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# Note: The New York "Good Samaritan Act"

# NOTES AND COMMENTS

## NOTE: THE NEW YORK "GOOD SAMARITAN ACT"

*But a certain Samaritan . . . bound up his wounds.*[1]

Good Samaritan legislation, a generic term for any law limiting the liability of a volunteer who renders medical assistance at the scene of an accident or emergency, has recently been the focal point of considerable debate.[2] Since the enactment of the first such law by the California Legislature in 1959,[3] thirty other states have followed course.[4] New York became the most recent by amending Section 6513 of the Education Law[5] to provide that, effective September 1, 1964, any duly licensed physician or surgeon who voluntarily renders first aid or emergency treatment at the scene of an accident shall not be liable for damages for injury or death by reason of any act or omission unless gross negligence is established.[6] The necessity of such legislation, the reasons for its enactment and the probability of its success comprise the subject of this note.

### *Common-law Liability*

At common law there was no duty to come to the aid of a person in peril.[7] However, if an individual attempted to render assistance he was held to the standard of care which a reasonable man would exercise under the circumstances.[8] This basic distinction, the immunity from suit for nonfeasance as contrasted with the civil liability for misfeasance, is a fundamental principle of the law of torts.[9] Thus, "the good Samaritan may find himself liable where those who passed by on the other side will not."[10] Apparently, the continually increasing number of malpractice suits and the fear of such litigation against them by strangers have prompted many physicians to "pass by on the other side." The object of Good Samaritan legislation is the elimination of such fear on the part of the physician and the encouragement of such emergency treatment.[11]

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[1] *Luke* 10:33-34.

[2] See, *e.g.*, Comment, 15 MERCER L. REV. 477 (1964); Note, 1964 WIS. L. REV. 494.

[3] CAL. BUS. & PROF. CODE § 2144.

[4] Note, 13 DE PAUL L. REV. 297 (1964). In addition to the twenty-eight states herein cited, Louisiana and Delaware have also enacted such legislation.

[5] N.Y. EDUC. LAW § 6513(10).

[6] The statute also specifically provides that the accident or emergency must occur "outside of a hospital, doctor's office, or any other place having proper and necessary medical equipment," and that the physician must provide the services "without the expectation of monetary compensation." *Ibid.*

[7] RESTATEMENT, TORTS § 314 (1938).

[8] *Id.* § 324(a).

[9] The exceptions to this rule are those cases in which the courts have found a special relationship between the parties such as master-servant, landlord-tenant, and common carrier-passenger. PROSSER, TORTS § 54 at 334-35 (2d ed. 1955).

[10] *Id.* § 38 at 186.

[11] "Frequently persons receive no emergency care when needed, because persons licensed to practice the healing arts or render services ancillary there-

*Frequency of Malpractice Actions*

Is the fear of a malpractice action in an emergency situation actual or, rather, does it exist merely in the psyche of the physician? The number of malpractice actions has generally increased;[12] 17.8 per cent of all physicians now practicing have been involved in malpractice actions as compared to 14.1 per cent in 1956.[13] "There can be no doubt that physicians are often reluctant to volunteer emergency care, because of the possibility of a legal action against them by a total stranger."[14] The results of a poll conducted by the *Medical Tribune* demonstrated that fifty per cent of all doctors interviewed said they would *not* render assistance to an accident victim lying in the road, citing fear of legal reprisals as their reason.[15] Yet, there is not a single appellate court case in which a physician has been found guilty of malpractice as a result of aid rendered at the scene of an emergency.[16]

There is the inherent possibility of a malpractice action whenever a physician acts in his professional capacity. The elements of a malpractice action are identical to those of any civil negligence action, viz., duty, breach, proximate cause, and damages.[17] The establishing of a breach of duty is the prospective plaintiff's most formidable task. In the law of negligence, "duty" refers to a legal obligation to conform to a particular standard of care under the circumstances.[18] In the case of a physician, the particular standard to which he is held must conform to that degree of care exercised by other doctors practicing in the same locality[19] or community.[20] The key to the requirement of duty can be found in the phrase "under the circumstances." In an emergency, a volunteer "cannot be held to the same conduct as one who has had an opportunity to reflect, even though it later appears that he made the wrong decision,"[21] since the greater the emergency, the less time there is for reflection. A mere error of judgment is not negligence[22] and for such error no liability will

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to at the scene of an accident or emergency are fearful their actions taken in good faith to care for the injured person might subsequently subject them to civil suit. The purpose of this bill is to encourage the rendering of aid to injured persons at the scene of an accident or emergency without fear of civil liability." Introductory Statement, N.J. Sess. Laws 1963, ch. 140.

[12] "The real danger . . . is the huge number of professional liability claims and suits which are not justly founded. It is this situation which causes a doctor on occasion to be overly conscious of litigation. . . ." 152 N.Y.L.J., Sept. 25, 1964, p. 4, col. 3.

[13] Law Department, AMA, *First Results: 1963 Professional-Liability Survey,* 189 A.M.A.J. 859 (1964).

[14] STETLER & MORITZ, DOCTOR AND PATIENT AND THE LAW 334 (4th ed. 1962).

[15] Newsweek, Sept. 4, 1961, p. 41.

[16] Note, 51 CALIF. L. REV. 816, 817 (1963); Note, *supra* note 2, at 498. Apparently the reason for the enactment of the first Good Samaritan statute in California was a single incident of a woman left unattended on a ski slope even though physicians were in the area. Kearney, *Why Doctors Are "Bad" Samaritans,* Reader's Digest, May 1963, p. 89.

[17] PROSSER, *op. cit. supra* note 9, § 35.

[18] *Id.* § 36.

[19] Hanson v. Thelan, 42 N.D. 617, 173 N.W. 457 (1919).

[20] Sinz v. Owens, 205 P.2d 3, 5-6 (Cal. Sup. Ct. 1949).

[21] PROSSER, *op. cit. supra* note 9, § 32 at 137; RESTATEMENT, TORTS § 296 (1938).

[22] Pike v. Honsinger, 155 N.Y. 201, 210, 49 N.E. 760, 762 (1898).

accrue.[23] In any event, to be held liable the physician must actually compound the injury.[24] Thus, at common law, the standard of care required of the physician may be so minimal under the circumstances that proof of a breach of duty will be difficult, if not impossible; correspondingly, the possibility of a successful malpractice action seems remote.[25]

Moreover, it is quite difficult for the plaintiff to obtain the expert testimony required in a malpractice action because most doctors are reluctant to so testify.[26] The common belief that there is a great number of malpractice claims against "Good Samaritan" physicians is not supported by the facts. The amount of protection afforded the physician at common law, due in part to the difficulty of establishing a breach of duty, is reflected by the absence of reported cases. It seems reasonable to conclude, therefore, that this marked absence shows the alleged fears of the physician to be without substantial merit.

*Malpractice Insurance*

The increasing number of general malpractice claims has resulted in a concurrent expansion in the use of malpractice insurance. On a nationwide basis, 94.3 per cent of all physicians have such insurance;[27] of these, 78.1 per cent maintain coverage of 50,000 dollars or more, with the majority (57.7 per cent) being covered to the extent of 50,000 to 100,000 dollars.[28] The cost of such insurance is not excessive[29] and, in any event, it is passed on to the patient through higher medical bills.[30] Since the risk has been shifted from the individual physician to the insurance carrier, the physician does not fail to respond in emergencies because of a fear of monetary liability.

It would seem that this increase in insurance coverage would decrease the number of *reported* claims, and perhaps camouflage those instances in which a physician has been negligent at the scene of an accident. It is to the advantage of all three parties, viz., the injured, the doctor and the insurer, to reach an out-of-court settlement. The claimant benefits in that he is not faced with the arduous task of proving a breach of a duty. The advantage to the physician is dual: (1) there is no adverse publicity from litigation, and (2) he need

[23] Linn v. Piersol, 37 Cal. App. 171, 173, 173 Pac. 763, 764 (1918).

[24] United States v. De Vane, 306 F.2d 182 (5th Cir. 1962).

[25] "Nor do I entertain any doubt but that the courts of the State, in such an action, would take into consideration all of the attendant circumstances and would not permit the unfair treatment of a physician who had responded to such an emergency." Message of Governor Otto Kerner, vetoing Ill. House Bill 1489 (Good Samaritan Bill), Aug. 26, 1963.

[26] "In most cases there are several choices of treatment available, and therefore for one doctor, with the benefit of hindsight, to brand the work of another as malpractice is often beyond the pale of good conscience." 152 N.Y.L.J., Sept. 25, 1964, p. 4, col. 1.

[27] Law Department, *supra* note 13, at 862.

[28] *Id.* at 863.

[29] "According to the Physicians', Surgeons', and Dentists' Professional Liability Manual . . . physicians may obtain coverage of $100,000 per claim and $300,000 in the aggregate for a one year period for a premium ranging from approximately $50 to $200, depending on the services provided by the physician." Note, 41 NEB. L. REV. 609, 614 n.27 (1962).

[30] There is a direct correlation between those states which have the most malpractice suits and those states in which physicians charge the highest fees. De Noyer, *The Doctor's Dilemma,* Traffic Safety, Feb. 1963, p. 8, 10.

not fear the remote possibility of an adverse decision. The insurance company benefits since, if the plaintiff reaches a jury, there is the possibility of a substantial judgment.

However, under most policies the physician must agree to the settlement and

> it has been observed time and again . . . that unless the case against the doctor is so overwhelming that he has no possible defense, he and his insurance carrier are prone to go through with a trial of the case because of the possible implication, if the case is settled, of the possible admission thereby that the dector [*sic*] did something wrong professionally in the care and treatment of the patient-claimant.[31]

*Constitutional Objections*

The New York "Good Samaritan Act" is in derogation of the common law to the extent that it deprives an injured victim of his common-law action in negligence against the physician. The standard of ordinary care has been replaced by a minimum standard immunizing the physician from liability for all but gross negligence. Because of this deprivation the statute is open to constitutional attack—as a general rule, a legislature is prohibited from abolishing a common-law remedy for injury to person or property.[32] However, "the Constitution does not forbid the creation of new rights, or the abolition of old ones recognized by the common law, to attain a permissible legislative object."[33]

Any action by a state in limiting liability must be justified under the concept of the police power. The test applied to the exercise of such power in order to determine its validity is the relationship between its effect on society and the burden imposed on the individual.[34] In regard to the "Good Samaritan Act," its basic intent is to encourage physicians to give assistance where they formerly would not. If this objective is not accomplished, the legal detriment imposed on an individual who is harmed by a negligent physician would surely outweigh any benefit to society.[35]

Certainly there is a "rational tendency to promote the safety . . . and general welfare of the public."[36] Since the act on its face is neither arbitrary, capricious nor unreasonable,[37] its constitutional validity will depend primarily on its effectiveness in motivating the physician, formerly hesitant because of the fear of legal action, to render assistance.[38] Consequently, if there is no substantial increase in assistance by physicians, the statute may be unconstitutional in that it merely deprives the victim

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[31] 152 N.Y.L.J., Oct. 2, 1964, p. 4, col. 3.

[32] Gibbes v. Zimmerman, 290 U.S. 326, 332 (1933). However, there are exceptions to this rule; for example, New York has abolished the actions of seduction, alienation of affections, and breach of promise to marry.

[33] Silver v. Silver, 280 U.S. 117, 122 (1929); therein the Court upheld the constitutionality of an automobile guest statute.

[34] Miller v. Schoene, 376 U.S. 272, 279-80 (1928).

[35] This should in no way be interpreted as an indorsement of all Good Samaritan legislation. Many problems arise under (1) those statutes which provide protection for other than physicians, and (2) those which make no provision for excluding gross negligence.

[36] Opinion of the Justices, 79 N.E.2d 883, 887 (Mass. 1948).

[37] There remains the possibility that Good Samaritan legislation "may be construed to be class legislation and thus in violation of the special privileges and immunities provisions of many state constitutions." STETLER & MORITZ, *op. cit. supra* note 14, at 335.

[38] "The police power may be exerted . . . only when such legislation bears a real and substantial relation to the public health, safety, morals or some other phase of the general welfare." Liggett Co. v. Baldridge, 278 U.S. 105, 111-12 (1928).

of a remedy with no perceptible contrasting benefit to society.

The question then arises as to the specific effect of the New York statute. As has been demonstrated, the purpose of the act is not to limit the liability of physicians, but rather to increase the possibility of their responding in emergency situations. Yet, whether a doctor will voluntarily become a Good Samaritan or, rather, continue to "pass by on the other side," remains extremely doubtful.

The physician or surgeon appearing at the scene of an accident or emergency is now faced with a perplexing problem. On the one hand, does the statute afford him sufficient protection as to eliminate the fear of legal retribution? On the other hand, is he morally obligated to stop?[39] The apparent effect of the "Good Samaritan Act" will be to so limit the liability of the physician as to make the possibility of a *successful* malpractice action quite remote. In reality, it may very well be that the physician does not fear the successful action as much as he fears the inception of *any* action.[40] Since virtually all physicians carry malpractice insurance, it would seem fair to hypothesize that they do not fear the personal financial liability, but rather the notoriety and ill will engendered by any litigation. As the statute does not eliminate the liability of the physician in the case of gross negligence a factual determination will often have to be made by a jury as to whether the acts of the physician were of such magnitude. Therefore, whether the standard is one of gross negligence or ordinary negligence, this fear of the physician will not be alleviated. The mere fact that the plaintiff will have even less chance of recovering will not eliminate the apprehension and corresponding failure to render emergency aid on the part of the physician.

In addition, a preliminary survey by the Legal Department of the American Medical Association indicates that physicians are not more likely to respond in emergency situations in those states which have enacted Good Samaritan legislation.[41] In replying to the query "does fear of a claim make you unwilling to furnish emergency medical care, away from your office or hospital, to a stranger injured in an accident or stricken with a sudden illness?," fifty per cent of all physicians answered "yes."[42] In those states which had not enacted Good Samaritan laws, 52.3 per cent said "yes," while in those states which had such laws, 48.5 per cent answered affirmatively.[43] These statistics indicate that the legislative goals have not been accomplished since the laws have not been effective in encouraging physicians to render assistance. Thus it is possible to conclude that the protection from liability afforded the physician by the statute will not substantially increase the possibility of his responding in an emergency situation.

[39] "If the present trend continues and if a physician must become increasingly apprehensive of legal suits, his own aggressive instinct will inevitably, in some measure, overcome his humanitarian and professional motivations." 152 N.Y.L.J., Sept. 25, 1964, p. 4, col. 3.

[40] "There is no more humiliating and terrifying ordeal for the professional man than the ordeal of a trial in which he must defend his professional competence and reputation, even though he does so successfully." *Id.* at col. 4.

[41] Law Department, AMA, *First Results: 1963 Professional-Liability Survey*, 189 A.M.A.J. 859, 865 (1964).

[42] *Ibid.*

[43] *Ibid.*

*Other Objections and Alternatives*

It has been suggested that in order to encourage assistance in emergency situations the legislature should impose an affirmative duty to render aid, rather than eliminate the physician's liability.[44] The concept of an affirmative duty is not completely foreign to the law of negligence; many states already impose a duty upon those involved in automobile accidents to render aid to the injured.[45] As early as 1908 it was suggested that "one who fails to interfere to save another from impending death or great bodily harm, when he might do so with little or no inconvenience to himself . . . shall be punished criminally and shall make compensation to the party injured. . . ."[46] However, such a rule would seem impractical from the standpoint of enforcibility. In most cases it would be impossible to factually determine whether someone did "pass by on the other side."

Moreover, such an obligation would not fall within the traditional concept of duty:

> The expression 'duty' properly imports a determinate person to whom the obligation is owing as well as the one who owes that obligation. There must be two determinate parties before the relationship of obligor and obligee of a duty can exist.[47]

However, this concept may be in the process of modification. In denying summary judgment the court in *Wilmington Gen. Hosp. v. Manlove*[48] declared that the liability of a hospital may be predicated on its refusal to render aid in the case of an unmistakable emergency. The plaintiff had taken his infant to the emergency ward of a private hospital. The hospital refused to treat the child on the ground that he was at the time under the care of a physician. Shortly thereafter the child died. The court rejected the principle that a private hospital could choose its patients and stated that a hospital may be liable if negligence in not recognizing an emergency may be established. It is not inconceivable that in the future the courts may determine that a physician, because of his special position in society, does in fact owe an affirmative duty to assist injured members of that society.

We should not fail to realize, however, that in the moral realm an affirmative duty to act on the part of the physician may already exist. The physician is bound by the Hippocratic Oath to render medical aid to his fellow man. Also, he is ethically bound by the Principles of Medical Ethics: "A physician may choose whom he will serve. In an emergency, however, he should render assistance to the best of his ability."[49] The physician who is already ethically bound by the precepts of his professional oath and by the tenets of his own American Medical Association has nevertheless failed to respond. It is doubtful whether the immunity granted by the statute will be more successful in encouraging the physician to respond. Furthermore, the stature of the physician in the public eye is not enhanced by the enforcement of an ethical obligation through the elimination of a legal one.

One may question the wisdom of a stat-

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[44] See generally Ames, *Law and Morals*, 22 HARV. L. REV. 97 (1908).

[45] *E.g.*, ILL. ANN. STAT. ch. 95½, § 135 (1958); MICH. STAT. ANN. § 9.2319 (1957); TEX. PEN. CODE art. 1150 (1961).

[46] Ames, *supra* note 44, at 113.

[47] 1 STREET, FOUNDATIONS OF LEGAL LIABILITY 94 (1906).

[48] 174 A.2d 135, 140 (Del. 1961).

[49] AMA Principles of Medical Ethics § 5.

ute which exempts from liability for negligence the one group which is trained to react in an emergency.[50] If the intent of the legislature was to encourage aid, why did it not extend the aegis of the statute to everyone? Of course, those opposing such a pervasive statute would argue that it is only the physician who should react and that in many instances no treatment at all is preferable to improper assistance rendered by a layman. The fact remains, however, that physicians trained to react and under a moral and ethical duty to respond are given preference over the non-physician who does respond with only the best intentions.

> The essential unfairness of this type of statute [limited to physicians] can be appreciated when it is considered that any private citizen untrained in first aid, who volunteers in an emergency may be held legally accountable for his actions, as may a nurse who is less trained than the physician. But, the doctor, who is the only one fully trained to render emergency care, would be the very one rendered immune by this Bill from the consequences of his negligent acts.[51]

### *Conclusion*

Theoretically, there can be no question that the major benefit of the "Good Samaritan Act" will inure to the injured party who, but for the enactment of such legislation, would go unaided. But what of the concededly atypical situation wherein the injured party is treated incompetently by a physician who negligently compounds the injury? Who can better bear the risk—the injured party who now has no recourse to the courts for compensation, or the physician fully protected by liability insurance? [52]

One can see the many factors militating in opposition to Good Samaritan legislation:

(1) the high degree of improbability of a successful malpractice action, as evidenced by the lack of reported cases;

(2) the shifting burden of liability as a result of malpractice insurance;

(3) the possible constitutional deficiency;

(4) the fact that such statutes have had little effect in other states; and

(5) the other moral and ethical pressures already operating on the physician.

These must be carefully weighed against the concern of a legislature to ensure the safety of its citizens. Certainly, a statute which encourages even one physician to render assistance where he normally would not because of fear of legal action cannot be completely without merit.

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[50] Norman Welch, former president of the American Medical Association, has stated: "I subscribe wholeheartedly to the principle that doctors in common with other people should be held responsible for damages due to their own acts of negligence." 152 N.Y.L.J., Sept. 24, 1964, p. 4, col. 3. It should be noted that this comment was made within the context of an argument against *absolute* liability for doctors.

[51] Message of Governor Otto Kerner, vetoing Ill. House Bill 1489 (Good Samaritan Bill), Aug. 26, 1963.

[52] "Facing the facts, it must be remembered that there are cases of actual malpractice in which a patient suffers injury as a result of accidents or carelessness or ignorance on the part of the physician. It has never been, nor will it ever become, our purpose to try to avoid responsibility for the physician in these cases. The persons injured as a result of such accidents or inefficiency have a right to be and should be compensated. That is why physicians carry professional liability insurance. It is one of the obvious results and dangers involved in the admittedly hazardous job of practicing medicine." 152 N.Y.L.J., Sept. 25, 1964, p. 4, col. 2.