifts from patients,[22] and provides an approach to clinical ethics that specifies several core values that ought to be balanced in patient care.[23–25] In the case of PTG, a core value of clinical pragmatism is that the psychiatrist should focus ethical deliberations on the specific results of that decision for the patient in question, not only on general moral principles. The psychiatrist must consider how PTG would affect the treatment relationship and the progress toward treatment goals—a thought process that may involve discussions with the patient, the patient's family, and a clinician's community of supervisors, colleagues, and consultants. In the following sections, we present a pragmatic model for PTG and describe three cases of PTG, highlighting important ethical dilemmas in multiple practice settings. Each case is discussed from the standpoint of the pragmatic model and as an example of how this model can help guide psychiatrists in their decision making about PTG.

PRAGMATIC FRAMEWORK

Before searching online for patients, a psychiatrist should engage in a conscious and complex decision-making process on a case-by-case basis. We propose the following pragmatic model for considering PTG, focusing on the practical results of searches and aiming to minimize the risk of exploiting patients. Our model avoids ideological assumptions about PTG. On one hand, we believe PTG can be an acceptable and ethically sound clinical tool (and even clinically required in some cases, as described above). On the other hand, we do not advocate unbridled PTG simply because online information about patients is legally available in the public domain. Instead, our pragmatic framework focuses on the practical questions of whether PTG serves a particular patient's best interests and might promote the therapeutic process. The pragmatic model does not specify whether a psychiatrist should or should not engage in PTG in any particular situation, but it urges the clinician, at the very least, to address the following six questions whenever he or she considers searching online for a patient.

1. Why Do I Want to Conduct This Search?

If the answer to this question about conducting a search involves nothing other than curiosity, voyeurism, prurient interest, or exploitation, then the psychiatrist should not go forward with the search. In addition, the psychiatrist in these circumstances should consider obtaining consultation or supervision regarding his or her potentially problematic thoughts and feelings about the patient. If the answer is that the search may ultimately promote the patient's best interests, then the psychiatrist should move on to question 2. In all cases, the psychiatrist should be thoughtful about whether he or she is deceiving himself or herself into believing that the online search is primarily in the service of the patient's best interests rather than primarily in the service of personal curiosity or voyeurism.

2. Would My Search Advance or Compromise the Treatment?

The psychiatrist must try to predict what information obtained online about a patient might promote the patient's best interests and guide important treatment decisions. For example, learning about a patient's suicidal thoughts or plans on an Internet Web log (or blog) might lead to a critical, potentially life-saving clinical intervention.[26] Conversely, the psychiatrist ought to consider whether any information obtained online might compromise the treatment relationship. For example, if the psychiatrist discovered that the patient held political beliefs contrary to his or her own, might the psychiatrist withdraw from the patient and thereby

compromise the therapeutic alliance? The psychiatrist must also try to predict the validity of information obtained online. What if the psychiatrist reads about a patient on another individual's blog, a context in which false information can be easily posted? Alternatively, if the psychiatrist reads about someone with the patient's name on a reliable newspaper Web site, how can he or sure be sure that it is the patient and not simply someone else with the same name? Another important consideration is that patients may intentionally represent themselves online in ways that are playful or dissonant with their real-world behaviors.[27] Would obtaining the information online, rather than by interviewing, affect the treatment relationship in a unique way? If the psychiatrist believes that PTG might advance the treatment and not seriously harm it in any obvious or identifiable way, then he or she can move forward to question 3. Before doing so, however, the psychiatrist should assess whether another approach or strategy might achieve the desired benefits without creating the risks inherent in PTG. For example, talking with a patient's family members as a source of collateral information in a safety assessment might pose less risk than engaging in PTG.

3. Should I Obtain Informed Consent from the Patient Prior to Searching?

While there is no established norm for obtaining consent before engaging in PTG, the clinician should reflect on its possible role in preserving the patient's privacy and enhancing the patient/doctor relationship. The process of informed consent for PTG would include discussion of all possible risks, including breaches of patient privacy and the potential for harm to the psychotherapeutic relationship, along with an acknowledgment of possible unpredictable and unknown consequences. The consent process itself might also contribute to treatment progress by enabling a discussion of the factors (e.g., countertransference or patient behaviors) that led the psychiatrist to consider PTG.

If the clinician is certain that the patient would feel hurt or violated if he or she learned that the psychiatrist searched online without consent, then the psychiatrist should seriously consider seeking formal consent prior to searching. If the clinician is uncertain about the patient's feelings about PTG, then he or she should carefully consider the risk-benefit ratio of engaging in PTG without prior informed consent. If there is a high likelihood of clinical benefit from the search and a low likelihood that the patient will feel angry or wronged if he or she later found out about it, then the search may be justifiable even in the absence of prior consent (but, as discussed below in question 4, the psychiatrist will have to decide whether to share the results of the search with the patient post hoc). Finally, if a prospective search presents a low likelihood of clinical benefit and a high likelihood of offending or otherwise upsetting the patient, then the clinician ought to seriously consider forgoing the search.

4. Should I Share the Results of the Search with the Patient?

After the online search has occurred, the psychiatrist needs to think carefully about how to use the information obtained and whether to share or discuss that information with the patient. This task may be easier if the patient consented to the search before it was conducted, as the patient in that scenario would already know that such a search might occur. If the psychiatrist conducted the search without prior consent, he or she has to consider benefits and burdens of sharing the information post hoc. In this scenario, the complexities of the particular patient/doctor relationship will determine whether and how the psychiatrist should share information about the occurrence of the search and the data that it revealed. In circumstances where the psychiatrist feels that the patient should know about the search but worries that the patient may feel upset, violated, or otherwise harmed if told about it (or about the information that the psychiatrist obtained online), the clinician might need to consider consulting with a clinical peer, an ethicist, a risk-management specialist, or other expert, as the particular situation dictates. If the psychiatrist chooses not to reveal to the patient either the occurrence of the search or the information thereby obtained, the psychiatrist must carefully consider the effects of this hidden knowledge on countertransference and on the psychotherapeutic relationship—and again might benefit from a consultation.

5. Should I Document the Findings of the Search in the Medical Record?

There is no clear medicolegal guidance about how psychiatrists should document PTG findings in the medical record. In general, psychiatrists should aim to document all relevant clinical data in the record accurately, but in a way that is sensitive to the fact that the patient may read the record at some point. PTG presents several complexities with regard to documentation. If the psychiatrist performs an online search without the patient's consent and in the course of that search discovers compromising information about the patient, it may not be clear if this information should be entered in the record. For example, if the psychiatrist performs an unauthorized search and discovers online that the patient smokes cigarettes, abuses illegal substances, or engages in other risky behaviors, entering that information in the record could lead to insurance or employment discrimination against the patient in the future. In the case of electronic medical records, the information would also be readily available to other current and future treaters. Such

occurrences might seriously violate the patient's privacy and confidentiality rights. The clinician who obtains sensitive information via PTG may therefore need to consult with an attorney in order to make a sound decision about whether to enter the findings in the medical record.

6. How Do I Monitor My Motivations and the Ongoing Risk-Benefit Profile of Searching?

To ensure ethical and patient-centered treatment, psychiatrists should reflect continually on their own needs, desires, drives, and emotions. When they consider learning about their patients via PTG, they must strive to acknowledge honestly to themselves the full range of their motivations, which may include straightforward curiosity and voyeuristic interest. As a psychiatrist assesses the possible risks and benefits of PTG with regard to an individual patient, he or she should avoid self-deception about the complex motivations that may underlie the consideration of an online search. This self-assessment should occur on a regular basis for any given patient, as the psychiatrist's thoughts and feelings about the patient may evolve over time. The psychiatrist should seek help—whether through personal psychotherapy, clinical supervision, ethical or legal consultation, or otherwise—whenever he or she faces an especially challenging situation that involves PTG or consideration thereof.

CASE VIGNETTES

We now present three cases that demonstrate ethical dilemmas arising in the context of PTG, and reflect on each case from the standpoint of the pragmatic model. The cases describe a wide spectrum of clinical scenarios in which PTG may occur. The cases are disguised and contain a composite of patients with whom we have worked directly, of scenarios shared by colleagues, and of plausible examples generated for demonstration. The cases have been chosen to contain typical clinical scenarios spanning treatment settings in which psychiatrists commonly work and train. Following each case we consider the applicability of the pragmatic approach.

Case 1

Jennifer is a 16-year-old girl who was brought in to the Psychiatric Emergency Department by her mother for missing school and staying out past midnight on a daily basis. Jennifer has a history of self-harm in the form of superficially cutting her upper arms. She has been seeing an outpatient therapist for dialectical behavior therapy since her first cutting episode, two years earlier. She had not cut herself in nine months, has never been psychiatrically hospitalized, and has been a B− to C− student in high school. She would like to attend college to study psychology. She lives with her mother, stepfather, and sister, and usually has a close relationship with her immediate family.

Recently, Jennifer has missed seven days of school over the past month and has been receiving failing grades. Her mother reported she has been "out of control" since starting a new relationship with a 35-year-old man and has not been returning home at night or following her mother's directions. Her mother brought Jennifer into the Emergency Department after they had an argument, and the mother felt she could not control her daughter's behavior.

In the Emergency Department, Jennifer described being in a consensual relationship with her new boyfriend and felt her mother was "blowing it out of proportion." She said, "I am just having some fun. Anyway, he loves me. My mom doesn't understand." She wanted to return home and promised to start listening to her mother, and to return to school. The psychiatry resident in the Emergency Department called Jennifer's outpatient therapist in order to gain collateral information as part of a safety assessment. Her therapist felt Jennifer was safe to return home, though incidentally brought up that Jennifer reported her boyfriend had been taking provocative pictures of her and posting them on his Web site. The therapist had not seen the alleged pictures and indicated Jennifer told her about them as a "secret" from Jennifer's mother.

To complete a more comprehensive safety assessment prior to discharging Jennifer home with her mother, the psychiatry resident decided it would be important to know more about the online pictures. He considered that the photos might be exploiting the underage patient in a way that would be illegal or that the Web page might identify the patient's school or contact information in a way that put the patient at risk. In the Emergency Department he searched for the alleged pictures on the Internet but was unable to find the boyfriend's Web site. The psychiatrist next contacted the on-call social worker, who evaluated Jennifer and filed a case with Child Protective Services on the basis of the allegations concerning the photos. The social worker noted that even if the pictures had been found on the Internet, the Emergency Department team would not have been able to verify the identities, ages, or existence of other photographs to a sufficient degree to eliminate concerns for the patient's safety. Regardless of what the psychiatrist had found on the Internet, a case would have been filed with Child Protective Services.

Discussion. In this case, a psychiatry resident engaged in PTG in the context of a safety assessment in the psychiatric emergency department. The psychiatry resident unsuccessfully attempted to search for alleged photographs of the patient and ended up filing a case with Child Protective

Services. The resident's primary motivation in the case was to protect the child patient. The intervention of filing a case with Child Protective Services, however, could have been accomplished without an Internet search. Other methods of protecting the child patient, such as inpatient hospitalization, could have been considered, rather than attempting to rely on an assessment of online information.

Would other motives have influenced the psychiatrist to venture down the path of PTG rather than exploring other possibilities? One motive, conscious or unconscious, could have been the resident's personal desire to view provocative pictures of his patient—a possibility that raises a number of concerns about patient exploitation and boundary violations.

Although the psychiatry resident's PTG in this case yielded no results, he did not fully consider the potential range or consequences of the information—which could and should have been thought about before undertaking the online search. For example, how would he identify the individuals in any alleged photographs? In a case with forensic implications, how would he document any Internet findings (or the absence of findings)? How would viewing possibly lewd photographs of his patient alter his care for her and their relationship? Would the psychiatrist tell the patient about the search? And if she perceived the search as violating a"secret" shared with her therapist, would that prevent her from reengaging in psychiatric or psychological care in the future? If the psychiatrist had attempted to obtain informed consent in advance of the search, might that have led to an empathic connection and allowed the patient to reveal more about her current life circumstances? Without consent, would she feel harassed by the psychiatrist of the opposite sex and file a complaint against him?

In this case, the primary motivation to protect a child patient would initially seem to justify the practice of PTG, but it is clear that the psychiatrist did not consider all of his possible motivations and did not consider all of the implications of his actions before the search. In the end, PTG had no benefit or impact on the treatment plan, and other avenues were available to protect this patient, possibly without exposing her or the resident to the risks of PTG. In the fast-paced Emergency Department, the resident relied on a now standard practice in his life—that is, searching for needed information online, in the face of a clinical question. Going straight to PTG without first consulting with a supervisor or other senior psychiatrist, and without considering other alternatives, may have placed this patient and psychiatrist at unnecessary risk.

Case 2

Thomas is a 22-year-old college student who was referred for an outpatient consultation for treatment of generalized anxiety disorder and panic attacks. He was referred by his primary care physician, who had been treating him with a selective serotonin reuptake inhibitor but felt the patient would benefit from psychotherapy as well, given his voiced difficulties in his relationships with his parents and girlfriend.

Thomas entered weekly psychodynamic therapy with a psychiatrist and, after two months, began to speak openly and insightfully about his feelings of anger toward his parents over their lack of emotional support. He began to feel less anxious and never missed a weekly appointment. Thomas communicated the positive results to his therapist: "This is really working. I really look forward to our sessions each week." After three months, however, Thomas noted that he would have difficulty affording the full fee for his therapy sessions, as a result of his impending tuition payments for the upcoming semester. The psychiatrist worked out a sliding-scale reduced fee with Thomas based on his means and continued weekly therapy. Over the next several months, Thomas began deferring payments and accrued a large bill. His psychiatrist discussed this topic in multiple sessions, but Thomas quickly brushed off the issue: "I am sorry. School has just been so busy. I have the money. I'll put a check in the mail this week. This is very important to me, and I want to keep seeing you."

In reviewing Thomas's bill, his psychiatrist noted that Thomas's street address was in a wealthy neighborhood. The psychiatrist searched for this street address with Google Maps, which enabled him to see photographs of the house and to verify the address as a large mansion. Additional Internet searches provided the psychiatrist with the last appraised and sale values of the house, both being several million dollars. The psychiatrist had feelings of anger that Thomas may have been misrepresenting his financial means to obtain a reduced fee. On Thomas's next visit, the psychiatrist confronted him about his unpaid bills: "It's surprising that you live in such an affluent neighborhood and yet you find yourself unable to pay even the reduced fee we agreed to. Your house looks quite large online." Thomas explained that he was renting a room in the basement of the mansion for a small fee, in addition to performing chores around the house, such as landscaping work. He felt offended by the psychiatrist's Internet search and did not come back for future therapy sessions. He did send a check in the mail the following week to cover all of his outstanding balance.

Discussion. In this case, a psychiatrist was able to learn about his patient's living environment (e.g., photographs and costs) in a matter of minutes, a process that, prior to the Internet, would have taken hours to days of library research or have even required driving through a patient's neighborhood. Although most psychiatrists would not make the effort to drive to a patient's house and would likely find

such behavior to be in violation of the patient's privacy, the ease of an online search may be more tempting.

The psychiatrist's goal for PTG in this case was to determine the veracity of Thomas's need for a reduced fee. At a deeper level, the psychiatrists' motivations likely ranged from selfish greed and a desire for justice to a voyeuristic curiosity to see the patient's home and a clinical desire to see how this information might provide an example of how the patient perceives himself in the world. In advance of the search, the psychiatrist did not fully consider alternatives to the search, the question of whether to secure consent, or the impact that the information obtained would have on the treatment relationship. The information proved to be accurate (house location, photographs, cost) but was misconstrued (e.g., in thinking Thomas or his family had the financial resources to own such as a house). The psychiatrist felt compelled to confront the patient with concrete information, in the hope of obtaining a higher fee. The unintended consequence was to end what had been a beneficial therapy relationship. The PTG also led the psychiatrist away from a more traditional therapy, which may have considered Thomas's late payments in the context of a transferential relationship and as a form of resistance to therapy. Maybe Thomas wanted his psychiatrist to end their relationship and thus played a role in enacting the PTG? If so, PTG served one of the psychiatrist's motives (viz., wanting to get paid appropriately), but in a way that was likely counter-therapeutic for the patient.

The psychiatrist was ultimately left with the task of documenting the PTG in a termination note in Thomas's medical record. If the psychiatrist had fully considered his or her motives prior to engaging in PTG, he or she might have delayed the Internet search in favor of addressing the perceived resistance directly in therapy or, at the very least, asking Thomas to consent to the PTG in advance of the search (a conversation that likely would have provided the psychiatrist with the desired information and may have avoided PTG and its associated risks altogether). Alternatively, after engaging in PTG, the psychiatrist could have avoided sharing the search or obtained data with Thomas (e.g., confronting him as in the vignette above) and continued more traditional psychotherapeutic techniques of addressing the missed payments and Thomas's financial situation in therapy. In that circumstance, the psychiatrist would need to carefully monitor countertransferential feelings and would likely benefit from consultation.

Case 3

Angela is a 25-year-old business school student, who presented to the clinic with a request for a psychotherapist. During her intake with Dr. P, a second-year female psychiatry resident, Angela reported a history of mildly depressed mood beginning during her college years. Angela stated, "A year ago, I found out my last real boyfriend was cheating on me using the Internet. Since then, I always do my research, but I don't trust men now." Dr. P eagerly began weekly psychotherapy with Angela, enjoying their similar age and experience. Across the next six months, Dr. P found it fascinating to explore Angela's romantic relationships, which sparked nostalgic memories in Dr. P.

Dr. P was supervised weekly by Dr. H, a senior faculty member. Dr. H recommended increasing the frequency of visits to further explore transferential issues with the patient. Dr. P welcomed the prospect of a more intimate connection. However, Dr. P then began talking less in therapy, taking more notes, and limiting her comments to what she felt Dr. H would approve. Dr. P began to feel more distant from Angela. After two months of closely supervised, biweekly therapy sessions, Dr. P was unable to meet with Dr. H for four weeks due to his travel plans.

While Dr. H was away, Angela revealed to Dr. P that she had begun to meet men through her MySpace page, but had been embarrassed to mention it for several months. She said to Dr. P, "It never works out. Maybe you should write my profile." Dr. P. replied cautiously, "I wonder what you think I would write." Between sessions, Dr. P. found herself curious about Angela's online persona, wondering if it might attract incompatible romantic partners. Dr. P searched online for the patient's Myspace page and found the description "Single: Nice body and brains to go with it . . . looking for a man who loves the finer things in life." Dr. P read the replies of men at the bottom of the Web page and found herself curious enough to view their personal pages. Dr. P did not disclose her Internet search to Angela, but during the next therapy session, Dr. P felt a new zest in the psychotherapy and felt her own comments to be more incisive.

In the following weeks Dr. P continued to check the Myspace page for updates between sessions. She also viewed satellite pictures of the patient's apartment on Google Maps, and she searched for information about the patient's college and high school. Each session brought new detail that could be explored online. Dr. P continued to feel a renewed connection and empathy with Angela. After several weeks away, Dr. H returned from vacation. As Dr. P considered supervision with Dr. H, she felt ashamed of her intense curiosity about Angela. Should she have told Dr. H about her Internet searching? Did he know much about the Internet? Might he suggest disclosing the search to Angela?

Discussion. In this case, a psychiatrist in training entered into an intensive psychotherapy with a patient and is supervised closely on the case. Dr. P began the therapy eagerly with a sense of camaraderie but, feeling frustrated by a lack

of progress, began a more intensive treatment schedule to explore transferential issues within the case. To her surprise, a change in therapy style contributed to a feeling of distance from the patient—which, in turn, fueled curiosity when she was given an opportunity to learn more on the Internet. In this case, PTG occurred during an extended absence from her supervisor and after the patient mentioned her previously undisclosed online dating activity that was relevant to the material discussed in therapy.

This therapist was motivated to perform an Internet search by a wish to gain insight into the case and perhaps also a by desire to feel closer to this patient with whom she identified. Despite her retrospective shame about PTG, the therapist's experience was that it advanced the treatment by intensifying the therapy. In this case, however, PTG cannot be justified in terms of clinical necessity. The therapist did not pause to consider the necessity, risks, or alternatives to the search. For example, in advance of viewing the Myspace page, the therapist might have discussed it with the patient, thereby providing an opportunity to obtain informed consent and to comment on transference. Another option was to determine whether the patient would agree to view the profile together during a therapy session.

Disclosing the results of the Internet search to the patient post hoc may harm the therapy relationship due to feelings of privacy violation. Furthermore, documenting this Internet search in the medical record could have several consequences for both the patient and the therapist. Documentation of PTG can have unanticipated results. For example, in a large hospital or clinic setting, patients are sometimes able to obtain their medical records without the therapist's consent or knowledge, in which case the discovery of a documented, but undisclosed, Internet search may anger the patient. As in the case example, the perceived risks related to disclosure of PTG to a patient can reduce the willingness of mental health practitioners to discuss or document PTG.

The awkwardness of PTG entered this therapist's mind only when she realized she might end up divulging the incident in supervision. In that respect, the case highlights that the supervision available to trainees may prove an invaluable means of gaining understanding of PTG. In particular, the supervisor can be helpful in deciding how to use the Internet information, whether to tell the patient, how it facilitates or obscures the trainee's understanding of the case, and how the data might be used therapeutically. Supervision is also vital in this case because the therapist developed a pattern of repeatedly searching online, in part to strengthen a sense of connection with the patient. It would be important to clarify the role of PTG in this treatment and in the trainee's development. Why was the experience of secretively experiencing the patient online so resonant for this therapist? While PTG may have helped the trainee to understand the patient and to overcome her sense of stagnation in the therapy, the trainee should have sought supervision before engaging in PTG to ensure that doing so was in service of the patient.

The trainee's ambivalence in telling her supervisor also points to a reality: supervisors differ with regard to their experience with the Internet, their views of current social expectations of personal privacy on the Internet, and their ideas about the possible counter-therapeutic impact of surreptitious attempts to gain information about patients. This trainee felt ashamed about sharing the Internet search in supervision—despite her belief that no harm was done. In part, the shame results from not knowing what to expect from her supervisor concerning an issue that had not been discussed in training. Also, the trainee may have been reluctant to discuss the Internet search in supervision because she did not want to relinquish the emotional rewards of this new habit. In our own experience, supervisors range from those who have unabashedly recommended searching for patients on the Internet, at one extreme, to those who condemn the practice in any therapy relationship, at the other. This polarity of supervisory views highlights the lack of professional dialogue or guidelines about this phenomenon.

DISCUSSION

In the three cases presented, we have proposed and applied a pragmatic model for considering the practice of searching online for patient information. This practice, which we call patient-targeted Googling, is now occurring on a regular basis and continues to grow as younger physicians enter the profession. Nevertheless, despite the obvious need for teaching and, more broadly, for further discussion and analysis, there continues to be no formal teaching about it.

Our pragmatic approach to PTG is an effort to provide guidance to clinicians and trainees and to develop a model for professional ethics in this area. The goals of the pragmatic model are to respect the patient's best interests and to minimize the risk of exploiting patients. Within this model, important factors include the intention of the Internet search, the potential impact of the search on the treatment, and the clinician's motivations for the search, along with questions about informed consent, disclosure, and documentation.

Our pragmatic model avoids reliance on specific abstract moral principles and does not specify whether a psychiatrist should or should not engage in PTG in any particular situation. Instead, it draws two major conclusions: (1) the questions raised by PTG need to be handled on a case-by-case basis by paying careful attention to the patient's best interests and the practical results of Internet searches, and (2) clinicians must consider the issues surrounding PTG

before engaging in the practice with respect to any particular patient. We hope that the pragmatic model will empower psychiatrists to think in a structured way about issues such as the balances between patient privacy and clinical necessity, and between exploitation/voyeurism and beneficence, *before* engaging in PTG. Our vignettes repeatedly point the psychiatrist to deliberate and to consult (e.g., with a supervisor, colleague, or ethicist) *before* engaging in PTG.

Many psychiatrists, psychiatry residents, and clinicians from other fields of medicine are actively involved in PTG. Younger clinicians, particularly residents graduating from college since the founding of social-networking Web sites in the early 2000s, are accustomed both to looking up information on the Internet and to interacting with others on social-networking sites. The need to develop formal training in this area is readily apparent, and we hope that our pragmatic model will help to move that process along.

We envision future work in this area to include formal surveys of psychiatrists (both trainees and senior clinicians) to investigate their use of the Internet in clinical practice. The goal would be to gain an empiric understanding of this phenomenon, the motivations behind its practice, and its perceived impact on patients. Aside from studies of boundary violations (not involving PTG), we have few data to indicate how patients might react to the suspicion or discovery that a provider has engaged in PTG. Further research could include prospective trials with patients—for example, in which participants engaged in specific Internet-based communications with clinicians, as through social-networking sites, in order to examine the effects of PTG on psychotherapeutic relationships.

On a wider scale, the practice of PTG requires us to think carefully about patient privacy. Patients have long sought help from psychiatrists (and other physicians), with the hope and expectation of compassion, competence, and confidentiality. With the continuing growth of the Internet as a public domain for information, the concepts of privacy and confidentiality evolve. Patients may currently experience a *perceived* privacy because they assume that their psychiatrists would not search online for them (e.g., much as they would assume that their psychiatrists would not eavesdrop on their conversations in restaurants) and also because they tend to think of online information as impermanent.[28] This sense of perceived privacy may also be reinforced by patients' perception that their online information is functionally invisible because it is buried in a vast sea of online material. Any privacy of that kind has been compromised, however, by the ever growing precision of Internet search engines such as Google and by the easy searchability of social-networking sites such as MySpace and Facebook. And even the publication of articles such as this one—on the clinical use of the Internet—will ultimately alter patients' perceptions of online privacy in relation to psychiatry. On the other side of the equation, clinicians may be assuming that their Internet searches are anonymous, but there have been notable occasions on which search records have been unexpectedly released in the past.[29] An awareness of PTG and its potential consequences may thus prompt both clinicians and patients to use the Internet more carefully and, more generally, may lead to a more careful and cautious assessment of the role of the Internet in psychotherapeutic relationships, especially regarding the use of online searches as a means of gathering information about patients.

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