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Is There a Role for Social Technologies in Collaborative Healthcare?

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The exponential growth, variety, and sophistication of the information communication technologies (ICTs) plus their growing accessibility are transforming how clinical practitioners, patients, and their families can work together. Social technologies are the ICTs tools that augment the ability of people to communicate and collaborate despite obstacles of geography and time. There is still little empirical research on the impact of social technologies in the case of collaborative health. Defining a set of social technologies with potential for developing, sustaining, and strengthening the collaborative health agenda should prove useful for practitioners and researchers. This paper is based on an extensive review of the literature focusing on emerging technologies and the experience of the author as a consultant to health care professionals learning about social technologies. A note of caution is required: the phenomenon is complex and hard to describe in writing (a medium very different from the technologies themselves). Hardware and software are in continuous development and the iterative adaptation of the emergent social technologies for new forms of virtual communication.

Keywords: information communication technologies, social networking, health care collaboration, ICTs

> . . . while networks are an old form of organization in the human experience, digital networking technologies . . . allowed their endless expansion and reconfiguration, overcoming the traditional limitations of networking forms of organization to manage complexity beyond a certain size of the network . . . space in society is not the same as space in astrophysics or in quantum mechanics . . . this new form of spatiality is . . . the space of flows: the material support of simultaneous social practices communicated at a distance *(Castells, 2010)*.

Digital technologies are ubiquitous. Teenagers (and at an increasing rate, all age group) are interacting virtually. Cell phones, laptops, e-readers, and many other forms of digital hardware are widely available and continuously evolving. Social technologies powered by the development of information and digital technologies continue to grow. *Facebook* and microblogging tools like *Twitter* are good examples of what have become mainstream social technology tools: tools that not only help spread information but also shape it. Our personal and professional lives are being redesigned as a result of our engagement through information communication technologies

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(ICTs). Numerous surveys have provided an in-depth qualitative and consistent statistical view of how the availability of ICTs is affecting the daily lives of millions of individuals, families, communities, and organizations. A review of any *Pew Internet and American Life Project* (www.pewinternet.org) survey should convince the reader that what can be experienced personally is reflected in the population at large. This growth is particularly striking in the case of technologies that support the virtualization of social relations, which earlier existed within a limited time and physical context.

What does this "social media revolution" (Qualman, 2009) have to do with collaborative health care (Rolland, 1994) and integrated primary care goals (Blount, 1998)? Will these social technologies have an impact on the quality of care, on confronting health disparities, and on the doctor-patient relationship? Notwithstanding the accelerated adoption of these technologies in the last decade, the collaborative health world seems to be developing without paying enough attention to the phenomenon. For the purpose of this paper, I define collaboration as health care practices in which mental and physical care are integrated, the patient's family is an intrinsic piece in the health intervention, and in which the professionals and institutions work together with the patient. This article outlines what these social technologies are and their potential impact on strengthening this collaborative health agenda.

KEY SOCIAL TECHNOLOGY TERMS

Social network technologies emphasize collaboration and community creation and often known as social networking. I have chosen social technologies to emphasize the social networking activity made possible by ICTs. Popular examples of social network sites are *Facebook, MySpace, Twitter, LinkedIn*, *Ning, YouTube*, or *Blip.fm*, defined as:

> Web-based services that allow individuals to (i) construct a public or semi-public profile within a bounded system, (ii) articulate a list of other users with whom they share a connection, and (iii) view and traverse their list of connections and those made by others within the system (boyd & Ellison, 2007, p. 211).

The social technologies (social networking and social media tools) are easily accessible for anyone with access to an Internet connection via a computer, phone, and other digital devices including games consoles, digital cameras with geographical location capabilities, medical equipment, and so forth They are interoperable, live in the "cloud"[1] and, for the most part, are not attached to a particular device or software. As a result, users do not need to have one specific device to interact with others. These tools allow anyone to go beyond observing what others have produced—as in traditional TV. We not only consume information but we also create it, we become "prosumers" and "produsers"(Bruns, 2008).

1. *Blogs* are web-based pages that usually represent and individual's thoughts in chronological order—an electronic repository of the author's thoughts. Blog entries invite readers to comment and participate becoming a powerful outlet for asynchronous conversations not limited by geographical distance. As a result of this collaborative dialogue, the author's ideas could be clarified and better articulated in later versions.
2. *Microblogging* is a form of blogging, but entries are briefer. *Twitter*, the most popular, allows written entries that cannot contain more than 140

[1] Cloud computing involves Internet-based shared resources—software and information are provided on-demand, like electricity. The information therefore does not reside in the computer with which the information is accessed.

characters. Microblogging tools also serve to promote blog traffic; the amount of people that click on the blog entries is often directly related to the amount of activity generated in the *Twitter* environment.

3. A *Wiki* is a web-based collaborative space that invites users to add, edit, and share information in a intuitive and simple to use platform. The primary goal for many Wikis is to encourage many authors to participate and incorporate links. Like the other tools, no special software is required and the community of users provides quality control that keeps the content "on topic" (Choy & Ng, 2007). This is the principle that guides the most widely known collaborative project in the Internet, the *Wikipedia* (a Wiki + Encyclopedia) with research suggesting that its accuracy is as close as peer review articles (Rajagopalan et al., 2010). The following basic features are common in Wikis (Ebersbach, Glaser, & Heigl, 2006):

Editing: Most Wikis use similar basic page editing functions such as text editing and image, table, list, hyperlink and file insertion.

Links: Articles can be linked.

History: Tracking function of editing process saves all previous versions or modifications of any single page.

Recent changes: Feature provides current overview of number of recent changes to Wiki pages or all changes within a time period.

Search Functions. Most wikis also offer a classic full text or title search.

4. *Podcast* is an asynchronous method of distributing multimedia files, such as audio or video programs for playback on mobile devices and personal computers. Usually a podcast features one type of "show," with new episodes released either sporadically or at planned intervals.
5. *E-Portfolio* is a digitized assembly of artifacts including demonstrations, resources, and accomplishments that represent an individual, group, or organization. This collection can be comprised of text-based, graphic, or other multimedia digital archives. An e-portfolio is more than a simple collection; it can also serve as an administrative tool to manage and organize work created with different applications and review the work by others encouraging personal reflection, exchange of ideas, and feedback (Sharpe, Beetham, & Freitas, 2010; Zubizarreta, 2009).
6. *Digital Stories*. Multimedia-authoring projects combining texts, images, and audio files into a short film clip (mostly 3 to 5 min). Digital storytelling have proven to be a powerful medium for individuals and communities to represent a theoretically informed understanding of texts and contexts (Courtney, 2007; Lundby, 2009).
7. *Asynchronous* tools are methods in which content is presented in an "anywhere anytime format." Asynchronous exchanges do not require the same time presence of participants. Presently, technologies have begun to incorporate collaborative forms of work (i.e., voice discussion tools) breaking the synchronous/asynchronous distinction, that is, *Twitter*.
8. *Synchronous* tools use chats and web-conferencing with interaction among individuals occurring at a specific time emulating interactions occurring in the same space.
9. *MUVE: Multi-User Virtual Environment* applications incorporate computer graphics and sound simulation to simulate the experience of real-time interaction between mul-

tiple users in a shared three-dimensional virtual world. Each user runs an interactive interface program on a "client" computer connected to a wide-area network. The interface program simulates the experience of immersion in a virtual environment by rendering images/sounds/ and so forth of the environment as perceived from the user's simulated viewpoint. Each user is represented in the shared virtual environment by an entity (avatar) rendered on every other user's computer (Bell & Trueman, 2008). Applications for MUVE technology include distributed training, simulation, education environments including medical modules and virtual meetings. The most well know MUVE is *Second Life*.

ICTs AND HEALTH CARE: A SECOND-ORDER CHANGE

Participation in virtual environments and backchannel communication (McNely, 2009) continues to accelerate and although it may seem like a temporary trend, recent events demonstrate its deep impact on how individuals, families, and communities connect to each other (Barak, 2008; Baron, 2008; Christakis & Fowler, 2009; Palfrey & Gasser, 2008). In the case of the uprising in Iran in 2009, for example, the images, video, and reports on mainstream media were mostly enabled by ICTs—common citizens carrying "smartphones," recording what was occurring in the streets, and broadcasting to anyone with access to the Internet. Similarly, during the Chilean earthquake in 2010, *Twitter* and other social technologies proved invaluable for family members and friends to come into contact and provide support and information. Organizations, clinicians, and volunteers in postdisaster recovery have also found innovative ways of seeking resources and information or simply maintaining their connection to their real-based and virtual network (Dimitruk, 2007; Tanner, Friedman, Koskan, & Barr, 2009) through social media.

The use of social technologies for health-related activities is generalized among the adult population (Atkinson, Saperstein, & Pleis, 2009; Hesse et al., 2005; Lupianez-Villanueva, 2010), with increasing reliance on the Internet as a source of information (Overberg et al., 2010), and for peer-to-peer support (Setoyama, Nakayama, & Yamazaki, 2009; Takahashi et al., 2009). For example, health related inquiries in Google account for 3.6% to 5.4% of the searches (Eysenbach & Kohler, 2004). Increasingly, patient demands for quality of care include virtual interactions (Institute of Medicine, 2001). Collaborative health care activities could be strengthen as this social networking activity opens up new ways of engaging in conversation, share information, analyze it collaboratively, and interact more efficiently (McNab, 2009). It may enhance the often-elusive collaborative process with patients and families who are more informed, have more questions, or can verify what professionals tell them. Homer and Baron (2010) have recognized that expanding and deepening the role of ICTs has a role in transforming primary care and developing the personal medical home. Despite acknowledging that health information technology "creates a 'necessary but not but not sufficient' platform on which transformation takes place; the human interaction with technology must be the focus of further research" (p. 628).

A transformation of how we communicate with each other, manage decisions, take action, and in turn of how we think about connections and personal networks may be analogous to a second order change. Patients and their families can access information about their own health much more readily and be more informed as they engage with clinical personnel. These new tools, which are not only technological but also suggest new culturally different interactions, can strengthen participation, col-

laboration, openness, and reduce the barriers to the inclusion of relevant stakeholders (Bacigalupe, 2010). "Medicine 2.0" or "Health 2.0" (Van De Belt, Engelen, Berben, & Schoonhoven, 2010), emphasize "apomediation" and social networking. Apomediation, the "explicit modeling of connections between people" (Eysenbach, 2008), implies patients having much more access to relevant data (i.e., clinical records) with professionals and peers helping them to navigate through this information.

Social technologies defy the financial, geographical, and logistical barriers that exist in creating a context for ongoing interaction, collaborative learning, fast access to information, and transparency. For self-help and support groups, the advantages are substantial; their development can be sustained through virtual social networks (Bedgood, Sadurski, & Schade, 2007; Eysenbach, Powell, Englesakis, Rizo, & Stern, 2004; Griffiths, Crisp, Christensen, Mackinnon, & Bennett, 2010; Kummervold et al., 2002; Patsos, 2001; Uden-Kraan, Drossaert, Taal, Seydel, & Laar, 2010). Moreover, these networks of support can bring together people with rare diseases who otherwise would not be able to find people coping with the same condition in their vicinity. For the latter, the virtual networks could impact their ability to find a new tailored treatment modality (Bedgood et al., 2007; Patsos, 2001). ICTs, therefore, have the potential to address perennial health care quality and access inequities.

ICTs also have implications in how researchers collaborate in collecting epidemiologic data (Stensgaard et al., 2009) and translational research initiatives (Reis et al., 2010). In the clinical-research arena, the recruitment of patients for a clinical trial would be much easier and more effective with these tools than regular advertisement in a local newspaper or a government sponsored website (Atkinson et al., 2008; Simon, Schramm, & Hillis, 2010). And this is just scratching the surface, because the same technologies may make it possible for patients to lead and organize their own clinical trials in collaboration with researchers and clinicians (Bloomrosen & Detmer, 2010). Ease of accessibility is a tremendous advantage of these technologies. Its applicability to resource scarce environments should not to be taken for granted (Gerber, Olazabal, Brown, & Pablos-Mendez, 2010). In sum, we are witnesses to and participants in the way social technologies are already shaping health care (Hawn, 2009; Hesse, 2010; Orsini, 2010).

COLLABORATION AND CONVERSATIONS

Why do professionals use social technologies tools like *Twitter*? A microblogging tool (Boyd, Golder, & Lotan, 2010; Hawn, 2009) provides a synchronous and asynchronous virtual meeting platform for individuals who share similar interests with little financial investment. In the case of a group of professionals, for example, the savings would include travel, lodging time, registration, dues, and so forth. *Twitter* is the equivalent of a changing virtual bulletin board in which each user chooses what stream to follow reaching individuals in the same room or anywhere in the world (Lane & Twaddell, 2010; Terry, 2009). Besides the ability of capturing wider audiences, at minimum cost, and faster, tools like *Twitter* may foster innovative ways for personal and professional interactions. Professionals, researchers, or managers, besides interacting with individuals they may know "in person", have also the opportunity to encounter others with whom they may have shared interests.

Regular discussions among a consistent but expanding set of individuals are common in the social media environment. For many, these virtual discussions can be as rich learning opportunities as the exchanges that occur in traditional professional or scholarly conference. The "Health Care and Social Media" (HCSM) discus-

sion, for instance, has been an ongoing 1-hr event occurring every Sunday for more than a year. To find each other and locate the conversation, participants use hash tags followed by an acronym or word in every entry. The hash tag identifying HCSM is #hcsm.[2] The discussion participants are an interdisciplinary set of individuals: researchers and academics, social scientists, clinicians, marketing and health care business specialists, and patients or e-patients (Fergurson, 2008; Finn, 2009) located across North America and beyond. The discussion focuses on a specific and emergent subject in the area of health care and social media with questions submitted by participants in previous days. The power to set up these virtual meeting spaces, the tools to implement them, and their control are not necessarily linked to the prestige of the convener (the #hcsm convener was an undergraduate senior). The weekly conversations are the basis for an interdisciplinary self-regulated community sustained around a theme, question, and shaped in a recursive process with new additional members joining every week. It is the kind of reflexive engagement that overspecialized professional and academic guilds make difficult or expensive to create. For those attempting to construct a collaborative health care movement or introduce relational ideas and value a reflective interdisciplinary practice with patients and their families and the community at large, it seems logic to adopt them as part of our set of available tools.

Similar hash tags are employed to orient individuals to a conference, an organization, and/or an ongoing event. In an embryonic stage, the Collaborative Family Health Association members have employed the hash tag #CFHA to promote collaborative ideas expressed in the official CFHA blog, to announce events, to highlight related organizations, to promote the annual conference and to include those outside the conference in the conversation.[3]

ADOPTING SOCIAL TECHNOLOGIES AS A CULTURAL CHALLENGE

Many clinicians and academicians still struggle with the learning and adoption challenges posed by ICTs. Access to sophisticated ICTs tools may not necessarily ensure the full use of their capabilities, in the same way that we use only a few of the features when writing with a word processor. Smartphones, for example, are extremely powerful tools that besides their traditional phone capabilities expand the way to connect virtually and collaborate with others (Aanensen, Huntley, Feil, al-Own, & Spratt, 2009; Aziz & Ziccardi, 2009; Gamble, 2009, 2010; Sethi, 2009; Terry, 2010). *Twitter* is counterintuitive at the start and requires an extra investment of time. *LinkedIn* may apparently seem too oriented toward business and marketing. *Facebook* still confuses or scares new adopters because issues of privacy are daunting and difficult to navigate. The technological hurdles are real. Learning to use the ICTs effectively and overcoming the barriers takes time and is frustrating. Clinicians are already under continuous demand for their time and strained by multitasking and other technologies.

There is, however, a dimension that may be more difficult to overcome. It resembles the struggles at becoming a culturally affirming agent in the doctor-patient relationship or in a psychotherapeutic relationship. It is a form of cultural resistance. A doctor asked to try a new way of communicating with patients using ICTs to track treatment adherence may ask, "What is in there and why should I be investing my precious time? Isn't E-mail enough?" These questions are legitimate. Yet, they may also reveal difficulties at construing virtual experiences as being as valid as those we take for granted as real—the ones

[2] http://wthashtag.com/hcsm.

[3] A good guide for learning the basics of microblogging can be found at http://mashable.com/guidebook/twitter.

that occur in the same geographical and time space. They can be experienced as not like the real thing one feels when one is with someone in person.

The adoption of ICTs is not necessarily a matter of age or gender—unless access is the issue. Despite the predominant view that emphasizes generational differences in levels of digital literacy, digital natives (Palfrey & Gasser, 2008; Tapscott, 2009)—the generation born at the time of ICTs explosion—are not always much better prepared to use these technologies than digital immigrants, those born when analogical tools of communication were dominant. Surveys suggest that the age difference are not as relevant and that the female/male ratio is almost the same with more women using social networking tools than men (Lenhart, Purcell, Smith, & Zickuhr, 2010).

There are many introductory social media and social networking guides—one of them is mentioned earlier—that address the technology learning needs of beginner and proficient users. To address what seems a cultural resistance toward adopting these technologies is a different challenge though. Even if one overcomes some of the skepticism and fear (at times), there are still many barriers for those not born in a digital environment. This shift requires learning digital skills, integrating or relearning former ways of working, and foremost, a cultural transformation. It changes the landscape of what may be possible and how it can be done.

The idea of resistance does not seem to be a good way of framing the problem though. A collaborative method is needed to approach the challenge of learning, integrating, and participating from the transformation of our way of working. When confronted with the frustration and uneasiness posed by these transformations, curiosity as a form of inquiry, with which family therapists, systemic or relational clinicians are expert, seems the best route. The goal is to try to understand and engage in a conversation about change and the difficulty in imagining what this all means. A few years ago, for instance, what was real and virtual had clear boundaries—some clear consensus existed about what constituted real relationships. Virtual projects like *PatientsLikeMe* (Frost & Massagli, 2009) or new developments in monitoring health via mobile phones (Gamble, 2009, 2010; Sethi, 2009; Terry, 2010) would be unimaginable a few years ago.

We may be experiencing a breaking down of what we took for granted as the real and the virtual (Jordan, 2009). Relational exchanges occurring through social technologies are often compared to communicational contexts in which individuals are simultaneously in the same space and time. ICTs do have the ability to approximate these contexts, although unsatisfactorily, if the same criteria applied to "real" situations are employed. They may add new experiences as emotionally and socially significant as those granted the status of "true" social relationships. One of the consequences is uneasiness among clinicians about what constitutes an authentic or real relationship as more individuals and communities claim the virtual as a valid social space. Indeed, for those who have fully adopted ICTs, geographical distance may be slowly becoming less relevant as a measure of closeness or distance in how they construe personal relationships (Brinkerhoff, 2009; Oiarzabal, Corcostegui, & Acheritogaray, 2009).

Some clinicians or researchers dismiss microblogging because they assume that what it is communicated through social media tools like *Twitter* is irrelevant or not adding to a body of knowledge. Like any other relationship, it is a matter of who individuals choose to engage in conversation, who they follow or what conversations they could engage in, and who they may let enter into their life or aspects of their life. The evolving nature of the technologies may be confusing but, as in the world of face-to face relating, boundary making is also part of the social

interactions occurring in the virtual world. It is occurring though at a different pace and speed and requires learning how to communicate with a different medium. Privacy, for example, concerns users and it has been reflected in the uproar about some companies' lack of care of in the handling of data shared in social networking sites. For experienced professionals and clinicians, these new developments require an acknowledgment that digital literacy is not a "natural" process that also calls for collaboration.

The consideration of two families confronted with rare diseases, through true stories portrayed in films, highlights ICTs possible impact. One is the story of the Odone family portrayed in the film *Lorenzo's Oil* (George Miller, 1992). The other family is the Crowleys, rendered in the recent film *Extraordinary Measures* (Tom Vaughan, 2010). In *Lorenzo's Oil* we learn about the lack of collaboration and dismissal among doctors, support groups, and scientists as the parents attempt to find a cure for Lorenzo, a child diagnosed with ALS. The isolation in which the family finds itself leads them to find one scientist willing to work with them but at a tremendous emotional, familial, and financial cost-something few families could afford.

The Odones in this decade could have joined many of the health social networks available: fostering an informed interaction when asking questions to clinicians, and allowing for quick-second consultation and cross-referencing like *MedHelp* or *PatientsLikeMe* (Frost & Massagli, 2009). If they wanted to advocate for policy changes or funding, they could have joined a health care activist social network like *WeGoHealth* (Swan, 2009), organized through a standard *Facebook* group (Farmer, Bruckner Holt, Cook, & Hearing, 2009) or an ad hoc tailored *Ning* social network (Holmes & Dubinsky, 2009), joined many of the rich health care communities in *Twitter*, set up a blog, and/or uploaded video and photo updates via *Flickr* and/or *YouTube*.

The Crowley's two youngest children were diagnosed with Pompe disease and were able to use the Internet technology to carry on research and learn about alternative treatments, including a drug development research team, and to organize with other families in the same situation. The use of technology has allowed the Crowley's to directly communicate with the public via a webpage. Their story has not been an isolated one. Their efforts were supported by the existence of ICTs. The two stories highlight the rich potential of social technologies and in particular social media in eliciting resources and fostering resilience. Social technologies could have fostered a richer collaborative process that would advance these children's health and family wellbeing as well as clinical research benefitting others, mobilized policymakers, and much more. Empowered patients, therefore, are not just patients able to talk assertively to their doctors but those who are positioned at the center of a network of collaborators. This is not easy, but social media may have made it more doable in the case of the Odones and clearly facilitated what the Crowley's accomplished.

These technologies are not only useful in the case of patient self-organized initiatives but in routine clinical situations. Doctors who use microblogging have found useful ways of incorporating this tool to enhance their doctor-patient relationship. Via *Twitter* and in some cases *Facebook*, a doctor can communicate delays reducing the waiting room time for patients or about preventive care. An untapped use of these tools is to help patients deal with the health insurance bureaucracy, reminding patients of paperwork that needs to be completed, copays, required IDs, and so forth. These messages would not disclose any information about patients but rather general practice procedures and policies or publicly available information in the case of general preventive care data.

In sum, informed patients with larger social networks as a result are more empowered. They have rapid access to medical information or data that they previously did not get through to and the ability to connect more efficiently with patients who suffer from similar diseases. For doctors, the ability to communicate more efficiently, directly, and rapidly with patients and their families should strengthen collaboration, adherence to treatment, and satisfaction. Health care quality should therefore be enhanced through the intelligent adoption of these technologies.

SOCIAL TECHNOLOGIES AND PROFESSIONAL ORGANIZATIONS: MEMORY AND PRESENT

Social technologies offer professional organizations solutions to many of the challenges posed by membership distributed across a nation or internationally, strained budgets, and governance leadership changes. A board member from a health care professional organization, Julia[4], asked how her organization could make use of social networking tools:

> *How could these technologies help us in doing our work? Our members are located all over the world and some of us meet annually during a three days conference at some hotel.*

If the question were about how to involve the technological tools alone, the answer might not be as complex. Organizational strategic issues quickly emerge in what it is apparently a purely technical question. Soon after starting a discussion of what tools are available, what appears are questions about the organization's identity, its strategic plan, and a careful assessment of the challenges in implementing a social media strategy that rather than resolving problems, could generate some more serious ones.

Her organization does not have a physical address. The organization documents are stored at various offices of former and present board members and not accessible to newly elected board members. An initial goal would be setting up a virtual office to archive the professional association documents—to build up the institutional memory and make it available to the governing body members and later to all members. As an alternative, members could archive the documents at a paid secure server or upload them to a free service like *GoogleDocs*. The same set up would allow various members of the board or committees to work on shared documents rather than getting confused with E-mail attachments being forwarded back and forth in between revisions. Having the documents in a server could allow the organization to share them with everyone or a selected group. An alternative would be setting up a *Wiki*. With a *Wiki*, board members could upload and download documents and at the same time display them and have threaded discussions.

A second goal would be to strengthen the development of transparent communication between and among the board and the general membership. For that purpose, the organization webpage could add a simple blog (i.e., *Blogger* or *WordPress*). The blog could be open to everyone arriving to the website or it could be password protected. If the board was worried that the entries could be inappropriate for a professional organization, it would be simple to arrange for various board members to approve the publication of the comments.

The discussion of microblogging led us to the question of creating a hash tag and "own it" via the website *What's the Hashtag?!* (http://wthashtag.com). For this health care organization, #hcr may identify a discussion on health care reform during the Congressional debates. By creating a hash tag, anyone can enter into a discussion that is relevant to the organization

[4] The name is a pseudonym, and the person has permitted the author to share the story.

without necessarily having members following each other.

During our conversations, we discussed *Facebook*. Julia asked whether Facebook would help us network. It is complex to provide solid advice on the subject besides looking at studying it carefully. At least two important issues emerge when considering *Facebook* in relation to a professional association. A lot of professionals are concerned about what they perceive as unresolved confidentiality and privacy issues. If they have an account, they may think that joining a group will mean that everyone in the organization will know about their private lives. It is not strictly the case but it is hard to counter this belief and the concern persists (Zheleva & Getoor, 2009), in part because of fear and in part because *Facebook* creators have made dubious decisions in this regard at various points of its development. Some doctors, however, have made *Facebook* pages into practice hubs, that is, sharing photos of recently born babies and reminding parents of vaccination schedules.

Second, for many, *Facebook* in itself may still be a "mystery." Despite the tremendous growth, many join and then they do not have a good sense of how to manage it or even login back again after a first or second try. If one is able to overcome these hurdles, *Facebook* groups are for the most part not very interactive. The action in *Facebook* occurs within the enclosed world of the individual or a small group. Presently—and the technology can always evolve—the drawback is that members of groups are not able to know if new information is being shared unless they purposely visit the group. Therefore, groups are more or less active as the membership grows initially but then they usually become a static shared webpage rather than a compelling and evolving discussion among peers.

An alternative social networking tool created for professional and business purposes that may better fit Julia's organization is *LinkedIn*. It offers an organization the ability to create groups and the interface is less distracting. For an association whose members are all academics and/or researchers, a good start would be the creation of profiles in one of the social networking sites created exclusively for those groups like the scientific network *ResearchGate* or the university oriented *Academia.edu.* If the organization were to decide to be more adventurous, Julia could set up a close organizational network using *Ning* as a way of consolidating the features we discussed. However, *Ning* requires a larger commitment and time learning it would be longer than the others. This lack of simplicity may not be as compelling to her core membership.

Before choosing a tool, an organization, association, or group, should select a representative group of members willing to experiment with them and find the appropriate fit between tools and tasks. The questions suggested below should be recursively asked as a subset of the organization explores the intentional use of ICTs. A small group within the organization can then reflect on questions that relate to further implementation:

- Are We Thinking About ICTs to Address Specific Organizational Needs and challenges?
- What Are Our Professional Association Social Networking needs?
- How Will the Adoption of Social Technologies Impact Our Mission, Strategic Plan, and Membership commitment?
- Once we have decided to adopt a set of tools, what core activities we could move into a virtual platform? What can we begin implementing during the time we meet in one place?

Once the organization decides on what social technologies to adopt, a social media policy is needed for each tool the organization adopts. Privacy, membership, control of information, accountability, accuracy

and transparency (Kane, Fichman, Gallaugher, & Glaser, 2009) are to be incorporated in these policies. The openness or level of control of information via one tool may require a different policy than another tool. For example, a *Facebook* page or a *LinkedIn* group may encourage membership participation and the addition of new materials but will require specific policies about who can be a member. In the case of *Twitter*, the organization may decide to have different accounts depending on who will be the accepted as a follower or if it will be an open or closed account. A good social media policy should not just be a list of what cannot be done but offer proactively suggestions about how to use the medium.

CONCLUSION

The goal of this paper has been to provide a basic primer on how social technologies could shape positively our professional practices and what some of the challenges may be. It is not anymore a matter of deciding if a clinician will adopt or not these technologies in practice. A more compelling question is how we as clinicians will engage in these conversations and appreciate their potential to further our work. Collaborative health care principles and the goal of enhancing quality in health care are congruent with what ICTs offer. The appropriate use of these technologies may empower all participants through rapid and efficient access to information plus the ability to expand the relationship beyond the consultation room. The evidence that links social technologies and media effectiveness and efficacy in the case of collaborative health is scant. There are few definitive assertions we can make about how social media will impact positively our work or about what limitations exist. Social technologies to enable our capacity to inform and foster transparency, openness, and communication should lead us to understand that collaboration in health care should and can be strengthened.

Patients increasingly will expect that clinical practitioners make use of the ICTs to address some routine challenges like waiting time or waiting lists and in more complex situations like chronic illness or rare diseases for which social technologies seem particularly practical. At the professional level, in developing interdisciplinary knowledge, addressing the research-clinical schism, and reducing the costs of meeting in the same space are all challenges for which the technologies reviewed here present a tremendous potential. The answer to the question in the title is definitely affirmative but how this role is constituted is still in its early development and what is being accomplished presently will need systematic evaluation and research. In a follow up report, the author will offer a systematic analysis and the resulting taxonomy of social technologies use as it relates to the audience, the author, the directionality of the message, and other variables that would help us to categorize them not based on the software tools but in relation to how individuals participate and create the information.

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Call for Fifty-Five Word Stories

Families, Systems, and Health announces the continuation of its creative writing feature to accompany the existing poetry column. Fifty-five word stories are brief pieces of creative writing which use elements of poetry, prose, or both to encapsulate key experiences in health care. We are seeking submissions of 55-word stories to consider for publication in the fall 2011 issue of *Families, Systems, and Health.* We will consider pieces of exactly 55 words (excluding title) in poetry or prose style which give insight into key moments of the healing arts.

Submissions for the column will be due by May 15, 2011. Please indicate "Fifty-five word story" in the submission.

Colleen T. Fogarty, MD, MSc; FSH Fifty-Five Word Story Editor
Carol Edelstein, MSW; FSH Poetry Editor