Your Attention Please:
Personal Electronic Devices in the Operating Room

February 2020
I have no conflicts of interest to disclose.

Tom Klumpner, MD
Clinical Assistant Professor
Anesthesiology and Obstetrics and Gynecology
Assistant Director, Informatics and Systems Improvement
How many of you have used the Internet intraoperatively to access medical reference material?

How many of you carry a smartphone or personal electronic device while you are in the operating room?

How many of you have read non-patient care related material on the Internet while delivering an anesthetic?

Sent a text message on your personal phone while delivering an anesthetic?
A Trip to the Fountain

A Trip to the Fountain
A Trip to the Fountain
A Trip to the Fountain
“I could see the pennies and nickels at the bottom of the fountain and then I was in it.”
All in the Palm of Your Hand

- Medical books online
- Medical websites
- Medical apps
- Electronic health record
- Imaging: ultrasound, airway
- Diagnostics: blood glucose
- Wearables: movement, vitals

All in the Palm of Your Hand… **All the time**

- Blurring of the boundaries of **personal** and **professional** use of your personal electronic device
As Doctors Use More Devices, Potential for Distraction Grows

By MATT RICHTEL  DEC. 14, 2011
2010 Survey on cell phone use while performing cardiopulmonary bypass

T Smith, E Darling, B Searles

Cell Phone Use on CPB

The majority (55.6%) of respondents reported that they have used a cell phone on CPB. When broken down to cell phone features, 54.1% have used a cell phone for phone calls, 49.2% have used one for text purposes, 21% have used it for checking/sending e-mails, 15.1% have used it for surfing the internet, and 2.9% have checked/posted on a social networking site while on CPB.
As Doctors Use More Devices, Potential for Distraction Grows

By MATT RICHTEL  DEC. 14, 2011

“I’ve seen texting among people I’m supervising in the O.R.,” said Dr. Stephen Luczycki, an anesthesiologist and medical director in one of the surgical intensive care units at Yale-New Haven Hospital. He said he had also seen young anesthesiologists using the operating room computer during surgery.

“He was making personal calls,” Mr. Eldredge said, at least 10 of them to family and business associates, according to phone records. His client’s case was settled before a lawsuit was filed so there are no court records, like the name of the patient, doctor or hospital involved. Mr. Eldredge, citing the agreement, declined to provide further details.
Driven to Distraction

With virtually every American owning a cellphone, distracted driving has become a threat on the nation’s roads. Studies say that drivers using phones are four times as likely to cause a crash as other drivers. Yet Americans have largely ignored that research. Device makers and auto companies acknowledge the risks, but they aggressively develop and market gadgets that cause distractions. Police in almost half of all states make no attempt to gather data on the problem. The federal government warns against talking on a cellphone while driving, but no state legislature has banned it.

Through articles, videos and interactive features, The Times has examined the risks of talking and texting behind the wheel. The series also explores the extent of the problem, its origins, and the pressures people feel to stay connected while driving. And the series shows the political, regulatory and scientific dimensions of an issue that has prompted conversations and action across the country, from the Oval Office and statehouses to corporate boardrooms and kitchen tables.

In order to view this feature, you must download the latest version of flash player [here](http://www.newyorktimes.com).

**OVERVIEW**

**Drivers and Legislators Dismiss Cellphone Risks**

By MATT RICHTEL

Research shows the dangers of distracted driving. But drivers increasingly talk and text, and state legislators have done almost nothing about it.

1. Poll: Americans on Distracted Driving

**BY THE NUMBERS**

11 percent of drivers talking on their phones at any given time, according to federal study

Promoting the Car Phone, Despite Risks

July 19, 2008

Drivers and Legislatures Dismiss Risks

December 7, 2009

570,000 accidents leading to minor and serious injuries caused each year by cell phone distractions, according to Harvard study

Promoting the Car Phone, Despite Risks

December 7, 2009

50 percent of Americans believe that texting behind the wheel should be punished at least as harshly as drunken driving

New York Times/CBS News Poll

October 23, 2009

**Bits**

Reframing the Debate Over Using Phones Behind the Wheel

December 19, 2011
Cell phones are involved in an estimated 27 percent of all car crashes, says National Safety Council**

Texting crashes estimated to have increased; those involving talking on phones may have dropped.
Figure 5
Drivers Visibly Manipulating Handheld Devices, by Age, 2006–2015


NHTSA's National Center for Statistics and Analysis

1200 New Jersey Avenue SE, Washington, DC 20590
Cell Phone/Texting While Driving:

- >0.5 seconds off-road glance
- 50% more swerving
- 140% increase in missed lane changes
- 6x increase in crashes during simulated driving
- 70% increase in risk of a culpable crash
- Worsens driving performance compared to BAL 0.08

A Comparison of the Cell Phone Driver and the Drunk Driver

David L. Strayer, Frank A. Drews, and Dennis J. Crouch, University of Utah, Salt Lake City, Utah

Address correspondence to David L. Strayer, Department of Psychology, 380 South, 1530 East, RM 502, University of Utah, Salt Lake City, UT 84112-0251; david.strayer@utah.edu. HUMAN FACTORS, Vol. 48, No. 2, Summer 2006, pp. 381–391. Copyright © 2006. Human Factors and Ergonomics Society. All rights reserved.

- 40 adults, age 22 to 34
- Average 8 years driving experience
- 87% used a cell phone while driving
- “social drinkers”
A Comparison of the Cell Phone Driver and the Drunk Driver

David L. Strayer, Frank A. Drews, and Dennis J. Crouch, University of Utah, Salt Lake City, Utah

• Within subjects design:
  – Baseline
  – While talking on cell phone
  – With blood alcohol level of 0.08

*Figure 1. A participant talking on a cell phone while driving in the GE-ISIM driving simulator.*
**TABLE 2: T Test Values for the Pair-Wise Comparisons**

<table>
<thead>
<tr>
<th>Measure</th>
<th>Alcohol</th>
<th>Baseline</th>
</tr>
</thead>
<tbody>
<tr>
<td>Brake reaction time (ms)</td>
<td>Alcohol</td>
<td>1.74*</td>
</tr>
<tr>
<td></td>
<td>Cell phone</td>
<td>5.46***</td>
</tr>
<tr>
<td>Maximum braking force</td>
<td>Alcohol</td>
<td>4.40***</td>
</tr>
<tr>
<td></td>
<td>Cell phone</td>
<td>0.67</td>
</tr>
<tr>
<td>Speed (mph)</td>
<td>Alcohol</td>
<td>0.47</td>
</tr>
<tr>
<td></td>
<td>Cell phone</td>
<td>1.69*</td>
</tr>
<tr>
<td>Mean following distance (m)</td>
<td>Alcohol</td>
<td>0.87</td>
</tr>
<tr>
<td></td>
<td>Cell phone</td>
<td>1.11</td>
</tr>
<tr>
<td>SD following distance (m)</td>
<td>Alcohol</td>
<td>1.25</td>
</tr>
<tr>
<td></td>
<td>Cell phone</td>
<td>4.18***</td>
</tr>
<tr>
<td>Time to collision (s)</td>
<td>Alcohol</td>
<td>0.16</td>
</tr>
<tr>
<td></td>
<td>Cell phone</td>
<td>1.76*</td>
</tr>
<tr>
<td>Time to collision &lt; 4 s</td>
<td>Alcohol</td>
<td>2.06**</td>
</tr>
<tr>
<td></td>
<td>Cell phone</td>
<td>1.10</td>
</tr>
<tr>
<td>Half recovery time (s)</td>
<td>Alcohol</td>
<td>0.32</td>
</tr>
<tr>
<td></td>
<td>Cell phone</td>
<td>3.68***</td>
</tr>
</tbody>
</table>

*Note. All comparisons have a df of 39 and are evaluated with a two-tailed significance level.

*p < .10. **p < .05. ***p < .01.
### TABLE 1: Means and Standard Errors (in Parentheses) for the Alcohol, Baseline, and Cell Phone Conditions

<table>
<thead>
<tr>
<th></th>
<th>Alcohol</th>
<th>Baseline</th>
<th>Cell Phone</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total accidents</td>
<td>0</td>
<td>0</td>
<td>3</td>
</tr>
<tr>
<td>Brake reaction time (ms)</td>
<td>779 (33)</td>
<td>777 (33)</td>
<td>849 (36)</td>
</tr>
<tr>
<td>Maximum braking force</td>
<td>69.8 (3.7)</td>
<td>56.7 (2.6)</td>
<td>55.5 (3.0)</td>
</tr>
<tr>
<td>Speed (mph)</td>
<td>52.8 (2.0)</td>
<td>55.5 (0.7)</td>
<td>53.8 (1.3)</td>
</tr>
<tr>
<td>Mean following distance (m)</td>
<td>26.0 (1.7)</td>
<td>27.4 (1.3)</td>
<td>28.4 (1.7)</td>
</tr>
<tr>
<td>SD following distance (m)</td>
<td>10.3 (0.6)</td>
<td>9.5 (0.5)</td>
<td>11.8 (0.8)</td>
</tr>
<tr>
<td>Time to collision (s)</td>
<td>8.0 (0.4)</td>
<td>8.5 (0.3)</td>
<td>8.1 (0.4)</td>
</tr>
<tr>
<td>Time to collision &lt; 4 s</td>
<td>3.0 (0.7)</td>
<td>1.5 (0.3)</td>
<td>1.9 (0.5)</td>
</tr>
<tr>
<td>Half recovery time (s)</td>
<td>5.4 (0.3)</td>
<td>5.3 (0.3)</td>
<td>6.3 (0.4)</td>
</tr>
</tbody>
</table>
The Need for Command and Control Instant Message Adaptive Interfaces: Lessons Learned from Tactical Tomahawk Human-in-the-Loop Simulations

M.L. CUMMINGS, Ph.D.
FIG. 1. The Tactical Tomahawk interface for monitoring and retargeting (TTIMR).
FIG. 2. The Tactical Tomahawk interface for monitoring and retargeting (TTIMR) chat box.

Unexpected results

During the conduct of the experiment and subsequent data analysis, an unexpected behavioral trend was noted in regards to the use of the instant message interface as the primary means of communication and as an embedded measurement tool. Many subjects fixated on the instant messaging and ignored primary tasking of retargeting missiles in urgent situations. This occurred despite the fact that all subjects were repeatedly instructed that retargeting situations were their primary priority tasking and that answering queries through the chat box was the least important of all tasks. Despite this heavy training emphasis on only attending to the chat box when nothing else was happening, many subjects fixated on the communications and would answer all queries before attending to the more pressing retargeting problems. Because operators must time-share attention between the monitoring task and the execution of any required actions, the addition of instant messages could be costly from an operational perspective both in terms of potential human error and overall attainment of goals.
What Drives Us to Communicate?

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iHeartRadio

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What Drives Us to Communicate?
Disclosing information about the self is intrinsically rewarding

Diana I. Tamir and Jason P. Mitchell

Fig. 1. Neural response during self-disclosure. In addition to robust activity in the MPFC, a whole-brain random-effects contrast comparing self > other trials reveals activity in bilateral NAcc (P < 0.05, corrected) in both (A) study 1a (peak MNI coordinates: −10, 6, −12) and (B) study 1b (peak MNI coordinates: −6, 6, −8; indicated by arrows). (C) A region of interest in bilateral NAcc was independently defined using the Monetary Incentive Delay task (MNI coordinates: 10, 6, −4; −8, 4, −6). (D) Analysis of parameter estimates in this independently defined region confirmed that bilateral NAcc showed significantly greater response during self than during other trials in both studies 1a and 1b. Error bars depict SE calculated for within-subject designs.
What Drives Us to Communicate?

Modified CAGE (m-CAGE) Questionnaire

<table>
<thead>
<tr>
<th>Question</th>
<th>Points</th>
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<tbody>
<tr>
<td>C  Have you ever felt you needed to Cut down on the use of your electronic device?</td>
<td>1</td>
</tr>
<tr>
<td>A  Has anyone ever Annoyed you by criticising the use of your electronic device?</td>
<td>1</td>
</tr>
<tr>
<td>G  Do you ever feel Guilty about your electronic device use?</td>
<td>1</td>
</tr>
<tr>
<td>E  Do you reach for your electronic device as soon as you wake up (Eye-opener)?</td>
<td>1</td>
</tr>
</tbody>
</table>

Used to identify very high users of electronic devices (2 or more points) who may be targeted for additional help with prevention of distraction from electronic device use in OR.

• Survey study, 647 respondents
• Anesthesiology Core Program Directors listserver: CRNAs, residents, anesthesiologists

## Modified CAGE (m-CAGE) Questionnaire

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</table>

Used to identify very high users of electronic devices (2 or more points) who may be targeted for additional help with prevention of distraction from electronic device use in OR.

- Survey study, 647 respondents
- Anesthesiology Core Program Directors listserver: CRNAs, residents, anesthesiologists
- 21% of respondents reported at least two risks on the modified CAGE questionnaire

Hypovigilance Due to Monotony
Hypovigilance Due to Monotony
THE BREAKDOWN OF VIGILANCE DURING PROLONGED VISUAL SEARCH

BY

N. H. MACKWORTH

(From the Medical Research Council Applied Psychology Research Unit, Cambridge)

I. Introduction (pp. 6-7). II. Method, Procedure and Subjects (pp. 7-11). III. Results (pp. 11-17). IV. Discussion (pp. 17-20). V. Summary (p. 20). VI. Acknowledgments (p. 20). VII. References (p. 21).
Hypovigilance Due to Monotony

Driving performance impairments due to hypovigilance on monotonous roads

Grégoire S. Larue\textsuperscript{a,4}, Andry Rakotonirainy\textsuperscript{a}, Anthony N. Pettitt\textsuperscript{b}

\textsuperscript{a} Centre for Accident Research and Road Safety - Queensland, Queensland University of Technology, 130 Victoria Park Road, Kelvin Grove 4059, Queensland, Australia
\textsuperscript{b} School of Mathematical Sciences, Queensland University of Technology, Gardens Point, Brisbane 4000, Queensland, Australia

- 25 adults, average age 29
- Driving at constant speed, in one lane, without having to stop
- 4 driving scenarios, each lasting 40 minutes
Hypovigilance Due to Monotony

Scenario 1

Scenario 2

Scenario 3

Scenario 4

* The curves are identical
Hypovigilance Due to Monotony

At the end, drivers spent 25% of 1 sec epochs in microsleep!
Driving monotonous routes in a train simulator: the effect of task demand on driving performance and subjective experience

Naomi Dunn* and Ann Williamson

School of Aviation, University of New South Wales, Sydney 2052, Australia

• 56 adults
• Driver group: train conductors paid by employer
• Control group: volunteers (not train conductors)
• Low demand group: Speed = 70
• High demand group: Speed = 53 + 17

Figure 1. Screen shot from high demand condition.

Decreased Performance Due to Monotony

• Low Demand Group:
  – More errors controlling speed overall
  – Spent more time traveling at wrong speed

• Performance worst at the end of the simulation

Figure 6. Mean number of errors per block for drivers and controls compared across the low and high demand conditions (error bars = ±1 SE).

Breaking Monotony
Disrupting monotony while increasing demand: benefits of rest and intervening tasks on vigilance

Brandon C. W. Ralph¹ · Kris Onderwater¹ · David R. Thomson¹ · Daniel Smilek¹

Psychological Research (2017) 81:432–444
DOI 10.1007/s00426-016-0752-7

Ralph, B. et. al. Disrupting monotony while increasing demand- benefits of rest and intervening tasks on vigilance. Psychological Research (2017) 81:432–444
**Effects of Intraoperative Reading on Vigilance and Workload during Anesthesia Care in an Academic Medical Center**

Jason M. Slagle, Ph.D., * Matthew B. Weinger, M.D.,†

- 172 general anesthetics, 45min to 6hr duration, ASA 3 or less, 1998-2002
- Wide case mix; no cardiac, thoracic or OB cases
- Reading observed by trained observer in 60 cases
- Subjects were residents, CRNAs, fellows and faculty
## Effects of Intraoperative Reading on Vigilance and Workload during Anesthesia Care in an Academic Medical Center

### Table 4. Workload Ratings and Vigilance During Maintenance

<table>
<thead>
<tr>
<th></th>
<th>Reading Cases</th>
<th>Non-Reading Cases</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Reading Periods</td>
<td>Non-Reading Periods</td>
</tr>
<tr>
<td></td>
<td>Mean ± SD Range</td>
<td>Mean ± SD Range</td>
</tr>
<tr>
<td>Observer workload §§</td>
<td>7.64 ± 0.77 7–11</td>
<td>8.61 ± 1.14 7–14</td>
</tr>
<tr>
<td>Participant workload §§</td>
<td>7.92 ± 1.08 7–12</td>
<td>8.86 ± 1.49 7–15</td>
</tr>
<tr>
<td>Workload density §§</td>
<td>0.66 ± 0.33 0.01–1.86</td>
<td>1.21 ± 0.13 0.8–21.42</td>
</tr>
<tr>
<td>Vigilance latency §‡</td>
<td>27.93 ± 38.12 1–207</td>
<td>29.42 ± 44.33 1–506</td>
</tr>
</tbody>
</table>

*Psychological workload rated on 6–20 scale. †Workload density is normalized. ‡Vigilance light response is in seconds. § All data are presented as mean ± SD. ||Significantly different from Reading Periods, P < 0.001, after Bonferroni correction.

Slagle, J., Weinger, M. Effects of Intraoperative Reading on Vigilance and Workload during Anesthesia Care in an Academic Medical Center. Anesthesiology 2009; 110:275–83
Intraoperative Non–Record-keeping Usage of Anesthesia Information Management System Workstations and Associated Hemodynamic Variability and Aberrancies

David B. Wax, M.D.,* Hung-Mo Lin, Sc.D.,* David L. Reich, M.D.†

• Retrospective audit of 1,061 cases in 2010
• Mostly general and gyne cases
  – Median EBL = 50cc
  – Rare hemodynamic aberrancies
• Residents, CRNAs and faculty
• 24% of cases were solo faculty
• Median of 16% of the procedure time was used in non-recordkeeping activity

Intraoperative Non–Record-keeping Usage of Anesthesia Information Management System Workstations and Associated Hemodynamic Variability and Aberrancies

David B. Wax, M.D.,* Hung-Mo Lin, Sc.D.,* David L. Reich, M.D.†

• No differences in hypertension (MAP > 120 mmHg), hypotension (MAP < 60), tachycardia (HR > 100) between recordkeeping and non-recordkeeping periods

Prevalence of Potentially Distracting Noncare Activities and Their Effects on Vigilance, Workload, and Nonroutine Events during Anesthesia Care

Jason M. Slagle, Ph.D., Eric S. Porterfield, M.S., M.S.N., R.N., F.N.P.-B.C., Amanda N. Lorinc, M.D., David Afshartous, Ph.D., Matthew S. Shotwell, Ph.D., Matthew B. Weinger, M.D.

- 319 general anesthetics, 45min to 6hr duration, ASA 3 or less, 2007-2009
- Wide case mix; no OB cases
- Distractions found in 171 cases by trained observer
- Subjects were residents, CRNAs, SRNAs
Breaking Monotony

Prevalence of Potentially Distracting Noncare Activities and Their Effects on Vigilance, Workload, and Nonroutine Events during Anesthesia Care

Jason M. Slagle, Ph.D., Eric S. Porterfield, M.S., M.S.N., R.N., F.N.P.-B.C., Amanda N. Lorinc, M.D., David Afshartous, Ph.D., Matthew S. Shotwell, Ph.D., Matthew B. Weinger, M.D.
### Table 6. Three Cases Where Reported Nonroutine Events Were Deemed to Have Associated Self-induced Distractions

<table>
<thead>
<tr>
<th>Surgical Procedure</th>
<th>Phase when NRE Occurred</th>
<th>Distraction Related to NRE?</th>
<th>Reviewers’ Annotative Comments (Distraction in <em>Italic</em> Font)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Varicose vein stripping/repair</td>
<td>Maintenance</td>
<td>Definitely related</td>
<td>Patient heart rate drops to 42 beats/min, pressure 100/54. Resident <em>drawing up drugs for next case</em>. Rate drops to 38 beats/min. Alarm threshold triggered but electrocardiogram alarm is off. Resident <em>looking at next patient on EHR</em>. Pulse alarm goes off and gets resident’s attention, attending physician calls simultaneously into room. Resident gives ephedrine <em>while talking to attending physician on phone</em>, blood pressure is 81/44.</td>
</tr>
<tr>
<td>Bilateral neurostimulator lead replacement</td>
<td>Maintenance</td>
<td>Definitely related</td>
<td>Preinduction 116/64 and heart rate 82 beats/min. Attending physician, who is doing patient charting and <em>checking pager and then checking day planner just prior</em>, notices low blood pressure (71/38) and bradycardia (47 beats/min) during cycle and decreased desflurane. Treats with 100 μg phenylephrine. No alarm. Cuff fails next auto-cycle.</td>
</tr>
<tr>
<td>Laryngoscopy with injection</td>
<td>Maintenance</td>
<td>Definitely related</td>
<td>Patient desaturates to 81% during surgery. Surgeon inserts endotracheal tube and certified registered nurse anesthetist easily bags patient to 100%. <em>CRNA on phone on case-unrelated matter</em> while actively intervening.</td>
</tr>
</tbody>
</table>

*EHR = electronic health record.*
• Cell phone use affects activities that require concentration and vigilance.

• Personal electronic devices and intraoperative internet use may potentially distract a clinician from patient care.

• The literature, however, is limited on the effect of personal electronic device use and intraoperative clinical performance.
A jury is a group of one’s peers that are sworn to give a verdict in a legal matter based on the testimony presented at trial.
Lawyer: Do you routinely play games on your phone while managing anesthetic care?

Anesthesiologist: No.

L: Do you surf the Internet?

A: No.

L: Ever?
A: Well, depending on your definition of surf. I do not spend an extended period of time accessing the Internet. I have logged on to the Internet before especially if — specifically if I have a question about the patient's medications, about the procedure, yes, we'll often, you know, do a search and find out information pertaining to the case. I will occasionally check e-mail. I will occasionally check scheduling for the office. But in general, no, I — the time spent on the Internet during a case is, you know, very brief, a couple, three minutes.

L: Do you post on Facebook while you're managing anesthetic?

A: No.

L: Do you think that would be an unsafe thing to do?
A: To post on Facebook, would it be unsafe? It wouldn't be recommended.

L: Why not?

A: Well, because you're supposed to be monitoring the patient. You wouldn't want to be spending time in extraneous activities that were not related to patient care. Is it possible to do so safely? Yes, because we have ways of monitoring the patient. But I don't do that.

L: You never do that?

A: Post on Facebook during a case?

L: (Nods head up and down.)
[The attorney introduces posts from the anesthesiologists Facebook page.]

L: Can you read the highlighted portion?


L: Can you read it?

A: "After enduring the shittiest Friday I've had in a while, I just found out my next patient has lice. Freakin lice. I didn't even know they still made those. Help."

L: So I think you told me earlier it would be inappropriate to post something on Facebook about your patients.

A: Yes, I did. I was — the point of it was the lice, but yes.
L: As at the corporate representative for [the company he works for], do you approve or disapprove of your decision to make that posting?

A: I disapprove. I would discourage it.

L: Are you going to implement some policies to help yourself not make these postings in the future?

A: Yes. I will never do it again.
[The anesthesiologist is shown another exhibit containing one of his Facebook posts.]
L: Can you read the highlighted portion?


L: And what is the photograph of?

A: An anesthesia monitor.

L: Is that anesthesia monitor hooked up to a patient?

A: Yes.
L: Now, I think you told me earlier that you never post on Facebook while you're doing anesthesia — while you're managing anesthesia.

A: Not to my recollection.

L: Well, clearly you do post on Facebook sometimes when you're managing anesthesia because you were managing anesthesia at that moment.

A: Well, not necessarily because I took the picture but that doesn't mean I posted it at that time, because you can take a picture and then go to your pictures and then upload it onto Facebook after —
L: Okay. So —

A: — wards.

L: — where it says "just sitting here watching the tube on Christmas morning," you are clearly referring to the fact that you have to be doing an anes — managing an anesthetic procedure on Christmas morning and you're watching the anesthetic monitor, fair?

A: Uh-huh.

L: So obviously —

A: Yes.
Leaving a bad impression

- Lawsuits involving allegations and evidence of distractions in the OR have led to:
  - Suspension of medical privileges
  - State medical board sanctions
  - Loss of employment
  - Negative media coverage

- More a matter of the **impression** left with the jury than quality of care

Distractions in the Operating Room: A Case Study

The following case highlights some of the significant challenges in detecting anesthesia providers in litigation involving allegations and evidence of distractions in the OR.

The case involved a 33-year-old male with medical history significant for atrial fibrillation and smoking who presented for an elective cardiac catheterization and ablation under general anesthesia. The anesthesia provider performed the pre-anesthesia examination and assigned the patient an ASA II classification.

Shortly after the induction of anesthesia and placement of the endotracheal tube (ETT), the cardiologist performed a transesophageal echocardiogram (TEE) that revealed an ejection fraction of 40-45%. Four minutes into the procedure, the patient's systolic blood pressure dropped into the 80s. The anesthesia provider administered 10 mg of ephedrine, but the blood pressure stayed in the 80s, and the pulse rate was up to 180 beats per minute (bpm). The anesthesia provider informed the cardiologist about the changes in vital signs, but the cardiologist indicated that he was not concerned about the heart rate because he was trying to locate the source of the atrial fibrillation, and there were no signs of ischemia on the EKG.

The anesthesia provider supported the blood pressure with phenylephrine 1IV in 300 mcg boluses. He informed the cardiologist of his treatment, and the cardiologist of was aware of the events due to the monitors in front of him. The anesthesia provider also lowered the anesthetic inhalational agent (sevoflurane) and gave fluid to maintain blood pressure. The blood pressure was labile and required multiple interventions throughout the case.

The patient's systolic blood pressure dropped into the 60s within two minutes. The anesthesia provider decided to begin a low-dose dopamine infusion to help control the blood pressure, and he notified the cardiologist of his actions. Once he initiated the dopamine infusion, the systolic blood pressure stabilized in the 80s. About 45 minutes later, the blood pressure dropped again, and the anesthesia provider increased the dopamine infusion and the phenylephrine boluses, at which point the systolic pressure rose to 118. He continued to communicate his treatment choices to the cardiologist throughout the procedure. Although the cardiologist was aware of the volatile shifts in the blood pressure, the anesthesia provider believed that he was not concerned because he continued with the ablation procedure.

Approximately 15 minutes after the systolic pressure had risen to 118, it again dropped into the 80s. Phenylephrine administration only assisted in bringing it up for a few minutes, and then it dropped into the 80s and would not increase in response to medications. The EKG showed that the patient's heart was generating electrical impulses, but it became clear that his heart was not beating, and he was experiencing pulseless electrical activity (PEA).

A Code was called and the cardiologist suspected the patient was experiencing a cardiac arrest. Multiple attempts to perform resuscitation were unsuccessful. Another cardiologist arrived to assist and was able to drain 450 to 600 mL of fluid from the pericardial sac. The heart rate was restored and the patient was transferred to ICU. Unfortunately, the patient never recovered from the Code and was eventually taken off the ventilation and passed away.

The patient's wife and son sued the anesthesia provider, the cardiologist, and the hospital. The patient's family alleged the anesthesia provider failed to recommend that the cardiologist stop the procedure due to the hemodynamic instability caused by the hypotension, properly evaluate the cause of the hypotension that persisted for over two hours prior to the cardiac arrest, and maintain an acceptable blood pressure. The patient's family alleged further that the anesthesia provider's negligence contributed to the cardiac arrest resulting in hypoxic ischemic brain injury and death.

Defense experts retained on behalf of the anesthesia provider were supportive of his care. The anesthesiology expert believed that the anesthesia provider's treatment of the hypotension met the standard of care, and he appropriately communicated the patient's changing vital and hemodynamic status to the cardiologist throughout the case. Further, he opined that the anesthesia provider does not have a duty or even an ability to stop the procedure as that decision is up to the cardiologist.

Despite the supportive expert witness, during discovery several nurses present in the OR testified the anesthesia provider was texting and reading articles on the internet throughout the entire case and even during the Code. The anesthesia provider's mobile phone records, however, confirmed the anesthesia provider did not receive or send a text during the procedure. In deposition testimony, the anesthesia provider acknowledged he was looking at emails on his mobile phone during the procedure. The Internet log for the computer in the cardiac catheter lab confirmed that the anesthesia provider was accessing the Internet at various times during the procedure. He last accessed the Internet approximately eight minutes before the Code started. While there was no specific evidence the anesthesia provider was on the Internet during the Code, there was electronic evidence that the anesthesia provider was reading news stories on Yahoo and accessing his personal email account during the procedure.

Based on this evidence, defense counsel opined a jury would likely react very negatively to evidence that the anesthesia provider was accessing the Internet and his personal email in the cardiac catheter lab just moments before the Code. In the face of testimony from multiple nurses that the anesthesia provider was using a mobile phone throughout the procedure, and even during the Code, defense counsel was concerned PPM would be unlikely to persuasively defend the anesthesia provider given this potentially inflammatory testimony.

Based on defense counsel's evaluation, the anesthesia provider consented to settlement. The parties participated in mediation, and the case was settled within the insurance policy limits.
The case involved a 53-year-old male with medical history significant for atrial fibrillation and smoking who presented for an elective cardiac atrial fibrillation ablation under general anesthesia.
Distractions in the Operating Room: A Case Study

“OR Distractions,” From Preceding Page

The following case highlights some of the significant challenges in defending anesthesia providers in litigation involving allegations and evidence of distractions in the OR.

The case involved a 33-year-old male with medical history significant for atrial fibrillation and smoking who presented for an elective cardiac ablation procedure under general anesthesia. The anesthesia provider performed the pre-anesthesia examination and assigned the patient an ASA II classification.

Shortly after the induction of anesthesia and placement of the endotracheal tube, the cardiologist performed a transesophageal echocardiogram (TEE) that revealed an ejection fraction of 40-45%. Four minutes into the procedure, the patient’s systolic blood pressure dropped into the 80s. The anesthesia provider administered 10 mg of phenylephrine and told the cardiologist that he was not concerned about the drop in blood pressure as long as it did not increase in response to medications. The cardiologist agreed and indicated that he would not increase the dose of phenylephrine further.

Approximately 15 minutes after the systolic blood pressure had risen to 110, it again dropped to the 80s. Phenylephrine administration was increased to 20 mg and then to 30 mg. Despite this increase, the blood pressure remained in the 80s and would not increase in response to additional doses of phenylephrine.

The anesthesia provider was present in the OR, and the cardiologist was also present. The anesthesia provider informed the cardiologist that he was not concerned about the drop in blood pressure as long as it did not increase in response to medications. The cardiologist agreed and indicated that he would not increase the dose of phenylephrine further.

A Code was called, and the cardiologist suspected the patient was experiencing a cardiac event. The anesthesia provider reported that the patient’s hemodynamic response to the Code was consistent with the expected response to a cardiac event.

The patient’s systolic blood pressure dropped into the 60s over the next 2 hours. The anesthesia provider decided to begin a low-dose dopamine infusion to help maintain the blood pressure, and he notified the cardiologist of his actions. Once the dopamine infusion was started, the systolic blood pressure stabilized in the 60s. About 45 minutes later, the blood pressure dropped again and the anesthesia provider increased the dopamine infusion and the phenylephrine boluses, which increased the patient’s blood pressure to 110. The cardiologist continued to monitor the patient’s hemodynamic response to the procedure.

The cardiologist was aware that the patient’s blood pressure was not increasing in response to the dopamine and phenylephrine infusions. He continued to monitor the patient’s hemodynamic response to the procedure.

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Four minutes into the procedure, the patient’s systolic blood pressure dropped into the 80s.
The anesthesiology expert believed that the anesthesia provider’s treatment of the hypotension met the standard of care, and he appropriately communicated the patient’s changing vital and hemodynamic status to the cardiologist throughout the case. Further, he opined that the anesthesia provider does not have a duty or an ability to stop the procedure as that decision is up to the cardiologist.

Despite the supportive expert witness, during the...
...the systolic pressure... again dropped... and it would not increase in response to medications. ... it became clear... he was experiencing pulseless electrical activity (PEA).
A code was called and the cardiologist suspected the patient was experiencing cardiac tamponade *[as a result of his procedure]*. Multiple attempts to perform pericardiocentesis were unsuccessful. Another cardiologist arrived and was able to drain... the pericardial sac ... Unfortunately, the patient never recovered...
The anesthesiology expert believed that the anesthesia provider’s treatment of hypotension met the standard of care, and he appropriately communicated the patient’s hemodynamic status to the cardiologist throughout the case…
...during discovery several nurses present in the OR testified the anesthesia provider was texting and reading articles on the Internet throughout the entire case and even during the Code.
In deposition testimony, the anesthesia provider acknowledged he was looking at emails on his mobile phone during the procedure. The Internet log for the computer…confirmed the anesthesia provider…last accessed the Internet approximately eight minutes before the Code started.
[Because] a jury would likely react very negatively to [this] evidence...the anesthesia provider consented to settlement.
Surgeon sued for talking on cell phone during an operation

by SkepticalScalpel | Dec 28, 2017 | 7 comments

“A surgeon took a Spanish language proficiency test while performing varicose vein surgery on a 70-year-old woman...”
Digital Footprints

• Over 70% of major U.S. corporations record employee communications and activities, including Internet browsing history at work.
  – Monitoring can be “centralized,” in that Internet related activities can be recorded by monitoring servers.

• Internet browsing history may also be stored remotely and associated with your personal account.

Internet Browsing History

- Visited [Preeclampsia Toolkit | California Maternal Quality Care Collaborative](http://cmqcc.org)
- Visited [California Maternal Quality Care Collaborative](http://cmqcc.org)
- Visited [Individual Blood Pressure | Galileo](http://aspirecqi.org)
Internet Browsing History

Google My Activity

Bundle view
- 4 items

Item view
- 7:26 PM

Delete activity by
- Other Google activity
- Activity controls
- My Account
- Help
- Send Feedback
- 10 items

Delete activity by
- Other Google activity
- Activity controls
- My Account
- Help
- Send Feedback
- 10 items

Viewed
- google.com
  - Said Money Pit Rotten Tomatoes
  - Said butter Rotten Tomatoes
- youtube.com
  - Watched The Raising of The Costa Concordia

www.google.com

Department of Anesthesiology
Welcome to the Google Privacy Policy

For legal reasons

We will share personal information with companies, organizations or individuals outside of Google if we have a good-faith belief that access, use, preservation or disclosure of the information is reasonably necessary to:

- meet any applicable law, regulation, legal process or enforceable governmental request.
- enforce applicable Terms of Service, including investigation of potential violations.
- detect, prevent, or otherwise address fraud, security or technical issues.
- protect against harm to the rights, property or safety of Google, our users or the public as required or permitted by law.

Things you and others do and provide.

- Information and content you provide. We collect the content, communications and other information you provide when you use our Products, including when you sign up for an account, create or share content, and message or communicate with others. This can include information in or about the content you provide (like metadata), such as the location of a photo or the date a file was created. It can also include what you see through features we provide, such as our camera, so we can do things like suggest masks and filters that you might like, or give you tips on using camera formats. Our systems automatically process content and communications you and others provide to analyze context and what's in them for the purposes described below. Learn more about how you can control who can see the things you share.

- Data with special protections. You can choose to provide information in your Facebook profile fields or Life Events about your religious views, political views, who you are “interested in,” or your health. This and other information (such as racial or ethnic origin, philosophical beliefs or trade union membership) could be subject to special protections under the laws of your country.

- Networks and connections. We collect information about the people, Pages, accounts, hashtags and groups you are connected to and how you interact with them across our Products, such as people you communicate with the most or groups you are part of. We also collect contact information if you choose to upload, sync or import it from a device (such as an address book or call log or SMS log history), which we use for things like helping you and others find people you may know and for the other purposes listed below.

- Your usage. We collect information about how you use our Products, such as the types of content you view or engage with, the features you use, the actions you take, the people or accounts you interact with, and the time, frequency and duration of your activities. For example, we log when you’re using and have last used our Products, and what posts, videos and other content you view on our Products. We also collect information about how you use features like our camera.
How do we respond to legal requests or prevent harm?

We access, preserve and share your information with regulators, law enforcement or others:

- In response to a legal request (like a search warrant, court order or subpoena) if we have a good faith belief that the law requires us to do so. This may include responding to legal requests from jurisdictions outside of the United States when we have a good-faith belief that the response is required by law in that jurisdiction, affects users in that jurisdiction, and is consistent with internationally recognized standards.

- When we have a good-faith belief it is necessary to: detect, prevent and address fraud, unauthorized use of the Products, violations of our terms or policies, or other harmful or illegal activity; to protect ourselves (including our rights, property or Products), you or others, including as part of investigations or regulatory inquiries; or to prevent death or imminent bodily harm. For example, if relevant, we provide information to and receive information from third-party partners about the reliability of your account to prevent fraud, abuse and other harmful activity on and off our Products.

Information we receive about you (including financial transaction data related to purchases made with Facebook) can be accessed and preserved for an extended period when it is the subject of a legal request or obligation, governmental investigation, or investigations of possible violations of our terms or policies, or otherwise to prevent harm. We also retain information from accounts disabled for terms violations for at least a year to prevent repeat abuse or other term violations.

https://www.facebook.com/about/privacy/
Cell Phone Data

- All major carriers store call details
- Some store text message content
- Most retain billing records

## Cell Phone Data

The date and time corresponds to Pacific Time (PST/PDT).

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“Anything you say (or do electronically) may be used against you…”

- Electronic communications are protected by the Federal Stored Communications Act (SCA)
- However, witness testimony has led courts to compel disclosure of electronic records
  - Morano v. Slattery Skanska Inc.
  - Detraglia v. Grant
- Private communications usually protected by the SCA may still be discoverable if you produce the information yourself.

846 N.Y.S.2d 881 (N.Y. Sup. 2007).
https://www.americanbar.org/content/dam/aba/administrative/litigation/materials/aba-annual-2013/written_materials/15_1_social_media_evidence.authcheckdam.pdf
“Anything you say (or do electronically) may be used against you…”
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<td>1. Please provide copies of all instant messaging logs or transcripts associated with any accounts identified in response to Interrogatory No. ___.</td>
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<tr>
<td>2. Please provide copies of any contributions you have made to any online forum or Website or online service associated with any accounts identified in response to Interrogatory No. ___.</td>
</tr>
<tr>
<td>3. Please provide copies of any Documents or electronically stored information you have created and/or stored using any third party online service provider, including, but not limited to, Google+, MySpace, Facebook, Twitter, Meetup.com, Orkut, Flickr, Gather.com, Tumblr, Windows Live Spaces, MSN Spaces, LinkedIn, Monster.com, CareerBuilder.com, blogs, or wikis, associated with any accounts identified in response to Interrogatory No. ___.</td>
</tr>
<tr>
<td>4. Please provide an electronic copy of your complete Facebook history, including any and all profile information, postings, pictures, and data available pursuant to Facebook’s &quot;Download Your Own Information&quot; feature.</td>
</tr>
<tr>
<td>5. For each Facebook account maintained by you, please produce your account data for the period of ______ through present. You may download and print your Facebook data by logging onto your Facebook account, selecting “Account Settings” under the “Account” tab on your homepage, clicking on the “learn more” link beside the “Download Your Information” tab, and following the directions on the “Download Your Information” page. [from Held v. Ferrellgas, Inc., Case No. 2:10-cv-2393-EFM-GLR (D. Kan.)]</td>
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Parties to litigation may satisfy party and non-party discovery requirements relating to their Facebook accounts by producing and authenticating the content of communications from their accounts and by using Facebook’s "Download Your Information" tool, which is accessible through the Settings drop down menu.

4. Please provide an electronic copy of your complete Facebook history, including any and all profile information, postings, pictures, and data available pursuant to Facebook’s "Download Your Own Information" feature.
“Anything you say (or do electronically) may be used to HELP you…”

- Electronic footprints can also be used to demonstrate usage of the device for direct patient benefit:
  - Medical references
  - Getting advice from a colleague

• Institutional policies have the potential to guide healthcare providers
• Many medical organizations and societies have developed suggestions and recommendations
Institutional Policy

- How do you decide what is acceptable?
  - Internet use
    - Medicine related
      - Patient – current case or to follow
      - General
    - Non-medicine related – vacation, retirement, social media
  - Email
  - Personal cell phone
    - Calls
      - Personal
      - Work related
Institutional Policy

APSF Newsletter February 2017

- Implement a “sterile cockpit” “no interruption zone” protocol during critical phases of procedures
- Eliminate all discretionary sources of noise during “sterile” periods
- Limit personal telephone calls and text messages to urgent or emergent situations
- Forward cell phone calls and transmissions to voice mail or memory

• Personal electronic devices and intraoperative internet use may potentially distract a clinician from patient care.

• Even though the effect of personal electronic device use on intraoperative clinical performance is up for debate, the judgement of your case is left to a jury.

• Anything you say or do (electronically) may be used against you.

• We need to start thinking carefully about how we use personal electronic devices in the operating room.
• Thank you!