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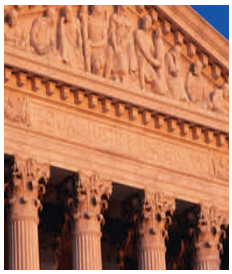

Florida Supreme Court prohibits physician discussions with attorneys

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Case Summary:

This involved a medical malpractice action by Ramsey Hasan (Ramsey Hasan, v. Lanny Garvar, D.M.D., et all, Respondents. No. SC10-1361–December 2012) against his dentist, Lanny Garvar, D.M.D., and his dental practice, alleging he failed to diagnose and treat dental issues and a bone infection, resulting in significant damages. As a result of these issues, Hasan presented to an oral and maxillofacial surgeon, Jennifer Schaumberg, D.M.D. for continued care. Schaumberg was not a party to this legal action.

Both Garvar and Schaumberg were insured by OMSNIC, which had also retained two separate attorneys to represent each. When scheduling depositions, Hasan discovered that Schaumberg was to have a private pre-deposition conference with her attorney. Hasan moved for a protective order to stop this conference, which the trial court denied, as did the Fourth District Court of Appeal, stating that a trial court order kept Schaumberg from discussing medical information regarding Hasan, and because she was meeting with her own attorney and not the attorney representing Garvar.

Hasan argues that such a pre-deposition conference violates 456.057(8), Florida Statutes (2009) which provides for physician-patient confidentiality and prohibits the non-party physician from speaking to her attorney about Hasan. Garvar argues that 456.057 does not prohibit this type of conference, and further argues that not allowing this type of conference violates the doctor's common law right to counsel and protections under the First Amendment.

Allegation:

Ex-parte conference between a nonparty treating physician and an attorney selected and hired by the defendant's insurance company violates the protection afforded by Florida's physician-patient confidentiality statute as delineated under 456.057 (8), Florida Statutes (2009) leaving the patient without protection from disclosure of information.

Analysis:

On December 20, 2012, the Supreme Court of Florida found that 456.057(8), Florida Statutes (2009) prohibits a non-party physician from discussing patient information with an attorney hired by that physician's insurance company, citing the statute in part:

> Except in a medical negligence action or administrative proceeding when a health care practitioner or provider is or reasonably expects to be named as a defendant, information disclosed to a health care practitioner by a patient in the course of the care and treatment of such patient is confidential and may be disclosed only to other health care practitioners and providers involved in the care or treatment of the patient, or if permitted by written authorization from the patient or

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> compelled by subpoena at a deposition, evidentiary hearing, or trial for which proper notice has been given.

Invoking the plain meaning of the statute, the Supreme Court references whether the physician reasonably expects to be named as a defendant but does not define or further elaborate how that determination is to be made. Nevertheless, it is to be construed narrowly with the primary purpose of the statute always being to protect physician-patient privileges.

The Supreme Court goes even further to state that, "meetings between a nonparty treating physician and ***outsiders*** to the patient-health care provider relationship are not permitted…even with the representations as to the content of the meeting…" (emphasis added). This includes counsel hired by the physician's insurer. They opined that if they held otherwise, insurance companies would seek to hire counsel and circumvent the protection provided by the statute. "Consequently, we hold that section 456.057 prohibits ex parte meetings between a patient's nonparty treating physician and counsel provided by the defendant's insurance company…"

The Supreme Court also cites *Hannon* v. *Roper*, 945 So. 2d 534 (Fla. 1st DCA 2006) wherein the insurer of a non-party physician retained an attorney to represent him for purposes of a deposition. The Supreme Court agreed with the First District Court of Appeal that 456.057 prohibited such communication, in part because the non-party physician did not expect to be named as a defendant. In *Dannemann v. Shands Teaching Hospital & Clinics, Inc.*, 2009 WL 1272330 (Fla. 1st DCA 2009) the First District Court of Appeal again dealt with an insurer hiring counsel for a non-party physician. The First DCA reiterated its findings in *Hannon* finding that the statute prohibited this type of communication.

With respect to arguments that this is a violation of the non-party physician's First Amendment rights, the court found this to be an appropriate balance between the rights of the patient and those of the physician, finding that the physician may discuss protected patient health information with their attorney once they become a party to the action. They make no mention however, of the common law right to counsel, other than to imply that counsel is not necessary as in each of these examples it is a non-party physician who appears to have no fear of litigation.

Further, in this case, it was argued that Schaumberg should be able to speak with her attorney outside of a deposition about legal issues unrelated to the care and treatment, for example, how to appropriately answer deposition questions, the right to refuse to answer questions, etc. The Supreme Court stated that this would, "foster an environment conducive to inadvertent disclosures of privileged information," and these efforts are, "impermissible."

Conclusion:

In a 5-2 decision, the Florida Supreme Court held that Florida Statute 456.057(8) prohibits exparte meetings between nonparty treating physicians and others outside the confidential relationship whether or not they intend to discuss privileged or non-privileged matters without measures to absolutely protect the patient and the privilege. Notably, the dissent stated that, "The practicing

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physicians and the lawyers of Florida deserve more respect as professionals who are faithful to their oaths of ethical conduct."

On April 2, 2013, the Senate Rules Committee approved Senate Bill 1792 that seeks, in part, to guarantee treating healthcare providers that are not parties to the legal action the right to consult with an attorney. The bill passed by a vote of 12-3 and is currently before the Senate.

Conflict in the health care workplace

MICHAEL A. E. RAMSAY, MD

"Reprinted with permission from *Baylor University Medical Center Proceedings* (2001;14:138-139)"

Managing conflict in the workplace is a time-consuming but necessary task for the physician leader. Conflicts may exist between physicians, between physicians and staff, and between the staff or the health care team and the patient or patient's family. The conflicts may range from disagreements to major controversies that may lead to litigation or violence. Conflicts have an adverse effect on productivity, morale, and patient care. They may result in high employee turnover and certainly limit staff contributions and impede efficiency.

Litigation is now readily available for those who feel that they are working in a hostile work environment. The hostile environment may be the result of abusive behavior by other employees, supervisors, or physicians. The abuse may take the form of a demeaning attitude, ridicule, off-color jokes, sexual harassment, or even physical violence. Societies have significantly decreased their tolerance of disruptive behavior. A group or organization can now hold vicarious liability for condoning a hostile work environment if it fails to act when a complaint is made.

DISRUPTIVE PHYSICIANS

Physicians, both male and female, often have hard-driving, type A personalities and little training in interpersonal skills. They may have high IQs but lack emotional intelligence. In the past, physicians were revered as charismatic people who could do no wrong; now they are seen as one part of the health care team. Temper outbursts—with throwing of instruments and loud profanity directed at any unfortunate person who happens to be near at hand—are no longer tolerated. Nurses and technicians have the right to be treated with respect, and they know it.

The dysfunctional physician presents an insidious cost to any practice or health care organization. He or she increases the stress in the work environment and the accompanying loss of efficiency. In a stressful workplace, such as the operating room with a berating physician, morale and team spirit suffer, which results in an increased turnover of staff and a dysfunctional team. Once this stage is reached, various negative factors begin to interplay. Communication is poor, and staff withhold information because of fear of an outburst. The information withheld may be vital for patient well-being. The physician loses staff support and may become isolated. If the problem is severe, retaliation may occur, and this may take many forms: failure to properly assist, the initiation of lawsuits, the support of the plaintiff in a malpractice suit against the physician, or even malicious sabotage of the practice.

Once this dysfunctional behavior pattern is recognized, an intervention should be made. This action is necessary not only for patient safety but also because lack of action could be interpreted by the courts as negligent or as condoning a hostile work environment. When a confrontation is necessary, a team approach should be used, and if possible, a

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member of the team should be a close acquaintance of the individual, setting up a "good cop–bad cop" scenario. If only one person is involved, the physician may view the intervention as a personal confrontation instead of a peer-related issue. Specific incidents should be documented, and the focus should be on behavior, not personality. Empathy should be expressed but change must be demanded, with a delineation of the consequences if behavior is not improved. The communication should be direct and clear, with the subject not given an opportunity to respond until the end of the dissertation. In this manner, a potential indignant response is often overwhelmed by the data and the presence of peers, and the physician will respond positively to the guidance given or help offered. The goal is to correct the situation and allow the highly trained physician to perform to an optimal degree. Those participating in the confrontation should look for the good in any situation. In this way, the good can be built on, and a positive outcome becomes more likely.

The competent leader will be able to handle difficult people and tense situations with diplomacy and tact. If possible, a win-win solution should be looked for, where the physician sees the advantage to his practice and patient care if resolution can be obtained. However, individuals who have a destructive effect on the workforce should be asked to leave before they cause harm.

PREVENTION OF CONFLICT

To prevent conflicts, a professional code of conduct should be established, not only in the hospital but also as part of group practice policies and medical staff bylaws. Ground rules make it easier to discipline, as they take personality out of the equation. A disciplinary structure should be developed, so that the mechanisms and the referral pattern to higher authority are well understood. General knowledge of this discipline pathway can often facilitate resolution at a lower level. Everyone needs to understand that there are firm limits on inappropriate behavior.

Understanding how conflicts arise is important in their prevention. From an employee's perspective, triggers include lack of communication, colleagues who don't pull their weight, unfair criticism, silly rules, preferential treatment, sexism or racial inequality, being put down, unreasonable expectations, and verbal abuse. On the management side, problems arise from poor communication, inappropriate responses, poor prioritizing, personal work interfering with professional work, and clock-watching.

Pitfalls that leaders should be careful to avoid include taking people for granted, failing to keep promises, failing to take responsibility for one's own errors, and failing to practice what one preaches. The key to survival as a leader is to develop emotional intelligence and to engender it in the work environment.

EMOTIONAL INTELLIGENCE

Emotional intelligence has been recognized as necessary not only to be a successful leader but also to be successful in life. A high mental intelligence quotient revolves around a narrow band of linguistic and mathematical skills, whereas emotional intelligence involves self-awareness, management of emotions, empathy, "people skills," and motivation.

The development of interpersonal intelligence allows understanding of other people—what makes them "tick," what motivates them, and how to work with them. This not only enables leaders to "get inside the other person's head," it lets them understand and recognize their own emotions, making control of those emotions easier. If emotional control is lost, smart people become stupid.

Anger is the most difficult mood to control; it can be energizing, exhilarating, and even seductive. It

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fuels itself and eventually becomes rage. Rage is a state beyond reason that revolves around revenge and reprisal, with no concern for the consequences and with minimal cognition. Early intervention provides the best chance of successfully defusing the angry situation. A cooling-off period may actually exacerbate the anger. Leaders should stay cool, avoid direct accusation, be good listeners, and repeat the argument in their own words to demonstrate that they are trying to understand the problem. Asking a meaningful question can be a powerful distraction. However, if all is lost, the leader should leave and return another day. Out-of-control emotions can paralyze cognitive function.

VIOLENCE IN THE WORKPLACE

The workplace is becoming more violent as people are unable to handle the stresses of life. Over 1 million workers are assaulted each year in the US workplace, and the health care industry is no exception to this frightening statistic. Violent incidences have been reported between physicians, as the changing pattern of medical practice creates enormous stress on both work and family. If the warning signs are not heeded, disastrous consequences can occur. Similarly, interactions with families of very sick patients can turn physical as emotions overcome rational thought.

The signs of impending violence include verbal threats, profanity, belligerence, and intimidating statements. Threats should always be taken very seriously. Physical signals of a violent confrontation are the gripping of fists, agitated movement, speaking through clenched teeth, and a paranoid stare. The leader should try to defuse the situation by being nonthreatening and by taking verbal control: using a calm, controlled voice, he or she should be very clear and respectful. The leader should take a nonaggressive posture—by not cornering the individual or getting into his or her "space," by allowing a buffer zone to exist, and by always staying at least an arm's length plus 1" distance! The leader should ensure that no objects that could be used as weapons are readily available. When a threatening situation appears to be developing, the leader should take it very seriously and summon help. Potentially vulnerable work areas should have a security evaluation. Access to certain areas should be controlled, particularly at night, so that the staff can feel safe. A protocol should be set in place that can be readily activated if a potentially violent situation arises. The safety of the staff must be a major concern of all administrative leaders.

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The Team Concept: Who's Got Your Back?

Jan Rebstock, RHIT, LHRM, CPHRM

Do you feel part of a cohesive, tight knit healthcare team who routinely looks out for each other's back? You may respond with an unequivocal "yes" or you may be thinking team dynamics could be a whole lot better. Certainly there are many who have participated in interdisciplinary team training sessions over the years and agree with the concept in theory but perhaps haven't seen much of an improvement in teamwork as a result of the training.

The concept of a team is very broad; it is something that exists anytime a group of people work together for a common purpose. Simply working with a team, however, doesn't necessarily equate to working "as a team." The Business Directory definition of team is a very good one and states "a team becomes more than just a collection of people when a strong sense of mutual commitment creates synergy, thus generating performance greater than the sum of the performance of its individual members." So how does one develop, achieve and sustain this synergy?

Hospitals are a good forum to apply principles of teamwork in an effort to improve patient safety as performance under pressure is routine in many areas. Over the past several years, attention has been given to how components of aviation's Crew Resource Management Model (CRM) could be applied in the health care setting. Perhaps best known, is the application of CRM training skills in the operating room which studies have shown resulted in improved team cooperation and patient outcomes. Components of the CRM model include routine briefings, standard operating procedures and checklists with a key component being the recognition that every member of the team brings a valuable set of skills and knowledge to the group. In order for everyone to feel comfortable in speaking up, the hierarchy is flattened and encouragement given for everyone to speak up, as well as listen to, what everyone has to say. In other words, egos are checked at the door.

One evidence-based tool that has gained traction over the past few years is TeamSTEPPS (Team Strategies and Tools to Enhance Performance and Patient Safety). The development of this toolkit, which you can order online, was a collaborative effort between the Department of Defense and the Agency for Healthcare Research and Quality (AHRQ). This project was designed for healthcare facilities and providers to help improve and develop a culture of patient safety through enhanced communication and other teamwork skills. It is a formalized approach to integrating the principles of teamwork in phases that address core competencies of team leadership, situational awareness, mutual support and communication.

There are many factors making teamwork an essential element of patient safety; the complex nature and specialization of the delivery of health care, increasing patient co-morbidities, workforce shortages and safe working hour initiatives. Dr. Paul Schyve, who is a senior advisor with the Joint Commission, has observed: "Our challenge…is not whether we will deliver care in teams but rather

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how well we will deliver care in teams."

In looking at various team training models or toolkits, there are several common essential characteristics consistent with effective health care teams and these include:

1. *A defined common purpose that includes collective interests and shared ownership.*
2. *Measurable goals that are focused on the team's task.*
3. *Effective leadership that maintains a supportive structure, manages conflict, fosters trust and support and encourages all team members to speak freely.*
4. *Effective communication that assures adequate, accurate and timely sharing of information among staff and between staff and patients.*
5. *Cohesive team spirit and commitment.*
6. *Mutual respect and appreciation of each other's talents and professional contributions.*

When it comes to being a team player, actions speak louder than words. One doesn't have to look far to find opportunities to help other team members when workloads are heavy. Being flexible, dependable, a good listener, and supportive of your team builds trust and good working alliances. It's a good feeling knowing that someone's got your back when you need it.

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