Safe Harbor Immunity: the Right Prescription for Providers’ 'Bad Law' Claims and Hyper-Risk-Averseness?

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ASLME Health Law Professors Conference
Chicago, IL  ●  June 10, 2011
Bad law
Education
Carrots + Sticks
Safe harbors
Safe harbor

“low risk”

conduct
Ex ante defined

AKS, Stark (e.g. FMV)

TX informed consent

EBM - CPG
Process defined

HCQIA

Negligent selection / retention
Safe harbor
“worthwhile”
conduct
EMT

Good Samaritan

Crisis standards of care
Good faith: UHCDA UAGA

Mandatory reporting

Conscientious objection

Lethal injection
Safe harbor
blatant
protectionism
Statutes of repose
Many more
Defensive Medicine
I order some tests or consultations simply to avoid the appearance of malpractice.

I feel pressured in my day-to-day practice by the threat of malpractice litigation.
<table>
<thead>
<tr>
<th>Action</th>
<th>% ordered for defensive reasons</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospital admissions</td>
<td>13.0%</td>
</tr>
<tr>
<td>Lab tests</td>
<td>17.9%</td>
</tr>
<tr>
<td>X-rays</td>
<td>21.9%</td>
</tr>
<tr>
<td>Ultrasound studies</td>
<td>24.0%</td>
</tr>
<tr>
<td>MRI studies</td>
<td>27.4%</td>
</tr>
<tr>
<td>CT scans</td>
<td>27.6%</td>
</tr>
<tr>
<td>Specialty referrals</td>
<td>28.4%</td>
</tr>
<tr>
<td>Factor</td>
<td>Extremely or Very Important</td>
</tr>
<tr>
<td>-------------------------------------------------</td>
<td>----------------------------</td>
</tr>
<tr>
<td>Patient’s prognosis</td>
<td>98.5</td>
</tr>
<tr>
<td>What was best for the patient overall</td>
<td>98.1</td>
</tr>
<tr>
<td>Respecting the patient as a person</td>
<td>96.6</td>
</tr>
<tr>
<td>Patient’s pain and suffering</td>
<td>94.6</td>
</tr>
<tr>
<td>What the patient would have wanted you to do</td>
<td>81.8</td>
</tr>
<tr>
<td>Providing the standard of care</td>
<td>81.5</td>
</tr>
<tr>
<td>Respecting the wishes of the family or surrogate(s)</td>
<td>80.9</td>
</tr>
<tr>
<td>Following the law</td>
<td>68.6</td>
</tr>
<tr>
<td>The burden on the family</td>
<td>44.8</td>
</tr>
<tr>
<td>Religious beliefs of the patient</td>
<td>35.3</td>
</tr>
<tr>
<td>Religious beliefs of the family or surrogate(s)</td>
<td>28.6</td>
</tr>
<tr>
<td>Cost to society of caring for the patient</td>
<td>14.2</td>
</tr>
<tr>
<td>Physician’s religious beliefs</td>
<td>10.7</td>
</tr>
<tr>
<td>Concerns about paying for medical care</td>
<td>9.3</td>
</tr>
<tr>
<td>Concern that the surrogate(s) might sue</td>
<td>8.4</td>
</tr>
</tbody>
</table>
Defensive medicine < Offensive medicine
Significant cost

Significant quality & safety
Medical Futility
Perceptions of “futile care” among caregivers in intensive care units

“Why they follow the instructions of SDMs instead of doing what they feel is appropriate, almost all cited a lack of legal support.”
“Remove the __, and I will sue you.”
Resolution 505-08

TITLE: LEGAL SUPPORT FOR NONBENEFICIAL TREATMENT DECISIONS

Author: H Hugh Vincent, MD; William Andereck, MD

Introduced by: District 8 Delegation

Endorsed by: District 8 Delegation

Reference Committee

October 4-6, 2008

This resolution constitutes a proposal for consideration by the California Medical Association House of Delegates and does not represent official CMA policy.

WHEREAS, it is still common for physicians who feel non-beneficial or futile treatments are being provided or considered to feel threatened by legal action by the patient’s family or other surrogates, and thus continue to provide such care against their best medical judgment; and
WASHINGTON STATE MEDICAL ASSOCIATION
HOUSE OF DELEGATES

Resolution: C-5
(A-09)

Subject: Legal Protection for Physicians When Treatment is Considered Futile

Introduced by: King County Medical Society Delegation

Referred to: Reference Committee C

WASHINGTON STATE MEDICAL ASSOCIATION
HOUSE OF DELEGATES

Resolution: A-2
(A-10)

Subject: WSMA Opinion on Medical Futility in End-of-Life Care

Introduced by: Shane Macaulay, MD, Delegate
WSMA Board of Trustees

Referred to: Reference Committee A
RESOLUTION 1 - 2004
(Read about the action taken on this resolution)

Subject: Futility of Care

Introduced by: Michael Katzoff, MD and the Medical Society of Milwaukee County

Resolved, That the Wisconsin Medical Society, concurrent with a recommendation of the American Medical Association, Medical Futility in End-of-Life Care policy E-2.037, supports the passage of state legislation which establishes a legally sanctioned extra-judicial process for resolving disputes regarding futile care, modeled after the Texas Advanced Directives Act of 1999.
Medical Futility
Medicine Law & Ethics

Thursday, October 21, 2010
7:30 am - 12:45 pm
Education & Resource Center (ERC)
Hartford Hospital, Heublien Hall
Cal. Prob. Code 4740

A . . . provider . . . acting in good faith . . . is not subject to . . . liability or to discipline . . . .
A . . . provider . . . may decline to comply with . . . decision that requires . . . health care contrary to generally accepted . . . standards . . . .
Model

1 of 2
TEXAS
The Lone Star State
You may stop LSMT for any reason - if your hospital ethics committee agrees.
Treatment conflict

Result worthy of respect
Corrupt
Biased
Careless
Arbitrary
NEW YORK
EMPIRE STATE
ALBANY
Model 2 of 2
Consent and Capacity Board
HEC as process-defined safe harbor

Minimum required

Workability
Safe harbors

Taxonomy

Essential attributes