Editorial

Negligent Samaritans Are No Good

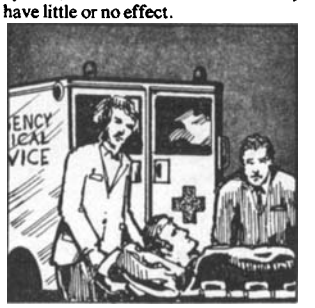
By George J. Annas, J.D., M.P.H.*

In the lead article attorney Miles Zaremski argues that ambiguities in good samaritan statutes have made them ineffective, and suggests that they be appropriately amended and clarified. This is one possible approach. However, after almost two decades of experimenting with this type of immunity legislation, an experiment which Zaremski seems to indicate has failed, it is worth considering at least two other alternatives: (1) repeal all good samaritan statutes; or (2) amend them to *require* health care professionals to stop and render emergency aid (the stated goal of good samaritan statutes).

Each deserves at least brief comment. While stopping short of recommending repeal, the *Report of the Secretary's Commission on Medical Malpractice* (HEW, 1973) concluded that "the legal risks in rendering emergency medical care to accident victims in non-health-care-settings are minimal, if not infinitesimal." The Commission adopted as one of its official findings the conclusion that "there is no factual basis for the commonly-asserted belief that malpractice suits are likely to stem from rendering emergency care at the scene of accidents." It recommended "widespread publicity be given to this fact in order to allay the fears of physicians, nurses, and other health-care providers in this regard and to encourage the rendering of aid in non-hospital emergency situations."[1]

This strategy has apparently either not been adopted or not succeeded. One of the reasons for failure is continuing concern, like that expressed by Zaremski, over the specific coverage of good samaritan statutes. Many health professionals are likely to assume that if state legislatures believe such statutes are necessary to protect them, they probably are, and therefore, if their wording is unsatisfactory, the statute itself could actually deter them from rendering emergency assistance. If this is true, good samaritan statutes may have caused more problems than they have solved for both the accident victim and his potential helper.

Nor is an acceptably-worded statute always an incentive. A survey was conducted in 1963, at the height of the lobbying effort for good samaritan statutes, by the legal department of the American Medical Association. Physicians were asked whether they were willing to stop to render aid to the victims of roadside accidents. Almost exactly 50 percent responded that they would not render such care, whether or not a good samaritan statute was in effect.[2] Also, while I know of no studies on this, it is likely that most competent practitioners feel little need to be protected from a negligence charge, and these statutes may only serve to bolster the confidence of the marginal or poorly-trained practitioner. A poorly-worded statute will discourage emergency care, and a well-worded statute may have little or no effect.



More recent moves are in the direction of requiring professionals to practice according to professional standards, rather than granting them immunity for practicing negligently. The American Medical Association's Judicial Council, for example, has recommended rephrasing the Ethical Canon on acceptance for treatment to read: "Physicians may choose whom they will serve *except in emergencies*" (added words emphasized). Adopting this ethical mandate as a legal standard, the Massachusetts Board of Registration and Discipline in Medicine promulgated a regulation in late 1977 requiring all physicians in the Commonwealth to stop and render aid to the best of their ability in an emergency situation. The regulation reads in part:

> A licensee shall render medical services to a person experiencing a medical emergency. A medical emergency is a set of circumstances which immediately threatens a person's life or is likely to cause serious injury absent the provision of immediate professional assistance. A licensee shall assume that a person who is referred to him by another licensee for the purpose of securing medical services of an emergency nature is experiencing a medical emergency.[3]

This regulation was suggested and supported by the Massachusetts Medical Society. I hope this will be the trend.[4] Immunity legislation is unnecessary and often counter-productive. Negligent samaritans are no good, and "good" samaritans don't need legislative immunity.

However, since such legislation now exists in one form or another in every state, choices must be made. The two most sensible options are to repeal the statutes based upon a legislative finding that good samaritans run almost no risk of suit and that statutes immunizing good faith emergency medical care providers are unnecessary; or to amend the statutes to not only meet the objections of Zaremski, but also to *require* professionals granted limited immunity to stop and render emergency assistance. Good samaritan legislation is a misadventure which has protected neither victim nor rescuer. It's time for another approach.

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References

1. *Report of the Secretary's Commission on Medical Malpractice*, H.E.W., DHEW Pub. No. (OS) 73-88, 1973, at 16.
2. *Id.*
3. Massachusetts Regulations Governing the Practice of Medicine, sec. 9 (Oct. 20, 1977).
4. Some wish to go even further, for discussion, *see* Annas, G. J., *Beyond the Good Samaritan: Should Doctors be Required to Provide Essential Services?*, HASTINGS CENTER REPORT 8(2): 16 (April 1978).